State of New Mexico
Human Services Department

Draft Section 1115 Medicaid Demonstration Waiver Renewal Request

to

Centers for Medicare & Medicaid Services (CMS)
US Department of Health and Human Services

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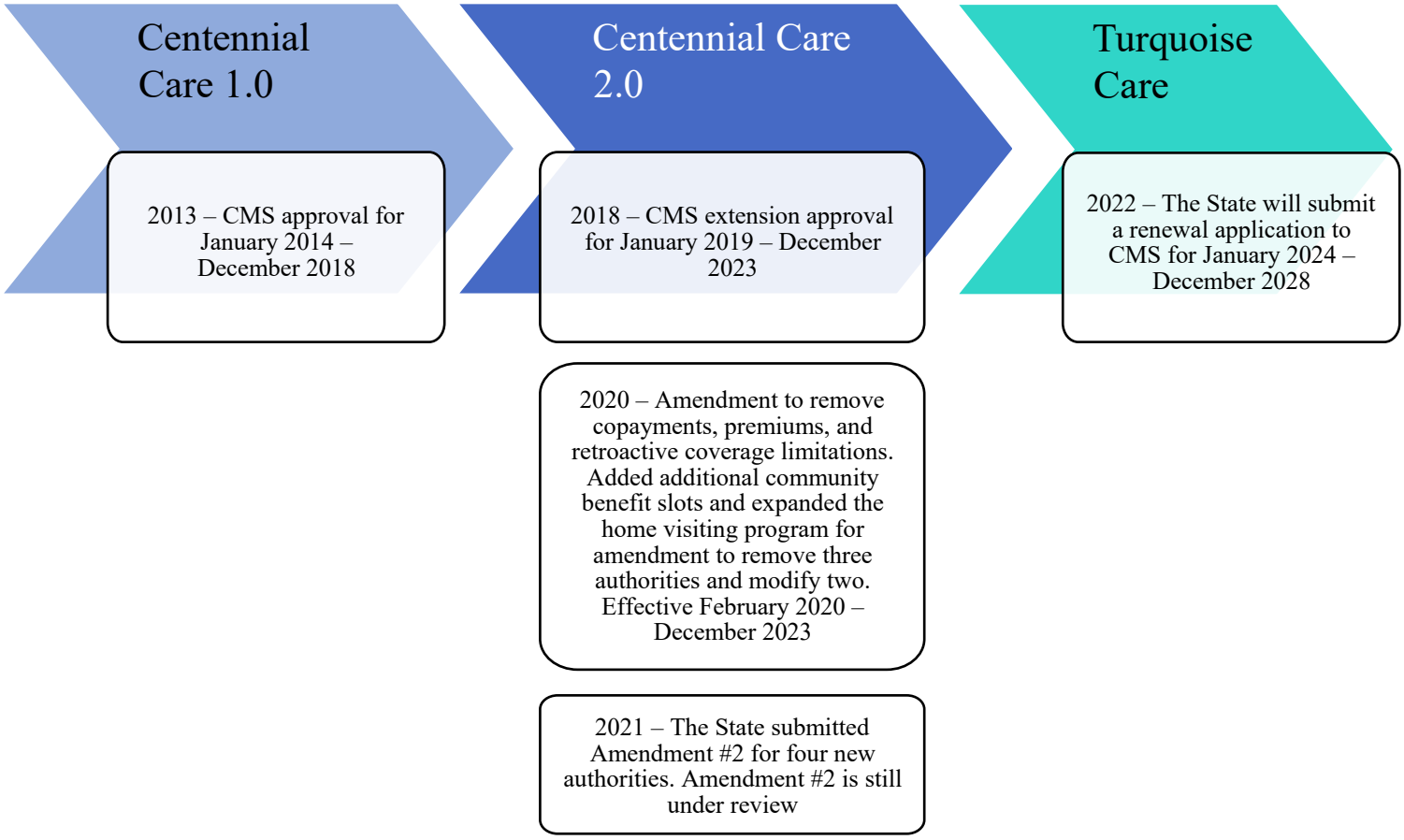
Section I: Introduction

The State of New Mexico (the State) primarily operates its Medicaid and Children's Health Insurance Program (CHIP) under a federal 1115 demonstration waiver authorized by the federal Centers for Medicare & Medicaid Services (CMS). Referred to as Centennial Care since 2014, the demonstration authorizes the comprehensive managed care delivery system, the home and community-based services (HCBS) Community Benefit (CB) program, and several transformative pilot initiatives that serve most of the State's Medicaid and CHIP beneficiaries. Building upon the strong foundation created by Centennial Care, the State is seeking a demonstration extension through this renewal application to CMS with an effective date of January 1, 2024 (the current demonstration period expires on December 31, 2023). The renewal period will hereafter be referred by the demonstration's new name: **Turquoise Care**. The chart below provides a timeline of the demonstration's current and planned milestones.

Figure 1.



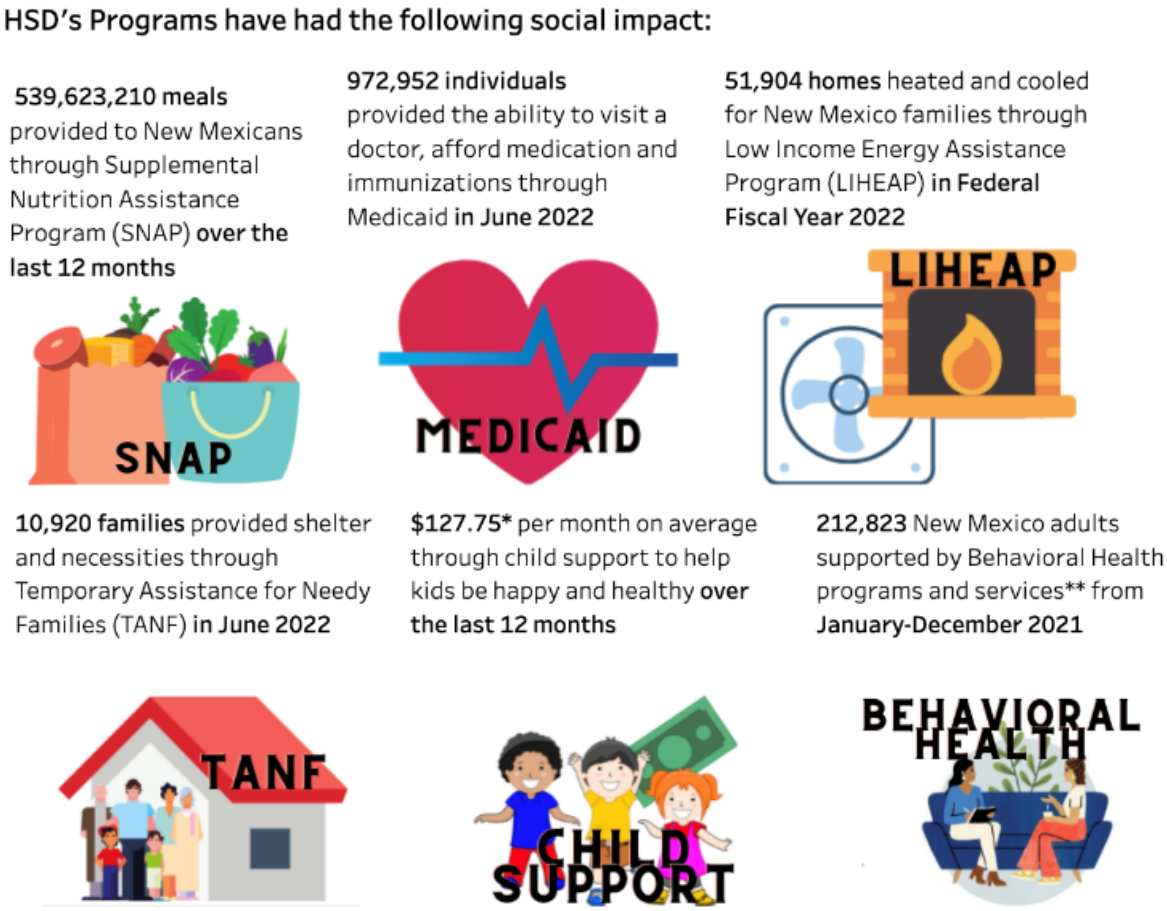
Over the last four years, the State has leveraged Centennial Care to transform care for Medicaid members by focusing on the following goals:

- Assuring that Medicaid members in the program receive the right amount of care, delivered at the right time, and in the right setting;
- Ensuring that the care and services being provided are measured in terms of their quality and not solely by quantity;

- Slowing the growth rate of costs or "bending the cost curve" over time without inappropriate reductions in benefits, eligibility, or provider rates; and
- Streamlining and modernizing the Medicaid program.

The State is deeply committed to incorporating principles of evidence-based governance, using data to drive decision making to achieve optimal results aligned to strategic priorities. As stewards of federal and state tax dollars, the State has a responsibility to use data in the delivery and monitoring of high-quality health and human services programs and to be transparent about and held accountable to its performance. As illustrated in Figure 2 below, Medicaid is a significant component of the State's modern and responsive social safety net for New Mexicans.

Figure 2.



Fundamentally, the vision is that every New Mexico Medicaid member has high-quality, coordinated, and person-centered care to achieve their health and wellness goals. New Mexico employs a member and provider centric philosophy, and is working to better support historically underserved populations whilst pursuing efficiencies in cost and quality of care through value-based purchasing (VBP), care coordination, and investments in providers and community-based care. Through collaboration with CMS, the State will continue to make significant investments in Medicaid with the support of this 1115 demonstration waiver renewal.

This renewal application satisfies the federal public notice requirements at 42 CFR §431.408 and sets forth the broader vision for Turquoise Care over the next five years. Additional information on the draft renewal application and information on scheduled public hearings and opportunities to provide valuable feedback is available at https://www.hsd.state.nm.us/medicaid-1115-waiver-renewal/.

Section II: Opportunities and Challenges: Key Background Data on New Mexico

Medicaid Enrollment

As of June 2022, 968,763 New Mexicans are enrolled in Medicaid,[1] representing 46% of the state's total population. Per analysis of CMS enrollment reports and US Census Bureau American Community Survey information, New Mexico's Medicaid enrollment percentage is the highest in the nation.[2,3] Figure 3 to the right depicts the state's Medicaid enrollment percentage breakdown by county.[4] Of note, the state's three largest counties by population (which represent 49.9% of the state's population[5]), Bernalillo, Doña Ana, and Santa Fe, have Medicaid enrollment per county of 39.7%, 55.1%, and 30.0%, respectively—all of which exceed the national enrollment of 27.7%. In light of this, the demonstration renewal holds tremendous opportunities to improve security and promote independence of New Mexico's most historically underserved citizens.

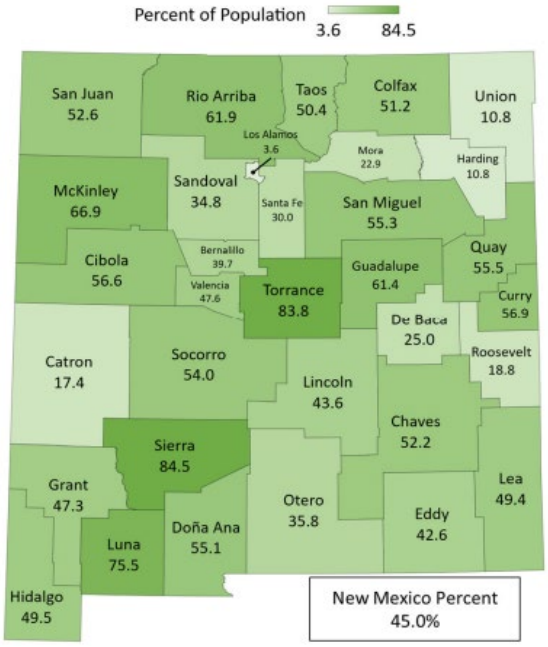


Figure 3.

Select Demographic and Socioeconomic Data

Societal inequities related to poverty, education, demographics (e.g., race/ethnicity, gender, sex, age, and disability status), food insecurity, and environmental factors are key drivers of population health. New Mexico's demographics and socioeconomic status present unique challenges for state health programs and the Medicaid delivery system in particular. According to the 2020 Census, New Mexico is one of six majority-minority states with the largest proportion of Hispanics and Latinos in the nation (49.3%) and the third largest percentage of Native Americans among the United States (10.6%). In terms of age, New Mexico ranks twelfth among states for the proportion of the population aged 65 and older (18.2%). From 2010 to 2020, the State had the lowest population growth rate (2.8%) in the western United States and the eleventh lowest nationally. The State has also has the third highest poverty rate (18.6%) in the nation, which is 8.1 percentage points higher than the national rate of 10.5%.[6] Educationally, the State has the fourth lowest percentage of adults aged 25 and over with a high school diploma or higher (85.9%) and, according to the US Department of Education, the lowest proportion of fourth grade students proficient in reading comprehension (23.7%) across the nation. In addition, 17.2% of New Mexicans experience severe housing problems, which is the thirteenth highest percentage in the country. New Mexico also has the nation's second highest crime rate per 100,000 population (832 per 100,000 population), well exceeding the national average of 379 per 100,000. [7]

[1] https://www.hsd.state.nm.us/wp-content/uploads/June-By-Managed-Care-Organization-Fee-for-Service-1.pdf
[2] CMS (2022). Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports (April 2022).
[3] US Census Bureau (2020). American Community Survey – 1 Year Estimates.
[4] New Mexico (2022). New Mexico Health & Human Services Data Book, Volume 3 2022.2. Retrieved from: https://www.hsd.state.nm.us/wp-content/uploads/Data-Book-2022-FINAL-Spring-2022.pdf.
[5] https://www.newmexico-demographics.com/counties_by_population
[6] US Census Bureau (2020). 2020 Decennial Census
[7] United Health Foundation (2022). America's Health Rankings. Retrieved from: https://www.americashealthrankings.org/explore/annual/state/NM

Population Health Data: Core Outcomes and Influences

Systemic barriers affecting the preceding demographic and socioeconomic factors compromise health status, behaviors, and core outcomes. New Mexico has the seventh highest premature death rate among states at 9,789 years of potential life lost before age 75 per 100,000 population. Compared to the nation, New Mexico ranks fortieth, forty-sixth, and forty-third in the nation for vegetable consumption percentage among adults (6.6%), new chlamydia rates per 100,000, ranked from lowest to highest (681.2 per 100,000), and teen births per 10,000 (24.4 per 10,000), respectively. In addition, 70.8% of adults have a dedicated health care provider, which is the fifth lowest among all states.[7]

Behavioral Health in New Mexico: An Exacerbated Crisis

The Coronavirus Disease 2019 (COVID-19) public health emergency (PHE) intensified demand for a behavioral health system already in crisis across the nation—severely straining an already limited workforce. In New Mexico, the effect is even more pronounced as the percent of need for mental health professionals met is 16.6% compared to the national average of 28.1%.[8] The result is the manifestation of unmet need, worsening behavioral health status, and increases in despair and unhealthy coping mechanisms. In fact, the state has the fourth highest rate of deaths by suicide in the nation at 24.7 per 100,000 population (for reference, the overall United States death by suicide rate is 14.5 per 100,000). Relative to substance use and deaths due to drug injury per 100,000, New Mexico has the eleventh highest rate among states at 29.5 per 100,000. The state also has a greater percentage of adults with moderate (61.2%) and severe mental illness (40.4%) not receiving treatment in comparison to the US average (53.5% and 35.0%, respectively).[7]

Disparities and Needs among the Traditionally Underserved

New Mexico has among the highest degree of Social Vulnerability in the country.[9] An evidence-based measure used by the Center for Disease Control (CDC), social vulnerability refers to the potential negative effects on communities caused by external stresses on human health (e.g., disasters or disease outbreaks). Reducing social vulnerability can decrease both human suffering and economic loss.

In light of New Mexico's unique profile, several traditionally underserved population groups experience health and socioeconomic disparities in addition to having greater health care related needs. The following data points illuminate the needs of five select populations and point to the need for comprehensive planning and a commensurate response:

Members with behavioral health conditions

- Among all states, New Mexico has the ninth highest prevalence of mental illness. [10]
- As stated above, New Mexico has the fourth highest rate of deaths by suicide per 100,000 population in the country.[11]
- New Mexico is forty-seventh among states and DC in terms of youth mental health per Mental Health America.[12]
- Compared to the median (66%), New Mexico has a lower rate for follow-up after hospitalization for mental illness for children ages 6 to 17 (53%).[5]

[8] US Health Resources and Services Administration (2022). Designated Health Professional Shortage Areas Statistics – As of June 30, 2022.
[9] https://svi.cdc.gov/map.html
[10] https://mhanational.org/issues/2022/ranking-states#prevalence_mi
[11] https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm
[12] Mental Health America (2022). Youth Ranking 2022. Retrieved from: https://mhanational.org/issues/2022/mental-health-america-youth-data

Pregnant/parenting members and young children

- New Mexico ranks forty-ninth out of 50 states and District of Columbia on 16 key Maternal Child Health indicators.
- Among all states, New Mexico has the third highest percentage of children and youth experiencing adverse childhood experiences at 22.3% (the national average is 14.8%).[13]
- Out of all infants born in New Mexico, 9.3% are considered low birthweight—tenth highest in the country.[14]
- The state has the sixth lowest percentage of children receiving recommended doses of the combined seven-vaccine series by age 35 months.[15]
- New Mexico has the fifth highest low birthweight racial disparity in the nation.[16]

Older adults and members with long-term services and supports (LTSS) needs

- New Mexico has the third highest rate of poverty in the United States for adults aged 65 and older.[11]
- According to projections, New Mexico will have the second highest proportion of adults aged 65 and older in the country at 26.5% by 2030. [17]

Native Americans

- Between 2015 and 2019, 40% of Native American children were living in poverty.[18]
- As of 2021, only 2% of behavioral health providers in New Mexico are Indigenous.[19]
- New Mexico has approximately 228,400 Native American citizens, representing 10.9% of the State's population.[20]

Justice Involved Members

- 80% of individuals released from prison each year have a substance use disorder, mental health condition, or chronic physical health condition.
- New Mexico has the thirteenth highest imprisonment rate in the county at 316 per 100,000 residents.[21]
- New Mexico has the twelfth highest racial disparity in incarceration rates across the nation at 1.8 per 100,000.[21]

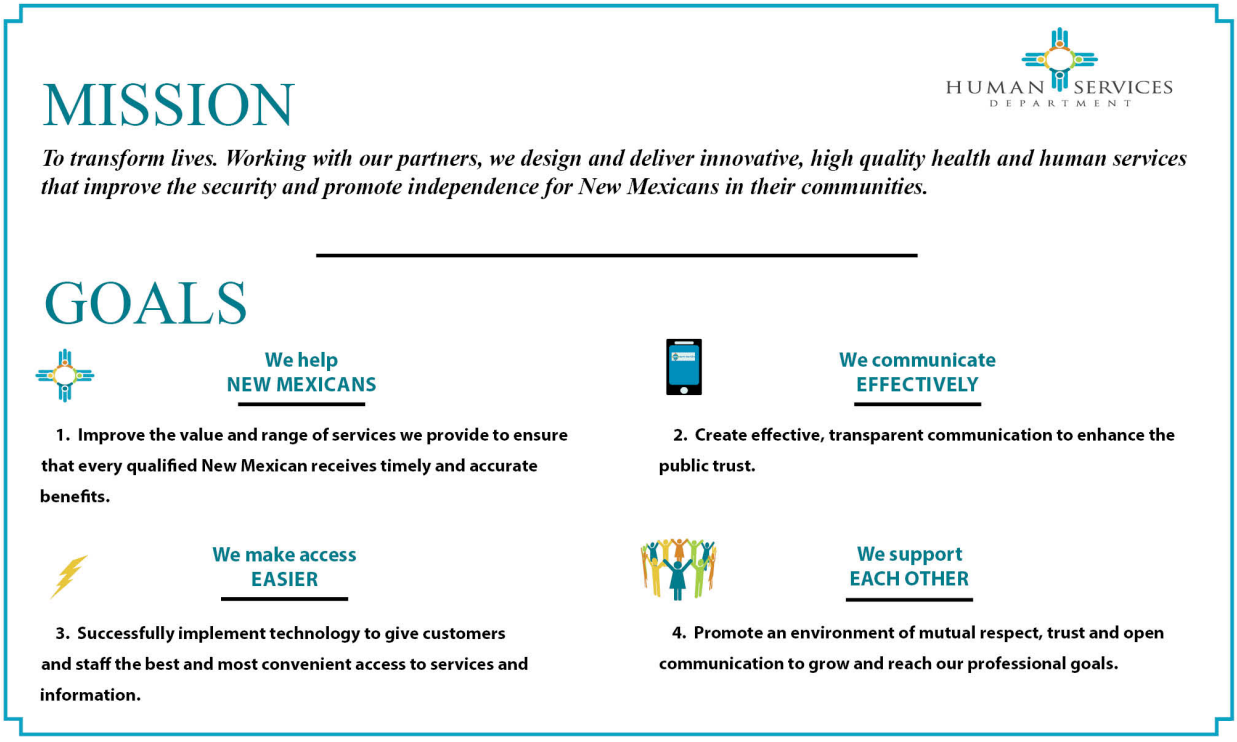
[13] United Health Foundation (2022). America's Health Rankings – Adverse Childhood Experiences. Retrieved from: https://www.americashealthrankings.org/explore/annual/measure/ACEs_8/state/NM
[14] United Health Foundation (2022). America's Health Rankings – Low Birthweight. Retrieved from: https://www.americashealthrankings.org/explore/annual/measure/birthweight/state/NM
[15] United Health Foundation (2022). America's Health Rankings – Childhood Immunizations. Retrieved from: https://www.americashealthrankings.org/explore/annual/measure/Immunize_b/state/NM
[16] United Health Foundation (2022). America's Health Rankings – Low Birthweight Racial Disparity. Retrieved from: https://www.americashealthrankings.org/explore/annual/measure/disparity_lbw_b/state/NM
[17] https://www.hsd.state.nm.us/2022-data-book/
[18] US Census Bureau (2020). American Community Survey – 1-Year Estimates, 2019.
[19] https://www.iad.state.nm.us/wp-content/uploads/2021/05/NMIAD_NBII_FINAL_REPORT.pdf
[20] https://www.iad.state.nm.us/about-us/history/#:~:text=New%20Mexico's%20Twenty%2DThree%20Tribes,of%20the%20state's%20entire%20population.
[21] https://www.sentencingproject.org/the-facts/#map

Section III: Turquoise Care Goals and Proposals for the Demonstration Renewal

Overarching Mission and Goals

The demonstration renewal's vision and goals are predicated on the State's overall mission and goals for providing health and human services to New Mexicans. Figure 4 provides the mission and goals for the New Mexico Human Services Department (HSD)—the single state agency for Medicaid in the State.

Figure 4.



Demonstration Renewal Vision and Goals for Turquoise Care

In addition to providing critical health coverage and access to care, Turquoise Care's goals and initiatives center on improving core health outcomes and attending to the social and economic determinants of health, particularly centered on addressing the needs of the State's historically underserved populations. Our vision is that every New Mexico Medicaid member has high-quality, well-coordinated, person-centered care to achieve their personally defined health and wellness goals.

To move closer to our vision, we propose to operate a data-driven Medicaid program that measures quality based on population health outcomes. To support this vision, the Turquoise Care waiver is constructed around three goals:

1. **Build a New Mexico health care delivery system where every Medicaid member has a dedicated health care team that is accessible for both preventive and emergency care that supports the**

whole person - their physical, behavioral, and social drivers of health.

Medical and non-medical providers must work in teams to improve members' health and wellbeing. The relationship between a member and their primary care provider or clinic and the team within that clinic serve as the foundation of patient-centered goals and wellness. Primary care is the only medical resource where the evidence supports that adding more of the resource leads to better patient outcomes. Referrals to medical and non-medical services should flow from that relationship and the support it provides. Placing primary care at the center of Medicaid is consistent with state priorities. In 2021, House Bill 67 enacted the Primary Care Council, which is charged with "revolutionizing primary care." The Council aims to create a multi-payer alternative primary care payment model in the State that is designed to move health care financing away from fee-for-service (FFS) and into a payment structure that reduces the total cost of care while improving patient outcomes and supporting the health care workforce. Finding ways to reimburse and support robust primary care teams is a key component of New Mexico's Medicaid program and this demonstration waiver.

2. **Strengthen the New Mexico health care delivery system through the expansion and implementation of innovative payment reforms and value-based initiatives.**
   Turquoise Care will continue to advance payment reform and value-based care through the next evolution of managed care. This continuous maturation of the managed care system will allow for new focus areas to emerge for 2024 and beyond. With managed care central to New Mexico's Medicaid delivery system and a key driver of health outcomes, strength and support for providers is essential to ensure all members from rural and frontier, to urban counties are able to receive quality care. This demonstration and additional support through the enhanced managed care contracting requirements will expand access and support rural and frontier hospitals and other providers.

3. **Identify groups that have been historically and intentionally disenfranchised and address health disparities through strategic program changes to enable an equitable chance at living healthy lives.**
   Five populations were selected as target populations given their experiences with societal inequities, disproportionately high demand for health supports and services, and disparities they have experienced within the state of New Mexico. These five populations are:
   a. Prenatal, postpartum, and members parenting children, including children in state custody (CISC);
   b. Seniors and members with Long-Term Services and Supports needs;
   c. Members with behavioral health conditions;
   d. Native American members; and
   e. Justice-involved individuals.

   As such, all of the initiatives proposed for Turquoise Care will support these populations to ensure they receive equitable care.

Table 1. Goals for Turquoise Care

Goals	Policy Name	Focus Population	Status in Renewal Request
Goal #1: Build a New Mexico health care delivery system where every Medicaid member has a dedicated health care team that is accessible for both preventive and emergency care that supports the whole person - their physical, behavioral, and social drivers of health. **Goal #2:** Strengthen the New Mexico health care delivery system through the expansion and implementation of innovative payment reforms and value-based initiatives. **Goal #3:** Identify groups that have been historically and intentionally disenfranchised and address health disparities through strategic program changes to enable an equitable chance at living healthy lives.	Centennial Care 2.0 Features	All	Continuing
	Provide Continuous Enrollment for Children up to Age Six	Pregnant and Parenting Members and Young Children	New
	Expanded Home Visiting Program	Pregnant and Parenting Members and Young Children	Continuing/Expanded
	Additional Community Benefit (CB) Enrollment "Slots"	Seniors and Members with Long-Term Services and Supports (LTSS) Needs	Continuing/Expanded
	Enhanced Services and Supports for Members in Need of LTSS	Seniors and Members with LTSS Needs	New
	Environmental Modifications and Transitional Services Benefit Limit Increases	Seniors and Members with LTSS Needs	Continuing/Expanded
	Home Delivered Meals Pilots	Pregnant and Parenting Members and Young Children and Seniors and Members with LTSS needs	New
	Enhanced primary care and care coordination through a Closed-Loop Referral System	All	New
	Medicaid Services for High-Need Justice Involved Populations 30 Days Before Release	Members Involved with the Justice System	New
	Traditional Healing Services	Native American members	New
	Chiropractic Services Pilot	All	New
	Medical Respite for Members Experiencing Homelessness	Members with Behavioral Health Conditions	New
	Support for Rural Hospitals	All, with an emphasis on Pregnant and Parenting Members and Young Children	New
	Medicaid Reimbursement for IMD settings for individuals with SUD, SMI/SED	Members with Behavioral Health Conditions	Continuing/Expanded (Waiver amendment pending with CMS)
	High-Fidelity Wraparound services for children and youth with complex care needs	Members with Behavioral Health Conditions	Continuing/Expanded (Waiver amendment pending with CMS)
	Funding and technical assistance for new or expanded primary care residency programs	All	Continuing/Expanded (Waiver amendment pending with CMS)

HSD will use other complementary authorities and initiatives to achieve our goals for Turquoise Care, including:

- Addition of new services through State Plan Amendments (SPAs), such as the addition of doula services, community-based crisis intervention and mobile crisis service enhancement, and Certified Community Behavioral Health Clinics (CCBHCs);
- Re-procurement and revision of the Managed Care Organizations (MCOs) contracts to enhance and implement HSD's vision and goals; and
- Partnering across state agencies, including the Departments of Health, Children Youth and Families, Early Childhood Education, and Aging and Long-Term Services to take meaningful steps towards whole person care, through policy and program coordination, as well as the use of technology to improve experiences for New Mexicans.

To learn more about New Mexico's vision for Medicaid under Turquoise Care, see Turquoise Care Vision available at https://www.hsd.state.nm.us/medicaid-1115-waiver-renewal/.

Section IV: History and Successes of New Mexico's 1115 Demonstration

1. **Pre-Centennial Care: Pre-2014**
   Prior to Centennial Care, the Medicaid system in New Mexico was fragmented, and there were ample opportunities for improvement and potential efficiencies. In 2013, 520,000 individuals, more than a quarter of the state's population, received health care through the Medicaid program. The challenges included:
   - An expensive program, consuming about 16% of the State budget, up 12% from the previous year;
   - An administratively complex program operating under 12 separate federal Medicaid waiver authorities to authorize and cover various benefits and eligibility groups within managed care., In addition, New Mexico operated a separate FFS program for those who either opted out of or were exempt from managed care;
   - Managing separate health plans administering different benefit packages for defined populations making it difficult for individuals, providers, and MCOs to manage complex medical and behavioral conditions and needs; and
   - A system that paid for the quantity of services delivered without emphasis on the quality of care being provided.

2. **Centennial Care: 2014-2018**
   In 2013, New Mexico received approval from CMS under the demonstration to consolidate many of the 12 separate federal waivers referenced above and expand coverage to adults with incomes up to 138% through the Affordable Care Act's Medicaid Expansion coverage creating a comprehensive managed care delivery system. Centennial Care's contracted health plans would offer the full array of current Medicaid services, including acute care, behavioral health, institutional care, and community-based LTSS. Other features of Centennial Care included the expansion of care coordination for all beneficiaries and a member-engagement focused beneficiary reward program, offered through MCOs to provide incentives for beneficiaries to pursue healthy behaviors. Centennial Care also created a Safety Net Care Pool (SNCP) for hospitals made up of two sub-pools: Uncompensated Care Pool and Hospital Quality Improvement Incentive (HQII) Pool.

   The State's goals in implementing Centennial Care, as specified in the special terms and conditions (STCs), were to:
   - Assure that Medicaid beneficiaries in the program receive the right amount of care, delivered at the right time, and in the right setting;
   - Ensure that the care and services being provided are measured in terms of their quality and not solely by quantity;
   - Slow the growth rate of costs or "bend the cost curve" over time without reductions in benefits, eligibility or provider rates; and
   - Streamline and modernize the Medicaid program in the State.

3. Centennial Care 2.0: 2019-Present

A. Overview of Centennial Care 2.0 (pre-amendments)

On December 14, 2018, CMS approved a five-year extension of the New Mexico 1115 demonstration and the state changed the demonstration name to Centennial Care 2.0. New Mexico's Centennial Care 2.0 program began January 1, 2019 and has built upon previous successes to achieve the stated goals of the Centennial Care program. The extension authorized a general renewal of existing programs and the continuum of services to treat addiction to opioids and other substances, including services provided to Medicaid enrollees with a SUD who are short-term residents in residential and inpatient treatment facilities that meet the definition of IMDs. In addition, the State received authority to implement two pilot programs, one for home visiting serving pregnant members and the other for pre-tenancy and tenancy supports for individuals living with Severe Mental Illness (SMI). The State also received authority to implement premiums and co-payments for certain beneficiaries as well as limitations on retroactive eligibility for some beneficiaries, which were later amended to remove. The following goals were codified within the approval of Centennial Care 2.0:

- Improving continuity of coverage, encouraging individuals to obtain health coverage as soon as possible after becoming eligible, and increasing utilization of preventive services;
- Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
- Continue to expand access to LTSS and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
- Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
- Expand payment reform through VBP arrangements to achieve improved quality and better health outcomes;
- Continue the SNCP and time-limited Hospital Quality Improvement Initiative;
- Provide culturally appropriate traditional healing benefits to select Native American members;
- Build upon policies that seek to enhance members' ability to become more active and involved participants in their own health care; and
- Further simplify administrative complexities and implement refinements in program and benefit design.

B. Covered Populations in Centennial Care 2.0

New Mexicans are covered under Medicaid and CHIP through both managed care and FFS delivery systems and as of June 2022, 83% of beneficiaries were enrolled in managed care. In state fiscal year (SFY) 2023, the State anticipates enrollment reductions of approximately 85,000 individuals due to eligibility re-determinations following the end of the COVID-19 PHE. Table 2 represents the eligibility groups currently served in Centennial Care 2.0.

Table 2. Eligibility Groups Covered in Centennial Care 2.0

Population Group	Populations
TANF and Related	Newborns, infants, and children CHIP children (Medicaid expansion) Foster children Adopted children Pregnant women Low income parent(s)/caretaker(s) and families Breast and Cervical Cancer Refugees Transitional Medical Assistance
SSI Medicaid	Aged, blind and disabled Working disabled
SSI Dual Eligible	Aged, blind and disabled Working disabled
Medicaid Expansion	Adults between 19-64 years old up to 133% of MAGI
HCBS	Individuals receiving Community Benefit HCBS services under "217-like" group

The following populations are excluded from Centennial Care 2.0:

- Qualified Medicare Beneficiaries;
- Specified Low Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency medical services;
- Program of All-Inclusive Care for the Elderly;
- Individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities;
- Medically Fragile 1915(c) waiver participants for HCBS;
- Developmentally Disabled 1915(c) waiver participants for HCBS;
- Individuals eligible for family planning services only;
- Mi Via 1915(c) waiver participants for HCBS;
- Supports 1915(c) waiver participants for HCBS; and
- Individuals eligible for the Optional COVID-19 Group.

Appendix E illustrates the complete table of mandatory and optional populations covered in the current waiver and the proposed Turquoise Care waiver.

C. Current Demonstration Benefits

Centennial Care 2.0 provides a comprehensive package of services that include, but are not limited to, behavioral health, physical health, and LTSS. These services make up the foundation of New Mexico's Medicaid delivery system, and the State is requesting to continue this system to support members in receiving the care and treatment they need. Appendix F provides a comprehensive list of benefits currently available to Centennial Care 2.0 members, and Section III of this application includes descriptions of what is requested to continue, proposed enhancements to current programs, and new program requests.

Highlighted benefits of the current demonstration focus on the following: Care Coordination, Centennial Home Visiting, Behavioral Health and LTSS, services for Native American Members, Member Engagement, Telehealth, and Community Health Workers (CHW). Details of these benefits follow this paragraph:

1. **Care Coordination**

   Benefits Overview

   According to the federal Agency for Healthcare Research and Quality (AHRQ), *"Care Coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."*[22] Centennial Care 2.0 established levels of care coordination support that range from a low level of care (LOC) coordination for members requiring a "light touch" (i.e., periodic service utilization monitoring) to higher levels of care coordination for members with the highest needs (i.e., members with chronic conditions and high utilizers) who require more intensive, hands on care coordination. The intent is for members to receive the care coordination level of support that is most appropriate to meet their needs. In the event a member's needs should change, MCOs are required to make the corresponding change in the member's care coordination level. Each member in Centennial Care 2.0 receives a standardized health risk assessment (HRA) to determine if they requires a comprehensive needs assessment (CNA) and/or a higher LOC coordination. The CNA identifies members requiring level 2 or level 3 care coordination and is followed by the development of a comprehensive care plan, which establishes the necessary services based on the physical health, behavioral health, and long-term care (LTC) needs identified in the CNA. Members designated to care coordination level 2 or level 3 are assigned to a care coordinator who is responsible for coordinating their entire care. MCOs routinely monitor claims and utilization data for all members to identify changes in health status and high-risk members in need of a higher LOC coordination. As a result, the fundamental components of care coordination in Centennial Care 2.0 include:

   - Assessing each member's physical, behavioral, functional, and psychosocial needs;
   - Identifying the specific medical, behavioral, and LTSS and other social support services (e.g., housing, transportation or income assistance) necessary to meet a member's needs;
   - Ensuring timely access and provision of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities while maximizing independence;
   - Facilitating access to other social support services and community-based assistance needed to promote each member's health, safety, and welfare; and
   - Coordinating Medicaid and Medicare services for dual-eligibles.

   Additionally, Centennial Care 2.0 encourages MCOs to build care coordination systems that maximize local community supports, such as CHWs.

[22] Agency for Healthcare Research and Quality. "Care Coordination". August 2018. Retrieved from https://www.ahrq.gov/ncepcr/care/coordination.html#:~:text=Care%20coordination%20involves%20deliberately%20organizing,safer%20and%20more%20effective%20care.

Centennial Care 2.0 Successes

- Timely Completion of HRAs.
  - From Q1 CY2019 to Q2 CY2022, timely completion for HRAs for newly enrolled members increased from 85% to 97%.
  - In 2020, MCOs completed over 50,000 HRAs, 95% of which were done within 30 days (up from 60% in 2018).
- Timely Completion of Telephonic Contacts.
  - Timely completion of telephonic contacts for CCL2 members increased from 49% in Q1 CY19 to 90% in Q2 CY22.
  - Timely completion of telephonic contacts for CCL3 members increased from 76% in Q1 CY19 to 91% in Q2 CY22.
- 76% of Level 3 members (those with the highest needs) received quarterly in-person visits through MCO care coordination in 2020 (compared to 60% and 41% in 2019 and 2018, respectively).
- HSD implemented systems changes to require all Managed Care members to be assigned a Care Coordination Level and an associated assessment type to better align and validate submitted data. After conducting an All MCO Workgroup, in Q2 CY21, focusing on members categorized as Unable to Reach (CCL0-UTR), Difficult to Engage (CCL5-DTE), and Refused Care Coordination (CCL4-RCC), this population decreased by 59%.
- MCOs reported an increase in members receiving Shared Functions Model Care Coordination Services, up from no reported members in Q1 CY2019 to 876 members in Q1 CY2022. MCOs also reported an increase in members receiving Full Delegation Care Coordination Services from 64 members in Q1 CY2019 to 893 members in Q2 CY2022.

2. Centennial Home Visiting Program

Benefits Overview

In collaboration with the New Mexico Early Childhood Education & Care Department (ECECD), MCOs are required to provide an evidence-based, early childhood home visiting program under the name Centennial Home Visiting (CHV) that focuses on pre-natal care, post-partum care, and early childhood development. The services are delivered to eligible pregnant and postpartum women residing in any county by agencies providing the evidence-based early childhood home visiting delivery model as defined by the US Department of Health and Human Services and as contracted with the MCOs. There are two existing programs that were implemented during Centennial Care 2.0:

- Nurse Family Partnership (NFP): The NFP is designed to reinforce maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. The program adheres to the NFP national program standards in services delivery to eligible pregnant members.
- Parents as Teachers (PAT): The goals of the PAT program are to provide parents with knowledge on child development, parenting support, early detection of developmental delays and health issues, as well as to prevent child abuse and neglect, and increase children's school readiness. The PAT program adheres to the PAT national model and curriculum in services to eligible pregnant enrollees.

Centennial Care 2.0 Successes

- CHV program continues steady growth in access to Medicaid members, with families served increasing by 1,600% from FY2018 to FY2022 (24 to 384 families served).
- The CHV program on-boarded two new providers in FY2021 that have begun serving families. At current, three (3) additional providers have completed the onboarding process and one (1) provider is currently in the onboarding process.
- In FY2022, the CHV program was able to screen 93.6% of parents for depression, and identified 26.0% of parents at risk for depression. Of those 26.0%, 48.5% were engaged in depression services.
- In FY2022, 97% of children enrolled in the CHV program were read to weekly by a caregiver.
- Children enrolled in the CHV program have a high rate of success to be fully immunized by the age of two (2). In FY201 and FY2022, 97.7% and 94.8% of children enrolled in the CHV program had received full immunization status by age two (2).

3. Behavioral Health Enhancements

Benefits Overview

Centennial Care 2.0 continued the path to integrating behavioral and physical health services whereby a member receives a person-centered and comprehensive set of benefits from the MCO in which they are enrolled. This integration occurs at the administrative and financial level, thus creating a foundation for more streamlined coverage and care coordination, as well as a basis for continued movement toward clinical integration. In addition, three new behavioral health services were added in Centennial Care 2.0 for eligible participants: family support, behavioral health respite, and recovery services. Details of these new benefits are as follows, respectively:

- *Family Support*: a community-based, face-to-face interaction with the eligible beneficiaries and family members/significant others to identify the recovery and resiliency service needs within a recovery plan to enhance their strengths, capacities, and resources to promote their ability to reach the recovery and resiliency behavioral health goals they consider most important.
- *Behavioral Health Respite*: supervision and/or care of children and youth (up to 21 years of age, diagnosed with a serious emotional or behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) residing at home to provide an interval of rest and/or relief to the person and/or their primary care givers. The service may include a range of activities to meet the social, emotional, and physical needs of the caregiver(s) during the respite period. These services may be provided on a short-term basis (i.e., few hours during the day) or for longer periods of time involving overnight stays.
- *Recovery Services*: peer-to-peer individual and group services that assist individuals with SMI, severe emotional disturbance (SED), and SUD to develop the skills they need to maximize their potential for a successful recovery.

Centennial Care 2.0 Successes

Investment of $34 million towards enhancements intended to fill behavioral health service gaps and expand services, including:

- Individual and Family Peer Support;

- After hours, weekends and holiday service;
- Assertive Community Treatment;
- Comprehensive Community Support Services (CCSS);
- Crisis Treatment Center and Crisis Stabilization;
- Intensive Outpatient Services;
- Opioid Treatment Program;
- Partial Hospitalization expansion/incentives;
- Screening, Brief Intervention and Referral to Treatment; and
- Accredited Residential Treatment Centers.

Improvements and efficiencies in SUD assessment and treatment, such as:

- The quarterly average number of members screened for SUD increased under Centennial Care 2.0 by 92% from 2018 to 2021 (2,270 in 2018 versus 4,367 in 2021);
- 100% of prescribers are utilizing the Pharmacy Prescription Monitoring Program (PMP);
- The PMP was updated to a new platform (PMPAWARxE), which allows end users, prescribers, and dispensers to make better informed decisions and intervene earlier through advanced analytics;
- 83% of providers are checking PMP appropriately; and
- Piloted the placement of telehealth certified peer support workers in five emergency departments 24/7, with plans to expand.

In 2020, HSD partnered with OpenBeds, a behavioral health bed registry solution, to provide better support and transparency in delivering behavioral health treatment to those in need. Through this partnership, HSD launched the New Mexico Behavioral Health Referral Network, allowing New Mexico's behavioral health provider community to quickly assess patient needs, find a facility to meet these needs, and conduct a digital referral. At the start of implementation, there were 69 treatment organizations included. Of these, 28 were referring organizations and 51 were receiving treatment organizations, with some listed as both referring and receiving.[23] In addition to these provider resources, this partnership also launched the www.treatmentconnection.com website, a resource that allows individuals seeking behavioral health treatment to figure out what type of care they need, find nearby providers, and confidentially self-refer to treatment organizations and providers listed by the State.

HSD also implemented the "Treat First" model of care as an innovative approach to behavioral health clinical practice improvement. It began with a six-month trial within six provider organizations. The organizing principle has been to ensure a timely and effective response to a person's needs as a first priority in the approach. It has been structured as a way to achieve immediate meaningful engagement while gathering needed historical, assessment and treatment planning information over the course of four therapeutic encounters as opposed to the expectation that these functions be completed within the first encounter. The results of this trial achieved significant improvements in patient and provider satisfaction including the

[23] Los Alamos Reporter. New Mexico Partners with OpenBeds to Launch the New Mexico behavioral Health Referral Network. June 22, 2020. Retrieved from: https://losalamosreporter.com/2020/06/22/new-mexico-partners-with-openbeds-to-launch-the-new-mexico-behavioral-health-referral-network/

quality of treatment planning, early resolution of presenting problems and the reduction of subsequent "no show" appointments. As a result, HSD has since implemented this approach as standard behavioral health practice.

4. Long-Term Services and Supports Enhancements

Benefits Overview

Centennial Care and Centennial Care 2.0 expanded the availability of CB services to individuals who qualify for full Medicaid coverage and meet a nursing facility level of care (NF LOC) by eliminating the requirement for a specific waiver slot in order to access the full suite of CB services. As part of this change, HSD removed the personal care services (PCS) benefit from the State Plan and included it as one of many services available in the CB service array, which resulted in increased access to PCS for eligible members. HSD continued to provide access to HCBS services by establishing 5,789 slots Centennial Care waiver slots. These slots supported members who did not meet standard Medicaid financial eligibility due to having household income that is higher than regular program guidelines.

In addition to the existing 5,789 slots, HSD has received approval through American Rescue Plan Section 9817 funding for up to 1,000 additional slots.

HSD also created an independent system that links together resources throughout the state to assist LTSS members—the New Mexico Independent Consumer Support System (NMICSS). NMICSS provides Centennial Care beneficiaries, their advocates, and counselors with information and referral resources in the following areas:

- Centennial Care health plan choice counseling;
- Grievance, appeals rights, and fair hearings; and
- Understanding care coordination and levels of care.

Centennial Care 2.0 Successes

- Centennial Care 2.0 continued New Mexico's trend of spending more LTSS monies on HCBS services versus services within an institutional setting. In fact, New Mexico was ranked among the top three states in fiscal year (FY) 2019 as spending more on HCBS expenditures as a percentage of total LTSS expenditures.[24] Today, over 32,000 members receive LTSS in their homes or community.
- In 2021, nearly 90% of members with a NF LOC were being served in the community.
- Based on enrollment data from 2020, the ratio of New Mexicans on Medicaid residing in nursing facilities was less than half of the national ratio: 0.63% versus 1.8%.
- HSD eliminated the asset test for members in Medicare Savings Program categories.

5. Native American Members in Centennial Care 2.0

Benefits Overview

Several protections were implemented in Centennial Care and continued under Centennial

[24] https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf

Care 2.0 to ensure that Native Americans have access to Indian Health Service, Tribal health providers, and Urban Indian providers (I/T/Us) and to facilitate access to timely, quality care. The following protections are addressed in the Special Terms and Conditions STCs of the 1115 waiver and in the MCO contracts:

- Each MCO must have a full-time staff person to work directly with I/T/Us and be proficient in at least one New Mexican Native American/pueblo language;
- MCOs are encouraged to use local resources, such as I/T/Us, Patient Centered Medical Homes (PCMHs), Health Homes, Core Service Agencies, and tribal services to perform care coordination activities;
- The MCO cannot impose cost sharing on Native Americans;
- Members can choose I/T/Us to serve as their primary care provider;
- At least one Federally Qualified Health Center (FQHC) shall be an Urban Indian FQHC in Bernalillo County;
- MCOs must allow members to seek care from any I/T/U whether or not the I/T/U is a contract provider;
- MCOs must track and report quarterly reimbursement and utilization data related to I/T/Us;
- MCOs must reimburse I/T/Us at least 100% of the rate currently established for Indian Health Services (IHS) facilities (with a few exceptions);
- Services provided within I/T/Us are not subject to prior authorization requirements;
- Native American members accessing the pharmacy benefit at I/T/Us are exempt from the MCO's preferred drug list; and
- Native Americans may self-refer to an I/T/U for services.

Additionally, the STCs of the waiver required that HSD form an advisory group, the Native American Technical Advisory Committee (NATAC), comprised of representatives from New Mexico's tribal organizations and Indian Health Services. HSD plans to continue the NATAC group and maintain all of the current protections for Native Americans in Turquoise Care. HSD and the MCOs receive ongoing input from the Native American Advisory Boards (NAAB). The NAAB meets quarterly in tribal communities that have high enrollment in Centennial Care 2.0 to discuss issues related to service delivery and operations. Each MCO is also required to employ a full-time Native American liaison that works directly with IHS, Tribal 638 providers and HSD's Native American liaison.

Centennial Care 2.0 Successes

- During the COVID-19 PHE, there was a shift of Native Americans from FFS to Managed Care, with 60% of total Native Americas enrolled in Managed Care as of July 2022.
- Continuation of the Native American Technical Advisory Committee (NATAC) for Tribal leaders and their designated representatives;
- Tribal Liaison for the Behavioral Health Services Division to assist with behavioral health services programming, outreach, education and collaboration; and
- Formation and development of Tribal 988 workgroup to provide technical assistance, training, education, outreach and implementation of 988 by Tribes.

6. Member Engagement

Benefits Overview

One of the core principles of the Centennial Care program is to encourage greater personal

responsibility of members to facilitate their active participation and engagement in their own health so they can become more efficient users of the health care system. Centennial Care and Centennial Care 2.0 required the MCOs to provide a member rewards program that offers incentives to members to become more actively engaged in managing their health.

Centennial Rewards

Centennial Care established a member-based rewards program known as Centennial Rewards, which was designed to encourage members to actively participate in their health care and drive improvements in health outcomes. It required the MCOs to collaborate and procure a vendor to implement a member rewards program. Finity was selected to administer the program, which was launched in the spring of 2014. Any Centennial Care member enrolled in an MCO may participate in the Centennial Rewards program and receive points for engaging in and completing healthy activities and behaviors. By doing so, members participating in the rewards program can redeem points for items in the Centennial Rewards catalog. Participation is defined as members who are engaged through Centennial Rewards and complete at least one healthy activity. As of December 2021 member participation reached 74.2%.

Table 3. The healthy activities and behaviors members may participate in include:

Healthy Activities	Age
Adult Primary Care Provider (PCB) Checkup – Complete annual Primary Care Physician (PCP) wellness checkup	Ages 22+
COVID-19 Vaccine or Booster – Complete COVID-19 vaccine or booster	All ages, as advised by CDC
Dental Checkup (Child) – Complete annual dental checkup	Ages 2-20
Diabetes HbA1C Test – Completion of HbA1C Test Bonus: Diabetes HbA1C Control – Attain HbA1c control (<8%)	Ages 10-75
Diabetes Retinal Eye Exam – Completion of diabetic retinal exam	Ages 10-75
Flu Shot - Receive flu vaccine	Ages 6 months+
1st Prenatal Care Visit – Complete prenatal care visit in the first trimester or within 42 days of enrollment	All ages
Postpartum Visit – Complete postpartum care visit between 7 and 84 days after delivery	All ages
Schizophrenia Medication Management – Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+
Well-Baby Checkups – Complete up to age six well-child visits with a PCP during the first 15 months of life and up to age two well-child visits with a PCP between 16-30 months of life Bonus: Complete all eight well-child visits with a PCP between 0-30 months of life	0-30 months
Antidepressant Medication Management - Reward on 30-, 60-, or 90-day prescribed refills	Ages 18+
Child & Adolescent Well-Care Visit - Complete annual wellness checkup with a PCP or an obstetricians/gynecologists (OB/GYN) Bonus: Adolescent Immunization Series – Complete adolescent immunization series by thirteenth birthday	Ages 3-21
Follow-up After Emergency Dept. Visit for Mental Illness – Complete follow-up visit within 30 days of emergency department visit for mental illness or intentional self-harm diagnoses	Ages 6+
Follow-up After Hospitalization for Mental Illness – Complete follow-up visit within 30 days of hospitalization for mental illness or intentional self-harm diagnoses	Ages 6+

Centennial Care 2.0 Successes

- In 2021, Member satisfaction with the Centennial Rewards program was 98%.
- The Centennial Rewards program has resulted in cost savings every year since the program's inception, based on reduced total medical spend for program participants compared to non-participants. In 2021, it is estimated that Centennial Rewards saved $38.8 million.
- Member participation in Q1 2022 reached an all-time high of 74.6%.
- In Q1 2022, members earned over $4.0 million in rewards, up 41% from Q4 2021.
- In Q1 2022, 161,000 members earned rewards, up 40% from Q4 2021.
- In 2021, between 92,000 and 164,000 unique members earned at least one reward each quarter.
- In 2021 the Centennial Rewards Program continued to grow.
  - Members redeemed $1.8 million in rewards, which is up 52% from Q3 2021.
  - 46,000 members redeemed points, up 48% from Q3 2021.

7. Payment Reform

Benefits Overview

A key program goal of the legacy Centennial Care programs has been to pay for value and not solely for volume of services rendered by rewarding providers for achievement in quality of care and improved member health outcomes. In 2015, HSD implemented payment reforms through a variety of pilot projects to test their effectiveness and to begin to engage providers in changing reimbursement methodologies to align with quality outcomes more effectively.

After testing a variety of payment reforms through multiple pilot projects implemented by the MCOs, HSD required, through specific contractual provisions, that the MCOs have a prescribed percentage of all provider payments in one of three levels of VBP arrangements. Throughout Centennial Care 2.0, HSD continued to increase the overall percentage of provider payments covered under a VBP arrangement and expand the types of providers covered in various models while also focusing on arrangements for behavioral health, LTC, and nursing facility providers.

Table 4. Demonstration Year (DY) 8 (CY2022) requirements were as follows:

VBP Level	Level 1	Level 2	Level 3
Required Spend	**11%**	**14%**	**8%**
Required Provider Types	Traditional Physical Health Providers with at least two small Providers Behavioral Health Providers (whose primary services are behavioral health) LTC Providers including nursing facilities	Traditional Physical Health Providers with at least two small Providers Behavioral Health Providers (whose primary services are behavioral health) LTC Providers including nursing facilities	Traditional Physical Health Providers Behavioral Health Providers (whose primary services are behavioral health) Actively build LTC Providers including nursing facilities full-risk contracting model

MCOs are required to meet minimum targets for the three levels of VBP payment arrangements. Minimum targets were set to both a required spend as a percentage of paid claims and required contracts with certain provider types. For DY8, two of the three MCOs met the target for all three levels, while one MCO met the target for two levels. However, all MCOs met the overall percentage requirement of 33%.

In CY2022, the MCOs are required to have 36% of provider payments in VBP arrangements across three different levels, with level one at the lower end of the risk continuum and level three at the higher end.

Centennial Care 2.0 Successes

- Centennial Care 2.0 established three levels of VBP arrangements and specific requirements for MCOs to meet annually:
  - Level 1: Pay-for-performance on defined outcomes or quality scores.
  - Level 2: Shared savings when agreed upon outcomes or quality scores are met.
  - Level 3: Provider risk-sharing or capitated payments with full risk.
- MCOs are required to develop VBP arrangements with the following providers: Traditional physical health providers including at least two small providers, behavioral health providers whose primary services are behavioral health and/or integrated providers who offer a continuum of specialty behavioral health services, and LTC providers including nursing facilities.
- All MCOs met the required VBP spending target in 2021 (33% of total MCO spending).
- In CY2022, the MCOs are required to have 36% of provider payments in VBP arrangements across three different levels.

8. Telehealth

Benefits Overview

As part of Centennial Care and Centennial Care 2.0, HSD focused on improvements in the utilization of telehealth for both physical and behavioral health care. MCOs were required to implement telemedicine initiatives for the convenience and benefit of members and to improve access to care in rural areas.

As a result of the COVID-19 PHE, the State also broadened access to telehealth services, opening new telephonic and e-visit billing codes. HSD intends to maintain access to telehealth services beyond the PHE given the success in expanding access and availability of services to Medicaid members.

Centennial Care 2.0 Successes

- The efforts of HSD and the MCOs have resulted in the following: annual increases in telemedicine utilization; active recruitment initiatives to pursue qualified telehealth providers; recruitment of behavioral health medication management providers; and the purchase of block time services of behavioral health medication management providers through an external vendor.
- During the COVID-19 pandemic, HSD authorized the use of telehealth for the majority of behavioral health services, delivered in all settings and using the same codes and rates that are in place for face-to-face services. In addition to

standard telehealth delivery methods, behavioral health providers are, for the duration of the emergency, permitted to deliver services telephonically.

- The results of expanded access to behavioral health services through telehealth have led to a 133% increase in utilization within DY7 (19,978 to 46,474 members).
- All MCOs reported significant increases in telehealth services to all age groups, in urban, rural and frontier counties, and to all populations of SMI, SED, and SUD clients. The type of telehealth service that experienced the largest increase by all MCO was psychotherapy with individuals and/or family member.

9. Community Health Workers

Benefits Overview

As part of Centennial Care 2.0, the State's MCOs increased the use of CHWs to provide care coordination services. CHWs are trusted members of the community who work within the local health care system in rural, frontier, tribal and urban areas. CHWs have been referred to as community health advisors, lay health advocates, Promotoras, outreach educators, community health representatives (CHRs), peer health promoters, peer educators, and community connectors. They are in a unique position to provide interpretation and translation services, culturally appropriate health education, and informal counseling and guidance on health behaviors, while encouraging self-efficacy. CHWs also serve as liaisons between the member and the health care system by assisting members in obtaining needed care.

Centennial Care 2.0 Successes

In the past four years, MCOs have been increasing their use of CHWs in care coordination roles as well as using CHWs to educate members about appropriate use of the delivery system. MCOs have also effectively used Patient-Centered Medical Homes (PCMHs) as an additional tool for delivery of care coordination. PCMHs have long been a part of the New Mexico Medicaid program landscape. However, with the implementation of Centennial Care, the MCOs have increased the availability and use of in PCMHs. As of December 2021, more than 400,000 members are receiving care PCMHs, which is an increase of 114.56% from 2014.

D. Other Notable Successes of Centennial Care 2.0

Centennial Care 2.0 transformed how Medicaid services are delivered to lower-income New Mexicans. Today, New Mexico's Medicaid managed care program features an integrated, comprehensive Medicaid delivery system in which the member's MCO is responsible for coordinating the full array of services, including acute and ambulatory care, pharmacy, behavioral health services, institutional services, and HCBS. Performance measures describing the success of Centennial Care 2.0 can be found on HSD's Performance Scorecard (https://sites.google.com/view/nmhsdscorecard).

Transformative successes of the last nine years of Centennial Care (2014-2022) include, but are not limited to, the following:

- ***Streamlining administration of the program*** by consolidating a myriad of federal waivers that siloed care by populations. Today, three MCOs administer the full array of services in an integrated model of care.

- ***Building a care coordination infrastructure*** that promotes a person-centered approach to care. Lower costs associated with inpatient stays and increased utilization of primary care office visits, preventive care and behavioral health services is evidence of the success.
- ***Increasing access to LTSS*** for people who previously needed a waiver slot to receive such services. Today, 32,309 individuals are receiving HCBS, which is an increase of 8.6% since 2019.
- ***Continuing to lead the nation*** in spending more of its LTSS dollars to keep members in their homes and in community settings rather than institutional settings. Today, 88% of LTC members are receiving HCBS in their homes compared to 12% in Nursing Facilities.
- ***Demonstrating both cost-effectiveness and improved utilization of health care services.*** Between SFY 2017 and SFY 2022 Medicaid/CHIP per capita expenditures increased 37%, from $6,209/year to $8,527/year. Between 2017 and 2020, HSD began increasing provider reimbursements on a statewide basis to follow Medicare reimbursement trends, primarily using adjustments in Medicaid fee schedules. Between 2020 and 2022, HSD responded to the COVID-19 PHE absorbing unprecedented growth in Medicaid/CHIP enrollment and reducing the financial burdens placed on medical service providers through enhanced payments. As described above, HSD also worked diligently during this time to expand access to telehealth in order to support continued delivery of needed care during the pandemic.

E. Demonstration Amendments

Over the course of the Centennial Care 2.0 program, New Mexico has continued to make meaningful changes to the demonstration to ensure the State is maximizing the authorities needed to serve its members. Since the approval of Centennial Care 2.0, the State has submitted three amendments. Two are still pending at the time of this writing. These amendments include:

1. Amendment Request #1: Increase Community Benefit Slots, Expand Home Visiting Pilot, and Remove Cost Sharing and Retroactive Eligibility Limitations (Approved February 2020)

Amendment #1, approved by CMS in February 2020, authorized three major changes to Centennial Care 2.0: 1) allowed the State to increase the number of CB slots by 1,500 throughout the remainder of the demonstration approval period; 2) allowed the State to expand the Centennial Home Visiting pilot program by removing restrictions on the number of counties and adding additional slots for members to participate; and 3) removed three provisions originally approved in the Centennial Care 2.0 2018 extension that were determined to no longer serve New Mexico's Medicaid program. The provisions include the following:

- Removal of co-payments for non-emergency use of the emergency room and non-preferred prescription drugs;
- Removal of monthly premiums for the Adult Expansion Group with incomes above 100% of the federal poverty level (FPL), as well as no longer allowing termination of coverage and lockouts for this group for non-payment of premiums; and
- Removing limitations on retroactive eligibility for non-pregnant adults.

2. **Amendment Request #2: Improvements to Behavioral Health Services, Workforce Development Programs, Intensive Care Coordination for High-Need Children and Youth, and Coverage/Benefit Enhancements per New Mexico's COVID-19 Response (PARTIALLY PENDING: only the COVID-19 requests were approved in March 2022)** This amendment requests four new authorities to address health system improvements, including:
    - Waive the IMD Exclusion for members with SMI/SED to allow members with a SMI or SED diagnosis to receive residential treatment in appropriate settings and increase access to necessary behavioral health treatment;
    - Establish a Statewide "High Fidelity Wraparound" program for children and youth with complex care needs to support an intensive care coordination approach to allow these children and youth to have better support, access to care, and outcomes;
    - Create a GME expansion funding mechanism to support the development of new and/or expanded programs for provider education. The funding would focus on the specialties of General Psychiatry, Family Medicine, General Pediatrics, and General Internal Medicine; and,
    - COVID-19 Coverage and Benefits (Approved March 2022): expenditure authority to allow State payments to providers for the administration of a COVID-19 vaccine to previously excluded populations, including individuals eligible for the optional COVID-19 group, individuals eligible for family planning benefits, those receiving pregnancy-only benefits, and those covered under Emergency Medical Services for Non-Citizens (EMSNC).

3. **Amendment Request: Home- and Community-Based Services Improvements (Pending)** HSD submitted an amendment in December of 2021 to request three authorities to enhance the HCBS system for members living in or transitioning to community settings. This amendment request was submitted to authorize initiatives that have been approved by CMS through American Rescue Plan Section 9817 funding. These include:
    - Increasing the number of CB allocation slots to increase access to HCBS services for elderly and disabled New Mexicans.
        - New Mexico received approval through New Mexico's American Rescue Plan Section 9817 HCBS Spending Plan for 1,000 CB enrollment slots. Through this amendment request, the State is seeking expenditure authority to sustain the slots..
    - Increasing the dollar amount limit for community transition services from $3,500, to $4,000 every five years. These services are funds that are one-time setup expenses for individuals transitioning from institutions or other provider-operated living arrangements into private residences in the community where they are responsible for their own living expenses.
    - Increasing the dollar amount limit for Environmental Modification Services from $5,000 to $6,000 every five years. These funds allow for the purchase and/or installation of equipment and physical adaptations to a member's residence that are necessary to ensure health, welfare, and safety of members, as well as enhance their level of independence.

F. Centennial Care 2.0 Post Award Forums

On April 15, 2019, HSD provided an update of the implementation of Centennial Care 2.0 to the Medicaid Advisory Committee (MAC). HSD has presented progress reports on the 1115 Demonstration Waiver at all subsequent MAC meetings. All MAC meetings have a Public Comment opportunity. To date, HSD has not received public comments related to the progress of the Centennial Care 2.0 Demonstration.

MAC Meeting Dates:

- April 15, 2019
- December 16, 2019
- January 27, 2020
- April 27, 2020
- August 3, 2020
- November 2, 2020
- January 19, 2021
- May 10, 2021
- August 9, 2021
- November 8, 2021
- January 24, 2022
- May 16, 2022
- August 8, 2022

Section V: Continuing Features and Changes Requested to the Demonstration

New Mexico's Turquoise Care Waiver builds upon the Centennial Care and Centennial Care 2.0 accomplishments and maximizes opportunities for targeted improvements and other modifications to support the State's vision.

In service to the State's vision and goals, New Mexico is requesting a five-year demonstration renewal with a focus on five populations:

1. Prenatal, postpartum, and members parenting children, including children in state custody (CISC);
2. Seniors and members with LTSS needs;
3. Members with behavioral health conditions;
4. Native American members; and
5. Justice-involved individuals.

Figure 5: Turqoise Care Initiatives Impacting Target Population

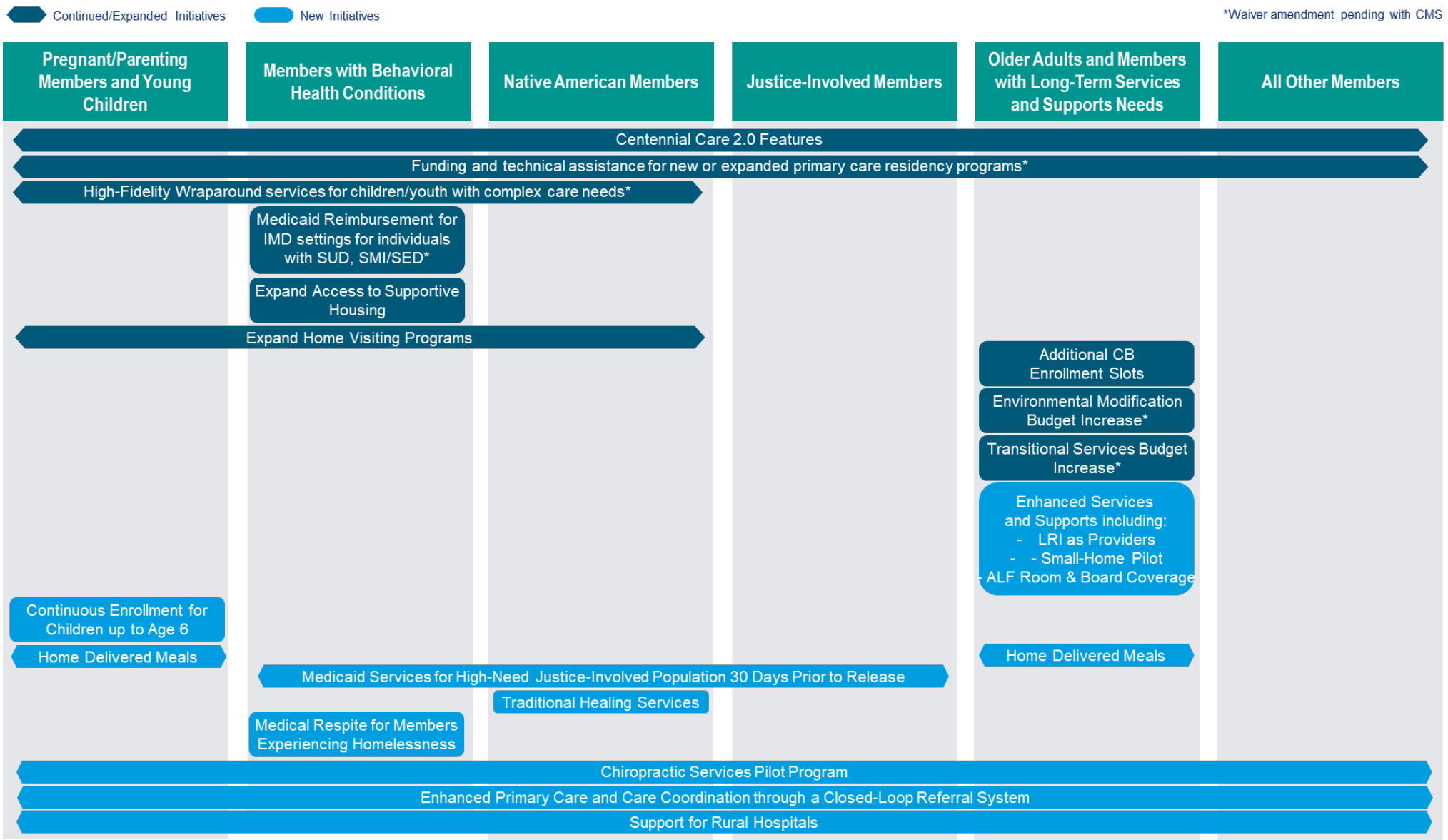


Table 5 below shows the financial impact of the continuing program elements, new Turquoise Care proposals and total expenditures over renewal period. For additional details related to the financial impacts of the proposed new impacts, refer to Section VIII.

Table 5.

Initiative Type	Estimated 5-Year Impact
Continuation of Programs Currently Approved	$39.5 Billion
Existing Programs with Enhancements and Proposed New Programs	$0.6 Billion
Total	$40.1 Billion

The following subsections provide a summary of continuing overarching demonstration features followed by programs continuing without enhancements, programs continuing with modifications, and proposed new programs.

Eligibility and Enrollment

1. **Continuing Demonstration Features**
   Turquoise Care will continue to include the Medicaid and CHIP State Plan eligibility groups and 1115 Waiver groups approved in Appendix E of the Centennial Care 2.0 approved demonstration, including the 217-like eligibility groups made eligible through demonstration authority. In state fiscal year (SFY) 2023, the State anticipates enrollment reductions of approximately 85,000 individuals due to eligibility re-determinations following the end of the COVID-19 PHE. Table 6 represents an overview of the eligibility groups currently served in Centennial Care 2.0.

   Table 6. Eligibility Groups Covered in Centennial Care 2.0

Population Group	Populations
TANF and Related	Newborns, infants, and children CHIP children (Medicaid expansion) Foster children Adopted children Pregnant women Low income parent(s)/caretaker(s) and families Breast and Cervical Cancer Refugees Transitional Medical Assistance
SSI Medicaid	Aged, blind and disabled Working disabled
SSI Dual Eligible	Aged, blind and disabled Working disabled
Medicaid Expansion	Adults between 19-64 years old up to 133% of MAGI
HCBS	Individuals receiving Community Benefit HCBS services under “217-like” group

   The following populations are excluded from Centennial Care 2.0:
   - Qualified Medicare Beneficiaries;

- Specified Low Income Medicare Beneficiaries;
- Qualified Individuals;
- Qualified Disabled Working Individuals;
- Non-citizens only eligible for emergency medical services;
- Program of All-Inclusive Care for the Elderly;
- Individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities;
- Medically Fragile 1915(c) waiver participants for HCBS;
- Developmentally Disabled 1915(c) waiver participants for HCBS;
- Individuals eligible for family planning services only;
- Mi Via 1915(c) waiver participants for HCBS;
- Supports 1915(c) waiver participants for HCBS; and
- Individuals eligible for the Optional COVID-19 Group.

Appendix E illustrates the complete table of mandatory and optional populations covered in the current waiver and the proposed Turquoise Care waiver.

2. New Demonstration Eligibility Proposals

Turquoise Care aims to expand eligibility and strengthen access to coverage, while also improving care delivery. In addition to the Medicaid eligibility groups currently enrolled in Centennial Care 2.0, Turquoise Care will:

- Provide continuous Medicaid enrollment for children up to age six and
- Expand HCBS CB enrollment opportunities through additional waiver slots. A full description of these two proposals proceeds this paragraph.

Eligibility Proposal #1: Provide Continuous Enrollment for Children up to Age Six

Proposal

To maximize our efforts to improve access to care and services for children, New Mexico is seeking authority under the Turquoise Care demonstration to provide continuous enrollment in Medicaid for children from the time of application up to age six.

Proposal Objectives

This proposal is part of HSD's work to support a person-centered and holistic approach to coverage and care for all New Mexicans. When children up to age six are continuously covered, MCOs, providers, State agencies, schools, and other child-focused organizations and programs can successfully focus efforts on engaging these children in appropriate services. Preventive care, care and treatment for physical and behavioral health conditions, and early childhood screenings are essential to setting children up for success in school and building a foundation to support their health and well-being through the rest of their lives. This coverage will yield improvements in access to essential care while reducing unnecessary costs associated with enrollment lapses. Moreover, HSD will not need to spend administrative resources currently associated with eligibility re-determinations, thereby reducing costs and allowing staff to focus on services that provide more value to our members. Specific benefits of this proposal include:

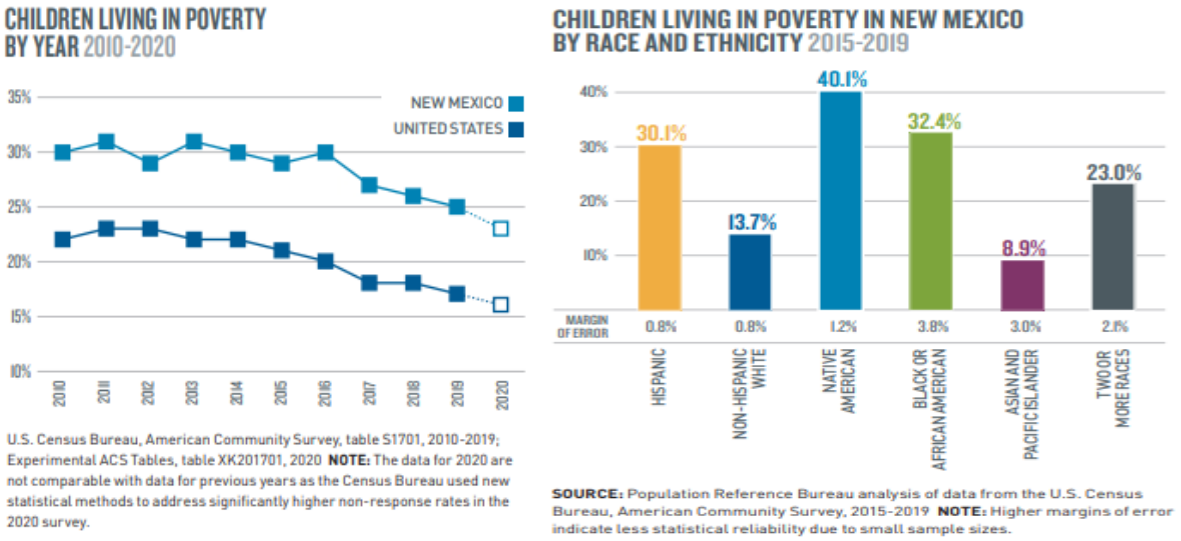
- Provision of consistent access to care, including early childhood screenings, primary and preventative services, and treatment;
- Reduction of administrative costs associated with application reprocessing;

- Decreasing the need for higher-cost services associated with delaying care; and
- Easing the stress and burden on families and caregivers as they navigate Medicaid coverage.

Background

In 2020, there were 170,435 children aged 0–6 in New Mexico, comprising 36.1% of all children less than 18 in the State.[25] Continuity of coverage in young children provides an essential foundation for health throughout life, setting them up for more opportunities and better wellness as they grow. When young children have uninterrupted coverage, providers and health plans are better able to focus their efforts on engaging these children and families, so that essential preventive care and early diagnosis and treatment of physical, behavioral, and learning conditions that could impact growth, development, and wellbeing are diagnosed and treated appropriately and consistently. There has never been a more important time to focus on the health and wellbeing of young children. The COVID-19 pandemic significantly disrupted the social, emotional, behavioral, and economic lives of children in the United States, as well as the programs in place to support children in these areas.[26] It is also important to highlight that these disruptions are more likely to happen to children of color, who disproportionately make up the majority of children in New Mexico living in poverty.

Figure 6.



The purpose of this continuous enrollment proposal is to reduce the temporary and detrimental loss of Medicaid coverage that children experience (often referred to as enrollment "churn"). This occurs when there are one or more temporary lapses in Medicaid coverage over a period of time. Research shows that it is common to have disruptions in Medicaid coverage, and these disruptions can lead to delays in needed care and treatment, less preventive care for members, and periods of no coverage.27 At the same time, enrollment lapses can cause extra administrative costs for the Medicaid program, as resources are needed to perform eligibility checks, disenrollment, and re-enrollments, as well as an increased need for care during periods of enrollment.

[25] https://datacenter.kidscount.org/data/#USA/1/0/char/0
[26] Jones, Kaitlyn. The Initial Impacts of Covid-19 on Children and Youth ... Aug. 2021, https://aspe.hhs.gov/sites/default/files/documents/188979bb1b0d0bf669db0188cc4c94b0/impact-of-covid-19-on-childrenand-youth.pdf.
[27] Sugar, S., Peters C., DeLew. N., Sommers, BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic (Issue Brief No. HP-2021-10). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. April 12, 2021. Available at https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

Table 7. Percent of Disenrolled who Re-Enroll within Three Months

Percent of Disenrolled who Re-Enroll within Three Months					
	All Beneficiaries with Full Benefits	Medicaid MAGI Children	Medicaid Non-MAGI Children (Non-Dual)	M-CHIP Children	S-CHIP Children
New Mexico	17.5%	20.7%	10.7%	19.7%	-

Source: Mathematica tabulations of the 2017 T-MSIS Analytic File (TAF) release 1, 2018 TAF release 1, and 2019 TAF preliminary release data.
Notes:
1. Re-enrollment measures are only calculated for beneficiaries whose first observed enrollment span in 2018 ends on or before December 31, 2018 (displayed in Table 7).
2. The gap between disenrollment and any subsequent re-enrollment was only calculated for the first enrollment span observed in 2018.
3. Re-enrollment within three months is defined as a break of less than 91 days between the first enrollment span in 2018 and the next observed enrollment span (if any).

Table 8. Percent of Disenrollees who Re-Enroll within 12 Months

Percent of Disenrollees who Re-Enroll within 12 Months					
	All Beneficiaries with Full Benefits	Medicaid MAGI Children	Medicaid Non-MAGI Children (Non-Dual)	M-CHIP Children	S-CHIP Children
New Mexico	38.9%	43.8%	28.1%	40.6%	-

Source: Mathematica tabulations of the 2017 T-MSIS Analytic File (TAF) release 1, 2018 TAF release 1, and 2019 TAF preliminary release data,
Notes:
1. Re-enrollment measures are only calculated for beneficiaries whose first observed enrollment span in 2018 ends on or before December 31, 2018 (displayed in Table 8).
2. The gap between disenrollment and any subsequent re-enrollment was only calculated for the first enrollment span observed in 2018.
3. Re-enrollment within 12 months is defined as a break of less than 365 days between the first enrollment span in 2018 and the next observed enrollment span (if any).

In New Mexico, enrollment lapses are notable among Medicaid and CHIP covered children. For Medicaid MAGI and M-CHIP children, 20.7% re-enroll every three months, and 43.8% re-enroll every year. This represents significant administrative burden for families while also representing gaps in coverage during critical life stages.

According to the Center for Health Care Strategies, the first 1,000 days of a child's life are a "critical window for cognitive, physical, and social development. Exposure to adverse childhood experiences during this period and beyond in early childhood dramatically increases the potential for lifelong poor health and social outcomes."[28] This is especially critical in New Mexico where there is a higher proportion of children in poverty than the United States average, and these children are disproportionately children of color. Coverage and access to timely and needed health services is an issue of equity and key to a fair start for all children.

Proposal Details

Coupled with other efforts to improve access to care and services for children, New Mexico requests federal authority and matching funds to provide continuous enrollment for children through the end of the month of their sixth. This continuous enrollment would begin at birth or whenever a member is first

[28] Magie, K., Shuell, J., Hron, J., Dodge, R., McCormick, C., Hertwig, R., Putnam, C. (2019, February 07). Preventing early childhood adversity before it starts: Maximizing Medicaid opportunities. Available at https://www.chcs.org/maximize-medicaidopportunities-prevent-early-childhood-adversity-starts/

enrolled or otherwise returns to Medicaid enrollment and would continue in spite of any income or household size changes that would otherwise cause a loss of eligibility.

The proposed continuous enrollment policy will apply to all Medicaid-eligible children under age six who continue to reside in the state of New Mexico. Children enrolled under this provision will have access to the full suite of Medicaid benefits they would otherwise be eligible for as part of their eligibility group.

Financial Impact
This proposal is expected to have a total five-year fiscal impact of $109.4M. See Section VIII for estimate by year.

Eligibility Proposal #2: Expand Home and Community Based services Community Benefit Enrollment Opportunities through Additional Waiver Slots

Proposal
New Mexico is seeking authority under the Turquoise Care demonstration to permanently add 1,000 CB enrollment "slots," which have been approved through New Mexico's American Rescue Plan Section 9817 HCBS Spending Plan and Attachment K temporary authority request. Over the course of the five-year waiver renewal period, HSD will evaluate and make targeted requests for new capacity to eliminate the current waitlist for CB services.

Proposal Objectives
HSD's goal is to eliminate the CB HCBS Waitlist by the end of 2028 in order to help more New Mexicans maintain independence and personal choice, two critical aspects of a person-centered approach. This expansion will expedite service provision for the individuals currently on the CB waitlist and allow these individuals to receive needed supports in their homes and communities.

Background
The CB program provides needed services to individuals residing in their homes and communities who need additional support to live and thrive independently. Individuals on the CB Waitlist do not qualify for Medicaid under state plan rules, yet do not have the financial resources needed to afford community-based services. Additionally, it is more costly to the State for members to reside in a nursing facility vs. CB members (average 2022 cost per member per month of $9,038.76 for nursing facility members compared to $3,582.48 for CB members). Under the special terms and conditions of the Centennial Care 2.0 Demonstration, HSD currently maintains a waitlist for HCBS CB services for individuals who are not otherwise eligible for Medicaid. (These individuals are sometimes referred to as the "217" eligibility group.) There are currently around 16,000 disabled and elderly New Mexicans on the CB waitlist.

HSD increased the CB slots by 1,500 in 2019 (from 4,289 to 5,789) and requested HCBS Spending Plan authority to fund up to 1,000 additional CB slots. By 2024, HSD expects to utilize all 1,000 of the slots requested through the American Rescue Plan Section 9817 HCBS Spending Plan and this Turquoise Care demonstration request. HSD has also committed to using HCBS Spending Plan funding to eliminate the waitlist for the 1915(c) Developmental Disabilities Waiver and Mi Via Waiver over a three-year period.

Proposal Details

To sustain this HCBS Spending Plan initiative, HSD proposes to permanently add these 1,000 CB slots to the Turquoise Care waiver and to continue to seek State funding that will enable HSD to eliminate the CB waitlist by the end of 2028.

Financial Impact

This proposal is expected to have a total five-year fiscal impact of $175.4M. See Section VIII for estimate by year.

Premiums and Cost Sharing

Premiums and cost-sharing will continue to follow the approved Medicaid State Plan. New Mexico removed premiums and cost sharing elements from Centennial Care 2.0 in the amendment approved in February 2020 and there will continue to be no cost sharing elements under Turquoise Care.

Benefits

1. Continuing Demonstration Features

Turquoise Care will continue to include the approved Centennial Care 2.0 benefits, including the CBs described in Attachment B of the Centennial Care 2.0 approved waiver. These include comprehensive benefits that are at least equal in amount, duration and scope to those described in the State Plan, with the exception of the Adult Group, who receive the benefits in their approved Alternative Benefit Plan (ABP). Those in the Adult Group who are medically frail will continue to have a choice of the approved ABP with the ten essential health benefits required by the Affordable Care Act,[29] or the ABP with the approved State Plan benefit package.

Turquoise Care benefits will also continue to include the demonstration benefits approved in Centennial Care 2.0, including: Community Intervener services, Medicaid home visiting services, Pre-Tenancy and Tenancy Services, Participant Direction for select CB services, OUD/SUD treatment services and withdrawal management during short-term residential and inpatient stays in IMDs, the Member Rewards Program approved in Centennial Care 2.0, and family planning-only eligibility to otherwise ineligible individuals age 50 and under who do not have other health insurance coverage and individuals who are under age 65 who have only Medicare coverage that does not include family planning benefits.

2. New Demonstration Benefits Proposals

Turquoise Care aims to expand eligibility and strengthen access to coverage, while also improving care delivery. In addition to the Medicaid benefits currently included in Centennial Care 2.0, HSD is requesting:

1. Expanded Centennial Home Visiting Pilot Programs;
2. Expanded Access to Supportive Housing;
3. Medicaid Services for High-need Justice-involved Populations 30 days Before Release;
4. Chiropractic Services Pilot;
5. Member-Directed Traditional Healing Services for Native Americans;
6. Enhanced Services and Supports for Members in Need of Long-Term Care;
7. Increased Environmental Modifications Benefit Limit (pending waiver amendment);

[29] This refers to the ten essential health benefits health plans are required to cover by the Affordable Care Act passed in 2010. These include ambulatory (outpatient) services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services and treatment, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, and pediatric services (including oral and vision care).

8. Increased Transitional Services Benefit Limit (pending waiver amendment);
9. Addition of a Closed-Loop Referral System;
10. Home-Delivered Meals Pilot Programs; and
11. Medical Respite for Members Experiencing Homelessness.

The following two Medicaid benefits are still pending approval under a waiver amendment request that is under CMS review:

1. Medicaid Reimbursement for IMD Settings for Individuals with SMI/SED.
2. HFW Services for Children and Youth with Complex Care Needs, including Behavioral Health and LTSS needs.

The proceeding parts of this subsection provide information on each of the new proposals.

Benefit Proposal #1: Expand the Centennial Home Visiting Programs

Proposal

HSD requests continuation and expansion of the Centennial Home Visiting (CHV) program. We are proposing to continue the two existing evidence-based models and expand the program to include four new evidence-based models on a pilot basis.

Proposal Objectives

Under Turquoise Care, HSD will expand home CHV programs to:

- Improve parental nurturing, including parenting skills and the ability to teach and encourage children for applicable models;
- Support child physical and mental health;
- Increase safety of families and children through screening and referral for domestic violence for applicable models; and
- Provide connections to community supports.

Background

New Mexico's CHV Program was established in 2019 as part of the State's Centennial Care 2.0 Medicaid 1115 Waiver (the "Waiver"). CHV services are provided in a home setting to young children, children with special health care needs, and to the parents(s)/primary caregiver(s) of those young children. New Mexico CHV's Program Goals are to:

- Improve maternal and child health;
- Promote child development and school readiness;
- Encourage positive parenting; and
- Connect families to the formal and informal support in their communities.

The original Waiver served as the State's CHV Pilot and provided CHV services to 150 eligible Centennial Care 2.0 MCO members who resided in Bernalillo, Curry, Roosevelt and Taos counties from July 1, 2019 – June 30, 2020, 152 families were served by the pilot program. In 2020, CMS accepted New Mexico's proposed Waiver amendment, which expanded CHV services Statewide and increased number of families served. CHV currently serves 299 families and is allocated to serve 1,500 families in fiscal year 2023.

In November 2020, the Early Childhood Home Visiting Medicaid Expansion Workgroup (or ECHV Medicaid Expansion Workgroup) was formed to address CHV program expansion as follows: to drive existing provider improvement, to increase existing provider program utilization, and to consider how the CHV could expand to include additional HV models and additional providers. The group culminated its work in April 2021, developing recommendations which included a recommendation to expand access to a variety of ECHV program models, which is the subject of this waiver request to add four new home visiting program models.

While the State has encountered a variety of challenges with scaling up this program over the course of Centennial Care, a majority of these challenges have been addressed or are in process. Table 9 below summarizes the challenges and the States response to ensure the future success of the CHV program.

Table 9. CHV Challenges and Responses

Challenge	Response
Majority of agencies had not billed Medicaid and did not have appropriate billing capabilities embedded in their systems.	Universal billing platform created and available to all interested agencies.
MCO communication lacking leading to stalled contracts and denial of claims.	Dedicated person embedded within Medicaid to act as a liaison between MCOs and agencies, improving speed of resolutions.
Cumbersome referral system through MCOs requiring two levels of consent (MCO level, agency level), leading to attrition of interest.	Referrals will be built into closed-loop referral system that is being requested in FY 2024 budget via Medicaid.
Confusion among agencies about which department within state government responsible for which step of onboarding. Confusion between departments about who is the direct contact.	Medicaid currently building a provider manual with a landing page on the Human Services Department website for CHV.
Unable to admit children to the program if member has already given birth.	Expand models available via this waiver request that include postpartum admission to CHV.

HSD will continue exploring the recommendations of the ECHV Medicaid Expansion Workgroup, including supporting CHV providers to successfully bill Medicaid, enhancing collaboration and communication between MCOs and HV providers, and improving the intake and referral processes to make the experience more person-centered for members and families while reducing administrative complexity.

Proposal Details

The CHV program will continue the existing two CMS-approved evidence-based early childhood home visiting delivery models – the NFP and PAT New Mexico – and proposes to add four additional evidence-based models[30] on a pilot basis. The four new models will enroll parents and children postpartum and do not require families to be enrolled while the individual is pregnant. These additional

[30] Evidence-based is defined as programs evaluated by the Department of Health and Human Services Home Visiting Evidence of Effectiveness (HomVEE). HomVEE conducts a thorough and transparent review of early childhood home visiting models and provides an assessment of the evidence of effectiveness for early childhood home visiting models that serve families with pregnant women and children from birth to kindergarten entry.

models will allow HSD to build upon the coverage extension of post-partum services for members up to 12 months. These four additional proposed programs are:

1. Child First (CF): CF targets children with social-emotional, behavioral, developmental, or learning problems. These children usually come from families experiencing trauma and adversity. Many of these families also experience multiple social, economic, or psychological challenges (e.g., depression, substance misuse, intimate partner violence, abuse and neglect, homelessness). CF will adhere to the CF national model and curriculum and serve families with children ages 6-36 months.

2. Healthy Families America (HFA): HFA is designed to serve the families of children who have increased risk for maltreatment or other adverse childhood experiences. HFA sites are able to determine which family and parent characteristics it targets. For example, sites may choose to target low-income families, single parent households, or families who have experienced substance use, mental health issues, or domestic violence. In alignment with the national model and curriculum, families are eligible to begin HFA during pregnancy or until a child is three months old. Services will be provided for a minimum of three years, up to when the child reaches five years old.

3. Family Connects (FC): FC is a population health model and systems-building strategy with nurse home visits at the center. The model offers newborn and postpartum health assessments via a registered nurse, who systematically assesses family needs, provides supportive guidance, and links families to community resources, as needed and desired. FC identifies and aligns community services that support families and young children, resulting in improved communication and continuity across service providers. Through this alignment, the model also identifies gaps between family needs and available community resources. FC will adhere to the FC national model and curriculum and will serve families beginning within six months of birth and will provide one to three visits.

4. Safe Care Augmented (SCA): SCA is an enhanced version of Safe Care, an in-home behavioral parenting program that promotes positive parent-child interactions, informed caregiver response to childhood illness and injury, and a safe home environment. It is designed for parents and caregivers of children birth through five who are either at-risk for or who have a history of child neglect and/or physical abuse. SCA requires additional training to help identify risk factors for domestic violence and increase provider awareness and ability to detect domestic violence.

Financial Impact
This proposal is expected to have a total five-year financial impact of $6.2M. See Section VIII for estimate by year.

Benefit Proposal #2: Expanded Access to Supportive Housing

Proposal
Under Turquoise Care, the Supportive Housing Program will continue providing pre-tenancy and tenancy support activities to members with SMI that are part of the Linkages Supportive Housing Program approved in Centennial Care 2.0. HSD also requests to increase enrollment of this program from 180 to 450 annually to provide services to members who are associated with a Local Lead Agency and provider and the Special Needs/Set Aside Housing Program (SAHP).

Proposal Objectives

This proposal aims to educate and support members on how to successfully access and maintain safe and stable housing. Additionally, Medicaid funding for Supportive Housing allows providers to reallocate funding to other necessary housing-related activities and build more supportive housing units.

Background

Within the Centennial Care 2.0 application, HSD submitted a proposal to provide robust pre-tenancy and tenancy support services to Centennial Care members with SMI (including those with co-occurring SUDs), utilizing the existing program infrastructure and network of provider agencies associated with the Linkages permanent supportive housing program. Linkages providers are expected to utilize peers for service delivery. This approach builds upon a successful Statewide supportive housing model; expands the peer workforce; and improves engagement, service delivery, and outcomes for individuals with SMI.

Homelessness in New Mexico continues to be a growing problem. Between 2018 and 2019, New Mexico experienced a 27% increase in homelessness, the largest increase of any state in the US by 10 percentage points.[31] Evidence is clear that lack of safe and stable housing is strongly linked to poor health outcomes, and that housing is an important social determinant of health and wellbeing.[32] Homelessness also worsens effects from mental health conditions and SUDs, makes chronic condition management difficult or impossible, and creates barriers to building and maintaining social and community connections.

Supportive housing and related services remain a clear solution to providing safe and stable housing to individuals more at-risk of adverse health outcomes, especially those with behavioral health conditions. While affordable housing has emerged as an important strategy to combat homelessness, many individuals with disabilities or behavioral health issues are not able to maintain housing without supportive services.

Proposal Details

In Turquoise Care, New Mexico proposes to continue the supportive housing program and expand support activities to members associated with a Local Lead Agency provider and the Special Needs/SAHP. SAHP eligibility criteria includes:

- Homeless or precariously housed individuals;
- Individuals with SMI;
- Individuals with SUDs;
- Individuals with intellectual/developmental disabilities;
- Individuals with physical, sensory, or cognitive disability occurring after the age of 22;
- Individuals with a disability caused by chronic illness (i.e., people with HIV/AIDS, diabetes, etc. or other incapacitating illness); and
- Individuals with an age-related disability (i.e., frail elderly, or, young adults with other special needs who have been in the foster care or juvenile services system).

[31] The US Department of Housing and Urban Development Office of Community Planning and Development. The 2019 Annual Homeless Assessment Report (AHAR) to Congress. January, 2020. Retrieved from: https://www.huduser.gov/portal/sites/default/files/pdf/2019-AHAR-Part-1.pdf

[32] Dohler, Bailey, Rice, and Katch. Supportive Housing Helps Vulnerable People Live and Thrive in the Community. Center on Budget and Policy Priorities. May 31, 2016. Retrieved from: https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community

HSD is also proposing to increase the maximum number of potential members that may benefit from these services from 180 to 450 annually. The specific pre-tenancy and tenancy support services offered in Centennial Care 2.0 will remain the same and continue to be provided by Certified Peer Support Workers. To increase access to the benefit, HSD is proposing to include Community Support Workers and/or Supportive Housing Coordinators as eligible provider roles of these services.

Financial Impact
This proposal is expected to have a total five-year financial impact of $7.8M. See Section VIII for estimate by year.

Benefit Proposal #3: Medicaid Services for High-Need Justice Involved Populations 30 Days before Release

Proposal
Expanding on the State's previous efforts to support the justice-involved population, New Mexico is proposing to provide active Medicaid coverage and a targeted set of benefits 30 days prior to exiting incarceration for a defined high-needs population. This population includes incarcerated persons in state prisons, local jails, youth correctional facilities, DOH forensic unit state hospitals, tribal holding facilities, or tribal jails, targeting members with high needs, including but not limited to those with SMI, SED, or SUD. The proposed benefits are commensurate to the population's needs, including enhanced care management and coordination, medication assisted treatment (MAT), and 30-day supplies of medications and durable medical equipment (DME), as appropriate.

Proposal Objectives
Coupled with the provision of MAT and the post-incarceration issuance of a 30-day supply of medication and DME, the goal of the proposal is to provide the requisite supports and services needed to provide health and social stability to individuals upon community re-entry. This will be achieved through the use of enhanced care management and coordination to optimize community re-entry and care transitions. Specific care management/coordination activities include transition planning, supports to assist in securing housing, linkages to other community supports that attend to the social determinants of health, conducting screening and referrals to community-based supports and services (including peer support services), providing culturally and linguistically sensitive health and social support education to beneficiaries and their families/caregivers, and developing a medication management plan with clinical providers. The overarching goals of this proposal include the following:

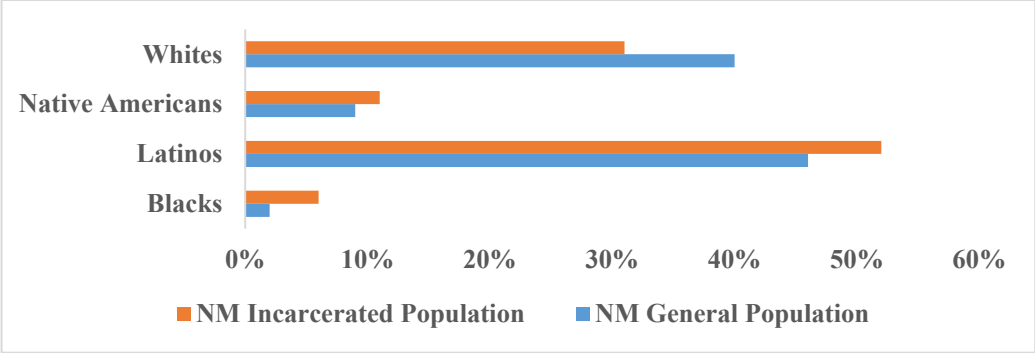
- Improve physical and behavioral health among returning citizens;
- Ensuring medication and medical resource continuity post-exit;
- Reduce recidivism;
- Strengthen community-based supports to prevent costly and avoidable emergency department visits or inpatient hospitalizations; and
- Decrease the number of formerly incarcerated individuals struggling with homelessness or housing insecurity.

Background
Persons involved with the justice system are subject to significant behavioral and physical health disparities compared to the general US population. This spans many areas of health, including greater prevalence of chronic medical conditions (e.g., high blood pressure, asthma), infectious diseases (e.g.,

Tuberculosis rates are four times higher, hepatitis is over eight times higher, and HIV/AIDS is two to seven times higher), and much larger needs related to behavioral health issues.[33] Data from the US Department of Justice and the National Institute on Drug Abuse shows, respectively, that 58.1% of United States incarcerated population had a mental health disorder and 65% had a SUD (compared to just 11% and 9% for the general population, respectively).[34][35]

The needs cited above translate into New Mexico's population and are further exacerbated by confounding factors such as a high per capita rate of incarceration, higher rate of adults living in poverty (16.7%) relative to the United States (11.5%), and a greater percentage of aged and minority populations.[36] At any given time in New Mexico, over 14,000 people are incarcerated in state, local, or youth correctional facilities. Specific to local jails, nearly 50,000 people cycle through these systems on a yearly basis. Factoring in other incarcerated settings, New Mexico has an incarceration rate of 733 per 100,000 population, exceeding the national average of 664 per 100,000 population. Moreover, New Mexico's justice-involved population is made up of a disproportionately higher percentage of people of color relative to the general population, while whites are comparatively underrepresented.[37] The figure below illuminates these demographic disparities:

Figure 7. Race/Ethnicity Composition – NM Incarcerated versus General Population



As health care disparities are already prevalent among minority populations, the disproportionately high share of minorities comprising New Mexico's incarcerated population coupled with the high needs of those involved with the justice system creates a highly vulnerable situation. In fact, New Mexico is demonstrably more affected than the overall United States population in myriad health indicators.[38] The table below displays examples of the relatively higher health care needs among New Mexico's general population:

[33] US Department of Justice (2015). Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12. Retrieved from: https://bjs.ojp.gov/content/pub/pdf/mpsfpji1112.pdf.
[34] US Department of Justice (2006). Mental Health Problems of Prison and Jail Inmates. Retrieved from: https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf.
[35] US National Institute of Drug Abuse (2020). Criminal Justice DrugFact. Retrieved from: https://nida.nih.gov/download/23025/criminal-justice-drugfacts.pdf?v=25dde14276b2fa252318f2c573407966
[36] US Census Bureau (2020). American Community Survey 1-Year Estimates.
[37] Prison Policy Initiative (2021). New Mexico Profile. Retrieved from: https://www.prisonpolicy.org/profiles/NM.html.
[38] Kaiser Family Foundation (2022). State Health Facts – Custom State Report: New Mexico and United States, Selected Health Statistics.

Table 10.

Selected Health Statistic	New Mexico	United States
Age-Adjusted Suicide Rate per 100,000 Population	24.2	13.5
Diabetes Deaths per 100,000 Population	29.3	24.8
Teens Ages 12-17 Reporting a Major Depressive Episode in the Past Year	17.3%	16.3%
Adults Ages 18+ Reporting a Major Depressive Episode in the Past Year	10.5%	8.1%
Opioid Overdose Death Rate per 100,000 (Age-Adjusted)	26.9	21.4
All Drug Overdose Death Rate per 100,000 (Age-Adjusted)	39.0	28.3

New Mexico has taken proactive steps to help support the justice-involved population over the last several years. This includes, but is not limited to, enhanced care coordination and electronic health records through the Justice Involved Utilization of State Transitioned Health Care Program (JUST Health) in addition to MCO contract requirements necessitating retroactive MCO enrollment for persons exiting incarceration dating back to the first of the month of release. Broadly, these initiatives have ensured Medicaid benefits are reactivated timely for Medicaid-eligible incarcerated beneficiaries. They have also allowed for MCOs to have a dedicated liaison for participating justice facilities.

Proposal Details

Research shows that proactive supports and services before an individual exits incarceration lead to improvements in population health, reduced recidivism, and cost-efficiencies, particularly when targeted to high-need populations.[39] As such, New Mexico's proposal expands its previous efforts and investments in the health of the justice-involved population by seeking to provide coverage and targeted services to high-need incarcerated persons 30 days before release is tailored to optimize the critical transition process back into the community. The eligibility and targeted services comprising this proposed benefit follow this paragraph. It is estimated that 7,500 people annually could benefit from this initiative.

Eligibility

This proposal will provide targeted benefits to eligible beneficiaries, including adults, the aged/disabled/blind, former foster care youth, pregnant individuals, and youth under 19 who are incarcerated in state prisons, local jails, youth correctional facilities, DOH forensic unit state hospitals, tribal holding facilities, or tribal jails – pretrial or post-conviction) during the 30 days before release (or fewer). The State will target high need members returning to the community, including but not limited to members with:

- SMI
- SED
- SUD
- Intellectual/Developmental Disability

Services

- Enhanced Care Management and Coordination
- MAT
- 30-day Supply of Medications (including MAT) and DME, as appropriate

[39] https://www.urban.org/sites/default/files/publication/97041/strategies_for_connecting_justice-involved_populations_to_health_coverage_and_care.pdf

Financial Impact
This proposal is expected to have a total five-year financial impact of $5.9M. See Section VIII for estimate by year.

Benefit Proposal #4: Chiropractic Services Pilot

Proposal
In order to provide a robust benefit package to support the State's focus on person-centered care, HSD is requesting to implement a pilot program to improve quality, access, and cost-effectiveness of needed chiropractic services for eligible members.

Proposal Objectives
Based on national studies about the impact of chiropractic care on patients, the overall goals of the pilot focus on improving quality, access, and cost-efficiency for eligible members. Evidence suggests that:

- Access to chiropractic care will improve health outcomes and reduce the need for high-risk treatment interventions for Medicaid patients with neck pain, back pain, musculoskeletal pain, and headaches;
- Adding chiropractic physicians will improve access to primary care for Medicaid patients with neck pain, back pain, musculoskeletal pain, and headaches;
- The addition of chiropractic services to the Turquoise Care benefit package will improve patient satisfaction; and
- Chiropractic services are cost-effective and will reduce per-member costs over time for patients with neck pain, back pain, musculoskeletal pain, and headaches.

Background
Chronic neck and back pain are a pervasive health problem in the US. Back pain is a leading cause of disability and time away from work, with an estimated 25% of long-term Social Security disability benefits being made to individuals with back or spine problems. New Mexico currently covers chiropractic care as one of the Specialized Therapies available under the Centennial Care 2.0 HCBS CB and the Mi Via Section 1915(c) HCBS Waiver, subject to a $2,000 annual benefit limit for Specialized Therapies. In January 2022, HSD convened a workgroup with a number of chiropractic physicians, policymakers, and clinical experts representing the Medicaid MCOs with the goal of designing a new chiropractic pilot program for additional select adult members who are not eligible for LTSS.

The New Mexico Medicaid program covers 968,763 individuals – or 46% of the State's total population. Chiropractic benefits are not covered for most adults enrolled in New Mexico Medicaid; however, they may be covered for children under early and periodic screening, diagnosis and treatment (EPSDT) and are available to individuals receiving LTSS through the Centennial Care 2.0 HCBS CB and Mi Via HCBS programs. Studies show that the addition of chiropractic benefits may improve health outcomes and reduce per-member costs over time, particularly in the area of chronic pain management. For example, chiropractic services can help some individuals avoid costly and sometimes high-risk interventions such as prescription medicines and/or surgery. The avoidance of these types of medical interventions, when medically appropriate, could offset some of the costs of adding these services to the Medicaid benefit package, while also improving outcomes and speeding recovery for Medicaid patients.

As of 2018, 24 of all US states provide some level of chiropractic benefit to their Medicaid members; however, 18 of the states that cover chiropractic services do so with certain limitations (such as an annual dollar cap or visit limit) and/or co-pay requirement (typically ranging between 50 cents and $3 per visit).[40] Eight states provide chiropractic services only to specific Medicaid populations or to individuals with certain diagnoses.

Proposal Details

New Mexico's chiropractic pilot will cover the full range of services allowed under the New Mexico Chiropractic Physicians Practice Act, with an annual benefit limit of $2,000 to align with the Centennial Care 2.0 HCBS CB and Mi Via HCBS programs. These chiropractic services will be available only to MCO enrolled members and there will be no co-payments. Prior authorization, if required, and utilization management controls will be determined by the contracted MCOs and monitored by the State to ensure that they are reasonable. Details regarding the eligibility, covered services, and provider requirements follow this paragraph.

Eligibility

The Centennial Care chiropractic pilot will be available Statewide to all MCO-enrolled adults in categories 100 (Other Adult Group) and 200 (Parent/Caretaker Group) who have a primary diagnosis of neck pain, back pain, or headaches.

Covered Services

- All services allowed under the New Mexico Chiropractic Physicians Practice Act;
- Evaluation and management codes that are used when addressing a new injury or condition, and clinical issues regarding non-procedural treatments;
- Manual manipulation or adjustment of the spine to correct or treat back pain, neck pain, headaches, or other related conditions; and
- Annual benefit limit of $2,000.

Provider Requirements

To participate in the chiropractic pilot, providers must meet the following qualification and enrollment requirements:

- Maintain a current New Mexico chiropractic license as outlined in the New Mexico Chiropractic Physician Practice Act;
- Hold a Doctor of Chiropractic diploma from a Council on Chiropractic Education accredited or board-accepted equivalent chiropractic college, as outlined in the New Mexico Chiropractic Physician Practice Act;
- Enroll with Medicaid, agree to the Medicaid Provider Participation Agreement, and bill according to Medicaid requirements, including rendering and referring provider rules;
- Complete the credentialing and contracting process with each MCO whose members they intend to serve under the pilot;
- Utilize evidence-informed/guideline-based practices as the basis for all service and treatment provision; and
- Agree to the requirements and limitations of the pilot design and the submission of data to support the project evaluation.

[40] https://www.kff.org/medicaid/state-indicator/chiropractor-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Financial Impact
This proposal is expected to have a total five-year financial impact of $16.1M. See Section VIII for estimate by year.

Benefit Proposal #5: Member-Directed Traditional Healing Benefits for Native Americans

Proposal
HSD is proposing to expand the availability of culturally competent, traditional healing benefits to all Native American members enrolled in Managed Care.

(Note: The State has hosted Tribal Listening Sessions to gather feedback on the new Member-Directed Traditional Healing Benefits for Native Americans. The State will continue to engage Tribal leaders while finalizing this proposal.)

Proposal Objectives
HSD is proposing to expand the availability of traditional healing services in order to provide culturally appropriate Medicaid services to Native American members enrolled in managed care. The communal and spiritual support provided by this type of healing can reduce pain and stress and improve quality of life.

Background
Centennial Care 2.0 added traditional healing benefits under the specialized therapies benefit available to Native American members enrolled in the Self-Directed CB (SDCB) Program. There are 23 sovereign Tribes, Nations, and Pueblos in New Mexico as well as numerous Native American individuals who come from many other tribal backgrounds. Native American healing therapies encompass a wide variety of culturally appropriate therapies that support members in their communities by addressing their physical, emotional, and spiritual health. These services can include but are not limited to: prayer, dance, ceremony and song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel and/or other sacred objects This form of therapy may be provided by community-recognized medicine men and women and others as healers, mentors, and advisors to members, and provides opportunities for members to remain connected with their communities. It is also important to note that some Tribes, Nations, and Pueblos prefer to keep these healing therapies and practices safeguarded due to the significance of their religious, historical ties and privacy. Each MCO contracts with a financial management agency (FMA) to facilitate this member-directed benefit.

Proposal Details
HSD is proposing to leverage the current CB self-directed model to expand traditional healing benefits in Turquoise Care to all Native American members enrolled in managed care. HSD proposes to provide a $500 budget per Native American member per year for traditional healing services provided by traditional healers. Individuals receiving traditional healing benefits through self-directed CBs will continue to have access through the SDCB option, but will not be eligible for the additional $500 budget allowance.

Financial Impact
This proposal is expected to have a total five-year financial impact of $51.6M. See Section VIII for estimate by year.

Benefit Proposal #6: Enhanced services and supports for members in need of long term care

1. **Legally Responsible Individuals as Providers of Home and Community Based Services Community Benefit Services:**

   Proposal

   Under Turquoise Care, HSD is proposing to permanently allow State-authorized relatives, guardians, and/or legally responsible individuals to render CB PCS.

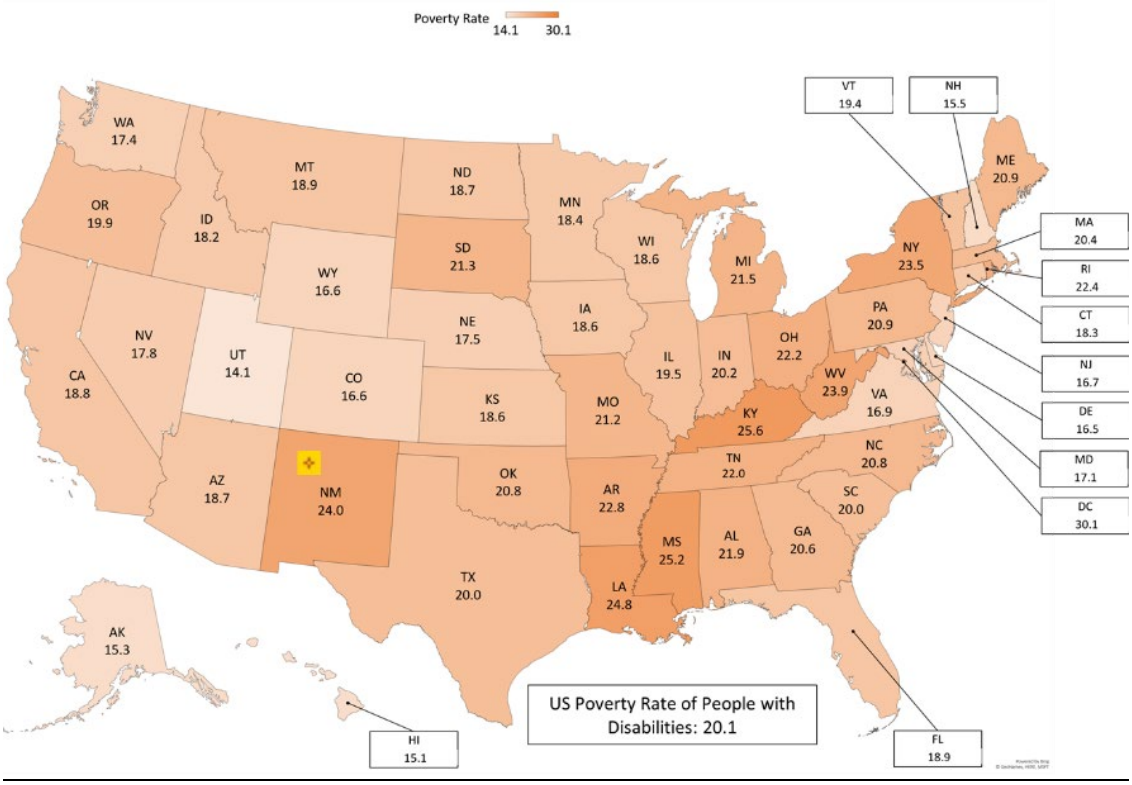
   Proposal Objectives

   HSD's intent in this proposal is to increase the proportion of individuals receiving PCS and enable more individuals to age in place.

   Background

   The COVID-19 pandemic created a notable shortage of health care workers, and also made it more difficult for adults with disabilities or an inability to perform their own activities of daily living (ADL) to find support in their homes and communities. As shown in Figure 8, in 2020, New Mexico had the fifth highest poverty rate among people with disabilities.[5]

Figure 8.



According to a state report, 419,000 New Mexicans provide unpaid care to adults per year, helping them overcome limitations in daily living like self-feeding, dressing, and mobility.[41]

Proposal Details

Under Turquoise Care, HSD is proposing to permanently allow State-authorized relatives, guardians, and/or legally responsible individuals to render CB PCS. This authority is currently granted under the temporary authority approved in the Centennial Care Appendix K during the COVID-19 PHE. Continuing this authorization is important to continue the State's support to unpaid caregivers, and ensuring that individuals eligible for HCBS services can get their needs met in the community. This approval under Turquoise Care will:

- Support access to HCBS by allowing a wider pool of qualified providers;
- Strengthen the provision of supports in the community using a cost-effective person-centered approach; and
- Ensure that relatives, guardians, and other legally responsible individuals can be justly compensated for their caregiving work.

HSD is proposing to permanently modify the provider qualifications to allow legally responsible individuals (LRIs) to provide PCS. The member's MCO must approve the LRI's provision of service before services are provided and report data to HSD quarterly. The LRI must meet all CB PCS caregiver requirements, including caregiver training.

Financial Impact

This proposal is expected to be budget neutral and no financial impact is expected. Because this proposal has no expected financial impact, it is not separately identified in Section VIII.

2. Long-Term Services and Supports Transformation: Expanding Access to Assisted Living Services and Promoting a person-centered Long-Term Services and Supports Experience for New Mexicans

Proposals

HSD is proposing to implement two new waiver strategies under Turquoise Care to transform the experience members have when accessing assisted living and nursing facility services, including: 1) Waiver Investments in Small-Home Assisted Living and Nursing Facility Pilots; and 2) Medicaid reimbursement for room and board in ALF settings when person-centered, cost-effective and clinically appropriate. These proposals complement the preceding request to increase CB slots.

Proposals' Objectives

These programs are in line with goals articulated by CMS, including:

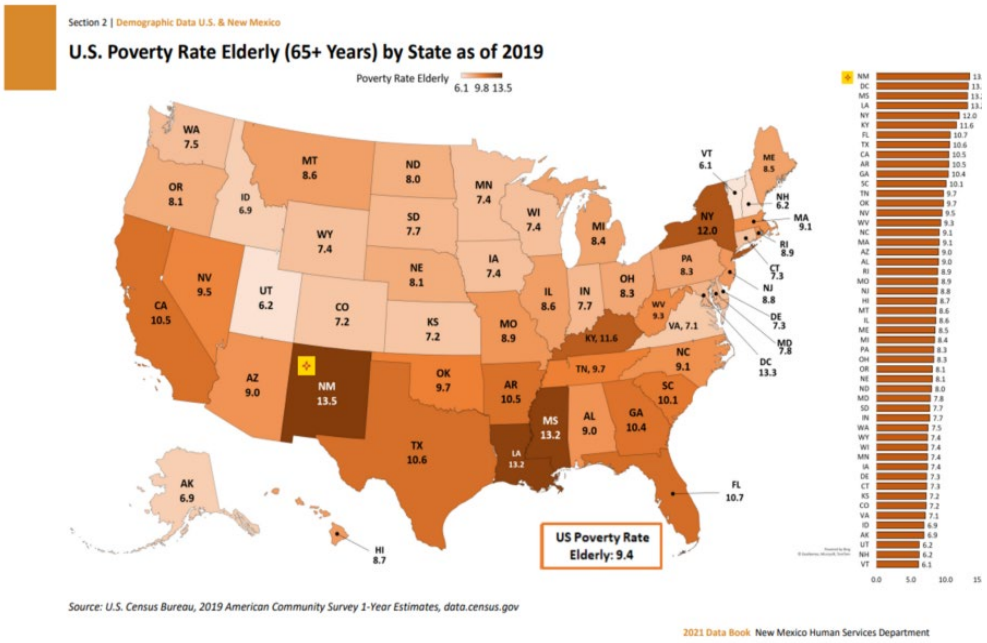
- Leveraging payment and regulatory flexibilities to ensure people supported by the LTSS system receive high quality, patient centered care;
- Shoring up staffing in long-term care settings to create higher staff ratios and ensuring the right level of provider is available to meet patient need; and
- Focusing on quality and transparency within community facilities to optimize outcomes and cost-efficiencies.

[41] New Mexico State Plan for Family Caregivers. No date. New Mexico Aging and Long Term Services Department and AARP. Retrieved from: https://nmaging.state.nm.us/uploads/files/New_Mexico_State_Plan_for_Family_Caregivers___final.pdf

Background

According to projections, New Mexico is one of just five states in the country whose population aged 65+ will exceed 25% by 2030.42 On top of New Mexico's large aging population, the State ranks highest in the nation for the elder poverty rate in 2019, at 13.5%, well over the national average of 9.4%.

Figure 9.



With the projected population of elderly New Mexicans steadily climbing, and a disproportionate amount of these elders living in poverty, it is imperative that the LTSS system transform to be able to accommodate this growth and address these disparities.

Strong improvements have been made through managed LTSS over the course of Centennial Care and Centennial Care 2.0 to address the needs of these people and their families, including the CB population and services, NF LOC determination, and community intervener services for the deaf and blind. Because of these efforts and the work of many key partners and stakeholders, New Mexico's LTSS system is already heavily weighted toward HCBS over institutional care. However, barriers remain for members requiring higher levels of care

Proposal Details

With a strong foundation of community-based supports for those with NF LOC needs, New Mexico seeks to further transform its LTSS system, particularly as the aged population continues to disproportionately grow faster than the United States average. This proposal seeks to demonstrate a comprehensive approach to LTSS reform consistent with efforts at the federal level to make Nursing Facility (NF) care more person-centered and home-like by focusing efforts to improve the quality and person-centeredness of LTSS within facilities, including ALFs and NFs. The recent CMS

[42] Iowa Census Data Tables: Projections. State Data Center of Iowa. Age 65 and older: State Rankings. Retrieved from: https://www.iowadatacenter.org/datatables/UnitedStates/usstprojectionsage65over20002030.pdf

memorandum QSO-22-19-NH reinforces this proposal. The memo included recommendations related to resident room capacity and highlighting the benefits of reducing the number of residents in each room given the lessons learned during the COVID-19 pandemic for preventing infections and the importance of residents' rights to privacy and homelike environment. The following two components of this proposal address "small home" concepts, optimized person-centered care, physical space enhancements within ALFs and NFs while simultaneously enabling members to remain in community-based ALFs, as appropriate.

1. Assisted Living and Nursing Facility Pilot
   HSD proposes to provide $1 million through the Turquoise Care waiver to incentivize the growth of smaller, more community-based spaces in both NFs and ALFs and to implement person-centered concepts through a quality incentive process to enhance living arrangements and care for members. The pilot would be comprised of two phases:

   Phase 1 (Demonstration Renewal Years 1-3)
   In year 1, funding would be made available through an application process to support strategic planning necessary to convert NFs to smaller settings within an institutional environment whilst allowing planning for implementation of person-centered concepts in care delivery in ALFs and NFs. Years 2 and 3 would be utilized to implement and evaluate person-centered concepts through training and scaled depending on the needs and capacity of providers.

   Phase 2: (Demonstration Renewal Years 4-5)
   Years 4 and 5 would leverage the person-centered concepts and continued strategic planning to implement and evaluate conversion pilots to enhance physical spaces within NFs.

2. Room and Board for ALFs
   HSD proposes to pilot the provision of Medicaid funding for room and board payments to ALFs for Medicaid members receiving the assisted living service through the CB package. While room and board is covered for members in an NF, federal statute prohibits payment of room and board in community-based settings, including ALFs. This creates a financial burden for members and families and a disincentive for members to remain in the community.

In New Mexico, members are determined as low NF LOC members if the member requires assistance with two or more activities of daily living.[43] Similarly, it is noted that most states require members to require assistance with two or more ADLs to qualify for an ALF. In 2021, there was an average of over 2,700 members residing in NFs with a low NF LOC designation and only an average of 500 members residing in ALFs. Comparatively, the average cost of the members with a low NF LOC designation were two and a half times higher than that of the members residing within an ALF. HSD aims to divert future NF stays when it is the member's (and family's) preference to remain in the ALF and this setting is a cost-effective, clinically appropriate setting for the member. The State will continue to work with existing ALFs to understand capacity constraints.

[43] https://api.realfile.rtsclients.com/PublicFiles/6c91aefc960e463485b3474662fd7fd2/8ef462f5-2b1a-4ae6-8896-37553c2108b0/NF%20LOC%20Criteria%20Instructions%202019

Payment for ALF room and board by Medicaid allows HSD to demonstrate cost-effective, clinically appropriate care in the setting of choice for many older adults as an alternative to a more expensive and less desirable institutional setting.

Financial Impact
This proposal is expected to have a total five-year financial impact of $69.8M. See Section VIII for estimate by year.

These LTSS Turquoise Care initiatives under the Waiver will complement HSD's plans to implement new reimbursement and supports to ALFs to enable higher-acuity CB members to remain in assisted living. Currently, individuals who may have ongoing nursing needs, require a two-person transfer, and/or need the support of a Hoyer lift for transfer are unable to remain in or receive ALF services. To enable members with higher acuity needs to remain in or enter an ALF, HSD will enhance assisted living services to support higher acuity members with a tiered reimbursement structure commensurate with staffing/resource and member needs. This will allow members to "age in place" and remain at an ALF rather than transition to a nursing facility and require more expensive care when compared to ALF reimbursement.

Benefit Proposal #7: Environmental Modification Benefit Limit Increase

Proposal
HSD proposes to increase HCBS environmental modifications benefit limits from $5,000 to $6,000 every five years for the CB population authorized expressly by New Mexico's 1115 demonstration.

Proposal Objectives
This proposal seeks to continue environmental modification services with an increased dollar limit to prevent members from needing to be institutionalized in nursing facilities or other LTC settings. Specific objectives include:

- Allowing current members receiving these services to remain in their homes; and
- Decreasing the proportion of members receiving these services from necessitating institutionalization in nursing or other LTC facilities.

Background
For the CB in the 1115 demonstration, construction and materials costs have increased during the PHE. Moreover, according to the US Bureau of Labor Statistics, the annual inflation rate in May 2022 was 8.6% – the highest level since 1981 as measured by the consumer price index.[44]

Over the five-year period of 2017 – 2021, 6,209 members used over 90% of their environmental modification budget. With the rising costs of construction and materials, the State anticipates that more members will utilize their maximum budget allotment and may not be able to receive all the home modifications they need to support aging in place.

Proposal Details
This proposal seeks to provide an increase in the HCBS environmental modifications benefit for the CB population to counter the effects of increased costs and inflation. The increased funding limit will

[44] US Bureau of Labor Statistics (2022). Consumer Price Index – May 2022. Retrieved from: https://www.bls.gov/news.release/pdf/cpi.pdf.

help ensure that essential physical adaptations to a member's home can be accommodated. In turn, these modifications will help support members to continue safely aging in their homes. Activities are targeted at members receiving services that are eligible under Appendix B of the CMS State Medicaid Director Letter (SMDL) #21-003.[45] These members are not receiving institutional Long-Term Services.

Financial Impact
This proposal is expected to have a total five-year financial impact of $4.4M. See Section VIII for estimate by year.

Benefit Proposal #8: Transition Services Benefit Limit Increase

Proposal
HSD proposes to increase limits on Community-Based Transition Services from $3,500 to $4,000 every five years for CB population authorized expressly by New Mexico's 1115 demonstration.

Proposal Objectives
Similar to Benefit Proposal #7, this proposal seeks to help establish members in community-based services as opposed to institutionalization, but from the angle of reintegration post nursing facility admission. The specific objectives of the proposal include:

- Successful transition of members from nursing facilities to home and community-based settings; and
- Reduced readmissions to nursing facilities.

Background
Akin to Proposal #7, costs for transition related services (e.g., housing/security deposits, household needs, pest removal/cleaning, utility fees, etc.) have increased over the course of the PHE. While the State has a successful system in place to transition members who reside in nursing facilities back to their communities, the current economic environment has stressed its effectiveness. The Transition Services benefit provides similar benefits to that of the Money Follows the Person (MFP) demonstration. Given the overlap in coverage, New Mexico will continue to provide this service through the 1115 demonstration and forego submission to CMS for the MFP demonstration.

Proposal Details
This proposal requests a modest increase in the overall limit for Community Transition Services for the CB population under the demonstration. The increase from $3,500 to $4,000 every five years will help ensure that New Mexico can continue to support these rebalancing efforts and bring members out of facilities. Activities are targeted at members receiving services that are listed in Appendix B of the CMS SMDL #21-003.[46]

Financial Impact
This proposal is expected to have a total five-year financial impact of $615,000. See Section VIII for estimate by year.

[45] US Centers for Medicare & Medicaid Services (2021). SMD# 21-003 RE: Implementation of American Rescue Plan Act of 2021 Section 9817… Retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf.
[46] US Centers for Medicare & Medicaid Services (2021). SMD# 21-003 RE: Implementation of American Rescue Plan Act of 2021 Section 9817… Retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf.

Benefit Proposal #9: Home-Delivered Meals Pilot Programs

Proposal

HSD is proposing two new home-delivered meals pilots through the Turquoise Care Waiver. These pilots aim to serve:

1. CB members who are facing food insecurity that jeopardizes the member's ability to remain in a community-based setting.
2. Pregnant members with gestational diabetes.

Proposal Objectives

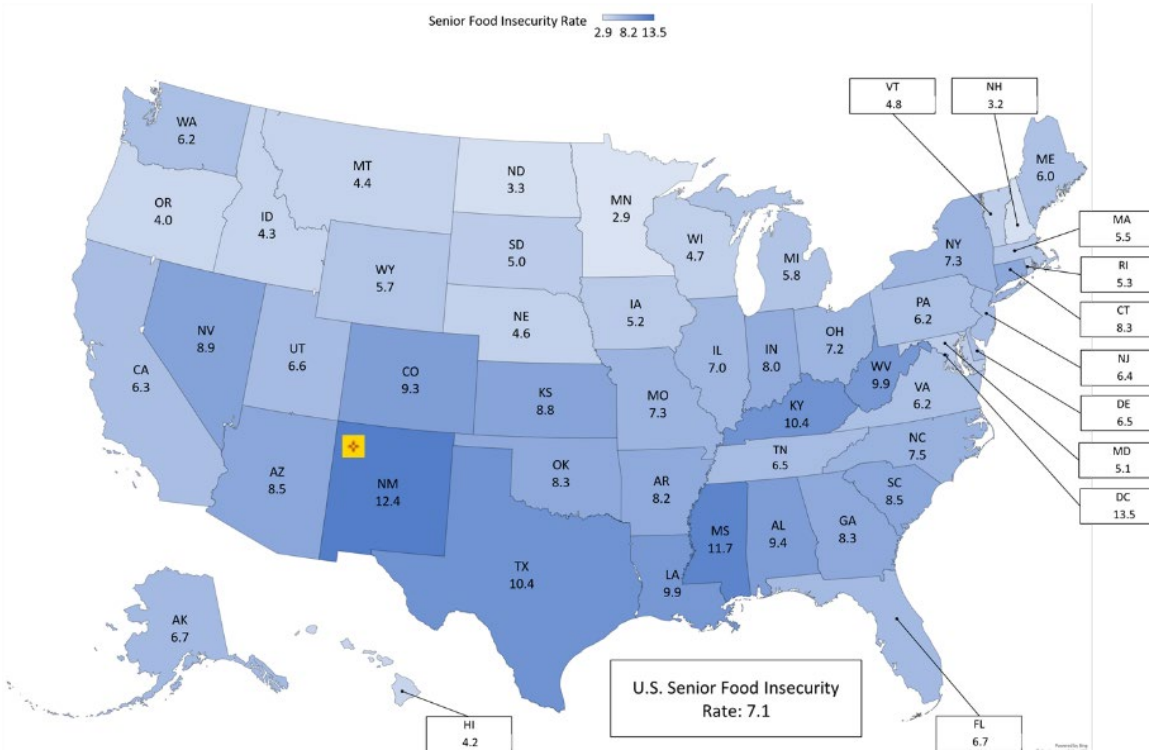
The main objective of this proposal is to minimize the impact that food insecurity can have on members in the pilot in order to improve health outcomes and ability to live independently. This proposal seeks to:

- Promote aging-in-place for those who are at risk of institutionalization;
- Increase health status and quality of life for members receiving home delivered meals;
- Support pregnant members with gestational diabetes in maintaining a medically tailored diet; and
- Promote healthy births with reduced gestational diabetes-related complications.

Background

As shown in Figure 10, in 2019, New Mexico had the second highest rate of food insecurity in the nation for seniors.

Figure 10.



Nutrition is a key social determinant and driver of health status. Frail, older adults and those with disabilities seeking to live independently may struggle with the ability to shop for or prepare meals

for themselves, presenting a barrier to adequate nutrition and wellness. Additionally, it can be difficult for members with gestational diabetes to find healthy and condition-appropriate food to eat, in order to support a healthy pregnancy and avoid related pregnancy complications.

Home Delivered Meals are an effective vehicle to ensure these members receive healthful sustenance.

Proposal Details
MCOs will provide up to two meals a day for eligible members in these two population groups.

Financial Impact
This proposal is expected to have a total five-year financial impact of $8.0M. See Section VIII for estimate by year.

Benefit Proposal #10: Addition of a Closed-Loop Referral System

Proposal
HSD seeks to establish an integrated closed-loop referral system to allow providers to securely and efficiently refer members with complex health and social needs to other organizations or services as needed. This system would be developed through a technological-based platform that electronically and securely exchanges information through a referral network of providers and organizations.

Proposal Objectives
This platform will enhance, expand, and strengthen care coordination for Turquoise Care members through efficient exchange of information among providers and other organizations to make referrals and provide resources to attend to their health and social needs. In addition, the bi-directional communication will allow initiating and receiving providers to ensure that proper follow-up occurred with documentation. Specific objectives of this proposal include:

- Decrease the time between referral and scheduled visit with the receiving provider; and
- Improve patient satisfaction among members utilizing the platform.

Background
Technological advancement and investments in workflow solutions have bolstered care coordination and connection to critical resources for patients. The "closed-loop referral" concept is a case in point—a system that allows providers and connected organizations to securely share patient information and make referrals to others to help meet a patient's needs. Moreover, the system "closes the loop" by offering two-way communication between the initiating provider or organization and the receiving entity (e.g., the initiating organization is made aware when a patient is scheduled for an appointment or has been provided with needed resources; the receiving organization can request additional information as needed to see through the referral visit). These systems may also have a patient portal whereby individuals can research and access information at their fingertips to help them feel empowered regarding their care and wellness. Activities are targeted at members receiving services that are listed in Appendix B (or could be listed in Appendix B) of the CMS SMDL #21-003.[47]

Proposal Details

[47] US Centers for Medicare & Medicaid Services (2021). SMD# 21-003 RE: Implementation of American Rescue Plan Act of 2021 Section 9817… Retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf.

In alignment with New Mexico's Health Information Technology (IT) Plan and SUD Health IT Plan, this proposal will create a "closed-loop referral" system between providers and organizations serving Turquoise Care members. The system will utilize a technology-enabled workflow that provides real-time view of the status of the patient, affording the exchange of data and information among participating organizations, making referrals using bi-directional communication, assigning tasks, and reporting on patient follow-up and other outcomes.

Financial Impact
This proposal is expected to have a total five-year financial impact of $25.7M. See Section VIII for estimate by year.

Benefit Proposal #11: Medical Respite for Members Experiencing Homelessness

Proposal
HSD is seeking expenditure authority for medical respite for members experiencing homelessness after discharge from the hospital. The State proposes a medical respite pilot in Albuquerque, New Mexico, operated by Healthcare for the Homeless, an FQHC in the process of constructing a medical respite unit. The payment delivery system is proposed through managed care with an adjustment to their capitated rate. Proposed services include care coordination, medical care on site, personal care services, and 24-hour staffing.

Proposal Objectives
The State's Medical Respite Pilot, implemented by Health Care for the Homeless in Albuquerque, will fill a critical gap for members experiencing homelessness who are discharged from the hospital and need a safe and supportive space to heal off the street or in a shelter. This is not only a humane response to the health needs of people who are unhoused, but one that has the opportunity to support better health outcomes and link members to needed services, including housing.
Specific objectives of this proposal include:

- Seamlessly connect members from hospital stay to medical respite to permanent housing;
- Reduce the number of hospital readmissions; and
- Improve the health, safety, and quality of care for members experiencing homelessness who are discharged from the hospital.

Background
A lack of adequate housing and homelessness is a growing issue in New Mexico. On a single night in the State, approximately 3,333 people experience homelessness, or 15.9 people per 100,000.[48] Albuquerque Health Care for the Homeless estimates that approximately 80% of homeless patients are eligible for Medicaid. Of unsheltered homeless adults in New Mexico, 43% identify as having a serious mental illness and 40% identify as having a SUD.[49]

Life expectancy for people experiencing homelessness is dramatically shorter than it is for the State's overall population. Table 11 compares the mean age at death for the individuals included in a New Mexico Office of the Medical Investigator death review of people experiencing homelessness, compared with the Statewide overall life expectancy for those same groups as reported by DOH.

[48] The 2020 Annual Homeless Assessment Report (AHAR) to Congress, January 2020, the US Department of Housing and Urban Development, https://www.huduser.gov/portal/datasets/ahar/2020-ahar-part-1-pit-estimates-of-homelessness-in-the-us.html
[49] 2022 Point in Time Count Joint Albuquerque and Balance of State Report, New Mexico Coalition to End Homelessness, https://www.nmceh.org/_files/ugd/6737c5_4ecb9ab7114a45dcb25f648c6e0b0a30.pdf

Table 11. Average Age at Death for People Experiencing Homelessness in New Mexico as Compared to General Population by Gender and Race and Ethnicity

	White	Hispanic	Native American	Black/African American
Homeless Male	45.65	38.26	37.43	39.91
Overall Male	74.8	72.1	60.0	68.3
Homeless Female	39.28	33.55	35.32	34.75
Overall Female	80.5	75.4	64.5	72.1

Persistent throughout New Mexico's diverse demographics, homelessness is a problem throughout all populations, as shown in Figure 11.

Figure 11.
Demographic Characteristics of People Experiencing Homelessness in New Mexico as of January 2020

	All Homeless People		Sheltered People		Unsheltered People	
	#	%	#	%	#	%
Total	**3,333**	**100.0%**	**2,074**	**100.0%**	**1,259**	**100.0%**
Age						
Under 18	482	14.5%	445	21.5%	37	2.9%
18 to 24	221	6.6%	108	5.2%	113	9.0%
Over 24	2,630	78.9%	1,521	73.3%	1,109	88.1%
Gender						
Female	1,197	35.9%	821	39.6%	376	29.9%
Male	2,103	63.1%	1,249	60.2%	854	67.8%
Transgender	19	0.6%	2	0.1%	17	1.4%
Gender Non-Conforming	14	0.4%	2	0.1%	12	1.0%
Ethnicity						
Non-Hispanic/Latino	2,008	60.2%	1,267	61.1%	741	58.9%
Hispanic/Latino	1,325	39.8%	807	38.9%	518	41.1%
Race						
White	2,011	60.3%	1,263	60.9%	748	59.4%
African American	227	6.8%	166	8.0%	61	4.8%
Asian	14	0.4%	7	0.3%	7	0.6%
Native American	831	24.9%	445	21.5%	386	30.7%
Pacific Islander	38	1.1%	14	0.7%	24	1.9%
Multiple Races	212	6.4%	179	8.6%	33	2.6%

Homeless people are sicker than the general population and have a harder time recovering from illness when they are hospitalized. This is in large part due to inadequate housing or a lack of housing as a significant barrier to healing from illness, as people experiencing homelessness may be discharged to a shelter or the streets. As a result, they incur more costly care. On average, homeless individuals spend 4.1 more days in the hospital, are twice as likely to be readmitted, are six times as likely to go to the ER within 30 days of the last time they went to the ER, and cost $4,000 more per day than their housed counterparts.[50]

Medical respite programs work to fill the gap that exists between a shelter and a rehab stay. Many members cannot recover from their illness on the streets, but do not have the level of health needs to require an inpatient admission to a facility. Medical respite programs provide a safe place to sleep and adequate nutrition. They also provide varying medical and the State's DOH interventions, including care coordination/case management, medication management, nursing oversight, and referrals to medical care, including behavioral health and SUD services. A systematic review showed that medical respite decreased 90-day readmissions for homeless individuals and reduced the hospital length of stay as well.[51]

HSD is also continuing to provide continued and expanded tenancy and pre-tenancy supports via Turquoise Care. This program provides case management supports to homeless individuals looking

[50] National Health Care for the Homeless Council. (2011). Clinical Recommendations for the Medical Respite Setting. Nashville, TN: Edgington, S. (Ed.). Available from www.nhchc.org.
[51] Doran, Kelly M. & Ragins, Kyle T. & Gross, Cary P. & Zerger, Suzanne. "Medical Respite Programs for Homeless Patients: A Systematic Review." Journal of Health Care for the Poor and Underserved, vol. 24 no. 2, 2013, pp. 499-524. Project MUSE, doi:10.1353/hpu.2013.0053.

for housing or to individuals in permanent housing with serious mental illness. The medical respite program takes support of homeless members a step further by providing them a safe place to stay in the interim between a hospitalization and permanent housing. It provides a place for pre-tenancy workers to meet with members and assist them with housing case management services.

Proposal Details

The State proposes a medical respite pilot in Albuquerque, New Mexico. Albuquerque Healthcare for the Homeless, an existing FQHC, is working to transform part of a former hospital that is no longer in use, Gibson Health Hub, into a medical respite unit. The unit has 24 rooms, and the pilot will begin with 12 of those rooms and then expand to all 24. Initially, all referrals will come from the University of New Mexico hospital, with plans to add other hospitals in Albuquerque over the five year demonstration. Payment for this pilot will come through the MCOs, with an adjustment to their capitated rate.

Medical Respite Services include:

- Care Coordination
  - Pre-tenancy services through Medicaid and other braided funding sources.
  - Transportation to offsite medical appointments.
  - Assistance with referrals and applications to social needs services, including SNAP benefits, WIC, and others as applicable.
  - Referrals to necessary clinical care, such as primary care, and behavioral health services including SUD treatment.
- Medical Care on Site
  - Daily visits with a health care provider.
  - Medical services as indicated by hospital discharge instructions, such as wound care, surgical site assessments, daily weights, and others per the medical condition the member is recovering from.
  - Medication management, which could include medication administration, education, or locked storage, depending on the needs of the member.
  - A place for home health care services such as physical therapy and occupational therapy providers to come perform these services for members.
  - Coordination between different providers, including on-site medical providers, nursing, and home health care services.
- Personal Care Services
  - Members will receive three meals per day.
  - 24-hour access to a bed, unlike shelters where individuals must leave during the day.
  - Access to a telephone to communicate about medical needs.
  - Access to transportation to medical appointments.
  - Wellness checks will be provided by staff members.
- 24-hour staffing at the facility

The average length of stay nationwide for medical respite is 30 days. HSD will require a two-month cap on reimbursement for the medical respite site after hospital discharge, per member per year. There will not be a cap on the number of stays or a lifetime limit.

The program will adhere to the 2021 Standards for Medical Respite Programs developed by the National Institute for Medical Respite Care.[52]

Financial Impact

This proposal is expected to have a total five-year financial impact of $16.4M. See Section VIII for estimate by year.

[52] The Standards for Medical Respite Programs can be found here: https://nimrc.org/wp-content/uploads/2021/09/Standards-for-Medical-Respite-Programs_2021_final.pdf

Delivery System

1. **Continuing Demonstration Elements**

New Mexicans are covered under Medicaid and CHIP through both managed care and FFS delivery systems and as of June 2022, 83% of beneficiaries were enrolled in managed care under Centennial Care. With the exception of Native American members, New Mexico will continue to direct mandatory managed care enrollment through MCOs in order to deliver quality care through integrated physical health, behavioral health, and managed LTSS to members. Turquoise Care will build upon the successes of Centennial Care 2.0 and will continue to include care coordination, targeted care coordination for high needs populations and transitions of care for high-needs populations, VBP arrangements and telehealth through MCO contract requirements. All managed care contracts will continue to comply with federal managed care requirements at 42 CFR Part 438 except that HSD will continue to request a waiver of federal regulations at 42 CFR 438.56(g) to allow HSD to automatically reenroll an individual who loses eligibility or whose eligibility is suspended for a period of three months or less in the same managed care plan in which the individual was previously enrolled. HSD will also continue to seek expenditure authority to allow HSD to include costs associated with the provision of beneficiary rewards program incentives in the calculation of the MCO capitation rates.

2. **New Demonstration Proposals**

Delivery System Proposal #1: Graduate Medical Education (GME) funding and technical assistance for new and/or expanded primary care medical residency programs

HSD has a pending waiver amendment under CMS review to provide funding and technical assistance to new and/or expanded primary care medical residency programs in community-based primary care settings, such as FQHCs, rural health clinics (RHCs), and tribal health centers. If approved, Turquoise Care will include this proposal in the renewal.

Delivery System Proposal #2: Request for expenditure and waiver authority to support rural hospitals

Proposal:

HSD is requesting expenditure authority for payment flexibility to support rural hospitals, with an additional focus on obstetric care and other services that support parents with infants or young children. This request has two parts: 1) Stabilize the rural hospital system through investments and 2) transform the rural health system to support continued access in rural communities through sustainable models and innovative reimbursement strategies that recognize the resources required of rural providers.

Proposal Objectives:

As noted above, New Mexico's predominantly rural geography makes it imperative for the rural hospital systems to function in an accessible and efficient manner. Addressing these payment and service delivery issues will allow for improved access for New Mexicans, regardless of their coverage status, while creating a supported provider infrastructure. Access to high quality and timely obstetric care is key to setting children up for a healthy life as they grow, and ensuring parents are supported in facilitating a healthy environment for their children. Lack of access and disproportionate risk factors and outcomes represents an important equity issue for the State, which can be ameliorated through addressing payment issues and transforming how care is delivered. Moreover, these two elements are directly aligned with

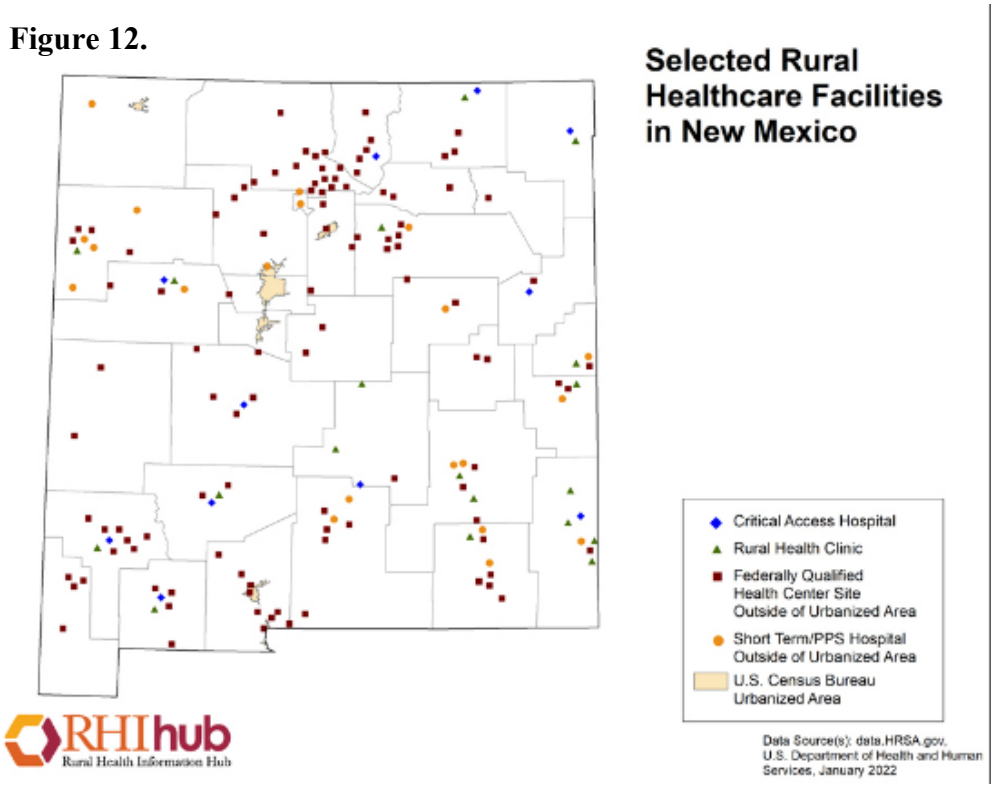
several of CMCS's Policy Principles for 1115 waiver demonstrations under the current administration. These include:

- Improved access to care for Medicaid beneficiaries and uninsured individuals;
- Improved quality and equity, and reduced health disparities; and
- A strong and sustainable health safety net.

Background:

New Mexico is a mostly rural state, with only seven of its 33 counties classified as metropolitan.[53] The remaining 26 counties are considered rural or frontier in nature. The term "frontier" is used here to describe territory characterized by a United States Department of Agriculture defined combination of low population size and high geographic remoteness: This characterization includes the following 15 counties in New Mexico: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel, and Cibola. Additionally, even counties where New Mexico's main urban areas are located have large rural spaces within them. Figure 12 shows the geographic distribution of selected rural health care facilities in New Mexico, with US Census Bureau urbanized areas highlighted.

Figure 12.



According to a needs assessment conducted in 2019, notable disparities exist for populations living in rural areas of New Mexico. These include disproportionately high numbers of people ages 65 and over, people of color and Native Americans, and children under 18. Rural areas in New Mexico also have the following: higher numbers of people living below the FPL, higher unemployment rates, and higher rate of people without health coverage.[54]

Of particular note in New Mexico are disparities related to maternal child health indicators. Compared to the United States average, pregnant individuals in New Mexico have lower rates of prenatal care engagement, are much more likely to be adolescents, and infants are more likely to be low birth weight.[55] Additionally, 80% of all births in the State are covered by Medicaid. The New Mexico Maternal

[53] New Mexico Department of Health. Report of the Rural Health Planning workgroup: New Mexico Rural Health Plan. June 30, 2019. Retrieved from: https://www.nmhealth.org/publication/view/report/5676/
[54] New Mexico Department of Health. Report of the Rural Health Planning workgroup: New Mexico Rural Health Plan. June 30, 2019. Retrieved from: https://www.nmhealth.org/publication/view/report/5676/
[55] New Mexico Department of Health. Public Health division. New Mexico Primary Care Needs Assessment. June 7, 2021. Retrieved from: https://www.nmhealth.org/publication/view/general/6782/

Mortality Review Committee in collaboration with DOH have presented data showing that New Mexico has a maternal mortality rate of 21.5 per 100,000 compared to the national average of 17.4 deaths per 100,000 live births. 60% of pregnancy related deaths since 2018 occurred 43-365 days post-partum, and 75% of the deaths were determined to be preventable. The most common causes: mental health conditions, cardiac conditions, embolism and hemorrhage. In New Mexico pregnancy associated deaths were 4.6 times greater for Medicaid covered women than those with private insurance.[56]

In the first iteration of Centennial Care, an uncompensated care pool was authorized to support hospitals in the State. This was not renewed in Centennial Care 2.0, and New Mexico moved to a directed payment model based on utilization. While this funding methodology is supporting health services for Medicaid enrollees, smaller rural hospitals with lower volume utilization are not receiving adequate support to address their fixed cost, and these hospitals are operating on thin or negative margins. This degrades access to key health care services in rural areas and is not sustainable. In short, hospitals do not have the resources to operate in a way that fully supports the needs of rural populations who depend on them. With regard to geographic access, 11 of New Mexico's 33 counties are designated as "maternity care deserts"[57] by the March of Dimes, with an additional four designated as "low access to maternity care."[58] This creates a reality where expectant parents experience significant barriers in access to needed services to support healthy pregnancies and births. For example, pregnant enrollees in the northeastern part of the state have to drive over 170 miles, or three hours round trip, to receive prenatal care and related services. Additionally, The New Mexico Maternal Mortality Review Committee reported that one of the leading contributing factors to maternal deaths were motor vehicle crashes (nearly 30%), which is another reason pregnant enrollees should have care options closer to where they live. Many key partners are working collaboratively to address these issues, however flexibilities and support from CMS are needed to strengthen these important safety-net providers in a sustainable way.

Proposal Details:

HSD is proposing to work with providers to develop a multi-year plan to sustain the rural health care delivery system. As described above, the State has worked on assuring access to safety net services by developing specialized payments over the years, including pools, directed payments, and increasing Medicaid rates through various payment strategies. As the State emerges from the COVID-19 pandemic, there will need to be some continued and immediate investments to stabilize the system and provide the foundation for it to evolve. Historically, rural hospital systems across New Mexico and the nation have struggled, hence the need for a two- part strategy to stabilize and then transform. This strategy will leverage stabilization payments with a focus on reimbursement, quality, and value. The second phase of this approach will include be the result of stakeholder conversations with communities and provider stakeholder collaboration s to develop more sustainable models, and implementation details will emerge over time.

The two part strategy is focused on the following:

1. Stabilization (2 years)
    - Directed payments and expenditure authority for systems that have committed to

[56] New Mexico Perinatal Collaborative. New Mexico Maternal Mortality Review: Updates, Processes, and Recommendations. NMPC Meeting presentation, October 2020. Retrieved from http://nmperinatalcollaborative.com/wp-content/uploads/2021/01/NMPC-2020-MMRC-Presentation.pdf

[57] According to March of Dimes, Maternity care deserts are counties in which access to maternity health care services is limited or absent, either through lack of services or barriers to a woman's ability to access that care.

[58] March of Dimes. Maternity Care Deserts, United States, 2018. Source: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2019. Retrieved from: https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx

participate in developing and implementing a transformation plan to assure long term sustainability of critical rural services; and

- Quality metrics focusing in particular on access to at-risk services and those that are critical to the community and Medicaid recipients including, but not limited to: Maternal and child health, women's health services, and specialty care.

2. Sustainability (3 years)
    - Participate in workgroups that run concurrent with the stabilization phase, providing both health care and community leadership. Key coordination with existing partners, like the Perinatal Coalition, will be required as well. The goal of the stakeholder process is to better understand and explore possible potential payment models, identify community needs, and gather provider resources required. This information will inform emerging models and alternative payment methodologies.
    - Utilize stakeholder feedback and work with CMS to authorize and establish sustainable payment methodologies that more accurately reflects the resources and infrastructure needed to provide health care in these rural communities.
        - This includes integrating the use of technology, including telehealth, project ECHO, and other tools to streamline and support the delivery of quality care.

This also allows for innovative solutions that go beyond traditional health care delivery, allowing for a focus on social drivers of health, health equity and the reduction of disparities, community-based solutions and linkages, and other related strategies.

Financial Impact

This proposal is expected to have a total five-year financial impact of $115.0M. See Section VIII for estimate by year.

Section VI: Requested Waiver and Expenditure Authorities

Table 12. Requested Waiver Authorities

	Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?
1.	Reasonable Promptness Section 1902(a)(8)	Consistent with existing HCBS waiver authority (Section 1915(c) of the Social Security Act), to the extent necessary to enable HSD to establish enrollment targets for certain HCBS for those who are not otherwise eligible for Medicaid. HSD will take into account current demand and utilization rates and will look to increase such enrollment targets in order to appropriately meet the LTC needs of the community.	Current
2.	Amount, Duration, and Scope of Services Section 1902(a)(10)(B)	To the extent necessary to enable the State to vary the amount, duration, and scope of services offered to individuals regardless of eligibility category, by permitting managed care plans to offer varied medically appropriate value added services to beneficiaries who are enrolled in Turquoise Care. To the extent necessary to enable the State to offer certain LTSS and care coordination services to individuals who are Medicaid eligible and who meet NF LOC. To the extent necessary to allow HSD to place expenditure boundaries on HCBS and personal care options. To the extent necessary to enable the State to offer pre-tenancy and tenancy services to a limited number of Turquoise Care recipients with SMI, and in limited geographical areas of the State. (Pending before CMS in waiver amendment) Waiver of any requirement in section 1902 of the Social Security Act (SSA) required to implement coverage and reimbursement for High Fidelity Wraparound (HFW) services for children and youth with high intensity needs. (New) To the extent necessary to enable the State to offer an annual budget of $2,000 for chiropractic services to Other Adult Group and Parent/Caretaker Group beneficiaries enrolled in managed care.	Current/New
3.	Freedom of Choice Section 1902(a)(23)(A) 42 CFR §431.51	To the extent necessary to enable the State to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. Mandatory enrollment of American Indians/Alaskan Natives (AI/ANs) is only permitted for beneficiaries with a NF LOC. No waiver of freedom of choice is authorized for family planning providers.	Current/New
4.	Self-Direction of Care Section 1902(a)(32)	To permit persons receiving certain services to self-direct their care for such services. To permit state-authorized relatives, guardians, and or legally responsible individuals to provide Community Benefit personal care services.	Current/New

	Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?
5.	NF LOC Redetermination Section 1902(a)(10)(A)(ii)(IV) 42 CFR §441.302(c)(2)	To the extent necessary to enable the State to implement a streamlined NF LOC approval with specific criteria for individuals whose condition is not expected to change.	Current
6.	Section 1902(a)(8) and (10)	To the extent necessary to enable the State to limit the provision of Medical Assistance (and treatment as eligible for Medical Assistance) for individuals described in the eligibility group under section 1902(a)(10)(A)(ii)(XX) of the Social Security Act (the Act) and the State Plan to only former foster care youth who are under 26 years of age, were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as such former state has elected), and who were enrolled in Medicaid on that date, and are now residents in New Mexico applying for Medicaid. To the extent necessary to enable the State to limit the provision of Medical Assistance (and treatment as eligible for Medical Assistance) for individuals described in the eligibility group under section 1902(a)(10)(A)(ii)(XXI) of the Act and the State Plan to only family planning services as described in section 1905(a)(4)(C) and only to individuals age 50 or under who do not have other health insurance coverage, or under age 65 who have only Medicare coverage that does not include family planning.	Current

Table 13. Requested Expenditure Authorities

	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?
1.	Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the SSA specified below. Managed care plans participating in the demonstration will have to meet all the requirements of Section 1903(m), except the following: (a) Section 1903(m)(2)(H) and federal regulations at 42 CFR §438.56(g), but only insofar as to allow HSD to automatically reenroll an individual who loses Medicaid eligibility for a period of three months or less in the same managed care plan from which the individual was previously enrolled. (b) Expenditures made under contracts that do not meet the requirements of 1903(m)(2)(A)(iii) and implementing regulations at 42 CFR §438.4 but only insofar as to allow HSD to include in calculating MCO capitation rates the provision of beneficiary rewards program incentives for health-related items or services. (c) (New) Expenditures made under contracts with MCOs that do not meet the requirements of 1903(m)(2)(A) and implementing regulations at 42 CFR §438 but only insofar as to allow HSD to include the costs of room and board in ALFs in the development of the MCO capitation rates.	Current/New

	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?
2.	Expenditures for Centennial Care recipients who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) of the SSA and 42 CFR §435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the SSA, if the services they receive under Centennial Care were provided under an HCBS waiver granted to HSD under SSA Section 1915(c) as of the initial approval date of this demonstration. This includes the application of spousal impoverishment eligibility rules.	Current
3.	Expenditures for community intervener services furnished to deaf and blind Turquoise Care beneficiaries.	Current
4.	Expenditures to pilot home visiting services to eligible pregnant individuals, postpartum individuals, infants, and children	Current/New
5.	Expenditures for peer-delivered pre-tenancy and tenancy supportive housing services for individuals who meet the eligibility criteria for the Special Needs/SAHP.	Current/New
6.	Expenditures to provide HCBS not included in the Medicaid State Plan to individuals who are eligible for Medicaid.	Current
7.	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder who are short-term residents in facilities that meet the definition of an institution for mental diseases.	Current
8.	Expenditures for members in managed care and FFS to receive expanded services provided through an IMD. Expanded services will be available to eligible adults with SMI and children with SED in the event they meet the diagnostic criteria mandated by the included assessment so long as the cost of care is the same as, or more cost effective than, a setting that is not an IMD.	Pending with CMS (Waiver Amendment)
9.	Expenditures authority to provide coverage and reimbursement for HFW services for children and youth with high intensity needs.	Pending with CMS (Waiver Amendment)
10.	Expenditure authority to provide GME grant funding and technical assistance to new and/or expanded primary care medical residency programs in community-based primary care settings, such as FQHC, RHCs, and tribal health centers.	Pending with CMS (Waiver Amendment)
11.	Expenditures for an annual budget of $2,000 for chiropractor services for members eligible under the Other Adult Group and Parent/Caretaker Group and enrolled in managed care.	New
12.	Expenditures for continuous enrollment for children up to age six.	New

	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?
13.	Expenditures for Medicaid services rendered to incarcerated enrollees in the 30 days pre-release from a correctional facility.	New
15.	Expenditures for room and board in ALFs as a cost-effective, medically appropriate substitute for nursing facility services.	New
16.	Expenditures to support staffing, design and care management for small-home models of nursing facility and assisted living facility care.	New
17.	Expenditures for the costs of member-directed traditional healing services provided to Native American members.	New
18.	Expenditures to increase the Environmental Modifications Benefit Limit increase by $1,000 to be used over five years.	New
19.	Expenditures to increase the Transitional Services Benefit Limit increase by $500 to be used over five years.	New
20.	Expenditures to cover meals for CB members who are facing food insecurity that jeopardizes the member's ability to remain in a community-based setting and pregnant members with gestational diabetes.	New
21.	Expenditures to provide one-time funding to develop a model for a closed-loop referral system.	New
22.	Expenditures for medical respite for member experiencing homelessness.	New

Section VII: State Quality Monitoring Activities

Overview

HSD will continue to monitor its 1115 Demonstration and MCOs for quality assurance and improvement to ensure progress towards and actualization of Turquoise Care goals and objectives. This includes, but is not limited to, Implementation of the State's Quality Strategy, External Quality Review Organization (EQRO) results and recommendations, and the quarterly and annual reports HSD submits in accordance with demonstration STCs. HSD will also continue to provide feedback and updates relative to quality assurance monitoring on pertinent CMS state monitoring calls. These monitoring and quality assurance activities will also span the SUD specific monitoring metrics per New Mexico's approved SUD Implementation Plan and Monitoring Protocol.

Quality Strategy Status and Summary

1. **Current Status**
   In May 2021, HSD submitted an updated draft Quality Strategy to CMS for review and feedback. The current draft Quality Strategy is available on HSD's website at: https://www.hsd.state.nm.us/wp-content/uploads/Quality-Strategy-2021-final.pdf.pdf
   While CMS does not approve state Quality Strategies, CMS noted sections that were incomplete and needed to be updated. HSD is working to comprehensively address CMS feedback and will resubmit the draft in August 2022.

2. **Summary of Draft Quality Strategy**
   Serving to guide the quality strategy for the state of New Mexico, the State's goals for the Centennial Care 2.0 have been to build upon the program's accomplishments to include providing the most effective and efficient health care possible for eligible New Mexicans, as well as continuing the health care delivery reforms of Centennial Care. Specifically, the State will further the following:
   - Assure that Medicaid Members in the program receive the right amount of care, delivered at the right time, and in the right setting;
   - Ensure that the care and services being provided are measured in terms of their quality and not solely by quantity;
   - Slow the growth rate of costs or "bend the cost curve" over time without inappropriate reductions in benefits, eligibility or provider rates; and streamline and modernize the Medicaid program in the State;
   - Provide an integrated, comprehensive Medicaid delivery system in which a member's MCO is responsible for coordinating his/her full array of services, including acute care (including pharmacy) behavioral health services, institutional services and HCBS.

   In service to these goals, New Mexico's draft quality strategy is focused on the following:
   - Track progress toward achieving the State's goals; and
   - Identify opportunities for improvement by applying measurable and relevant activities that focus on:
     - Monitoring and assessing member outcomes;
     - MCO performance and compliance; and
     - Member satisfaction.

New Mexico's Quality Strategy utilizes a Continuous Quality Improvement (CQI) model to achieve goals and objectives outlined for the Centennial Care program. HSD, through the Quality Management (QM)/Quality Improvement (QI) standards, requires the MCOs to apply the CQI model and identify opportunities for measurable improvement taking into consideration the health status of all populations served by the MCOs. New Mexico conducts an annual review of each MCO's QM/QI program that includes a Work Plan and Evaluation by an integrated team from the Medical Assistance Division (MAD) and Behavioral Health Services Division (BHSD). Finally, New Mexico's draft quality strategy includes detail of MCO penalties and sanctions, required care coordination standards, non-duplication assurances for EQRO activities, and the process for strategy development.

Relevant highlights from the draft Quality Strategy include:

- MCO Quality Management/Quality Improvement
  Each MCO is required to establish a QM/QI program using clinically sound, nationally developed and accepted criteria. Activities are required to be data-driven, inclusive, transparent, and supportive of a continuous striving for improvement on behalf of Centennial Care members. MCOs are required to implement Performance Improvement Projects (PIPs), submit annual reports, and develop an annual work plan. A full list of MCO QM/QI requirements can be found in the draft strategy.

- Utilization Management
  HSD requires the MCOs to establish and implement a utilization management (UM) system that follows the National Committee for Quality Assurance (NCQA) UM standards and promotes quality of care, adherence to standards of care, efficient use of resources, member choice, and the identification of service gaps within the service system.

- MCO Accreditation Standards
  New Mexico requires the MCOs be either (i) NCQA accredited in the state of New Mexico or (ii) accredited in another state where the MCO currently provides Medicaid services and achieves New Mexico NCQA accreditation by January 1, 2020. Failure to meet the accreditation standards and/or failure to attain or maintain accreditation is considered a breach of the MCO contract with HSD. Violation, breach or noncompliance with the accreditation standards may be subject to termination for cause as detailed in the contract.

3. Centennial Care 2.0 monitors MCOs on Performance Measures and Tracking Measures

A. Centennial Care 2.0 Performance Measures

In 2020, New Mexico revised the Centennial Care 2.0 performance measures (PMs) and penalty structure. All PMs and targets are based on Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications for the current year. Failure to meet the HSD designated target for each performance measure during the calendar year (CY) will result in a monetary penalty based on 2% of the total capitation paid to the MCO for the contract/agreement year, divided by the number of PMs specified in contract/agreement.

HSD established performance targets for four years by applying the result of the CY2018 MCO aggregated Audited HEDIS data, calculating an average increase for each CY until reaching the

CY2018 Quality Compass Regional Averages plus one percentage point. The MCOs are required to meet HSD designated targets for CY2020, CY2021, CY2022, and CY2023 for each PM below:

- PM #1 (1 point) – Well Child Visits in the first fifteen (15) Months of Life (W30). The percentage of Members who turned 15 months old during the measurement year and had six or more well-child visits.

- PM #2 (1 point) – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC). The percentage of Members ages three through 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year.

- PM #3 (1 point) – Prenatal and Postpartum Care (PPC). The percentage of Member deliveries of live births between October 8 of the year prior to the measurement years and October 7 of the measurement year that received a prenatal care visit as a Member of the MCO in the first trimester or within 42 Calendar Days of enrollment in the MCO.

- PM #4 (1 point) –PPC. The percentage of Member deliveries that had a postpartum visit on or between seven and 84 Calendar Days after delivery.

- PM #5 (1 point) – Childhood Immunization Status: Combination 3. The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday.

- PM #6 (1 point) – Antidepressant Medication Management (AMM): Continuous Phase. The percentage of Members age 18 years and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression during the intake period and received at least 180 Calendar Days (six months) of continuous treatment with an antidepressant medication.

- PM #7 (1 point) – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Initiation. The total percentage of adolescent and adult Members with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD Treatment.

- PM #8 (1 point) – Follow-Up After Hospitalization for Mental Illness: 30 Day. The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.

- PM #9 (1 point) – Follow-Up After Emergency Department Visit for Mental Illness: 30 Day. The percentage of emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness

within 30 days of the ED visit.

- PM #10 (1 point) – Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications. The percentage of Members 18-64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

B. Centennial Care 2.0 Tracking Measures

New Mexico has directed the MCOs to report on Tracking Measures (TMs) that focus on specific target populations to monitor and implement interventions for improvement, if needed. The TMs are based on HEDIS, CMS Adult Core Set or HSD defined technical specifications. HSD analyzes the TMs to identify performance trends, best practices, and gaps in care and MCO interventions. Feedback is shared and discussed with the MCOs during quarterly quality workgroup meetings. The TMs do not have associated penalties. The Centennial Care 2.0 TMs are as follows:

- TM#1-Fall Risk Management
- TM#2-Diabetes, Short-Term Complications Admission Rate
- TM#3-Screening for Clinical Depression and Follow-Up Plan
- TM#4-Follow-up after Hospitalization for Mental Illness
- TM#5-Immunizations for Adolescents
- TM#6-Long-Acting Reversible Contraceptive (LARC)
- TM#7-Smoking Cessation
- TM#8-Ambulatory Care
- TM#9-Annual Dental Visit
- TM#10-Controlling High Blood Pressure

C. External Quality Review Organization (EQRO)

HSD, in accordance with 42 CFR §438.354, has retained the services of an EQRO, Island Peer Review Organization, to perform External Quality Reviews (EQRs). The EQRO will conduct all mandatory EQRs to assess quality outcomes and timeliness of, and access to, the services provided to Medicaid members and covered by each MCO. The EQRO will follow CMS protocols for the following activities:

- Compliance Monitoring: an annual review designed to determine the MCO compliance with State and federal Medicaid regulations and applicable elements of the contract between the MCO and HSD;
- Validation of PMs; an annual review designed to evaluate the accuracy of HSD defined performance measures reported by the MCOs;
- Validation of PIPs; an annual review designed to verify the projects developed by the MCO were designed, conducted and reported in a methodically sound manner and address the target population defined by HSD;
- Validation of Network Adequacy; an annual review designed to determine the MCO compliance with State and federal Medicaid regulations and applicable elements of the contract between the MCO and HSD; and
- Technical Report; an annual report summarizing the findings on access and quality of care. [25] The MCOs are required to cooperate fully with the EQRO and demonstrate compliance with New Mexico's managed care regulations and quality standards as set forth in federal

regulation and State policy. The EQRO reports findings and recommendations to HSD and if appropriate, are incorporated into New Mexico's Quality Strategy.

D. Health Disparities and Health Equity

A 2021 federal report on health equity, *Paving the Way to Equity: A Progress Report (2015-2021)*, describes how many communities face significant disparities in health care quality, outcomes, and access. Individuals who identify as nonwhite, lower-income individuals, sexual and gender minorities, people with disabilities, and individuals living in rural areas are disproportionately affected. For example:

- In 2017, across nearly every state and territory Black, Hispanic/Latino, Asian Pacific Islander, and American Indian and Alaska Native Medicare beneficiaries have a higher prevalence of chronic conditions including hypertension, diabetes, chronic kidney disease, and heart failure than Whites.
- The LGBTQ population has the highest rates of tobacco use, and certain LGBTQ subgroups have more chronic conditions as well as higher prevalence and earlier onset of disabilities than heterosexuals.
- Individuals with disabilities experience worse health and poorer access to mental health care services compared to people without a disability. Women with disabilities are less likely to receive regular breast and cervical cancer screenings and are more likely to have cancer and then be diagnosed at a later stage, than women without disabilities.
- The prevalence of diabetes is 8.6% higher in rural areas than in urban areas, and those diagnosed with diabetes in rural areas are at higher risk of amputations and inpatient death. They are less likely to receive a professional foot exam, and less likely to be able to access diabetes self-care education than their urban counterparts.

The disparities outlined in the federal report, and many others, are common for too many New Mexicans. Turquoise Care seeks to advance health equity in New Mexico. According to the CDC, communities achieve health equity when every person attains their full health potential, and neither social position nor other socially determined circumstances disadvantages anyone from achieving their potential.

HSD enlists a variety of methodologies and resources, including enrollment files delivered daily to the MCOs, to identify, evaluate, reduce and overcome any barriers that limit access to appropriate care for New Mexico's Medicaid members. Most notably, resources include stratified data tracking, HSD directed interventions and monitoring of MCO-directed interventions, requirement of MCOs to maintain an adequate provider network, establishment of care coordination infrastructure, requirement of MCOs to develop a Cultural Competence and Sensitivity Plan, a Member Rewards program, and a peer support program.

HSD is committed to, and requires the MCOs participate in, promoting the delivery of covered services to all Medicaid beneficiaries in a culturally competent manner, regardless of gender, sexual orientation, or gender identity and including members who have a hearing impairment, limited English proficiency, a speech or language disorder, physical disabilities, developmental disabilities, differential abilities and diverse cultural and ethnic backgrounds

4. Summary of EQRO Reports

A. EQRO 2020 Annual Technical Report – April 2022

Link to the full report

1. Introduction

To comply with the standards of 42 CFR §438.364, HSD contracted with Island Peer Review Organization (IPRO) an EQRO, to assess and report the impacts of its Medicaid program on the quality, timeliness, and accessibility of health services. Specifically, this report provided IPRO's independent evaluation of the services provided by New Mexico's three managed care plans: Blue Cross Blue Shield of New Mexico (BCBS), Presbyterian Health Plan, Inc. (PHP), and Western Sky Community Care, Inc. (WSCC) in 2020.

2. Description of EQR Activities

The report focused on the four federally mandatory EQR activities, including:

- Validation of PIPs;
- Validation of PMs;
- Review of compliance with Medicaid standards; and
- Validation of network adequacy.

The report also included validation of quality of care surveys as one optional EQR activity.

3. Summary of Results

Performance Improvement Projects

IPRO's validation of the MCOs' PIPs conducted in 2020 confirmed the State's compliance with the standards of 42 CFR §438.330(a)(1); and confirmed the MCOs' compliance with the HSD requirement to conduct a PIP for each of these overarching topics: LTC services and supports, prenatal and postpartum care, adult obesity, diabetes prevention and management, and clinical depression screening and follow-up.

The results of the validation activity determined BCBS and WSCC were fully compliant with the standards of 42 CFR §438.330(d)(2) for each of their five PIPs while PHP was fully compliant for four of their five PIPs. Fully compliant PIPs were conducted in a manner consistent with the EQRO PIP process. Concerning PHP's PIP that did not achieve full compliance, validation findings identified issues related to topic selection, data collection, and interpretation of study results.

HEDIS Performance

As part of the HSD PM program, the MCOs were required to calculate and report 2020 rates to HSD for ten HEDIS measures. A total of ten points were available for each MCO to achieve based on individual rate performance towards the target rate. No MCO earned all ten of the available points. BCBS earned eight points, PHP earned six points, and WSCC earned two points.

For two PMs, all MCOs reported rates that exceeded the targets:

- Antidepressant Medicaid Management – Continuation Phase; and
- Follow-Up After Hospitalization for Mental Illness – 30 Day.

Seven Centennial Care PM averages (the aggregate PM rates of all MCOs) exceeded their respective target rates:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – Physical Activity Counseling;
- Timeliness of Prenatal and Postpartum Care – Postpartum Care;
- Childhood Immunization Status – Combination 3;
- Antidepressant Medication Management (AMM) – Continuation Phase;
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation;
- Follow-Up After Hospitalization for Mental Illness – 30 Day; and
- Follow-Up After Emergency Department Visit for Mental Illness – 30 Day.

No MCO met the target rates for:

- Well-Child Visits in the First 30 Months of Life – First 15 Months; and
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications.

Three Centennial Care PM averages (the aggregate PM rates of all MCOs) did not meet their respective target rates:

1. Well-Child Visits in the First 30 Months of Life – First 15 Months;
2. Timeliness of Prenatal and Postpartum Care – Timeliness of Prenatal Care; and
3. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications.

4. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Compliance with Federal Medicaid Standards: IPRO's conduct of the compliance review activity for the January 1, 2020–April 15, 2021, review period confirmed the State's compliance with evaluating MCO adherence to the standards of 42 CFR Part 438 Subpart D and 42 CFR §438.330. Each MCO achieved full compliance determinations for these standards.

Compliance with State Medicaid Standards: Each MCO achieved full compliance for the January 1, 2020–April 15, 2021, review period. The overall compliance score for each MCO exceeded the 90% threshold. BCBS achieved an overall compliance score of 98.28%, PHP achieved a score of 98.21%, and WSCC achieved an overall score of 98.86%. There were no areas in which all MCOs performed below the 90% threshold.

5. Validation of Network Adequacy

Based on the results of the 2020 Compliance Review, it was determined that the MCOs were compliant with adopting the access, distance, and timeliness standards outlined in the Centennial Care Managed Care Agreement. Each MCO exceeded the 90% threshold to achieve a full determination for the Provider Network section of the 2020 Compliance Review.

The MCOs continued to increase contract provider telemedicine capabilities and increased utilization of these services by their Medicaid members. All three MCOs met the 5% minimum of membership with telemedicine visits for 2020. Approximately 141,357 unique Centennial Care members received telemedicine services in 2020. Physical health care accounted for 65% of telemedicine visits in 2020.

The MCOs met geographic access standards in all regions for the following physical health providers: adult and child PCPs, cardiologists, certified nurse midwives, certified nurse practitioners, dental providers, FQHCs, OBs/GYNs, orthopedists, pharmacies, physician assistants, podiatrists, and surgeons. The MCOs met HSD standards in all regions for the following behavioral health providers: FQHCs providing behavioral health services, other licensed independent behavioral health providers, outpatient provider agencies, psychiatrists, and Suboxone® certified medical providers. Additionally, the MCOs met HSD standards in all regions for the following LTC providers: general hospitals, nursing facilities, personal care service agencies, and transportation. At the same time, the following geographic access standards were not met by MCOs for any region: I/T/Us, day treatment services, Indian Health Services and Tribal 638s providing behavioral health services, non-Accredited Residential Treatment Centers (ARTCs) and group homes, partial hospital programs, and treatment foster care I and II.

6. Validation of Quality-of-Care Studies

The MCOs were compliant with state requirements to report on member experience using the NCQA Consumer Assessment of Healthcare Providers and Systems (CAHPS) tool. When compared to national Medicaid benchmarks, no MCO achieved an adult CAHPS score for Measurement Year (MY) 2020 that exceeded the national Medicaid fiftieth percentile. However, BCBS achieved scores for Rating of Health Plan and How Well Doctors Communicate that exceeded the national Medicaid mean; and WSCC achieved a score for Rating of Personal Doctor that performed at the national Medicaid mean.

7. Recommendations

A. Statewide provider shortages continue to be the greatest challenge Centennial Care MCOs face while developing and maintaining their Medicaid provider networks. HSD should implement immediate and practical solutions to decreasing these shortages, which may include contracting with out-of-state providers and increasing its support of advancing telehealth/telemedicine capability and utilization.

B. Establish appointment availability thresholds for the managed care program to reinforce MCO accountability for increasing the availability of timely appointments.

C. Continue to push for the adoption of telehealth services across the State and identify opportunities to provide support to clinicians who participate in State health care programs.

D. Consider ways to increase professional clinical resources across the State with a specific focus on regions of the State with network adequacy issues.

E. Maximize the patient-centered provisions in the Centennial Care contract to direct the MCOs toward supporting initiatives that prioritize improving quality of care.

B. EQRO 2019 Annual Technical Report – April 2021

Link to the full report

1. Introduction

To comply with the standards of 42 CFR §438.364, HSD contracted with IPRO an EQRO, to assess and report the impacts of its Medicaid program on the quality, timeliness, and accessibility of health services. Specifically, this this report provided IPRO's independent evaluation of the services provided by New Mexico's three managed care plans: BCBS, PHP, and WSCC in 2019.

2. Description of EQR Activities:

The report focused on the four federally mandatory EQR activities:

- Validation of PIPs;
- Validation of PM;
- Review of compliance with Medicaid standards; and
- Validation of network adequacy.

3. Summary of Results

Performance Improvement Projects

In 2019, Centennial Care MCOs were required to implement one PIP in each of the following areas: LTC services and support, prenatal and postpartum care, adult obesity, diabetes prevention and management, and clinical depression screening and follow-up. All three MCOs achieved full compliance for each PIP.

HEDIS Performance

For the 2019 report, IPRO summarized findings by MCO.

Blue Cross Blue Shield of New Mexico (BCBS):

- Nutrition and Physical Activity for Children/Adolescents (WCC)
- PM 4 WCC Body Mass Index (BMI) Percentile
- PM 4 WCC Nutrition Counseling
- PM 4 WCC Physical Activity Counseling
- PM 5 Comprehensive Diabetes Care (CDC)
- PM 5 CDC Hemoglobin A1c (HbA1c) Testing
- PM 5 CDC HbA1c Poor Control
- PM 5 CDC Retinal Eye Exam
- PM 6 Timeliness of Prenatal and Postpartum Care (PPC) Prenatal Care
- PM 7 AMM Engagement

BCBS did not meet PM targets for the following measures:

- PM 2 Children and Adolescents' Access to Primary Care Practitioners (CAP) 12 Months-24 Months
- PM 2 CAP 7-11 Years of Age
- PM 2 CAP 12-19 Years of Age
- PM 5 CDC Nephropathy Screening
- PM 6 PPC Postpartum Care
- PM 8 IET Initiation

BCBS met or exceeded the PM targets for the following measures:
- PM 1 Well-Child Visits in the First Fifteen (15) Months of Life (W15)
- PM 2 CAP 25 Months-6 Years of Age
- PM 3 Adult BMI Assessment (ABA)
- PM 4 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Presbyterian Health Plan
PHP met or exceeded the PM targets for the following measures:
- PM 1 W15
- PM 2 CAP 12-19 Years of Age
- PM 3 ABA
- PM 5 CDC HbA1c Testing
- PM 5 CDC HbA1c Poor Control
- PM 5 CDC Nephropathy Screening
- PM 6 PPC Prenatal Care
- PM 6 PPC Postpartum Care
- PM 7 AMM Acute Phase
- PM 7 AMM Continuation Phase
- PM 8 IET Engagement

PHP did not meet the PM targets for the following measures:
- PM 2 CAP 12 Months-24 Months
- PM 2 CAP 25 Months-6 Years of Age
- PM 2 CAP 7-11 Years of Age
- PM 4 WCC BMI Percentile
- PM 4 WCC Nutrition Counseling
- PM 4 WCC Physical Activity Counseling
- PM 5 CDC Retinal Eye Exam
- PM 8 IET Initiation

Western Sky Community Care, Inc. (WSCC)
WSCC was exempt from achieving HSD targets for this period as CY2019 was WSCC's baseline period. WSCC will be required to meet these targets starting with CY2020.

4. **Review of Compliance with Medicaid and CHIP Managed Care Regulations**
In November 2020, IPRO concluded the compliance review for CY2019 for the three Medicaid MCOs that were operational under the New Mexico Medicaid program referred to as Centennial Care: BCBS, PHP, and WSCC. The results of this compliance review are displayed in Table 14.

Table 14. CY2019 Compliance Results by MCO

MCO	CY2019 Overall Average	Compliance Level Achieved
Blue Cross Blue Shield of New Mexico	97.41%	Full
Presbyterian Health Plan, Inc.	94.54%	Full
Western Sky Community Care, Inc.	94.95%	Full

5. **Validation of Network Adequacy**
Based on the results of the CY2019 Compliance Review, it was determined that the MCOs were compliant with adopting the access, distance and timeliness standards outlined in the Centennial Care Managed Care Agreement.

6. **Recommendations**
   A. Continue to push for the adoption of telehealth services across the State, and identify opportunities to provide support to clinicians who participate in State health care programs.
   B. Identify gaps in care created by the COVID-19 pandemic and support interventions to mitigate these gaps.
   C. Consider ways to increase professional clinical resources across the State with a specific focus on regions of the State with network adequacy issues.
   D. Maximize the patient-centered provisions in the Centennial Care contract to push MCOs towards initiatives that prioritize improving quality of care.

5. SUD Monitoring and Oversight

Per New Mexico's SUD Monitoring Protocol approved by CMS on July 21, 2020,[59] HSD will continue to monitor and report on all SUD Implementation Plan, metrics,[60] and SUD Health IT Plan updates in accordance with reporting timelines.

[59] US Centers for Medicare & Medicaid Services (2020). CMS Letter of Approval for New Mexico's SUD Monitoring Protocol. Retrieved from: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-apprvd-monitoring-prtcl-part-b-07212020.pdf.
[60] US Centers for Medicare & Medicaid Services (2020). CMS Approved Monitoring Protocol—Excel Sheet. Retrieved from: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-apprvd-monitoring-prtcl-part-a-07212020.xlsm.

Section VIII: Impact on Enrollment and Expenditures

The State is not proposing any changes to Turquoise Care eligibility requirements in the Section 1115 demonstration renewal request that negatively impacts demonstration enrollment. Historical and projected demonstration enrollment are provided in the tables below. Enrollment reductions are anticipated solely due to eligibility redeterminations following the end of the COVID-19 PHE. Preliminary estimates of enrollment impacts for new demonstration proposals include the following:

- Continuous eligibility for children is expected to impact 71,797 children enrolled in the waiver.
- Reducing the CB waitlist is expected to add at least 800 individuals to the waiver.
- The justice-involved proposal is expected to impact 48,970 individuals enrolled in the waiver.

No impact to enrollment is anticipated for the remaining new demonstration proposals.

A summary of aggregate historical and projected demonstration expenditure data is provided in the tables below. Note that not all Medicaid expenditures are captured in these tables. For example, State administrative expenditures and expenditures for populations excluded from the current 1115 waiver are not included. Data is limited to expenditures that are considered as part of the current 1115 waiver budget neutrality and current CHIP allotment neutrality and projected new expenditures where data and estimates are currently available.

Demonstration projections are approximate assumptions for the purposes of the waiver renewal planning. Demonstration enrollment, financing and budget neutrality assumptions will continue to evolve throughout the course of the waiver renewal process and as new enrollment and budget data becomes available.

Table 15. Historical Data for Current Demonstration Period

	DY6 CY 2019	DY7 CY 2020	DY8 CY 2021	DY9* CY 2022	DY10* CY 2023	Five Year Total
Total Enrollment	851,880	864,076	864,123	878,365	793,365	
Total Expenditure (in billions)	$5.1	$5.9	$6.5	$6.8	$7.0	$31.3

*Based on projections including those from the current approved waiver and pending amendment request. Differences may exist due to rounding.

Table 16. Projected Data for Demonstration Renewal Period

	DY11 CY 2024	DY12 CY 2025	DY13 CY 2026	DY14 CY 2027	DY15 CY 2028	Five Year Total
Total Enrollment	827,633	864,314	872,957	881,686	890,503	
Total Continuing Demonstration Expenditures (in billions)	$7.3	$7.6	$7.9	$8.2	$8.5	$39.5
Total New Demonstration Expenditures (from Table 17)	$91,147,000	$110,979,000	$132,961,000	$136,625,000	$140,487,000	$612,199,000
Total Expenditure (in billions)	$7.4	$7.7	$8.0	$8.3	$8.7	$40.1

Note: Differences may exist due to rounding.

Table 17. Projected Expenditures for New Demonstration Proposals in Renewal Period

	DY11 CY 2024	DY12 CY 2025	DY13 CY 2026	DY14 CY 2027	DY15 CY 2028	Five Year Total
Continuous Enrollment for Children Up to Age 6	$20,438,000	$21,136,000	$21,858,000	$22,605,000	$23,379,000	$109,416,000
Expand HCBS CB Enrollment Opportunities through Additional Waiver Slots	$7,065,000	$25,693,000	$45,778,000	$47,512,000	$49,311,000	$175,359,000
Expanded Centennial Home Visiting Pilot Program	$828,000	$1,031,000	$1,161,000	$1,507,000	$1,662,000	$6,189,000
Expanded Access to Supportive Housing	$1,458,000	$1,504,000	$1,552,000	$1,601,000	$1,652,000	$7,767,000
Medicaid services for high-need justice-involved populations 30 days before release	$1,061,000	$1,119,000	$1,180,000	$1,244,000	$1,312,000	$5,916,000
Chiropractic Services Pilot	$2,967,000	$3,085,000	$3,207,000	$3,334,000	$3,466,000	$16,059,000
Member-Directed Traditional Healing Services for Native Americans	$10,125,000	$10,226,000	$10,328,000	$10,431,000	$10,536,000	$51,646,000
Waiver Investments in Small-Home Assisted Living and Nursing Facility Pilots	$300,000	$300,000	$300,000	$50,000	$50,000	$1,000,000
Medicaid reimbursement for room and board in Assisted Living Facility settings when cost-effective and clinically appropriate	$12,498,000	$13,101,000	$13,733,000	$14,395,000	$15,090,000	$68,817,000
Closed-Loop Referral Network	$5,700,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$25,700,000
Environmental Modification Benefit Limit Increase	$884,000	$884,000	$884,000	$884,000	$884,000	$4,420,000
Community-Based Transition Services Benefit Limit Increase	$123,000	$123,000	$123,000	$123,000	$123,000	$615,000
Home Delivered Meals Pilot Programs	$1,590,000	$1,590,000	$1,590,000	$1,590,000	$1,590,000	$7,950,000
Rural Hospital Initiative	$23,000,000	$23,000,000	$23,000,000	$23,000,000	$23,000,000	$115,000,000
Medical Respite for Members Experiencing Homelessness	$3,110,000	$3,187,000	$3,267,000	$3,349,000	$3,432,000	$16,345,000
Total	**$91,147,000**	**$110,979,000**	**$132,961,000**	**$136,625,000**	**$140,487,000**	**$612,199,000**

Note: All amounts in this table are included in the total expenditures in Table 16.
Differences may exist due to rounding.

Section IX: Interim Evaluation Results and Renewal Evaluation Design

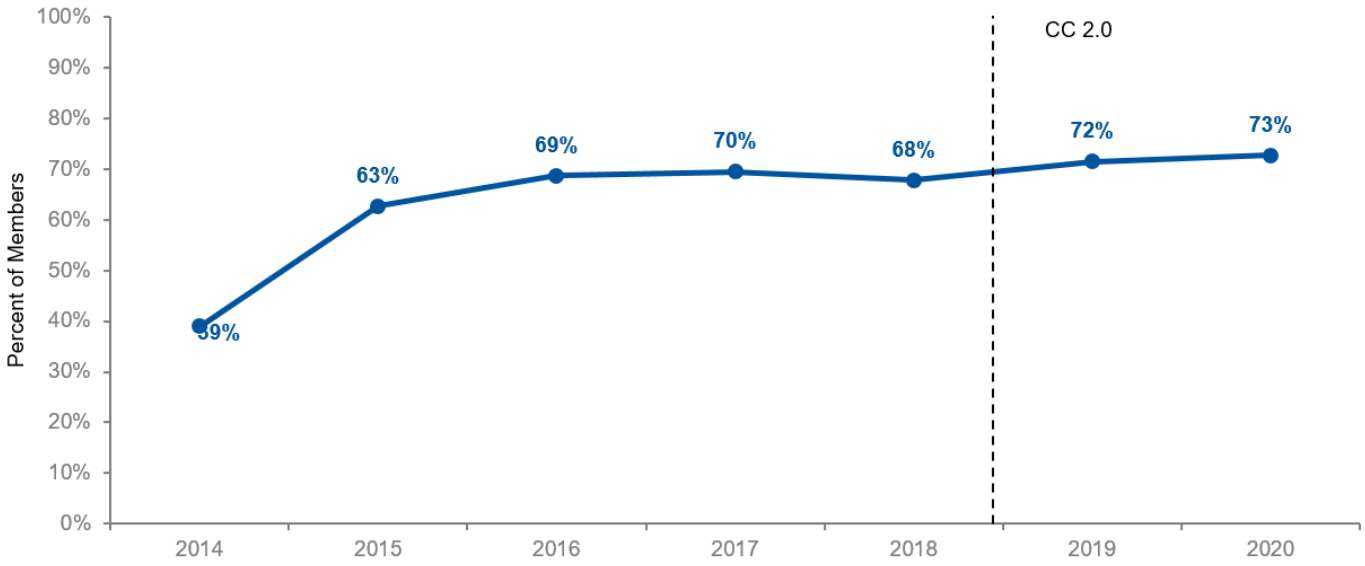
Per STC 114, an independent external evaluator is tasked with evaluating the demonstration, including data analysis and validation relative to the demonstration hypotheses, the development of quarterly monitoring reports, an interim evaluation report, and a final evaluation report. For Centennial Care 2.0, New Mexico commissioned the Health Services Advisory Group, Inc. (HSAG) as the independent external evaluator. New Mexico is in the process of selecting its independent external evaluator for the demonstration renewal. The following parts of this section discuss the draft interim evaluation report followed by preliminary and provisional plans to evaluate the impact of the demonstrational renewal. A copy of the Draft Interim Evaluation Report can be found in Appendix B andhttps://www.hsd.state.nm.us/wp-content/uploads/NMWaiverEval_InterimRpt_D2-1.pdf .

Draft Interim Evaluation Report
The Draft Interim Evaluation Report for the Centennial Care 2.0 program will be completed by November 15, 2022 and the final report submitted with the renewal application to CMS. Key preliminary findings from draft evaluation activities to-date, documented in quarterly monitoring reports, are as follows:

- To-date, HSAG has completed preliminary analyses for 50 evaluation measures. Preliminary conclusions presented in this section are organized by demonstration aim and hypothesis. These conclusions are preliminary and subject to change upon finalization and may not represent the final results in the Interim Evaluation Report.
- HSD and HSAG continued discussions on the impacts of COVID-19 pandemic on the demonstration waiver. In addition, HSAG utilized a range of methodologies in measure analyses to control for COVID-19 impacts on the demonstration results. Specifically, HSAG utilized indicator variables where possible as statistical controls to account for time periods impacted by COVID-19. These were employed primarily in interrupted time series (ITS) analyses.
- Overall, preliminary evidence on measures evaluated to-date either support, weakly support, or are consistent with their respective hypotheses, with 24 out of 50 measures supporting, weakly supporting or consistent with their hypothesis, with eight failing to support the hypothesis and two failing to support the hypothesis but trending in the favorable direction. Additionally, 12 out of 50 measures neither supported nor failed to support the hypothesis and four measures had insufficient data from which to draw a conclusion. For the full list of Centennial Care 2.0 evaluation hypotheses, please see the quarterly monitoring report from Q1 and Q2, 2022s, located in Appendix I.
- Notable Centennial Care 2.0 hypotheses that are supported by all their accompanying measures include:
    - **Aim One: Continue the use of appropriate services by members to enhance member access to services and quality of care.**
        - Hypothesis 1: Continuing to expand access to LTSS and maintaining the progress achieved through rebalancing efforts to serve more members in their homes and communities will maintain the number of members accessing CB services.
        - Hypothesis 2: Promoting participation in a Health Home will result in increased member engagement with a Health Home and increase access to integrated physical and behavioral health care community.
    - **Aim Four: Improved quality of care and outcomes for Medicaid beneficiaries with SUD.**
        - Hypothesis 2: The demonstration will increase peer support services which will result in more individuals engaging in and retained in AOD Dependence Treatment.

- Additionally, several additional measures are supportive of their respective hypotheses based on preliminary conclusions. These include:
  - **Aim One: Continue the use of appropriate services by members to enhance member access to services and quality of care.**
    - Hypothesis 5: Expanding member access to and incentives for preventative care through the CHV pilot program and Centennial Rewards will encourage members to engage in preventative care services.
      - *Measure 12—Percentage of CC members participating in Centennial Rewards.*

Figure 13. Centennial Rewards Participation Rate, 2014–2020[1]



[1] Rates were provided by Finity and have not been independently verified or validated by HSAG.

  - **Aim Two: Manage the pace at which costs are increasing while sustaining or improving quality, services, and eligibility.**
    - Hypothesis 1: Incentivizing hospitals to improve health of members and quality of services and increasing the number of providers with VBP contracts will manage costs while sustaining or improving quality.
      - *Measure 16: Has the number of providers with VBP contracts increased?*

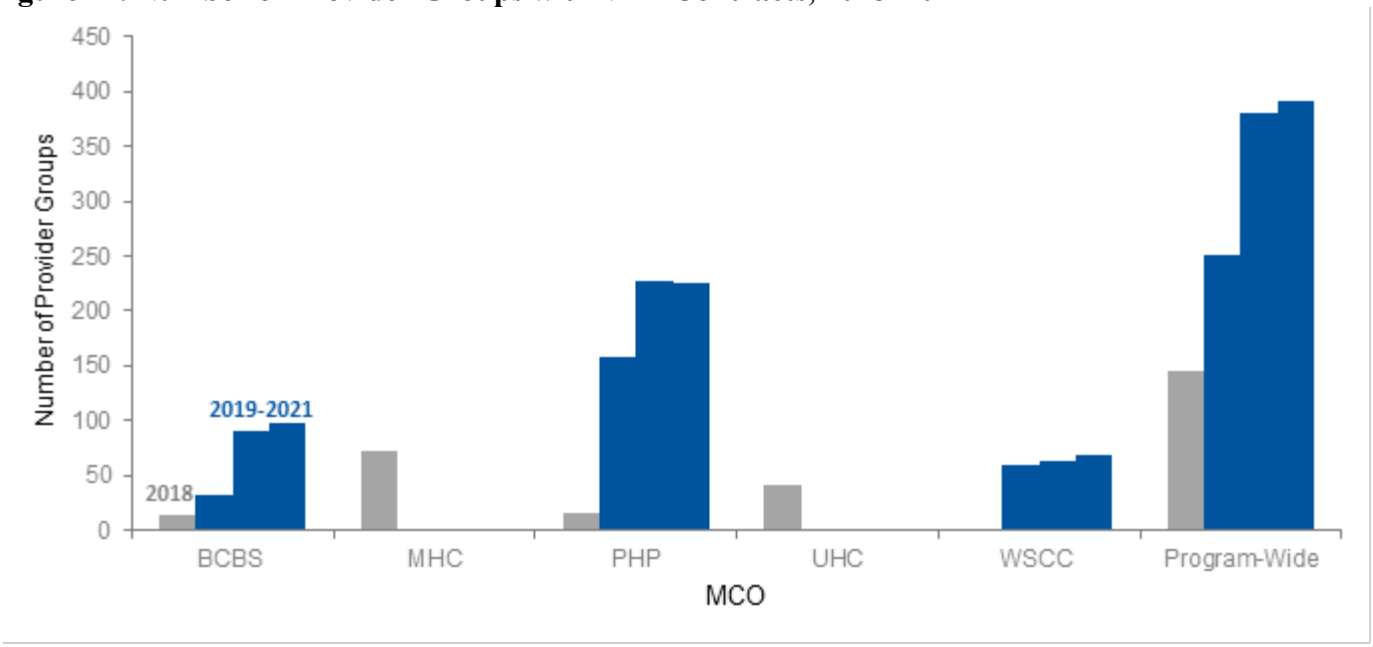
Table 18 and Figure 14 display the total number of Centennial Care provider groups with VBP contracts between 2018 and 2021 for each MCO and aggregated program wide. During this period, the number of provider groups with VBP contracts increased for MCOs and Centennial Care as a whole. In 2018, prior to the implementation of Centennial Care 2.0, there were a total of 145 provider groups with VBP contracts, which increased by 170% to 392 provider groups in 2021. The largest annual increase in program wide VBP provider groups, 73%, occurred between 2018 and 2019.

Table 18. Number of Provider Groups with VBP Contracts, 2018–2021

MCO	2018	2019	2020	2021
Blue Cross Blue Shield (BCBS)	15	33	90	98
Molina Healthcare of New Mexico, Inc. (MHC)	72	--	--	---
Presbyterian Health Plan (PHP)	16	159	228	225
UnitedHealthcare of New Mexico, Inc. (UHC)	42	--	--	--
Western Sky Community Care (WSCC)	--	59	63	69
Program-Wide	**145**	**251**	**381**	**392**

Note: -- indicates years in which an MCO was not contracted with Centennial Care.

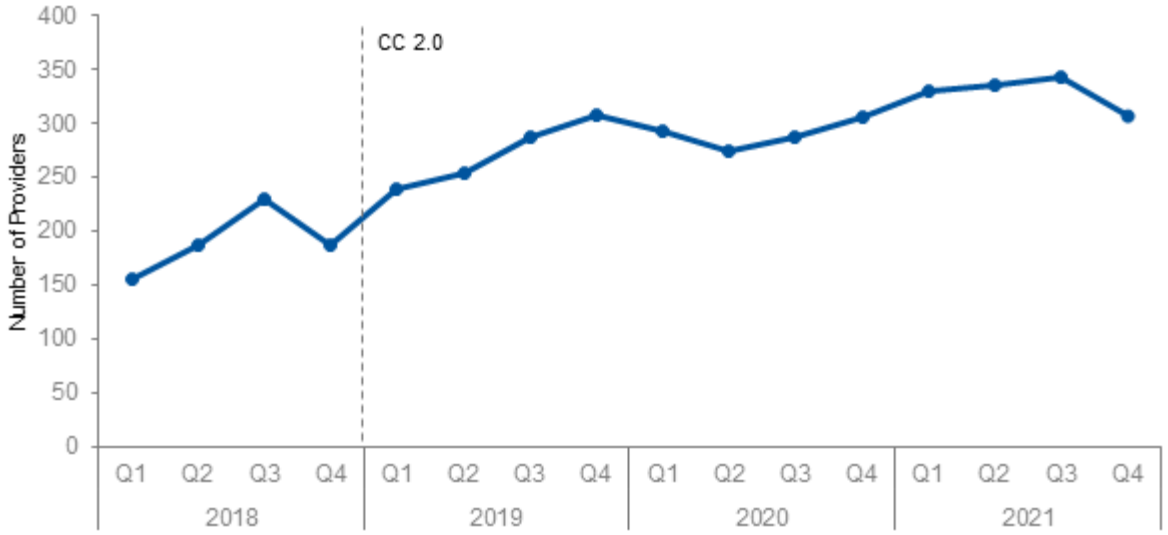
Figure 14. Number of Provider Groups with VBP Contracts, 2018–2021



- **Aim Four: Improved quality of care and outcomes for Medicaid beneficiaries with SUD.**
  - Hypothesis 1: The demonstration will increase the number of providers that provide SUD screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for AOD dependence treatment.
    - *Measure 30—Number of providers who provide SUD screening*

HSAG assessed the number of providers who had a claim for SUD screening by quarter. Overall, the quarterly average number of providers increased 73% during Centennial Care 2.0, from 190 providers per quarter in 2018 (prior to the demonstration) to 329 providers per quarter in 2021. However, after reaching a peak of 342 providers in 2021 Q3, the number of providers decreased to 308 in 2021 Q4. This decline may be due to incomplete Q4 data but should be monitored to assess if the trend continues into 2022.

Figure 15. Number of Providers Offering SUD Screening, 2018-2021



- Several other measure results either did not support their respective hypotheses or were inconclusive. These include several measures that Turquoise Care intends to positively impact through new and continuing initiatives:
  - Children and adolescents' access to primary care practitioners (CAP);
  - Live births weighing less than 2,500 grams (low birth weight);
  - Percentage of individuals with a SUD diagnosis who received any SUD service during the measurement year;
  - Percentage of individuals diagnosed with SUD receiving care coordination; and
  - Rate of deaths due to overdose.

Plans for Evaluating Impact of Demonstration Renewal

During Turquoise Care, HSD will continue relevant hypotheses from Centennial Care 2.0, as well as add new hypotheses in order to evaluate the impact of policies and programs in this renewal application. As stated above, HSD is in the process of selecting its independent external evaluator for the demonstration renewal; therefore, the plans for evaluating the impact of the demonstration renewal are preliminary and provisional. When the independent external evaluator is selected, the comprehensive evaluation strategy, including details surrounding the goals, hypotheses, methodology, and data sources, will be formalized. That said, HSD has developed provisional hypotheses and goals reflective of new and continuing initiatives within the demonstration renewal. Table 19 describes these hypotheses and whether they are new or continuing (please note the methodology and data sources are reserved and will be updated upon selection of the independent evaluator):

Table 19. Demonstration Goals and Evaluation Hypotheses

Goal	Hypothesis	Methodology	Data Sources	New/Continuing?
Goal 1: Build a New Mexico health care delivery system where every Medicaid member has a dedicated health care team that is accessible for both preventive and emergency care that supports the whole person - their physical, behavioral, and social drivers of health.				
1.1	Promoting participation in a Health Home will result in increased member engagement with a Health Home and increase access to integrated physical and behavioral health care in the community.	The number of members receiving services through a Health Home will increase annually throughout the demonstration.	Administrative claims data	Continuing
1.2	Access to chiropractic care will reduce the need for high-risk treatment interventions for Medicaid patients with neck pain, back pain, musculoskeletal pain, and headaches.	Members receiving chiropractic care services will have less utilization of high-risk treatment services associated with neck pain, back pain, musculoskeletal pain, and headaches at the end of the demonstration compared to the previous four years of utilization prior to the renewal period.	Administrative claims data	New
1.3	Chiropractic services are cost-effective and will reduce per-member costs over time for patients with neck pain, back pain, musculoskeletal pain, and headaches.	Members with diagnoses of neck pain, back pain, musculoskeletal pain, and/or headaches receiving chiropractic services will have reduced PMPM costs at the end of the demonstration compared to the previous four years of the utilization prior to the renewal period.	Administrative claims data	New
1.4	Modernized care coordination provided by the MCOs supports integrated care interventions and improved access to preventative/ambulatory health services.	Members receiving MCO care coordination will have increased utilization of preventative/ambulatory health services annually throughout the demonstration.	Administrative claims data	Continuing
1.5	Engagement in a Health Home and care coordination supports integrative care interventions, which improve quality of care.	Members receiving Health Home services will report increases in patient satisfaction.	Member engagement surveys	Continuing

1.6	Implementation of electronic visit verification (EVV) is associated with increased accuracy in reporting services rendered.	Services provided by providers utilizing EVV will have improved service reporting in terms of timeliness and specificity of services.	EVV data/chart review	Continuing/New
Goal 2: Strengthen the New Mexico health care delivery system through the expansion and implementation of innovative payment reforms and value-based initiatives.				
2.1	Incentivizing hospitals to improve the health of members and quality of services and increasing the number of providers with VBP contracts will manage costs while sustaining or improving quality.	VBP contracts with hospitals will slow the increase in hospital related costs and improve patient satisfaction annually throughout the demonstration.	Administrative claims data, member engagement surveys	Continuing
2.2	Stabilizing and sustaining rural hospital infrastructure will increase access to critical services in rural areas, including obstetric care.	Members will have increased utilization of necessary hospital and obstetrical care services at rural hospitals receiving infrastructure investments annually and in comparison to the four years preceding this investment.	Administrative claims data	New
2.3	Expanded GME program to increase the number of graduates in the following specialties: General Psychiatry, Family Medicine, General Pediatrics, and General Internal Medicine.	Investments in GME will lead to increase number of graduates in primary care and pediatric specialties annually and over the course of the demonstration.	GME program data	New
Goal 3: Identify groups that have been historically and intentionally disenfranchised and address health disparities through strategic program changes to enable an equitable chance at living healthy live				
3.1	Continuing to expand access to LTSS and maintaining the progress achieved through rebalancing efforts to serve more members in their homes and communities will maintain the number of members accessing CB services. This includes expansion of environmental modification benefits, transitional service limits, and home delivered meals.	Members receiving LTSS environmental modification benefits, transitional service limits, and home delivered meals will maintain the member utilization of CB services annually.	Administrative claims data	Continuing/New
3.2	Continuous enrollment will improve access and completion of early childhood screenings, preventative visits, and routine care for children aged 0-6.	Members with continuous enrollment will have greater utilization of early childhood screenings, preventative visits, and routine care in comparison	Administrative claims data	New

		to the four years prior to the issuance of the COVID-19 public health emergency.		
3.3	Expanding member access to and incentives for preventative care through Centennial Rewards will encourage members to engage in preventative care services.	Members participating in Centennial Rewards will have greater utilization of routine and preventative care services annually throughout the demonstration.	Administrative claims data	Continuing
3.4	The demonstration will relieve administrative burden by implementing a continuous NFLOC approval with specific criteria for members whose condition is not expected to change over time.	Utilization of a continuous NFLOC approval for qualifying members will have reduced administrative expenditures versus prior to the implementation of the continuous NFLOC approval process.	Administrative cost data	Continuing
3.5	The ability for legal representatives to provide personal care services to individuals receiving CB services will increase PCS workforce.	Members receiving personal care CB services from legal representatives will have greater utilization of necessary HCBS services annually throughout the demonstration and in comparison to the four years preceding the implementation of this benefit.	Administrative claims data	New
3.6	Covering room and board in ALFs will reduce the number of members requiring nursing facility care.	Members with ALF room and board reimbursement will have fewer nursing facility admissions in comparison to the four years preceding the implementation of this benefit.	Administrative claims data	New
3.7	Adding "small home" concepts and architectural changes will increase Nurse Aid hours per resident per day. Decrease the percentage of Nurse Staff turnover.	Total nurse aid hours per resident. Percentage of nurse turnover as compared to the previous year.	Administrative claims data	New
3.8	The demonstration will increase the number of providers that provide SUD screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for AOD dependence treatment.	The number of SUD screening services will increase annually and in comparison to the four years preceding the addition of this benefit; the percentage of individuals initiating treatment for AOD dependence will increase	Administrative claims data	Continuing

		annually and in comparison to the four years preceding the addition of this benefit.		
3.9	The demonstration will increase peer support services which will result in more individuals engaging in and retained in AOD Dependence Treatment.	Members will have increased utilization of peer support services annually and in comparison to the four years preceding the start of this benefit; members will have increased retainment in AOD dependence treatment annually and in comparison to the four years preceding the addition of this benefit.	Administrative claims data	Continuing
3.10	The demonstration will improve access to a comprehensive continuum of SUD care which will result in decreased utilization of ED and inpatient hospitalization and SUD inpatient readmissions.	Members receiving SUD care will have decreased utilization of SUD-related ED and inpatient hospitalizations and reductions of SUD inpatient readmissions annually and in comparison to the four years preceding this benefit.	Administrative claims data	Continuing
3.11	The demonstration will increase the number of individuals with fully delegated care coordination which includes screening for co-morbid conditions, which will result in increased utilization of physical health services.	Members with fully delegated care coordination will increase annually and in comparison to the four years preceding this benefit; members receiving delegated care coordination will have greater utilization of screening for comorbid conditions annually and in comparison to the four years preceding this benefit; members receiving delegated care coordination will have increased utilization of preventative health services annually and in comparison to the four years preceding this benefit.	Administrative claims data	Continuing
3.12	The demonstration will increase use of naloxone, MAT and enhanced monitoring and reporting of opioid prescriptions through the prescription monitoring program, which will result in fewer overdose deaths due to opioid use.	Utilization of naloxone, MAT, and enhanced PDMP monitoring/reporting will increase annually and in comparison to the four years preceding this benefit; members receiving these services will have fewer opioid overdose deaths annually and in comparison	Administrative claims data, PDMP data	Continuing

		to the four years preceding this benefit.		
3.13	Providing targeted benefits to high-need justice-involved members 30 days prior to release will increase access to and utilization of necessary behavioral and physical health services and medications (including MAT and DME).	Members exiting incarceration will have increased utilization of preventative services at 30 days, 90 days, and annually after release in comparison to a similar population in the four years preceding this benefit.	Administrative claims data	New
3.14	Members with specific behavioral health conditions receiving pre-tenancy and tenancy housing support services will increase access to and utilization of necessary behavioral and physical health services.	Members receiving housing support services will have greater utilization of behavioral and physical health services annually and in comparison to a similar population in the four years preceding this benefit.	Administrative claims data	New
3.15	Participation in CHV will reduce infant hospitalizations and emergency room visits.	Percentage of children 0-1 participating in CHV with a hospital admission/ED visits as compared with those not participating in the CHV program	Administrative claims data	New
3.16	Participation in CHV will increase the percentage of children receiving immunizations by age 2	Childhood immunizations	Administrative claims data	New
3.17	Native Americans and Tribal Populations will have increased access to culturally appropriate services, including traditional healing services, with the ability to voluntarily participate in managed care programs and/or other pilot initiatives.	Native American and Tribal members will have increased utilization of traditional healing as demonstrated by the issuance of service vouchers.	Administrative claims data	New
3.18	Members experiencing homelessness post-hospital discharge will have reduced hospital readmissions after utilizing Medical Respite Services.	Members receiving medical respite services will have reduced hospital readmissions annually and in comparison to a similar population in the four years preceding this benefit.	Administrative claims data	New

Section X: Compliance with Public Notice Process

Reserved for documentation of compliance with the public notice (transparency) requirements

Appendices

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Appendix A: Glossary

Acronym	Term
ABA	Adult BMI Assessment
ABA	Applied Behavioral Analysis
ABCB	Agency-Based Community Benefit
ABP	Alternative Benefit Plan
ADL	Activities of Daily Living
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indians/Alaskan Natives
AMM	Antidepressant Medication Management
ALF	Assisted Living Facility
AOD	Alcohol or Other Drug
ARTC	Accredited Residential Treatment Centers
BCBS	Blue Cross Blue Shield
BHSD	Behavioral Health Services Division
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Children and Adolescents' Access to Primary Care Practitioners
CB	Community Benefit
CCBHC	Certified Community Behavioral Health Clinics
CCSS	Comprehensive Community Support Services
CDC	Comprehensive Diabetes Care
CDC	Centers for Disease Control
CF	Child First
CISC	Children in State Custody
CHIP	Children's Health Insurance Program
CHR	Community Health Representative
CHW	Community Health Worker
CHV	Centennial Home Visiting
CNA	Comprehensive Needs Assessment
COVID-19	Coronavirus Disease 2019
CMS	Centers for Medicare & Medicaid Services
CQI	Continuous Quality Improvement
CY	Calendar Year
DME	Durable Medical Equipment
DOH	Department of Health
DSM-V	Diagnostic and Statistical Manual of Mental Disorders
DY	Demonstration Year
ECECD	Early Childhood Education & Care Department
ED	Emergency Department
EMSA	Emergency Medical Services for Aliens
EMSNC	Emergency Medical Services for Non-Citizens
EPSDT	Early Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
EVV	Electronic Visit Verification

FC	Families Connect
FFS	Fee-for-Service
FMA	Financial Management Agency
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
FY	Fiscal Year
GME	Graduate Medical Education
HCBS	Home- and Community-Based Services
HCBW	Home- and Community-Based Waiver
HFA	Health Families America
HFW	High-Fidelity Wraparound
HEDIS	Healthcare Effectiveness Data and Information Set
HRA	Health Risk Assessment
HQII	Hospital Quality Improvement Incentive
HSAG	Health Services Advisory Group, Inc.
HSD	New Mexico's Human Services Department
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
ITS	Interrupted Time Series
I/T/U	Indian Health Service, Tribal health provider, and Urban Indian providers
IHS	Indian Health Service
IMD	Institution for Mental Disease
IPRO	Island Peer Review Organization
LARC	Long-Acting Reversible Contraceptive
LOC	Level of Care
LPN	Licensed Practical Nurse
LRI	Legally Responsible Individual
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MAD	Medical Assistance Division
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MEG	Medicaid Eligibility Group
MFP	Money Follows the Person
MLTSS	Managed Long-Term Services and Supports
MY	Measurement Year
NAAB	Native American Advisory Board
NATAC	Native American Technical Advisory Committee
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NFLOC	Nursing Facility Level of Care
NFP	Nurse Family Partnership
NM	New Mexico
NMICSS	New Mexico Independent Consumer Support System
OB	Obstetrics
OUD	Opioid Use Disorder
PACE	Program for All-Inclusive Care for the Elderly
PAT	Parents as Teachers

PCMH	Patient-Centered Medical Homes
PCP	Primary Care Physician
PCS	Personal Care Services
PDL	Preferred Drug List
PIP	Performance Improvement Projects
PHE	Public Health Emergency
PHP	Presbyterian Health Plan, Inc.
PMP	Pharmacy Prescription Monitoring Program
PM	Performance Measures
PPC	Prenatal and Postpartum Care
QM/QI	Quality Management/Quality Improvement
RHC	Rural Health Clinic
SAHP	Set Aside Housing Program
SDCB	Self-Directed Community Benefit
SED	Severe Emotional Disturbance
SFY	State Fiscal Year
SNCP	Safety Net Care Pool
SMI	Serious Mental Illness
SMDL	State Medicaid Director Letter
SPA	State Plan Amendment
SSA	Social Security Act
SSI	Supplemental Security Income
STC	Standard Terms and Conditions
STR	State Targeted Response
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TM	Tracking Measures
UC	Uncompensated Care
VBP	Value-Based Purchasing
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
WSCC	Western Sky Community Care, Inc.

Appendix B: Interim Evaluation Report

State of New Mexico Human Services Department,
Medical Assistance Division

Medicaid 1115 Demonstration and Substance Use Disorder Waiver—Centennial Care 2.0

Interim Evaluation Report

August 2022

—Draft Copy for Review—

HSAG HEALTH SERVICES ADVISORY GROUP

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Executive Summary

The New Mexico Human Services Department's (HSD's) Section 1115 Demonstration Waiver renewal application, Centennial Care 2.0, was approved by the Centers for Medicare & Medicaid Services (CMS) on December 14, 2018, effective from January 1, 2019, through December 31, 2023.[1] The waiver allowed HSD to continue the goals and objectives of the original waiver, Centennial Care, working to further improve administrative simplification, care coordination, member engagement, and benefit and delivery system payment reforms. In addition, Centennial Care 2.0 was designed to support four new aims:

- **Aim One**: Continue the use of appropriate services by members to enhance member access to services and quality of care.
- **Aim Two**: Manage the pace at which costs are increasing while sustaining or improving quality, services, and eligibility.
- **Aim Three**: Streamline processes and modernize the Centennial Care health delivery system through use of data, technology, and person-centered care.
- **Aim Four**: Improve quality of care and outcomes for Medicaid beneficiaries with a substance use disorder (SUD).

Pursuant to the Special Terms and Conditions (STCs) of the Section 1115 Demonstration Waiver, HSD contracted with Health Services Advisory Group, Inc. (HSAG), as an independent evaluator to conduct a comprehensive evaluation of Centennial Care 2.0.[2] The goal of this evaluation is to provide CMS and HSD with an independent evaluation that ensures compliance with the Section 1115 Demonstration Waiver requirements; assist in both State and federal decision making about the efficacy of the Demonstration; and enable HSD to further develop clinically appropriate, fiscally responsible, and effective Medicaid demonstration programs. This is the Interim Evaluation Report for the Centennial Care 2.0 Section 1115 Demonstration Waiver. This report evaluates the first three years of the Demonstration Waiver, January 1, 2019, through December 31, 2021. After the conclusion of the Demonstration Waiver in 2023, a Summative Evaluation Report will include analysis of the full five-year Demonstration period.

Results

Of the four aims associated with the Demonstration Waiver, Aim One and Aim Two are supported by the results of the analyses. Aim Three is generally supported by the analyses; however, no conclusions could be drawn for two of the three associated hypotheses. The results for Aim Four are mixed. Table 1 provides results for each measure, hypothesis, and aim. Note, results of "NS/FS" are given for measure that neither support nor fail to support the hypothesis. This finding may arise through two primary reasons:

1. Results were not statistically significant, or
2. Results were mixed in terms of their support

[1] State of New Mexico Human Services Department. Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0. Available at https://www.hsd.state.nm.us/wp-content/uploads/Centennial-Care-2_0-Waiver-Application-NM-Dec-2017-1.pdf. Accessed on July 8, 2022.

[2] Centers for Medicare & Medicaid Services. Special Terms and Conditions Centennial Care 2.0 Medicaid 1115 Demonstration. *Human Services Department.* 2020. 11W-00285/6. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-ca.pdf. Accessed on July 8, 2022.

Table 1—Summary of Results by Measure, Hypothesis, and Aim

Measure Number	Measure Name	Measure Supports Hypothesis
Aim One: Continue the use of appropriate services by members to enhance member access to services and quality of care		
Hypothesis 1: Continuing to expand access to Long-Term Support Services and Supports (LTSS) and maintaining the progress achieved through rebalancing efforts to serve more members in their homes and communities will maintain the number of members accessing Community Benefit (CB) services.		
1	Number of Centennial Care members enrolled and receiving CB services	Yes
Hypothesis 2: Promoting participation in a health home (HH) will result in increased member engagement with a health home and increase access to an integrated physical and behavioral health care community.		
2	Number/Percentage of Centennial Care members enrolled in a health home	Yes
3	Number/Percentage of Health Home members with at least one (1) claim for physical health (PH) service in the calendar year	Yes
Hypothesis 3: Enhanced care coordination supports integrated care interventions, which lead to higher levels of access to preventive/ambulatory health services.		
4a	Adults' access to preventive/ambulatory health services (AAP)[1]	NS/FS
5a	Children and adolescents' access to primary care practitioners (CAP) [1]	No
6	Well-child visits in the third, fourth, fifth, and sixth years of life (W34)	NS/FS
4b	Adults' access to preventive/ambulatory health services (AAP) – HH population	Yes
5b	Children and adolescents' access to primary care practitioners (CAP) – HH population	Yes
Hypothesis 4: Engagement in a health home and care coordination support integrative care interventions, which improve quality of care.		
7	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD) – HH population	NS/FS
8	Anti-depressant medication management (AMM) Effective Acute Phase Treatment – HH population	NS/FS
9	Anti-depressant medication management (AMM) Effective Continuation Phase Treatment – HH population	NS/FS
10	7-day follow up after hospitalization for mental illness (FUH) – HH population	Yes
11	30-day follow up after hospitalization for mental illness (FUH) – HH population	NS/FS
Hypothesis 5: Expanding member access to preventive care through the Centennial Home Visiting (CHV) pilot program and providing incentives through Centennial Rewards (CR) will encourage members to engage in preventive care services.		
12	Percentage of CC members participating in CR	Consistent[2]
13	Percentage of CR participating members with an annual preventive/ambulatory service	NS/FS
14	Percent of CR users responding positively on satisfaction survey to question regarding if the program helped to improve their health and make healthy choices	—[3]
15	Live births weighing less than 2,500 grams (low birth weight)	No
Aim Two: Manage the pace at which costs are increasing while sustaining or improving quality, services, and eligibility		
Hypothesis 1: Incentivizing hospitals to improve health of members and quality of services and increasing the number of providers with value-based purchasing (VBP) contracts will manage costs while sustaining or improving quality.		
16	Number of provider groups with VBP contracts	Consistent
17	Number/percentage of providers meeting quality threshold	—
18	Percentage of total payments that are for providers in VBP arrangements	Yes

Measure Number	Measure Name	Measure Supports Hypothesis
19	Percentage of qualified Domain 1 safety net care pool (SNCP) Hospital Quality Incentive measures that have maintained or improved their reported performance rates over the previous year	NS/FS
20	Cost per member trend	Yes
21	Cost per user trend	No
Aim Three: Streamline processes and modernize the Centennial Care health delivery system through use of data, technology, and person-centered care		
Hypothesis 1: The Demonstration will relieve administrative burden by implementing a continuous Nursing Facility Level of Care (NFLOC) approval with specific criteria for members whose condition is not expected to change over time.		
22	Number of continuous NFLOC approvals	Consistent
Hypothesis 2: The use of technology and continuous quality improvement (CQI) processes align with increased access to services and member satisfaction.		
23	Number of telemedicine providers	Consistent
24	Number of members receiving telemedicine services	Consistent
25	Member rating of health care	Yes
26	Member rating of health plan	NS/FS
27	Member rating of personal doctor	NS/FS
Hypothesis 3: Implementation of electronic visit verification (EVV) is associated with increased accuracy in reporting services rendered.		
28	Number of submitted claims through EVV	Consistent
29	Percentage of paid or unpaid hours retrieved due to false reporting	—
Aim Four: Improved quality of care and outcomes for Medicaid beneficiaries with SUD		
Hypothesis 1: The Demonstration will increase the number of providers that provide SUD screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for alcohol and other drug (AOD) abuse and dependence treatment.		
30	Number of providers who provide SUD screening	Yes
31	Number of individuals screened for SUD	Yes
32	Percentage of individuals with a SUD diagnosis who received any SUD service during the measurement year	No
33	Initiation of AOD Abuse or Dependence Treatment (IET)	No
Hypothesis 2: The Demonstration will increase peer support services which will result in more individuals engaging in and retained in AOD dependence treatment.		
34	Percentage of individuals with a SUD diagnosis who received peer support	Yes
35	Engagement of AOD Abuse or Dependence Treatment (IET)	Yes
36	Average Length of Stay (ALOS)	Yes
37	Continuity of Pharmacotherapy for opioid use disorder (OUD)	Yes
Hypothesis 3: The Demonstration will improve access to a comprehensive continuum of SUD care which will result in decreased utilization of emergency department (ED) and inpatient hospitalization and SUD inpatient readmissions.		
38	Continuum of services available	NS/FS
39	Number of providers and capacity for ambulatory SUD services	Yes
40	Percentage of ED visits of individuals with SUD diagnoses	NS/FS

Measure Number	Measure Name	Measure Supports Hypothesis
41	Percentage of Inpatient admissions for SUD-related treatment	NS/FS
42	Percentage of Inpatient admissions of individuals with a SUD for withdrawal management	No
43	7- and 30-day inpatient and residential SUD readmission rates	Yes
44	Total and per member per month (PMPM) cost (medical, behavioral, and pharmacy) for members with a SUD diagnosis	N/A[4]
45	Total and PMPM cost (medical, behavioral, and pharmacy) for members with a SUD diagnosis by SUD source of care	N/A
46	Total and PMPM cost for SUD services for members with a SUD diagnosis	N/A
47	Total and PMPM cost for SUD services by type of care (inpatient [IP], outpatient [OP], prescription [RX], etc.)	N/A
Hypothesis 4: The Demonstration will increase the number of individuals with fully delegated care coordination which includes screening for co- morbid conditions, which will result in increased utilization of physical health services.		
48	Percentage of individuals diagnosed with a SUD receiving care coordination	No
49	Percentage of individuals with a SUD receiving preventive/ambulatory health services (AAP)	Yes
Hypothesis 5: The Demonstration will Increase use of naloxone, medication assisted treatment (MAT), and enhanced monitoring and reporting of opioid prescriptions through the prescription monitoring program, which will result in fewer overdose deaths due to opioid use.		
50	Number of naloxone training and kit distributions	No
51	Number of managed care organization (MCO) network MAT providers	No
52	Percentage of individuals diagnosed with a SUD with MAT claims	No
53	Number of policy and procedure manual references	Yes
54	Rate of deaths due to overdose	No

[1]To concisely evaluate the Health Home Program, results for Measures 4b and 5b (health home-specific measures) are presented after Measure 6.

[2]Consistent = The measure does not directly address the hypothesis, but provides contextual information on the hypothesis.

[3]— = Insufficient data to draw a conclusion.

[4]N/A = The measure is not directly connected to the hypothesis, but provides critical program information.

*The following abbreviations are used in the measure descriptions—ALOS: Average Length of Stay; AOD: alcohol and other drugs; CB: Community Benefit; CC: Centennial Care; CR: Centennial Rewards; ED: emergency department; EVV: electronic visit verification; HH: health home; IP: inpatient; NCQA: National Committee for Quality Assurance; NFLOC: nursing facility level of care; MAT: medication assisted treatment; MCO: managed care organization; OP: outpatient; OUD: opioid use disorder; PH: physical health; PMPM: per member per month; RX: prescription; SNCP: safety net care pool; SUD: substance use disorder; VBP: value-based purchasing

Conclusions

Analysis suggests that at this point in the Demonstration, the State is meeting Aim One and Aim Two. Aim Three is being met to the extent that conclusions could be drawn from the available data. The coronavirus disease 2019 (COVID-19) public health emergency (PHE) has impacted several measures in Aim Three, particularly those related to telemedicine services, which increased substantially as a result of the PHE. As additional data become available, it is expected that a more nuanced picture around Aim Three can be drawn. HSAG will work with the State to explore additional data sources or additional measures that will ensure a more complete picture of Aim Three performance for the Summative Evaluation Report. As of this Interim Report, the results for Aim Four are mixed. However, several aspects of Aim Four have been substantially impacted by the COVID-19 PHE. HSAG believes that as additional data become available and the impacts of the PHE diminish, the performance of the

program should be separable from PHE impacts, allowing for a more refined analysis of the diagnosis and treatment of SUD elements of Centennial Care 2.0.

Peer support services represent the most notable success emerging from the interim evaluation analyses. The number of individuals with a SUD diagnosis increased during Centennial Care 2.0 and all peer support services performance measures have shown improvement against declines for individuals not enrolled in per support services. The peer support services performance improvements continued against the backdrop of the COVID-19 PHE, which appears to have substantially impacted other elements of Aim Four, to improve the quality of care and outcomes for Medicaid beneficiaries with SUDs.

Health homes were moderately successful, although the PHE clearly had an impact. Health home enrollment continued to grow at a moderate rate; however, the results of only four of the 11 outcome/utilization measures (3, 4b, 5b, and 10) support the associated hypotheses and aims. The results of the analyses suggest that the PHE may have had a substantial impact on the performance of health homes. Measures 4a, 5a, and 6 all showed improvement in 2019, followed by sharp declines beginning in 2020. While statistical methods were applied to control for the impacts of the COVID-19 PHE, it is probable that due to the scale of the PHE, standard statistical methods are insufficient. Other health home measures were generally mixed but were not statistically significant.

The financial analyses suggest the cost of care has been below or around the estimated costs had the Centennial Care 2.0 not been implemented (the counterfactual) until early calendar year (CY) 2021, at which time costs began to increase substantially. If the CY 2021 trend continues, costs of care are likely to exceed the estimated counterfactual cost of care. It is possible that the increases in costs of care in CY 2021 resulted from the release of pent-up demand and increased Medicaid enrollment during the PHE. Data for subsequent years to be included in the Summative Evaluation Report should provide additional insight into the extent of the PHE impact on costs of care.

Telehealth services greatly expanded due to the COVID-19 PHE; however, it is worth noting that the number of telemedicine providers and the number of members receiving telemedicine services both increased in 2019, prior to the COVID-19 PHE.

Several of the measures for which analysis results failed to support their associated hypotheses showed some degree of improvement in 2019 before declining in 2020, including:

- Percentage of individuals with a SUD diagnosis who received any SUD service during the measurement year.
- Percentage of individuals diagnosed with a SUD receiving care coordination
- Number of naloxone training and kit distributions
- Number of MCO network MAT providers

However, there were other SUD-related measures that were analyzed where the 2019 results did not show improvement from previous years:

- Percentage of Inpatient admissions of individuals with a SUD for withdrawal management (2019 rates trended upward [lower rates are better], with the PHE period trending slightly higher than the 2019 trend)
- Percentage of individuals diagnosed with a SUD with MAT claims (2019 was lower than the estimated counterfactual, with a further decrease beginning in 2020)
- Overdose Proportionate Mortality, which is a part of Measure 54 and looks at the difference between the statewide and Medicaid overdose mortality rates (the difference between the statewide and Medicaid rate remained stable across all years)

- Overdose Cause-Specific Death Rates per 100k Individuals, which is a part of Measure 54 (the rate increased in 2020, but the difference between the statewide and Medicaid rate widened starting in 2020)

While the analysis results generally suggest that the Centennial Rewards program encourages members to engage in preventive care services, the measures for the program lack a valid comparison group or sufficient historical data to reliably assess the impact of the program. HSAG will work with HSD and Finity to develop more informative and robust measures for the evaluation of the program for the Summative Evaluation Report.

1. Background

Section 1115 of the Social Security Act allows states the flexibility to design and test their own methods for providing and funding healthcare services that differ from services required by federal statute but meet the objectives of the federal Medicaid program and Children's Health Insurance Program (CHIP). Thus, Section 1115 Demonstration Waivers allow states flexibility in how to operate and fund their healthcare. The Centers for Medicare & Medicaid Services (CMS) has designed a national evaluation strategy to ensure demonstrations meet program objectives while also comparing to other states' Section 1115 Medicaid waivers.

CMS approved the New Mexico Human Services Department's (HSD's) Section 1115 Demonstration Waiver renewal application, Centennial Care 2.0, on December 14, 2018. Centennial Care 2.0 is effective from January 1, 2019, through December 31, 2023.[1-1] The demonstration was amended on February 7, 2020, and two additional amendments, submitted on March 1, 2021, and December 30, 2021, are awaiting approval from CMS. This section outlines the history, guidance, and application of Centennial Care 2.0 including goals of the demonstration, timelines for evaluation, and demographics of the beneficiaries, both in total and program specific in accordance with the special terms and conditions (STCs).[1-2]

Historical Background of New Mexico's Section 1115 Waiver

New Mexico's Medicaid program, administered through HSD, provides healthcare to the State's eligible population. HSD's overall mission is to transform lives, with the intent of providing high quality services to improve the security and promote the independence of its citizens. Over the course of New Mexico's Medicaid program, new populations have been incorporated and covered, such as CHIP, and new delivery methods have been tested through the advent of different types of federal waivers.

Originally, New Mexico's Medicaid program operated entirely on a fee-for-service (FFS) model. Starting on July 1, 1997, HSD implemented the Salud! program as part of a mandate to implement a managed care program. A proposal was submitted under a Section 1915(b) waiver to provide medical and social services under managed care for approximately 65 percent of the New Mexico Medicaid population with the goal of improving quality and access to care while making cost-effective use of State and federal funds. Furthermore, CHIP, and other Medicaid safety net programs for children were all combined into a single program called New Mexikids.[1-3]

Prior to Centennial Care, New Mexico's Medicaid program was administered under a number of home and community-based services (HCBS) Section 1915(b) and 1915(c) waivers in addition to Salud! and New Mexikids. Each waiver targeted a different population including beneficiaries with acquired immune-deficiency syndrome (AIDS), autism, intellectual and developmental disabilities (IDD), and those deemed medically fragile. The number of waivers created an intense administrative burden, siloed care for beneficiaries within certain population groups, and consumed an ever-growing portion of the State budget, leading HSD to apply for a Section 1115 Demonstration Waiver on April 25, 2012.

1-1 State of New Mexico Human Services Department. Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0. Available at https://www.hsd.state.nm.us/wp-content/uploads/Centennial-Care-2_0-Waiver-Application-NM-Dec-2017-1.pdf. Accessed on Jan 4, 2022.

1-2 Centers for Medicare & Medicaid Services. Special Terms and Conditions Centennial Care 2.0 Medicaid 1115 Demonstration. *Human Services Department.* 2020. 11W-00285/6. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-ca.pdf. Accessed on Jan 4, 2022.

1-3 HSD Medical Assistance Division. New Mexico Medicaid Managed Care Program Quality Strategy. Available at: https://www.hsd.state.nm.us/wp-content/uploads/2017-nm-quality-strategy-final-1.pdf. Accessed on Dec 29, 2021.

In January 2013, New Mexico elected to expand Medicaid effective January 2014 under the Affordable Care Act (ACA), providing coverage to adults ages 19–64 up to 138 percent of the federal poverty level (FPL) resulting in an enrollment surge of nearly 600 percent for low-income adults. Additionally, CHIP enrollment saw a large increase of 85 percent since early 2014.[1-4] Overall, the expansion helped increase the total number of beneficiaries to 831,398 as of February 2019.[1-5]

On January 1, 2014, HSD started providing care via a Section 1115 Demonstration Waiver commonly referred to as Centennial Care. The goals of Centennial Care are as follows:

- Ensure that Medicaid beneficiaries in the program receive the right amount of care, delivered at the right time, and in the right setting.
- Ensure that the care and services being provided are evaluated in terms of their quality and not solely by quantity.
- Slow the growth rate of costs or "bend the cost curve" over time without inappropriate reductions in benefits, eligibility, or provider rates.
- Streamline and modernize the Medicaid program in the State.

In addition to its goals, Centennial Care operated following four guiding principles:

- Developing a comprehensive service delivery system that provides the full array of benefits and services offered through the State's Medicaid program.
- Encouraging more personal responsibility so that recipients become more active participants in their own health and more efficient users of the healthcare system.
- Increasing the emphasis on payment reforms that pay-for-performance rather than for the quantity of services delivered.
- Simplifying administration of the program for the State, for providers and for recipients where possible.

Prior to the implementation of Centennial Care, New Mexico's Medicaid program was administratively complex, running under 12 separate waivers and an FFS program, and contracting with seven separate managed care organizations (MCOs). Six MCOs provided physical or long-term support services and supports (LTSS) while behavioral health care was provided through the statewide behavioral health MCO; members would have to manage their individual care through multiple MCOs. The program was also taking up a growing portion of the State budget, increasing from 12 percent to 16 percent from 2012 to 2013.[1-6] With the creation of Centennial Care, HSD streamlined its administration and folded most previous waivers under one Section 1115 Demonstration Waiver, with a few exceptions. HSD also reduced the number of contracted MCOs, from seven to four. Additionally, each MCO began providing comprehensive integrated managed care. CMS approved Centennial Care for renewal on December 14, 2018, as Centennial Care 2.0, and became effective starting January 1, 2019, through December 31, 2023.

1-4 State of New Mexico Human Services Department. Centennial Care 1115 Waiver Renewal Subcommittee Issue Brief: Member Engagement & Personal Responsibility, January 2017. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-pa.pdf. Accessed on Jan 5, 2022.

1-5 State of New Mexico Human Services Department Medical Assistance Division. Medicaid 1115 Demonstration and Substance Use Disorder Waiver Evaluation Design Plan. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/download/nm-centennial-care-apprvd-eval-des-04022020.pdf. Accessed on Jan 4, 2022.

1-6 State of New Mexico Human Services Department. Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0. Available at https://www.hsd.state.nm.us/wp-content/uploads/Centennial-Care-2_0-Waiver-Application-NM-Dec-2017-1.pdf. Accessed on Jan 4, 2022.

On March 13, 2020, the President of the United States invoked Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5207 (the "Stafford Act") and declared coronavirus disease 2019 (COVID-19) a federal emergency. Following the President's declaration, the Secretary of the U.S. Department of Health and Human Services declared COVID-19 to be a national public health emergency (PHE) and invoked his right, pursuant to Section 1135 of the Social Security Act, to modify and waive certain Medicare and Medicaid federal requirements.

Accordingly, HSD was granted, via an Appendix K contract, the temporary ability to do the following: [1-7]

- Provide services in alternative settings including those licensed for other purposes.
- Expand services, including telehealth options.
- Allow provider enrollment, re-enrollment with modified risk screening elements such as suspending fingerprint checks or modifying training requirements to all HCBS service providers.
- Permit payment for services rendered by family caregivers or legally responsible individuals.
- Modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances.
- Continue all care coordination activities using telephonic visits, or, if the capacity exists for the member and MCO, virtual visits.
- Include retainer payments for approved personal care services.
- Allow for payment for services for the purpose of supporting waiver participants by allowing personal care services in an acute care hospital or short-term institutional stay when necessary supports are not available in that setting during this emergency.
- Suspend the Nursing Facility Level of Care (NFLOC) redetermination for the duration of the COVID-19 PHE.

Demonstration Background

On December 14, 2018, CMS approved HSD's request to renew New Mexico's Section 1115 Demonstration Waiver under the name Centennial Care 2.0 for a five-year period from January 1, 2019, through December 31, 2023. The waiver allowed HSD to continue the goals and objectives of Centennial Care with the intent of furthering progress in several areas that saw considerable improvement in the original demonstration. These areas include administration simplification, care coordination, benefit and delivery system payment reforms, and member engagement. Additionally, Centennial Care 2.0 will work to support four new aims:

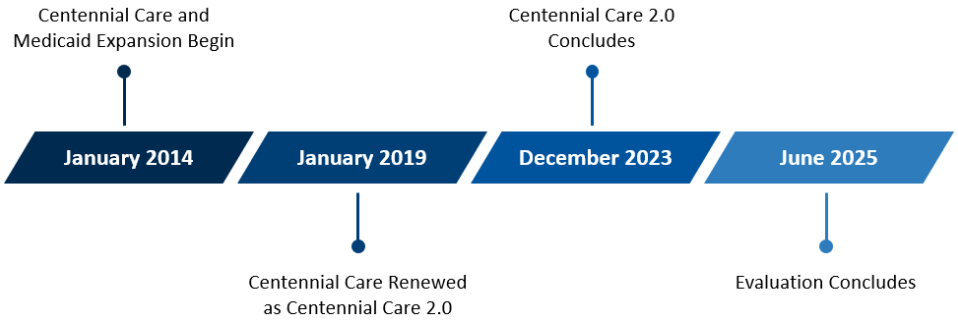
- **Aim One**: Continue the use of appropriate services by members to enhance member access to services and quality of care.
- **Aim Two**: Manage the pace at which costs are increasing while sustaining or improving quality, services, and eligibility.
- **Aim Three**: Streamline processes and modernize the Centennial Care health delivery system through use of data, technology, and person-centered care.

[1-7] Comeaux, N. Emergency Preparedness and Response Appendix K. October 9, 2020. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-appendix-k-appvl-ltr-10092020.pdf. Accessed on Jan 5, 2022.

- **Aim Four**: Improve quality of care and outcomes for Medicaid beneficiaries with a substance use disorder (SUD).

Figure 1-1 displays a timeline of the key demonstration milestones for Centennial Care 2.0.

Figure 1-1—Centennial Care 2.0 Timeline of Key Demonstration Events



Administration Simplification

Prior to Centennial Care, New Mexico's Medicaid program was fragmented, functioning under 12 waivers with seven MCOs administering different benefit packages for defined populations, leading to an administratively complex system. The number of federal waivers was reduced and combined into the Centennial Care 1115 Demonstration Waiver, and the number of MCOs was reduced with each providing a full array of services in an integrated model of care. Centennial Care 2.0 aimed to continue simplifying the program and increase efficiency while reducing administrative and healthcare costs. Changes included phasing out retroactive eligibility coverage due to a low utilization rate from beneficiaries, speeding up transitions off Medicaid when a beneficiary receives increased earnings, and restricting eligibility of the family planning program to ensure only beneficiaries needing the program are utilizing it.

Care Coordination

Care Coordination for high needs members was a focal point of Centennial Care. MCOs were required to conduct a Health Risk Assessment (HRA) with all newly enrolled members and members, not already engaged in Care Coordination, who had a change in condition that required a higher level of care. The HSD standardized HRA confirmed whether the member requires a Comprehensive Needs Assessment (CNA) and targeted care coordination services. Care Coordination provided members with a central point of contact for resources and services to improve member health outcomes. HSD directed MCOs to focus particular attention on high needs groups such as members diagnosed with a traumatic brain injury or a developmental disability, justice involved members, Native American members, and children in state custody. HSD directed MCOs to increase their Transition of Care (TOC) services for members transitioning from an inpatient or nursing facility and may be in need of Community Benefits

Additionally, HSD directed MCOs to transition more members to delegated Care Coordination through either a Full Delegation Model or Shared Functions Model. The Full Delegation Model required the presence of a value-based purchasing (VBP) arrangement in which providers were paid based on the health outcomes of their patients and the quality of services rendered. In the Shared Functions Model, the MCO retained some Care Coordination functions and allowed other Care Coordination activities to be conducted by a partner. The Shared Functions Model has been especially beneficial for use with Paramedicine programs in conducting HRAs with hard-to-reach members.

Centennial Care saw the creation of health homes, a system that provides care coordination to children and adults with chronic behavioral health conditions, administered through CareLink NM. Health homes provide physical and behavioral health services, long-term care, housing assistance, transportation support, and other social needs services.[1-8] First implemented on April 1, 2016, in two pilot counties (Curry and San Juan), the program was expanded in April 2018 and again in July 2018. Currently, there are seven Health Homes operating across 10 counties, including two health homes in Bernalillo County (Albuquerque) and two in Sandoval County.

In addition to implementing and expanding health homes as a care coordination model, which was a primary focus of both Centennial Care and Centennial Care 2.0, Centennial Care 2.0 also expanded patient-centered medical homes (PCMHs) to create a focus on integrated patient-centered care driven by providers. MCOs engaged with PCMH providers to provide care through delegated arrangements.

In addition, HSD improved transitions of care for individuals released from incarceration or detention facilities; children returning home post-foster care placement; and those discharged from a Crisis Triage Center (CTC), a residential or institutional facility, an inpatient stay, or a nursing facility. HSD and the MCOs were responsible for creating VBP initiatives to support successful transitions. Lastly, Centennial Care 2.0 encouraged partnerships between MCOs and community agencies to expand successful programs that target high need populations. Such partnerships include, but are not limited to Project Extension for Community Healthcare Outcomes (ECHO), wellness centers, paramedicine agencies, community health workers, and leveraging use of the Emergency Department Information Exchange.[1-9]

Benefit and Delivery System

One of the greatest successes of Centennial Care came from changing how member benefits are managed. Before the demonstration, a beneficiary would receive physical health services through a physical health care or LTSS MCO and behavioral health care through the statewide behavioral health MCO, creating fragmented care. By changing the benefits and delivery system, beneficiaries were able to receive integrated health care through a single MCO. Additionally, Centennial Care focused on both increasing access to community-based services for LTSS beneficiaries, who previously required a waiver slot to receive such services and increasing funding to keep LTSS beneficiaries in their homes, rather than in institutional settings.

Due to the large number of beneficiaries in both self-directed community benefits (SDCB) and agency-based community benefits (ABCB), HSD aimed to align services between these two groups as part of Centennial Care 2.0. With the goal of providing care to beneficiaries at the right time in the right place, HSD sought to provide items that encourage successful self-management for the SDCB group and allowed one-time start-up goods for beneficiaries who transition from ABCB to SDCB. To contain costs, HSD established limits on costs for certain services, such as non-medical transportation and specialized therapies, for beneficiaries in the SDCB model with the goal of ensuring the sustainability of services.

HSD collaborated with the New Mexico Department of Health (DOH) and New Mexico Children, Youth, and Families Department (CYFD) to increase the services provided for pre-natal care, post-partum care, and early childhood development through the Centennial Home Visiting (CHV) Pilot Program. The CHV Pilot Program aligned with two home visiting delivery models, the Nurse Family Partnership (NFP) and the Parents as Teachers (PAT) programs. During prenatal home visits to pregnant mothers the CHV Pilot Program offered monitoring for

1-8 CareLink NM. CareLink NM HEALTH HOMES 2021 Policy Manual. https://www.hsd.state.nm.us/wp-content/uploads/CLNM-POLICY-MANUAL-FINAL-081121.pdf. Accessed on Mar 25, 2022.

1-9 State of New Mexico Human Services Department. Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0. Available at https://www.hsd.state.nm.us/wp-content/uploads/Centennial-Care-2_0-Waiver-Application-NM-Dec-2017-1.pdf. Accessed on Jan 4, 2022.

high blood pressure, diet and nutritional education, stress management, and depression screening, among several other services. Postpartum home visits were provided to Medicaid-eligible mothers within 60 days postpartum, offering additional services such as breastfeeding support and education, maternal-infant education and safety assessments, and assistance establishing primary care and a primary provider for the mother and infant through two different program models. For infants in the NFP program, breast feeding support and education and child development screenings at major developmental milestones were offered until 2 years of age. These services were offered until 5 years of age or entry into kindergarten for infants in the PAT program.

To address the unique needs of members with a serious mental illness (SMI) diagnosis, HSD created housing support services to assist SMI beneficiaries in finding, acquiring, and maintaining a stable living situation with the goal of allowing SMI beneficiaries the opportunity to participate in their own treatment plan.

HSD also expanded the SUD continuum of care in the renewal demonstration. Opportunities for expansion involved extending Screening, Brief Intervention, and Referral to Treatment (SBIRT) to primary care, community health centers, and urgent care facilities across New Mexico. SBIRT helped to identify beneficiaries who could benefit from SUD services and placed them in the right care setting. Beneficiaries requiring an advanced level of care at American Society of Addiction Medicine (ASAM) Level Three were able to receive residential treatment with expanded services. Centennial Care 2.0 allowed increased stays in institutions for mental disease (IMD) from 15 to 30 days for beneficiaries with a SUD diagnosis with a transition to community-based SUD treatment in place afterwards. Furthermore, non-SUD beneficiaries were granted access to IMD services for 30 days, as long as the services provided are more cost-effective than care provided in a non-IMD setting.[1-10]

Payment Reforms

In 2015, HSD began implementing payment reforms as a method to achieve the goal of paying for quality of services provided rather than the quantity of services provided. One such reform was VBP. Through VBP arrangements, MCOs were expected to expand pay for value strategies within their provider network using VBP models, where MCOs must spend a specified percentage of all provider payments through VBP arrangements. The goal of VBP was to expand payment reform to achieve improved quality and better health outcomes for members. There were three levels of VBP payment arrangements. Level one is at the lower end of the risk continuum and correlates to incentives/withholds, level two refers to shared savings and bundled payments, and level three refers to partial- or full-risk capitation payments at the higher end of the risk continuum. As of January 1, 2017, MCOs were required to contribute at least 16 percent of provider payments to the VBP levels; a minimum of 5 percent had to be designated to level one, 8 percent to level two, and 3 percent to level three. [1-11]

Centennial Care 2.0 increased risk-based provider payments and required MCOs to continue increasing the percentage of provider payments that must be contributed to VBP levels two and three. Additionally, MCOs had to improve provider's readiness to participate in the higher risk payment arrangements while focusing specifically on increasing VBP payments to behavioral health, LTSS, and smaller-volume providers.

Beyond provider payments, VBP was used to drive other key program goals, such as key care coordination goals, physical and behavioral health integration, transitions of care improvements, and reducing avoidable emergency department (ED) utilization. Payment reforms also altered safety net care pools (SNCPs) by incrementally changing the percentage of funds that go to additional hospital funding. At the beginning of the demonstration,

[1-10] State of New Mexico Human Services Department. Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0. Available at https://www.hsd.state.nm.us/wp-content/uploads/Centennial-Care-2_0-Waiver-Application-NM-Dec-2017-1.pdf. Accessed on: Jan 4, 2022.

[1-11] Centennial Care Value-Based Purchasing Brief. Available at https://www.hsd.state.nm.us/wp-content/uploads/Value-Based-Purchasing-Issue-Brief-Jan-13-2017.pdf. Accessed on: Mar 31, 2022.

more funding was designated for uncompensated care (UC) while a smaller percentage went to hospital quality improvement incentive (HQII). In CY 2020, the proportion of funding going to HQII was equal to UC funding and in CY 2021 HQII funding surpassed the proportion of funding designated to UC. [1-12]

Member Engagement

Under Centennial Care, HSD focused on increasing member engagement to encourage beneficiaries to be responsible for their own health. As a result, the Centennial Rewards incentive program was created. Beneficiaries receive reward points for completing pre-determined healthy behaviors and can redeem the points for a qualifying gift. Centennial Care 2.0 aimed to continue to improve member engagement by growing the Centennial Rewards Program.

Amendments

On February 7, 2020, CMS approved HSD's request to amend the Section 1115 Demonstration Waiver to increase the number of Community Benefit (CB) slots by 1,500 and expand the CHV Pilot Program. The CHV program utilized home visiting delivery models to improve the health of pregnant women and their children. In the amendment, HSD requested removing restrictions on the number of counties and number of individuals that may participate in the pilot program. All changes were effective immediately upon approval. Additionally, the increased number of CB slots and expanded CHV program will allow the program to reach more members than originally planned.[1-13]

HSD submitted a second waiver amendment on March 1, 2021, with the goal of maintaining beneficiary access to behavioral health services in appropriate settings and ensuring individuals receive care in appropriate facilities by seeking a waiver of the IMD exclusion for all Medicaid beneficiaries to ensure beneficiaries can receive behavioral health services in the most appropriate setting for their needs. The amendment also requested establishment of high-fidelity wraparound (HFW) services for high intensive needs children with the intent of providing services to achieve better health outcomes and the development of a graduate medical education program to increase the number of primary care specialties in the State, including general psychiatry, family medicine, general pediatrics, and general medicine. Lastly, the amendment requested coverage of the COVID-19 vaccine to beneficiaries with limited benefit plan coverage once funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act discontinues.[1-14] As of this interim report, this amendment has yet to be approved by CMS.

On November 5, 2021, HSD received partial approval for its Section 9817 American Rescue Plan Act (ARPA) HCBS Spending Plan from CMS.[1-15] In response, HSD submitted its third waiver amendment on December 30,

1-12 State of New Mexico Human Services Department. Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0. Available at https://www.hsd.state.nm.us/wp-content/uploads/Centennial-Care-2_0-Waiver-Application-NM-Dec-2017-1.pdf. Accessed on: Jan 4, 2022.

1-13 Centers for Medicare & Medicaid Services. *CMS Approval Letter*. February 7, 2020. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-cms-amendment-appvl-02072020.pdf. Accessed on Feb 16, 2022.

1-14 State of New Mexico Human Services Department. *Centennial Care 2.0 1115 Waiver Amendment #2 Request.* March 1, 2021. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-pa3.pdf. Accessed on Feb 16, 2022.

1-15 Centers for Medicare & Medicaid Services. "CMS Partial Approval 11.5.2021" Available at: https://www.hsd.state.nm.us/wp-content/uploads/NM-9817-partial-approval-11-05-2021.pdf. Accessed on: June 7, 2022.

2021.[1-16] The amendment was designed to effectuate the initiatives outlined in the HCBS Spending Plan. The amendment sought to increase the number of CB allocation slots by 1,000 beginning in Demonstration Year (DY) 9 for members who have been determined to meet a NFLOC and do not meet standard Medicaid financial eligibility. [1-17] Additionally, the amendment sought to raise the service limits on Community Transition Services from $3,500 to $4,000 every 5 years beginning in DY 9 and continuing through the end of the demonstration period. Finally, the amendment requested to increase the Environmental Modification service limit from $5,000 to $6,000 per person every 5 years, also beginning in DY 9 and continuing through the end of the current demonstration period.

Demographics

The waiver is intended to target four New Mexico Medicaid beneficiary population groups including:

- Temporary assistance for needy families (TANF) and related group.
- Supplemental security income (SSI) Medicaid Only group.
- SSI Dual Eligible group.
- Medicaid Expansion groups.

The TANF and related group consists of families living in New Mexico with dependent children under the age of 18 that are under a set income.[1-18] Populations covered under the TANF and related groups for Centennial Care 2.0 include newborns, infants, and children; CHIP beneficiaries; pregnant women; low-income parents or caretakers; and beneficiaries with breast or cervical cancer.

The SSI Medicaid and SSI Dual Eligible populations consist of beneficiaries who are either aged, blind, or disabled or working disabled. Beneficiaries who are additionally eligible for Medicare will fall into the SSI Dual Eligible population while beneficiaries who are only eligible for Medicaid are in the SSI Medicaid group.

The Medicaid Expansion groups consist of individual beneficiaries between the ages of 19–64, and whose poverty status is limited to 133 percent of the Federal Poverty Level (FPL), corresponding to the ACA of 2014.

The Maintenance of Effort (MOE) subpopulation consists of individuals entering Medicaid because of the COVID-19 PHE and their eligibility is presently maintained under CMS MOE requirements.

Table 1-1 illustrates the evolution of Medicaid enrollment in New Mexico from 2013 through 2021, across various milestones. Medicaid enrollment in January 2013 represented TANF, SSI, and SSI Dual Eligible populations, together accounting for 578,000 beneficiaries. The following year, the Medicaid Expansion group began entering the Centennial Care Program, initially reaching 638,442 beneficiaries in January 2014. Over the next 6-year period (2014–2020) the overall Medicaid population increased at an average annual rate of 4.5 percent, reaching 829,830 by January 2020. Subsequently, Medicaid enrollment expanded from the COVID-19 PHE and related MOE requirements, reaching 911,572 by January 2021.

1-16 Human Services Department. "Pending Application – HCBS Amendment" Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-pa4.pdf. Accessed on: June 7, 2022.

1-17 After the amendment was approved, HSD elected not to increase the number of CB allocation slots.

1-18 Human Services Department. "Temporary Assistance for Needy Families." Available at: https://www.hsd.state.nm.us/lookingforassistance/temporary_assistance_for_needy_families/. Accessed on: April 1, 2022.

Table 1-1—Total Medicaid Enrollment, 2013–2021

Year	2013	2014	2015	2016	2017	2018	2019	2020	2021
Medicaid Enrollment	578,316	638,442	766,510	842,710	898,976	857,309	832,571	829,830	911,572

Figure 1-2 demonstrates Centennial Care and Centennial Care 2.0 enrollment from 2013 to 2021. Centennial Care members make up the majority of total Medicaid enrollment. Overall Centennial Care enrollment increased with the ACA expansion and start of the Centennial Care Program in 2014 and again as a result of the COVID-19 PHE.

Figure 1-2—Managed Care Enrollment, 2013–2021

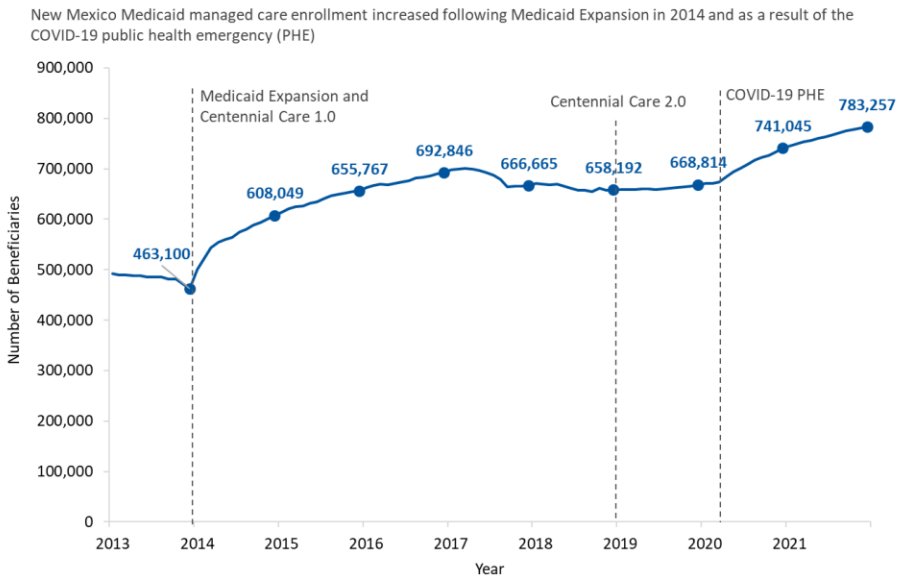


Figure 1-3 shows that at least two-thirds of beneficiaries were enrolled for a full 12 months in each year (excluding 2014) and increased to 86 percent by 2021. Less than 20 percent of beneficiaries had fewer than six months of Medicaid enrollment in each year.

Figure 1-3—Percentage of Members Enrolled for Full or Partial Year

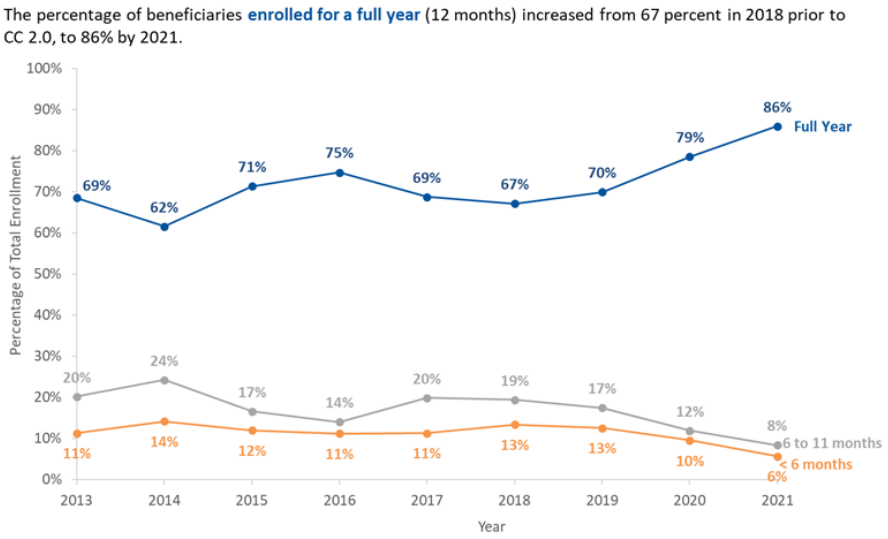
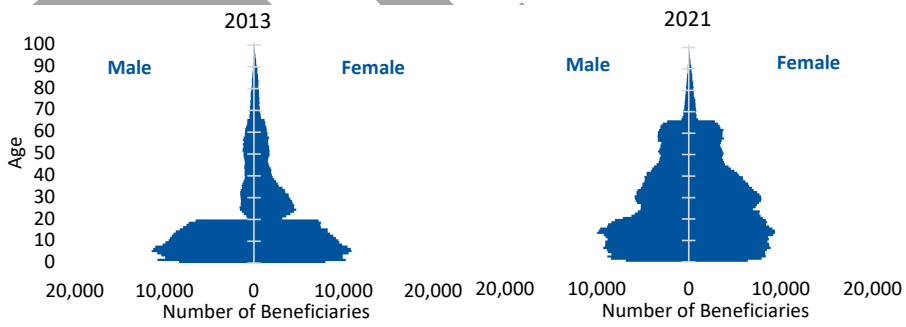


Table A-1 contains specific values for the change in age and gender distribution between 2013 and 2021.

Figure 1-4 illustrates the changes in age and gender distribution between pre-Medicaid expansion in 2013 and current enrollment following Medicaid expansion and increases due to the COVID-19 PHE. Unsurprisingly, prior to Medicaid expansion, there were few adult males enrolled in Medicaid while the majority of enrolled beneficiaries (approximately two-thirds) were children. The Centennial Care 2.0 population as of 2021 has relatively more adults, accounting for 58 percent of total enrollment. Table A-1 contains specific values for the change in age and gender distribution between 2013 and 2021.

Figure 1-4—Change in Age and Gender Distribution Among Beneficiaries



Evaluation Activities

In response to the STCs, HSD has contracted with an independent evaluator, Health Services Advisory Group, Inc. (HSAG), to conduct comprehensive evaluations (i.e., interim and summative) of Centennial Care 2.0, New Mexico's Medicaid Section 1115 Demonstration Waiver. [1-19] The purpose of this evaluation is to provide CMS

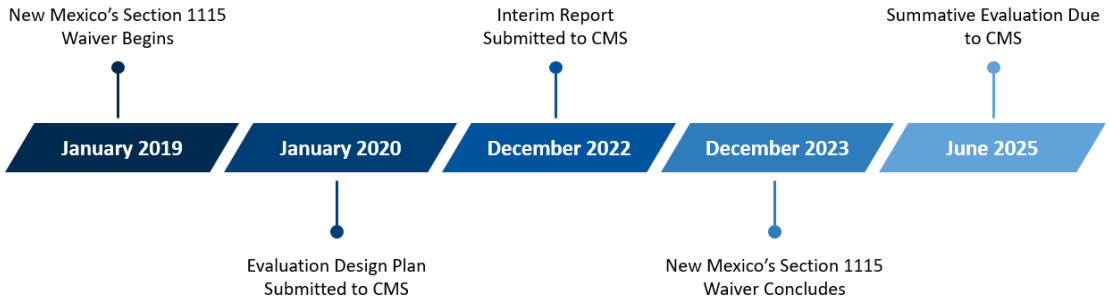
[1-19] The evaluation for Centennial Care was conducted by Deloitte.

and HSD with an independent evaluation of Centennial Care 2.0, ensure compliance with Medicaid Section 1115 requirements, and provide recommendations to improve program efficacy along the way.

- Evaluation Design Plan[1-20]—The plan for how to accomplish the evaluation explaining how it is expected to achieve the goals of the waiver along with specifying hypotheses, evaluation questions, associated measures, and analytic methods. The evaluation design plan for Centennial Care 2.0 was developed by Mercer and approved by CMS on April 2, 2020.
- Interim Evaluation Report—The report will include the goals of the evaluation, the hypotheses related to the demonstration, and the methodology of the evaluation. The report will provide interpretations of the findings, assessments of the outcomes, explanations on the limitations of the design, data, and analyses, and recommendations to the State from January 1, 2019, to December 31, 2021.[1-21]
- Summative Evaluation Report—The report will follow the same structure as the interim report for the entirety of the demonstration period (January 1, 2019, to December 31, 2023).

Figure 1-5 displays the timeline of the evaluation activities.

Figure 1-5—Timeline of Evaluation Activities



1-20 The CMS-approved Evaluation Design Plan is available in Appendix B of the Interim Evaluation Report.

1-21 Centers for Medicare & Medicaid Services. Special Terms and Conditions Centennial Care 2.0 Medicaid 1115 Demonstration. *Human Services Department.* 2020. 11W-00285/6. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-ca.pdf. Accessed on: Jan 4, 2022.

2. Evaluation Questions and Hypotheses

The primary purpose of the interim evaluation is to determine whether the Centennial Care 2.0 Demonstration Waiver is achieving the four aims outlined in the Background section above. Section 2 provides the program's logic models, hypotheses, and research questions, which focus on evaluating the impact of these goals.

Demonstration Goals

The Centennial Care 2.0 demonstration supports improvements to achieve four primary aims:

3. Continue the use of appropriate services by members and to enhance member access to services and quality of care.
4. Manage the pace at which costs are increasing while sustaining or improving quality, services, and eligibility.
5. Streamline processes and modernize the Centennial Care health delivery system through use of data, technology, and person-centered care,
6. Improve quality of care and outcomes for Medicaid beneficiaries with a substance use disorder (SUD).

To accomplish these aims, the demonstration includes key activities and interventions to maintain current levels of improved performance and health outcomes for Centennial Care 2.0 members.

Hypotheses and Research Questions

Fourteen hypotheses, tested by 45 research questions, were identified to comprehensively evaluate the aims of the Demonstration Waiver. Hypotheses were developed based on the potential for improvement, the ability to measure performance, and the use of comparison groups to isolate the effects of the demonstration and interventions. The hypotheses and research questions are presented below with the program aims they were designed to evaluate.

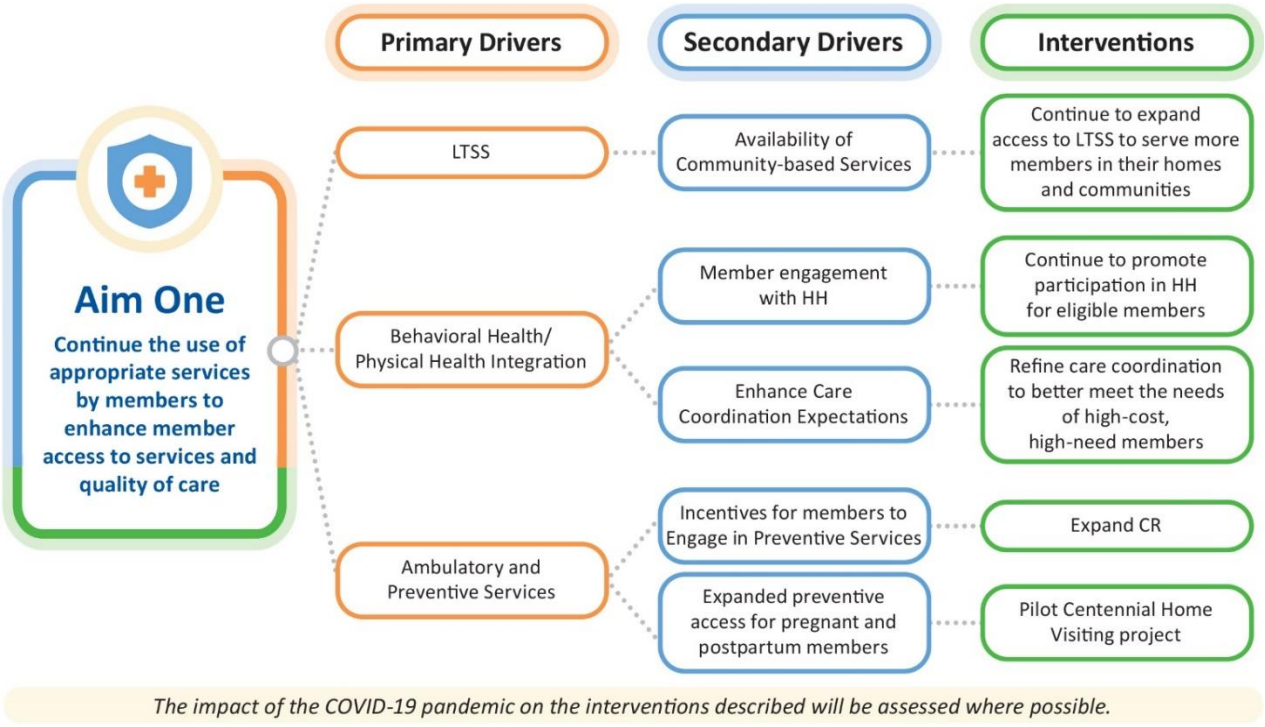
Aim One: Continue the Use of Appropriate Services by Members to Enhance Member Access to Services and Quality of Care

Logic Model

Centennial Care 2.0 seeks to ensure that Medicaid members in the program receive the right amount of care, delivered at the right time, in the right setting. Additionally, the demonstration seeks to ensure that the care and services being provided are measured in terms of their quality rather than quantity alone.

A logic model was developed which relates interventions, initiatives, healthcare concepts, and program goals. Evaluation hypotheses and research questions for each aim were derived from and organized based on the logic model. Figure 2-1 displays the logic model for Aim One.

Figure 2-1—Aim One Logic Model



Note: CR: Centennial Rewards, HH: Health Home, LTSS: long-term services and supports

Hypotheses and Research Questions

The hypotheses and associated research questions for Aim One are presented in Table 2-1.

Table 2-1—Aim One Hypotheses and Research Questions

Hypothesis 1: Continuing to expand access to Long-Term Support Services and Supports (LTSS) and maintaining the progress achieved through rebalancing efforts to serve more members in their home and communities will maintain the number of members accessing Community Benefit (CB) services.	Q1: Has the number of members accessing CB services been maintained year-over-year?
Hypothesis 2: Promoting participation in a health home will result in increased member engagement with the health home and increase access to integrated physical and behavioral health care in the community.	Q1: Is there an increase in the number/percentage of members enrolled in a health home? Q2: Is the proportion of members engaged in a health home receiving any physical health (PH) services higher than those not engaged in a health home?
Hypothesis 3: Enhanced care coordination supports integrated care interventions, which lead to higher levels of access to preventive/ambulatory health services	Q1: Is there an increase in Centennial Care members who have at least one claim for preventive/ambulatory care in a year? Q2: Does engagement in a Health Home result in beneficiaries receiving more ambulatory/ preventive health services?
Hypothesis 4: Engagement in a health home and care coordination support Integrative care interventions, which improve quality of care.	Q1: To what extent is health home engagement associated with improved disease management? Q2: Does health home engagement result in increased follow up after hospitalization for mental illness?

Hypothesis 5: Expanding member access to preventive care through the Centennial Home Visiting (CHV) Pilot Program and providing incentives through Centennial Rewards (CR) will encourage members to engage in preventive care services[2-1]	Q1: Has the percentage of Centennial Care members participating in CR increased? Q2: Are CR incentive redeeming members likely to receive more preventive/ambulatory services on an annual basis than those who have not redeemed incentives in the 12-month period following the initial redemption? Q3: Does use of CR encourage members to improve their health and make healthy choices? Q4: Is the percentage of babies born with low birth weight (< 2,500 grams) to mothers participating in the CHV Pilot Program lower than the percentage of low-birth-weight babies born to Medicaid mothers who do not participate in the CHV Pilot Program?

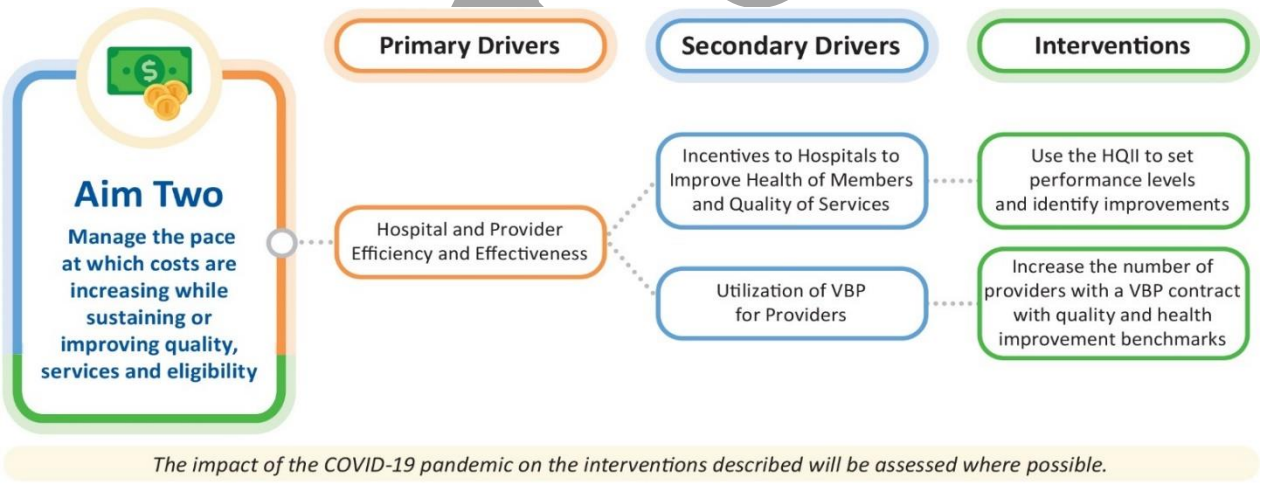
Aim Two: Manage the Pace at Which Costs Are Increasing While Sustaining or Improving Quality, Services, and Eligibility

Logic Model

Centennial Care 2.0 aims to slow the growth rate of costs or "bend the cost curve" over time without inappropriate reductions in quality, benefits, eligibility, or provider rates.

A logic model was developed which relates interventions, initiatives, healthcare concepts, and program goals. Evaluation hypotheses and research questions for each aim were derived from and organized based on the logic model. Figure 2-2 illustrates the logic model for Aim Two.

Figure 2-2—Aim Two Logic Model



Note: HQII: hospital quality improvement incentive, VBP: value-based purchasing

2-1 The hypothesis has been revised slightly from that in the CMS-approved Evaluation Design. The original hypothesis was misleading as it suggested that both programs provide incentives for preventive care. Only CR provides preventive care incentives.

Hypotheses and Research Questions

Table 2-2 presents the hypotheses and research questions corresponding with Aim Two.

Table 2-2—Aim Two Hypotheses and Research Questions

Hypothesis 1: Incentivizing hospitals to improve health of members and quality of services and increasing the number of providers with value-based purchasing (VBP) contracts will manage costs while sustaining or improving quality.	Q1: Has the number of providers with VBP contracts increased? Q2: Has the number of providers participating in VBP arrangements, who meet quality metric targets increased? Q3: Has the amount paid in VBP arrangements increased? Q4: Has reported performance of Domain 1 measures in the Safety Net Care Pool (SNCP) Hospital Quality Improvement Program been maintained or improved? Q5: Do cost trends align with expected reimbursement and benefit changes?

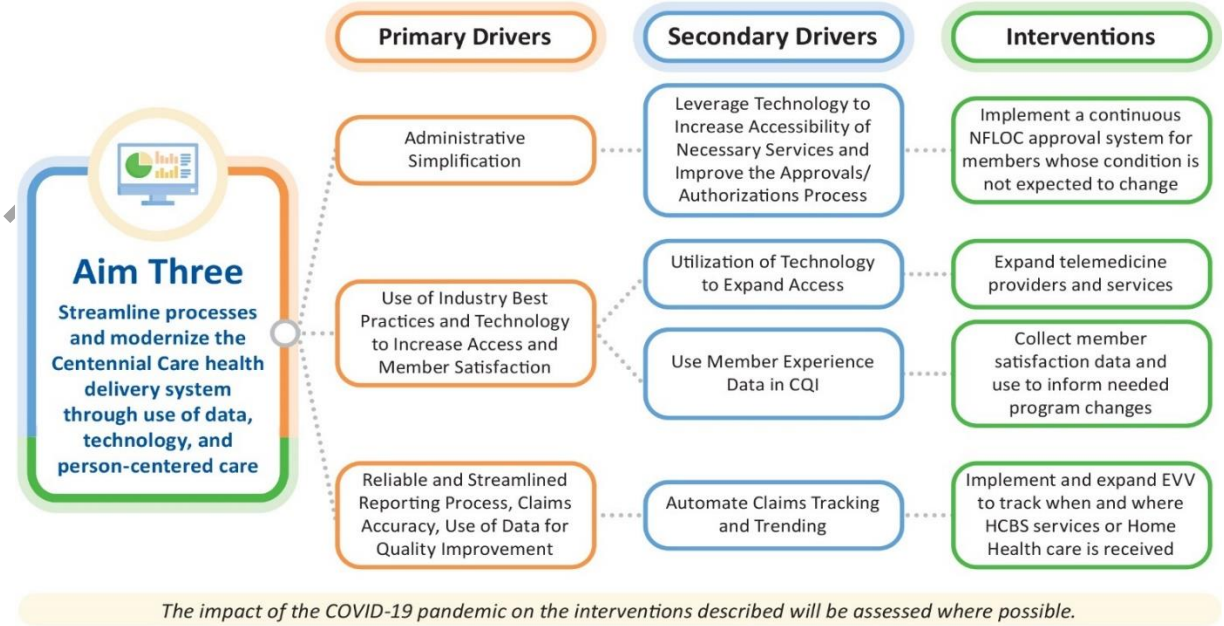
Aim Three: Streamline Processes and Modernize the Centennial Care Health Delivery System Through Use of Data, Technology, and Person-Centered Care

Logic Model

The Demonstration Waiver targets the streamlining and modernization of the Medicaid program in the State of New Mexico as an area for improvement.

A logic model was developed which relates interventions, initiatives, healthcare concepts, and program goals. Evaluation hypotheses and research questions for each aim were derived from and organized based on the logic model. Figure 2-3 presents the logic model for Aim Three.

Figure 2-3—Aim Three Logic Model



Note: CQI: continuous quality improvement, EVV: electronic visit verification, HCBS: home- and community-based services, NFLOC: nursing facility level of care

Hypotheses and Research Questions

The hypotheses and research questions for Aim Three are displayed in Table 2-3—Aim Three Hypotheses and Research Questions.

Table 2-3—Aim Three Hypotheses and Research Questions

Hypothesis 1: The Demonstration will relieve administrative burden by implementing a continuous Nursing Facility Level of Care (NFLOC) approval with specific criteria for members whose condition is not expected to change over time.	Q1: Has the number of continuous NFLOC approvals increased during the Demonstration?
Hypothesis 2: The use of technology and continuous quality improvement (CQI) processes align with increased access to services and member satisfaction.	Q1: Has the number of telemedicine providers increased during Centennial Care 2.0? Q2: Has the number of unduplicated members with a telemedicine visit increased during Centennial Care 2.0? Q3: Has member satisfaction increased during Centennial Care 2.0?
Hypothesis 3: Implementation of electronic visit verification (EVV) is associated with increased accuracy in reporting services rendered.	Q1: Has the number of claims submitted through EVV increased? Q2: Has the proportion of paid or unpaid hours retrieved due to false reporting decreased?

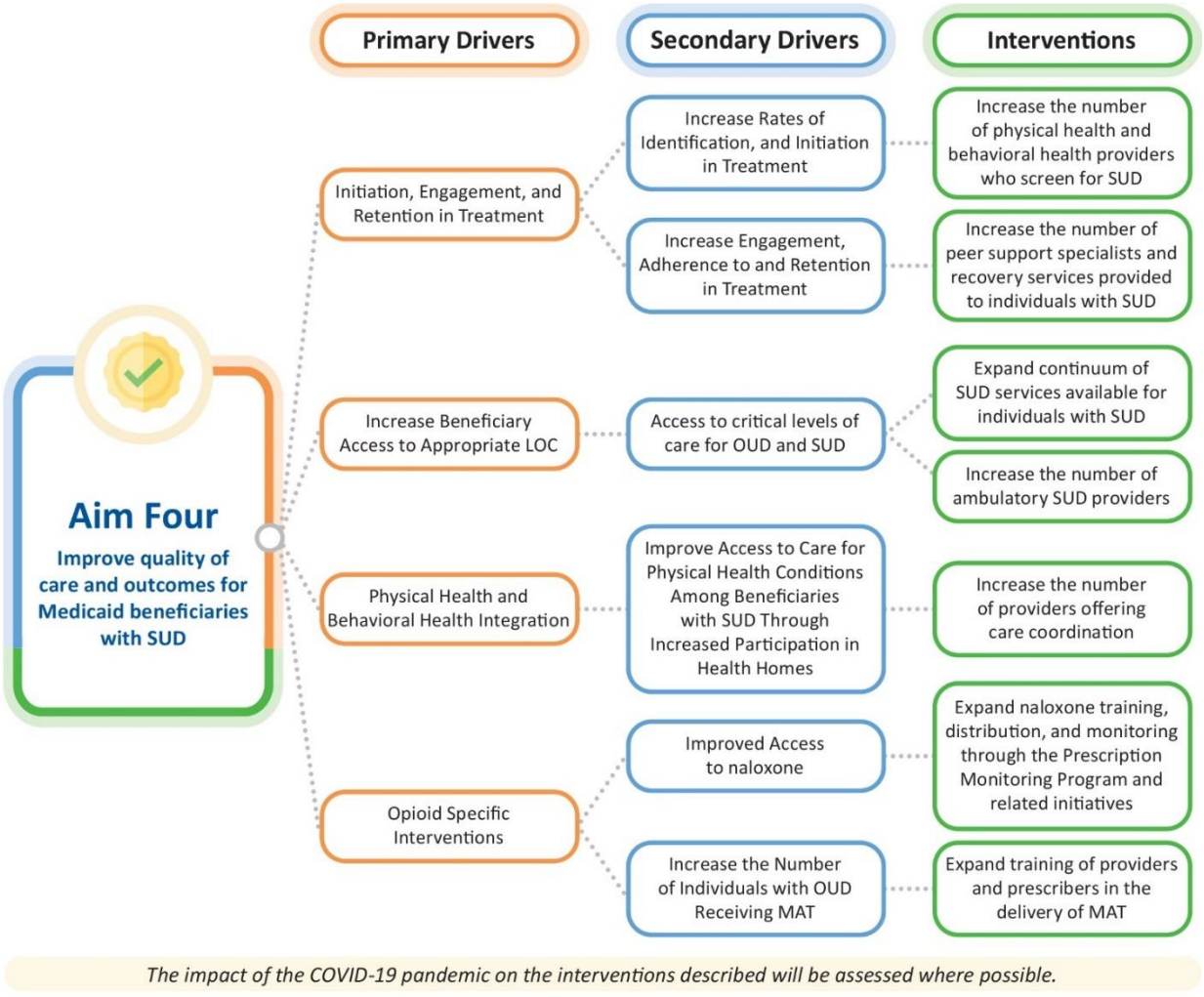
Aim Four: Improved Quality of Care and Outcomes for Medicaid Beneficiaries With a Substance Use Disorder

Logic Model

Centennial Care 2.0 seeks to ensure members have access to high quality, evidence-based opioid use disorder (OUD) and other SUD treatment services. These services range from medically supervised withdrawal management to ongoing chronic care for these conditions in cost-effective settings.

A logic model was developed which relates interventions, initiatives, healthcare concepts, and program goals. Evaluation hypotheses and research questions for each aim were derived from and organized based on the logic model. Figure 2-4 displays Aim Four's logic model.

Figure 2-4—Aim Four Logic Model



Note: LOC: level of care, MAT: medication-assisted treatment, OUD: opioid use disorder, SUD: substance use disorder

Hypotheses and Research Questions

Table 2-4 presents the hypotheses and research questions associated with Aim Four.

Table 2-4—Aim Four Hypotheses and Research Questions

Hypothesis 1: The Demonstration will increase the number of providers that provide SUD screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for alcohol and other drug (AOD) dependence treatment.	Q1: Did the number of behavioral health and physical health providers who screen beneficiaries for SUD increase? Q2: Did the number of individuals screened for SUD increase? Q3: Has the percentage of individuals with a SUD who received any SUD related service increased? Q4: Did the percentage of individuals who initiated AOD abuse and dependence treatment increase?

Hypothesis 2: The Demonstration will increase peer support services which will result in more individuals engaging in and retained in AOD dependence treatment.	Q1: Has the percentage of individuals with a SUD diagnosis who received peer support services increased? Q2: Does receiving peer support increase the percentage of individuals engaged in AOD abuse and dependence treatment? Q3: Does receiving peer support increase the treatment tenure for individuals receiving AOD abuse and dependence treatment? Q4: Does receiving peer support increase the treatment tenure for medication assisted treatment (MAT) for OUD?
Hypothesis 3: The Demonstration will improve access to a comprehensive continuum of SUD care which will result in decreased utilization of emergency department (ED) and inpatient hospitalization and SUD inpatient readmissions.	Q1: Has the continuum of services available for individuals with a SUD expanded in terms of which services are available? Q2: Has capacity for ambulatory SUD services increased? Q3: Has the utilization of EDs by individuals with a SUD decreased? Q4: Has the utilization of inpatient hospital settings for SUD-related treatment decreased? Q5: Has the utilization of inpatient hospital settings for withdrawal management decreased? Q6: Have inpatient SUD readmissions decreased for individuals with SUD diagnoses? Q7: Have increasing trends in total cost of care been slowed for individuals with SUD diagnoses? Q8: Have SUD costs for individuals with SUD diagnoses changed proportionally as expected with increased identification and engagement in treatment?
Hypothesis 4: The Demonstration will Increase the number of individuals with fully delegated care coordination which includes screening for co-morbid conditions, which will result in increased utilization for physical health conditions.	Q1: Has the percentage of individuals diagnosed with a SUD receiving care coordination increased? Q2: Has the number of individuals with a SUD receiving preventive health care increased?
Hypothesis 5: The Demonstration will increase use of naloxone, medication assisted treatment (MAT) and enhanced monitoring and reporting of opioid prescriptions through the prescription monitoring program, which will result in fewer overdose deaths due to opioid use.	Q1: Has there been an expansion of naloxone distribution and training? Q2: Has the number of providers using MAT services increased? Q3: Has the number of individuals with a SUD receiving MAT increased? Q4: Is there evidence of enhanced policies and practices related to the prescription monitoring program, real time prescription monitoring program updates, member/provider lock-in programs and limits/edits at pharmacy points-of-sale? Q5: Is there a decrease in the number of deaths due to overdose?

3. Methodology

The primary goal of an impact assessment in policy and program evaluation is to establish a causal relationship between the introduction of a policy or program and related outcomes. To accomplish this, a comparison of outcomes between the intervention group and a valid counterfactual—the intervention group had its members not been exposed to the intervention—must be made. The gold standard for experimental design is a randomized controlled trial which would be implemented by first identifying an intervention population, and then randomly assigning individuals to the intervention and the rest to a control group, which would serve as the counterfactual. However, random assignment is rarely feasible in practice, particularly as it relates to healthcare policies.

As such, a variety of quasi-experimental or observational methodologies have been developed for evaluating the effect of policies on outcomes. The research questions presented in the previous section will be addressed through at least one of these methodologies. The selected methodology largely depends on data availability factors relating to (1) data to measure the outcomes, (2) data for a valid comparison group, and (3) data collection during the time periods of interest—typically defined as one or two years prior to implementation and annually thereafter. Table 3-1 illustrates a list of analytic approaches that will be used as part of the evaluation and whether the approach requires data gathered at the baseline (i.e., pre-implementation), requires a comparison group; or allows for causal inference to be drawn. It also notes key requirements unique to a particular approach.

Table 3-1—Analytic Approaches

Analytic Approach	Baseline Data	Comparison Group	Allows Causal Inference	Notes
Difference in Differences	✓	✓	✓	Trends in outcomes should be similar between comparison and intervention groups at baseline
Interrupted Time Series	✓		✓	Requires sufficient data points prior to and following implementation
Trend Analysis	✓			Requires multiple baseline data points
Descriptive Time Series Analysis				Relies on descriptive interpretation; does not involve statistical testing

Evaluation Design Summary

The evaluation design of the 1115 Demonstration Waiver utilized a mixed-methods evaluation design. Quantitative methods included descriptive statistics showing change over time in both counts and rates for specific metrics, interrupted time series (ITS) analysis or difference-in-differences (DiD) to assess whether the waiver interventions effected changes across specific outcome measures. Where possible, comparison groups were used to demonstrate that effects were likely due to the Demonstration Waiver. For some measures related to the Health Home Program, Centennial Home Visiting (CHV) Pilot Program, peer support services, and Centennial Rewards, a comparison group was possible. In many cases, however, a valid comparison group could

not be used because data were unavailable for a comparable population not targeted by the intervention.[3-1] This occurred for interventions that were implemented for all members throughout the State simultaneously. Beneficiary surveys, administered by the managed care organizations (MCOs) as part of their Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3-2] surveys, were used to assess beneficiaries' rating of their personal doctor, health plan, and overall health care.

Target and Comparison Populations

The target populations for the hypotheses in Aim One through Aim Four were managed care Centennial Care 2.0 members, subgroups of managed care members receiving the Demonstration interventions, and providers serving Centennial Care members.

Within Aims One through Three, the specific member subgroups studied include:

- Long-term care members.
- Long-term services and support (LTSS) members enrolled in the Community Benefit (CB) Program.
- Members enrolled in health homes.
- Members receiving fully delegated care coordination from value-based purchasing (VBP) contracted providers.
- Members engaged in the Centennial Rewards program.
- Members enrolled in the Centennial Home Visiting (CHV) Pilot Program.

Provider subgroups studied in the evaluation include safety net care pool (SNCP) hospital quality improvement incentive (HQII) hospitals, and providers with VBP contracts.

Within Aim Four, specific member subgroups studied were Centennial Care members with a substance use disorder (SUD) diagnosis, and members with a SUD diagnosis who received medication-assisted treatment (MAT). Providers serving members with a SUD diagnosis were also studied.

The evaluation design did not include a randomized treatment and a control group. That is, there was not a group of managed care members who were eligible for the waiver interventions and who received them based on random assignment. Certain waiver programs (e.g., Health Homes, CHV Pilot) did allow for comparisons between groups. These groups were based on member self-selection or specific outreach criteria, not randomization. Where possible, adjustments were made to account for differences between the intervention and comparison groups.

Evaluation Period

The time periods covered in this report are presented in Table 3-2.

3-1 Because the Centennial Care 2.0 demonstration targeted most managed care beneficiaries in the State, no in-state comparison could be used. An out-of-state comparison group could be constructed ideally using Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) data. However, due to the two-to-three-year lag, with only preliminary data for 2020 available as of this writing, the T-MSIS data is expected to be feasible for only the summative evaluation report. Depending on access fees and the restrictions around using the T-MSIS data, the independent evaluator will determine the most cost-effective and feasible approach for developing an out-of-state comparison group.

3-2 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

Table 3-2—Time Periods

Baseline Period	Interim Report Evaluation Period
January 1, 2018 – December 31, 2018	January 1, 2019 – December 31, 2021

Evaluation Measures

The evaluation measures were based on data sources that provided valid and reliable data which were readily available throughout the Demonstration and evaluation activities. Health Services Advisory Group, Inc. (HSAG), reviewed the quality and completeness of each data source to determine if the data used were complete and accurate. The New Mexico Human Services Department (HSD) used a comprehensive standardized reporting framework based on recommendations from the Centers for Medicare & Medicaid Services (CMS) State Toolkit for Validating Medicaid Managed Care Encounter Data for the Centennial Care Program quarterly and for annual MCO reports. As often as possible, measures in the evaluation were selected from nationally recognized measure stewards for which there are strict data collection processes and audited results. Table 3-3 displays which measure steward was used for each measure. Information from additional data sources, such as the Department of Health, Office of the Medical Investigator, hospital associations, and pharmacy boards, was assessed for completeness and accuracy and was based on State knowledge of the provider community and experience in New Mexico.

Table 3-3—Measure Stewards

Measure Number	Measure Name	Steward
1	Number of Centennial Care members enrolled and receiving CB services	—
2	Number/Percentage of Centennial Care members enrolled in a health home	—
3	Number/Percentage of health home members with at least one (1) claim for physical health (PH) service in the calendar year	—
4a	Adults' access to preventive/ambulatory health services (AAP)	National Committee for Quality Assurance (NCQA)
5a	Children and adolescents' access to primary care practitioners (CAP)	NCQA
6	Well-child visits in the third, fourth, fifth, and sixth years of life (W34)	NCQA
4b	Adults' access to preventive/ambulatory health services (AAP) – Health Home (HH) population[1]	NCQA
5b	Children and adolescents' access to primary care practitioners (CAP) – HH population[1]	NCQA
7	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD) – HH population	NCQA
8	Anti-depressant medication management (AMM) Effective Acute Phase Treatment – HH population	NCQA
9	Anti-depressant medication management (AMM) Effective Continuation Phase Treatment – HH population	NCQA
10	7-day follow up after hospitalization for mental illness (FUH) – HH population	NCQA
11	30-day follow up after hospitalization for mental illness (FUH) – HH population	NCQA
12	Percentage of Centennial Care (CC) members participating in Centennial Rewards (CR)	—
13	Percentage of CR participating members with an annual preventive/ambulatory service	—

Measure Number	Measure Name	Steward
14	Percent of CR users responding positively on satisfaction survey to question regarding if the program helped to improve their health and make healthy choices	—
15	Live births weighing less than 2,500 grams (low birth weight)	Centers for Disease Control and Prevention (CDC)
16	Total number of providers with VBP contracts	—
17	Number/percentage of providers meeting quality threshold	—
18	Percentage of total payments that are for providers in VBP arrangements	—
19	Percentage of qualified Domain 1 SNCP Hospital Quality Incentive measures that have maintained or improved their reported performance rates over the previous year	—
20	Cost per member trend	—
21	Cost per user trend	—
22	Number of continuous nursing facility level of care (NFLOC) approvals	—
23	Number of telemedicine providers	—
24	Number of members receiving telemedicine services	—
25	Member rating of health care	NCQA
26	Member rating of health plan	NCQA
27	Member rating of personal doctor	NCQA
28	Number of submitted claims through electronic visit verification (EVV)	—
29	Percent of paid or unpaid hours retrieved due to false reporting	—
30	Number of providers who provide SUD screening	—
31	Number of individuals screened for SUD	CMS
32	Percentage of individuals with a SUD diagnosis who received any SUD service during the measurement year	—
33	Initiation of alcohol or other drug (AOD) Abuse or Dependence Treatment (IET)	NCQA
34	Percentage of individuals with a SUD diagnosis who received peer support	—
35	Engagement of AOD Abuse or Dependence Treatment (IET)	NCQA (modified)
36	Average Length of Stay (ALOS)	—
37	Continuity of Pharmacotherapy for opioid use disorder (OUD)	University of Southern California (USC) (NQF #3175)
38	Continuum of services available	—
39	Number of providers and capacity for ambulatory SUD services	—
40	Percentage of emergency department (ED) visits of individuals with SUD diagnoses	—
41	Percentage of Inpatient admissions for SUD-related treatment	—
42	Percentage of Inpatient admissions of individuals with a SUD for withdrawal management	—
43	7- and 30-day inpatient and residential SUD readmission rates	—

Measure Number	Measure Name	Steward
44	Total and per member per month (PMPM) cost (medical, behavioral, and pharmacy) for members with a SUD diagnosis	—
45	Total and PMPM cost (medical, behavioral, and pharmacy) for members with a SUD diagnosis by SUD source of care	—
46	Total and PMPM cost for SUD services for members with a SUD diagnosis	—
47	Total and PMPM cost for SUD services by type of care (inpatient [IP], outpatient [OP], prescription [RX], etc.)	—
48	Percentage of individuals diagnosed with a SUD receiving care coordination	—
49	Percentage of individuals with a SUD receiving preventive/ambulatory health services (AAP)	Centers for Medicaid & Medicaid Services (CMS) (modified NCQA)
50	Number of naloxone training and kit distributions	—
51	Number of MCO network MAT providers	—
52	Percentage of individuals diagnosed with a SUD with MAT claims	—
53	Number of policy and procedure manual references	—
54	Rate of deaths due to overdose	—

[1]Note: To concisely evaluate the Health Home Program, results for measures 4b and 5b (health home-specific measures) are presented after Measure 6.
*The following abbreviations are used in the measure descriptions—ALOS: Average Length of Stay; AOD: alcohol and other drugs; CB: Community Benefit; CC: Centennial Care; CDC: Centers for Disease Control and Prevention; CMS: Centers for Medicare & Medicaid Services; CR: Centennial Rewards; ED: emergency department; EVV: electronic visit verification; HH: health home; IP: inpatient; NCQA: National Committee for Quality Assurance; NFLOC: nursing facility level of care; NQF: National Quality Forum; MAT: medication assisted treatment; MCO: managed care organization; OP: outpatient; OUD: opioid use disorder; PH: physical health; PMPM: per member per month; RX: prescription; SNCP: safety net care pool; SUD: substance use disorder; USC: University of Southern California; VBP: value-based purchasing. Measures with no steward, indicated by a dash ("—"), are customized measures specific to the evaluation.

Data Sources

Multiple data sources were used to evaluate the 14 hypotheses for the evaluation. Data collected included administrative claims/encounter data, MCO reports, MCO CAHPS reports, data submitted by Finity, birth registry data, VBP reports, and CMS 64 files supplied by the State. Unredacted capitation rate certification files provided by HSD and budget neutrality workbooks publicly available on Medicaid.gov were utilized for the cost-effectiveness review. Administrative data sources included information extracted from the Medicaid Management Information System (MMIS). MMIS was used to collect, manage, and maintain Medicaid recipient files (e.g., eligibility, enrollment, and demographics) and managed care encounter data.

Administrative

Administrative data extracted from the MMIS were used to calculate most measures presented in this Interim Evaluation Report. These data included administrative claims/encounter data, beneficiary eligibility, enrollment, and demographic data. Provider data were also used as necessary to identify provider type and beneficiary attribution.

Use of managed care encounters was limited to final, paid status claims/encounters. Interim transaction and voided records were excluded from all evaluations because these types of records introduce a level of uncertainty (from matching adjustments and third-party liabilities to the index claims) that can impact reported rates and cost calculations.

Form CMS 64s provided by HSD were used as part of the cost-effectiveness review and contain statements of expenditures for which states are entitled to federal reimbursement under Title XIX.

Analytic Methods

Multiple analytic techniques were used, depending on the type of data for the measure and the availability of data.

Descriptive, content analysis was used to present data related to process evaluation measures gathered from document reviews. The data were summarized to describe the activities undertaken, including highlighting specific successes and challenges.

Descriptive statistics, including frequency distributions and time series (presentation of rates over time), were used for quantitative process measures to describe the output of specific waiver activities. These analysis techniques were also used for some short-term outcome measures in cases where the role of the measure was to describe changes in the population, but not to show specific effects of the Demonstration Waiver.

Difference-in-Differences

A DiD analysis was performed for measures in which a suitable comparison group could be identified (e.g., all health home measures using claims/encounter data and peer support measures). This approach compared the changes in outcome rates between the baseline period and the evaluation period, across the intervention and comparison groups. For the DiD analysis to be valid, the comparison group must accurately represent the change in outcomes that would have been experienced by the intervention group in the absence of the program. DiD analysis was conducted with member-level rates, using a logistic regression model for measures with binary outcomes.

The general form of the DiD model used was:

$$Y_{it} = \beta_0 + \beta_1 * T + \beta_2 * post + \beta_3 * (post * T) + \varepsilon$$

Where Y is the outcome for group i in year t, T is a binary indicator of the intervention group, *post* is a binary indicator for the evaluation period, and ε is an error term. The coefficient β_1 identifies the average difference between the groups during the baseline period prior to the implementation of the waiver. The time period dummy coefficient β_2 captures the change in average outcome between the baseline and evaluation time periods for the non-intervention group. The coefficient on the interaction term β_3 represents the DiD estimate of interest in this evaluation. In other words, it is the difference in the average outcome between the baseline and evaluation time periods for the intervention group, compared to the difference in average outcome between the baseline and evaluation time period for the non-intervention group.

The DiD approach was used where possible, as it controls for any factors external to the program that are applied equally to both groups, such as the coronavirus disease 2019 (COVID-19) public health emergency (PHE). However, the method is still susceptible to external factors that may have differentially impacted one group and not the other.

While a suitable out-of-state comparison group was not available for the entire New Mexico Centennial Care 2.0 Demonstration, two programs, Health Home and Peer Support Services, were available to smaller member subgroups, and thus allowed for an in-state comparison group.

Health Home

To construct the most appropriate comparison group for the health home population, a logistic regression model was used to predict the probability that each member would participate in the program, conditional on their observed baseline characteristics (i.e., the propensity score). These characteristics included sex, age, race, county of residence, an indicator for having a serious mental illness (SMI) or serious emotional disturbance (SED) diagnosis at any point during the baseline year,[3-3] a Chronic Illness and Disability Payment System (CDPS) risk score, and indicators for disease conditions related to participation in the Health Home Program. Each health home-enrolled member was matched to a non-health home member based on the propensity score and county of residence (see Appendix A for matching details).

Peer Support

The DiD analysis was used for Measures 35, 36, and 37, related to assessing the impact of peer support services on alcohol and other drug (AOD) dependence treatment (Aim 4, Hypothesis 2). Although the CMS approved evaluation design plan did not specify a comparison group, it was possible to create an in-state comparison group and utilize the DiD approach—a potentially strong evaluation design.[3-4] To control for potential differences in health profiles between members receiving peer support services and those not receiving peer support services, HSAG controlled for members' weighted CDPS risk score in the analysis.

Interrupted Time Series

The ITS design included annual or quarterly observations of each measure over time, beginning at least one year prior to the Demonstration implementation. The counterfactual for the analysis was the trend, as it would have happened, without being "interrupted" by the Demonstration. Specific outcome measures were collected for multiple time periods both before and after the first demonstration period, waiver renewal, and related interventions. The measurements collected after the Demonstration are then compared to the projected outcome to evaluate the impact the demonstration had on the outcome. The generic ITS model is:

$$Y_t = \beta_0 + \beta_1 time_t + \beta_2 post_t + \beta_3 time \times post_t + \mu_t$$

where Y_t is the outcome of interest for the time period t, *time* represents a linear time trend, *post* is a dummy variable to indicate the time periods post-implementation, and $time \times post$ is the interaction term between *time* and *post*. The coefficient, β_0, identifies the starting level of outcome Y, β_1 is the slope of the outcome between the measurements before the program, β_2 is the change in the outcome at a various point in time, and β_3 is the change in the slope for the measurements after the program.

For measures calculated quarterly, indicator variables were added to the ITS model specified above for each quarter of the year to adjust for seasonality in the trend. Adjustment for the COVID-19 public health emergency (PHE) was conducted by creating an indicator variable for quarter 2 (Q2) of 2021 to represent the initial wave of COVID-19 PHE—related shutdowns and stay-at-home orders, and a separate indicator variable for Q3 of 2020 through the end of Q1 of 2021 to reflect subsequent New Mexico-specific public health orders.[3-5] For measures calculated annually, an indicator variable for 2020 was included in the model to adjust for the COVID-19 PHE.

3-3 SMI/SED diagnosis codes were obtained from the New Mexico Managed Care Policy Manual. Available at: https://www.hsd.state.nm.us/wp-content/uploads/2020/12/Centennial-Care-Managed-Care-Policy-M.pdf. Accessed on: Jul 5, 2022.

3-4 Contrear, K, Bradley K, and Chao, S, "Best Practices in Causal Inference for Evaluations of Section 1115 Eligibility and Coverage Demonstrations," Mathematica Policy Research White Paper, June 2018.

3-5 New Mexico Department of Health. Public Health Orders and Executive Orders. Available at: https://cv.nmhealth.org/public-health-orders-and-executive-orders/. Accessed on: June 21, 2022.

Comparative interrupted time series (CITS) was used to assess *Measure 13: Percentage of Centennial Rewards Participating Members with an Annual Preventive/Ambulatory Service*. This was estimated using linear regression modeling of the following comparative ITS equation:

$$Y_t = \beta_0 + \beta_1 T + \beta_2 X_t + \beta_3 T X_t + \beta_4 Z + \beta_5 ZT + \beta_6 Z X_t + \beta_7 Z X_t T + \varepsilon$$

Where *Y* is the measure rate, *T* is time, *X* is study phase (pre- or post-interruption), *XT* is time after interruption, *Z* is treatment or control, *ZT* is time for treatment, *ZX* is study phase for treatment, and *ZXT* is time after interruption for treatment.

Trend Analysis

For measures where an ITS analysis was not available, a regression model incorporating both the linear trend in the baseline period and dummy variables for the evaluation period years was used for trend analysis. In this model, observed rates during the evaluation period were compared against the projected rates if the baseline trend had continued. Logistic regression was utilized to evaluate measures with binary outcomes.

The general form of the model is:

$$\ln(Y) = \beta_0 + \beta_1 TIME + \sum \beta_t \delta_t$$

Where β_0 is the intercept representing the natural log of the rate at the first baseline year; β_1 is the average annual change in the logged rate during the baseline period, as a function of *TIME*; and $\sum \beta_t \delta_t$ represents the impact of a series of dummy variables representing each evaluation year t. The coefficients for these dummy variables represent the difference in the logged rate from the last year of the baseline period to the year represented by the dummy variable. *TIME* is the piecewise trend parameter for the baseline period defined as a linear trend in the baseline period and is held constant in the evaluation period by setting it equal to the value of the last year of the baseline period.

A series of hypothesis tests of the linear combination of coefficients were performed to determine if the evaluation period rates were significantly different from the projected evaluation period rates based on the *TIME* coefficient and the intercept.

Descriptive Time Series

Measures in which there are insufficient data points for a robust ITS analysis and no viable comparison group for DiD testing will be assessed through a descriptive analysis of trends in the data.

Financial Analysis Trend and Cost Development

The goal of the financial analysis of Centennial Care 2.0 is to compare the costs to the State for the programs covered under the 1115 Demonstration Waiver against the estimated expected costs had the 1115 Demonstration Waiver not been implemented. The program cost effectiveness evaluation is designed to assess the impact on costs and trends (i.e., year-over-year percentage changes) of the shift to managed care throughout the course of the waiver. To accomplish this, costs and trends are developed two ways, normalized and un-normalized.

Un-normalized and normalized claim/encounter costs and trends are calculated and analyzed at two levels. Level one analysis reviews the per member per month (PMPM) cost and trend by year and compares the average annual trend from the baseline period, the average normalized annual trend from the baseline period, and the expected

average annual trend. The second level of analysis for un-normalized and normalized claims/encounters is completed on a per utilizing member per month (PUMPM) basis. A utilizing member month is any month in a calendar year during which a member incurred a claim or encounter. Level two analysis reviews the PUMPM cost and trend by year and compares the average annual trend from the baseline period, the average normalized annual trend from the baseline period, and the expected average annual trend.

Un-normalized claim trends and costs represent the cost from the Centennial Care MCO reported utilization data. The information presented is aggregated for all Medicaid populations. Un-normalized data analysis does not account for known demographic differences from one Demonstration year to the next. When completing an evaluation by comparing year to year changes of the un-normalized costs, program impacts and results may be biased due to the demographic changes in the underlying population. In an un-normalized analysis, cost changes are not adjusted to account for changes in the underlying population.

Normalization is the term used to describe the process of adjusting cost data for the known quantifiable changes that impact utilization and cost such as demographic changes, risk, and inflation. Normalization analysis was employed with the goal of removing all known and quantifiable variation by analysis period, leading to a more accurate comparison between time periods. Below are the high-level steps of the normalization process. Detailed descriptions of each step are outlined further below.

1. Calculate the risk-adjusted PMPM for the analysis cohort.
2. Calculate the age-band/gender factor for the analysis cohort.
3. Calculate the area factor for the analysis cohort.
4. Apply risk, age-band/gender, and area factors to paid claims to calculate the normalized PMPMs for the analysis cohort.

To account for demographic differences throughout the Demonstration, all claims/encounters were normalized for condition-based risk score, combined age and gender variation, and variation in cost by geographic area. HSAG employed the CDPS model version 6.5to develop person-level condition-based risk scores. CDPS is a diagnostic-based risk adjustment model widely used to adjust capitated payments for health plans that enroll Medicaid beneficiaries. CDPS uses International Classification of Diseases (ICD) codes to assign CDPS categories that indicate illness burden related to major body systems (e.g., Cardiovascular) or types of chronic disease (e.g., Diabetes). Within each major category is a hierarchy reflecting both the clinical severity of the condition and its expected effect on future costs. Each of the hierarchical CDPS categories are assigned a CDPS weight. CDPS weights are additive across major categories. The condition risk score output from CDPS was applied to the member-level claims by dividing the condition risk score into the claims PMPM to develop a risk-adjusted PMPM.

$$R_t = \frac{M_t}{C_t}$$

Where *R* represents the risk-adjusted member level individual claim cost, *t* is time, *M* is actual member-level expenditure, and *C* is the condition based CDPS risk score for the enrollee.

The risk adjusted PMPM was then used to develop the combined age/gender factors utilizing the largest populated county, Bernalillo, to remove any bias in the claims cost due to variance by geographic area. Category of service level risk-adjusted PMPM costs are calculated at an age-band and gender grouping level as well as at the total level for the entire population.

$$A_x = \sum R_x / D_x$$

Where *A* represents the annual risk-adjusted claim cost PMPM for an age-band/gender grouping, *X*; *R* is risk-adjusted member-level individual claim cost and *D* represents corresponding eligible member months for the represented age-band/gender grouping. The risk-adjusted individual claim level expenditures and corresponding eligible members for a selected age-band/gender grouping are summed across each year. The annual risk-adjusted member-level PMPM claims were developed to calculate age-band/gender ratios, also referred to as age-band/gender factors, between each stratification comparing the risk adjusted, age-band/gender grouping PMPM to the total population-level annual risk-adjusted member level claim cost PMPM. For example, if female members ages 20–24 have an annual risk-adjusted claims cost PMPM of $105 and the entire population has an annual risk-adjusted claims cost PMPM of $100, then the age-band/gender factor would be 1.05 for the female 20–24 cohort.

Age-band/gender factors are calculated based on the annual risk-adjusted member-level claim cost PMPM. The factors are calculated for each year in the Demonstration by dividing the age-band/gender grouping risk-adjusted claim cost PMPM by the overall annual risk-adjusted population level claim cost PMPM. The annual age-band/gender factors are as follows.

$$AB_x = A_x / A_T$$

Where AB represents the annual age-band/gender factor and age-band/gender grouping, X is the age-band/gender grouping, Ax is risk-adjusted member-level individual claim cost, and AT represents the annual risk-adjusted claim cost PMPM for the entire population. The calculated factors are reviewed over multiple time periods, and final factors are developed to ensure highest statistical R2 for a given age-band/gender grouping. A single set of age-band/gender factors are developed ensuring that changes in age factors are applied consistently across all areas and years.

Once consistent age factors are developed, they are applied to the member-level annual risk-adjusted claim cost PMPM for members in each age-band/gender grouping by dividing the calculated age-band/gender factor into the corresponding claims PMPM to develop an age-band /gender and risk adjusted PMPM. At this point the age-band/gender and risk-adjusted PMPM represents a PMPM that has been netted of any impact of age, gender, and risk. This allows for a focus on the variation of cost in order to develop an adjustment factor by geographic region as outlined below.

$$G_x = \sum R_x / AB_x$$

Where *G* represents the annual risk and age-band/gender factors adjusted claim cost PMPM for a geographic area, *X* is the geographic area, *R* is risk-adjusted member-level individual claim cost, and *AB* represents the annual age-band/gender age factor for an age-band/gender. The risk-adjusted individual claim level expenditures and corresponding eligible members for a selected age-band/gender grouping are summed across each year. The annual risk and age-band/gender factors adjusted claim PMPM output is developed to calculate relativities between geographic regions and the overall annual risk-adjusted member-level claim cost PMPM. The annual geographic factor is calculated as:

$$GF_x = G_x / G_T$$

Where *GF* represents the annual geographic factor, *X* is the geographic grouping, G_x is risk and age-band/gender factors adjusted claim cost and G_T represents the annual risk and age-band/gender factors adjusted PMPM for the entire population. The calculated factors are reviewed over multiple time periods and final factors are developed to ensure highest statistical R^2 for a geographic grouping. A single set of geographic factors are developed ensuring that changes in geographic stratification of the enrolled population are applied consistently across all years.

The resulting PMPM is then used to develop the normalized claims cost PMPM and the normalized claims trends. Normalized claims PMPM are calculated by dividing the risk-adjusted claim cost PMPM for an age-band/gender and geographic grouping by the calculated geographic factor for a given geographic stratification and the selected inflation rate, given by the formula below.

$$N_t = \sum (G_x / (GF_x i_t)) / D_x$$

Where *N* represents the normalized claims PMPM for a given geographic and age-band/gender, *t* represents the annual review period, *G* represents the annual risk and age-band/gender factors adjusted claim cost PMPM for a geographic area, *X* is the geographic area, *GF* represents the annual geographic factor, *i* represents the inflation rate, and *D* represents the corresponding eligible member months for the represented age-band/gender and geographic grouping.

The resulting normalized claims PMPM is then used to develop the normalized claims trend. Normalized claims trends are calculated as the ratio of the normalized claims PMPM between two periods.

$$NT_t = N_t / N_{t-1}$$

Where *NT* represents the normalized claims trend for a given geographic and age-band/gender, *N* represents the normalized claims PMPM for a given geographic and age-band/gender, and *t* represents the annual review period.

Costs and trends were calculated and reviewed seven ways:

- ***Actual Total Cost*** represents the total expenditure for each review period.
- ***Actual PMPM*** represents the per member per month cost over the review period.

  $$Y_t = \sum X_t / \sum Z_t$$

  Where *Y* represents the claims PMPM cost, *t* represents the annual review period, *X* represents the actual total cost for the population or time period under review, and *Z* represents the total enrolled population for the analysis cohort.
- ***Expected PMPM*** represents the expected per member per month cost over the review period. It is calculated by multiplying the ratio of the age-band/gender factor between the review period and the year prior, the ratio of the area factor between the review period and the year prior, and the inflation rate for the review period.

  $$E_t = E_{t-1} \left(\frac{AB_t}{AB_{t-1}}\right)\left(\frac{GF_t}{GF_{t-1}}\right)\left(\frac{C_t}{C_{t-1}}\right) i \ \ where\ t \geq 1$$

  $$E_t = Y_t \ \ where\ t = 0$$

  Where *E* represents the expected PMPM cost, *t* represents the review period, *AB* represents the annual age-band/gender age factor for an age-band/gender, *GF* represents the annual geographic factor, *i* represents the inflation rate, and *Y* represents the claims PMPM cost.
- ***Expected Total Cost*** represents the expected total expenditure for each review period. It is calculated by taking the total enrolled population for the analysis cohort and multiplying by the expected claims PMPM.

  $$EC_t = E_t Z_t$$

Where *EC* represents the expected total expenditure for each review period, t represents the review period, *E* represents the expected PMPM cost, and *Z* represents the total enrolled population for the analysis cohort.

- ***Average Annual Trend*** represents the average annual growth in cost of care between the baseline and each year. The annualized trend is then adjusted to smooth the individual annual trends to determine the average across the represented time period.

$$L_t = \left(\left(\frac{Y_t}{Y_0} \right)^{\left(\frac{1}{t}\right)} \right) - 1$$

Where *L* represents the average annual trend, *t* represents the review period, Y_t represents the claims PMPM cost for the review period at time *t*, and Y_0 represents the claims PMPM cost for the baseline year.

- ***Average Annual Normalized Trend*** represents the average annual growth in cost of care adjusted for known variances between the baseline and each year. The normalized annual trend is then adjusted to smooth the individual annual trends to determine the average across the represented time period.

$$M_t = \left(\left(\frac{N_t}{N_0} \right)^{\left(\frac{1}{t}\right)} \right) - 1$$

Where *M* represents the average annual normalized trend, *t* represents the review period, N_t represents the normalized claims PMPM for a given geographic and age-band/gender for the review period at time *t*, and N_0 represents the normalized claims PMPM for a given geographic and age-band/gender for the baseline year.

- ***Expected Average Annual Trend*** represents the average annual growth in cost of care for the expected cost between the baseline and each year. The expected annualized trend is then adjusted to smooth the individual annual trends to determine the average across the represented time period.

$$K_t = \left(\left(\frac{E_t}{E_0} \right)^{\left(\frac{1}{t}\right)} \right) - 1$$

Where *K* represents the expected average annual trend, *t* represents the review period, E_t represents the expected claims PMPM cost for the review period at time *t*, and E_0 represents the expected claims PMPM cost for the baseline year.

4. Methodological Limitations

The following sections details the methodological limitations of the Interim Evaluation Report for the Centennial Care 2.0 Demonstration Waiver.

Evaluation Design

In this Interim Evaluation Report, Health Services Advisory Group, Inc. (HSAG), presents baseline and evaluation period rates for performance measures and other metrics that align with the primary objectives of the Demonstration Waiver. A particular strength of this evaluation is the use of varied data sources to address a wide breadth of metrics spanning access to services and quality of care; modernization of the health delivery system through data, technology, and person-centered care; and specific attention to Medicaid beneficiaries with a substance use disorder (SUD). The metrics included in the evaluation were selected because of their relevance to the processes and outcomes intended to be impacted by the Centennial Care 2.0 Program. Additionally, many of the performance measures in this report are based on standardized, well-validated metrics from recognized measure stewards. The quantitative analyses presented in this report are intended to assess the change in measure rates and beneficiary survey responses associated with the introduction of the Centennial Care 2.0 Program. The Interim Evaluation Report is therefore based on data and analyses that provide a strong foundation for the final Summative Evaluation Report.

Three key limitations exist for the data, measures, and methods used for this Interim Evaluation Report. First, with the exception of the Health Home Program, members receiving peer support, and the Centennial Home Visiting (CHV) Pilot Program, no in-state comparison population exists since the Demonstration Waiver was implemented for all members throughout the State simultaneously, and all members who would be eligible for the waiver interventions received them. A comparison group of similarly situated Medicaid beneficiaries who have not received the programming changes delivered by Centennial Care 2.0 will be critical for obtaining a proper counterfactual comparison in the Summative Evaluation Report. The comparison group will serve as the basis for understanding what may have happened to the healthcare and health outcomes of Centennial Care 2.0 beneficiaries if the program being evaluated was not put in place. It is possible that Transformed Medicaid Statistical Information System (T-MSIS) data from the Centers for Medicare & Medicaid Services (CMS), while unavailable for this report, may become available for use in forming a counterfactual comparison group for Centennial Care 2.0 by the time the Summative Evaluation Report is written. Additionally, at the time of the Interim Evaluation Report, data could not be obtained from another state with similar population characteristics and Medicaid policies and procedures in place. Therefore, the counterfactual comparison used in this report is the comparison of measure rates across the baseline and evaluation periods of the Demonstration. The results indicate whether the measure rates increased or decreased, and whether the results represented statistically significant changes in performance.

A second key limitation of the results presented in this Interim Evaluation Report is the impact of the global coronavirus disease 2019 (COVID-19) public health emergency (PHE). The COVID-19 PHE impacted the healthcare industry and the entire population on a global scale, requiring substantial changes to the processes used in the delivery of healthcare. In New Mexico, as in other locations, healthcare utilization was significantly reduced in 2020 and is likely to have impacted the results shown in this Interim Evaluation Report. Where possible, adjustments for the impact of the COVID-19 PHE were made in the analyses. For measures analyzed using interrupted time series (ITS), knowledge on state-specific case counts, shutdowns, and stay-at-home orders was incorporated into the model to account for the effect of COVID-19 through controlling for affected quarters or years in regression analyses. For measures wherein a difference-in-differences (DiD) approach was possible

and a proper comparison group could be identified, the *relative change* over time in outcomes between groups is the estimate of interest, and thus stronger inferences about program impacts may be drawn as the COVID-19 effect is assumed to apply equally to both groups. For many other measures, however, the specifications for calculating rates require lengthy look back periods, or annual assessments of beneficiaries that would not allow such adjustments to be made. Because of this limitation, for some measures, the 2020 rates confound the impact of the COVID-19 PHE with any program impacts, and the analysis cannot disentangle the two sources of change.

Lastly, for programs wherein a comparison group was identified, it is possible that there were differences unaccounted for between the groups, resulting in biased results. Unlike in a true randomized controlled trial, members voluntarily choose to participate in the Health Home Program or receive peer support services, thus they may be systematically different from those who were eligible but elected not to participate in meaningful ways not captured by administrative data. The use of a matched comparison population for the comparison group should, in theory, mitigate any bias caused by the lack of randomization; however, no method can completely remove the effect of self-selection bias.

Furthermore, it is possible that there were remaining unobserved differences between the matched groups that created a "regression to the mean" (RTM) effect. This statistical phenomenon occurs when matching selects units that are extreme relative to their respective group means in order to achieve balance in the matched sample.[4-1] For this to happen, otherwise "healthy" members would have to be matched during a time period of unusually high utilization and/or prevalence of comorbidities, and then "regress" back to their mean from prior to the period used for matching. This may result in biased conclusions.

However, since the measures used to evaluate the Health Home program are reported as rates consisting of numerator and denominator criteria, the probability of numerator events must be affected by RTM for it to bias conclusions. If outcome measures included costs or service utilization, then it is expected that RTM would bias results because the comparison group would "regress" back to their means during the evaluation year. In those cases, it would be plausible that the comparison group at baseline had higher costs and utilization since they would have been matched during a high utilization period under the assumption of RTM. However, due to the nature of the measures included in this study, it is expected that any bias from RTM will be minimal.

For example, Measure 11, *30-day Follow Up After Hospitalization for Mental Illness (FUH)*, demonstrates a decline in the denominator among the non-health home group between baseline and each evaluation year. This suggests there is a possibility of RTM due to fewer hospitalizations for mental illness among the comparison group in the evaluation year. However, since the measure is reported as a rate, in order for RTM to bias results, the probability of the numerator event must change between the baseline and evaluation years. That is, the likelihood of receiving a follow-up visit must change due to RTM. Although this effect is unclear, the probability of the numerator event to change for this measure or any other measure included in the evaluation of the Health Home Program is expected to be negligible.

Data Sources

The data used in the Interim Evaluation Report include administrative data, Medicaid enrollment data, demographic data, claims and encounter data, as well as additional data sources such as managed care organization (MCO) reports, Department of Health, Office of the Medical Investigator, hospital associations, and

4-1 Daw JR, Hatfield LA. Matching and Regression to the Mean in Difference-in-Differences Analysis. *Health Serv Res*. 2018 Dec;53(6):4138-4156. doi: 10.1111/1475-6773.12993. Epub 2018 Jun 29. PMID: 29957834; PMCID: PMC6232412.

pharmacy boards. The variety of data sources for this evaluation is a major strength as it allows the State to uniquely answer research questions that might not otherwise be possible with administrative data.

While using numerous data sources in this Interim Evaluation Report is a desirable strength, each source has weaknesses as well which are important to understand within the context of the evaluation. For example, the claims/encounter data used to calculate performance metrics are generated as part of the billing process for Medicaid and, as a result, may not be as complete or sensitive for identifying specific healthcare processes and outcomes as may be expected from a thorough review of a patient's medical chart.[4-3] This weakness may be mitigated in part if the lack of sensitivity in the claims/encounter data remains relatively stable over time and if the measures calculated from these data follow trends consistent with the underlying processes and outcomes of interest. The additional data sources had their own unique challenges. For example, the MCO report data files varied in terms of data elements reported from year to year; this may have been due to changes in the reporting template, making it unclear whether the data provided were reflecting a true change to the measure or merely an artifact of reporting. These data were provided to HSAG as reported by each MCO, and thus could not be confirmed or independently validated.

Methods

The methodology used in the Interim Evaluation Report comprises a mix of ITS, DiD, trend analyses, and descriptive analyses. Excluding descriptive analyses, the results give the reader an understanding of whether the measures exhibited statistically significant changes after Centennial Care 2.0 was implemented.

When data are available for multiple time points during the baseline period and evaluation period, an ITS design offers a robust quasi-experimental approach for evaluating treatment effects. The strength of a single group ITS lies in its adjustment of underlying trends in the baseline period as well as the ability to control for confounding factors such as seasonality. However, without a valid comparison group, the internal validity of a single group ITS analysis is threatened, as other policies or interventions may affect the outcome simultaneous with Centennial Care 2.0, resulting in biased conclusions about the impact of the Demonstration.[4-2] Where possible, a comparison population was used in the ITS analysis to control for concurrent changes. Furthermore, in time series analyses, repeated observations of the outcome taken both before and after the intervention allows for the construction of an estimated counterfactual trend during the evaluation period. The counterfactual is based on a projection of the underlying trend in the baseline period into the evaluation period. Power in ITS depends on the number and distribution of data points before and after the intervention, among other factors; when there are few data points during either the baseline or evaluation period, the results should be interpreted with caution.[4-3,4-4] It is possible that too few data points may have impacted the analysis; in particular, annual measures analyzed using ITS included four data points during the baseline period and three data points during the evaluation period and may not allow for accurate representations of trends in the data.

For the Health Home program population and the population of members receiving peer support services, the use of a DiD approach was taken and a proper comparison group was identified. The results from this analysis allow

4-2 Becker Friedman Institute. Testing the Validity of the Single Interrupted Time Series Design. Available at: https://bfi.uchicago.edu/wp-content/uploads/BFI_WP_201997.pdf. Accessed on July 5, 2022.

4-3 Hategeka C, Ruton H, Karamouzian M, et al. Use of interrupted time series methods in the evaluation of health system quality improvement interventions: a methodological systematic review. BMJ Glob Health. 2020 Oct;5(10):e003567. doi: 10.1136/bmjgh-2020-003567. PMID: 33055094; PMCID: PMC7559052.

4-4 Bernal JL, Cummins S, Gasparrini A. Interrupted time series regression for the evaluation of public health interventions: a tutorial. Int J Epidemiol. 2017 Feb 1;46(1):348-355. doi: 10.1093/ije/dyw098. Erratum in: Int J Epidemiol. 2020 Aug 1;49(4):1414. PMID: 27283160; PMCID: PMC5407170.

the reader to draw stronger conclusions about program impacts because the members participating in a health home or receiving peer support services are compared to similar members who did not participate in a health home or receive peer support services. However, a fundamental assumption of the DiD analysis is that the trends between the intervention and comparison group are parallel prior to implementation of the program. By identifying baseline trends in the outcomes, the parallel trends assumption can be directly tested and controlled for if not satisfied. To be included in the DiD analysis, the same group of members are followed from the baseline period to the evaluation period. The baseline period should be close in time to the start of Centennial Care 2.0 in January 2019 to maximize the number of members enrolled during both periods. Choosing a baseline period far removed from the start of Centennial Care 2.0 would result in a greater number of members who were not enrolled in Medicaid during both time periods due to the relatively high rate of enrollment and disenrollment patterns among the Medicaid population. These members would consequently be excluded from the DiD analysis. Due to ramp-up effects of the first year of health home implementation, as well as the county-by-county phased nature of program roll-out, the first year of the Health Home Program would not provide an accurate measurement of its performance from which to base an evaluation. As a result, measures based on administrative data are evaluated based on a single year of baseline data. With only one pre-intervention data point, the parallel trends assumption cannot be tested. To the extent the health home and non-health home groups had different pre-intervention trends, the results would be biased.

Another limitation of the methods used in this report is associated with the trend analysis comparing performance measure rates in each evaluation year to the projected rate obtained from the baseline trend. While this analysis takes advantage of the multiple baseline years to obtain a trend projection into the evaluation period, the comparison may become less meaningful for measures wherein the baseline trend exhibited very large increases or decreases, and when a baseline measure rate is nearly zero. The comparison in this analysis is based on an assumption that the baseline trend would continue during the evaluation period if the Demonstration program was not implemented. For measures with steep baseline trends, this assumption is unlikely to hold, making the resulting comparison less informative. Additionally, when measure rates are nearly zero, then small absolute changes in the rate represent large relative changes because the measure rate is low. For these measures, projections in the evaluation period rise more quickly than may otherwise be expected, and the comparison of observed to projected rates becomes less informative.

In contrast, for some measures, only a descriptive comparison of measure rates during the baseline period to rates during the evaluation period was possible, and thus highlights a primary limitation in the inability to draw causal inferences. A descriptive analysis does not provide a sufficiently strong comparison group to definitively conclude whether the Centennial Care 2.0 Demonstration caused changes in the measure rates, as it does not attempt to isolate the impact of the Demonstration on measured outcomes. Other factors outside of the Demonstration may have contributed to changes in measure rates, such as the COVID-19 PHE, changes in coding and reporting practices in the claims/encounter data, and changes in prescribing practices for opioids. The forthcoming Summative Evaluation Report will seek to establish a causal link between the implementation of the Demonstration and changes in outcomes.

A final limitation of the methodology is associated with its ability to speak to why specific measures may have improved, worsened, or remain unchanged. The statistical analysis performed in this Interim Evaluation Report characterizes the direction, magnitude, and statistical significance of measure rate changes. As this evaluation did not include any qualitative components such as interviews with stakeholders or MCOs, the ability to explain why specific measures changed in the ways that they did is limited. Therefore, the causes of changes in specific measure rates, or the lack thereof, cannot be identified.

5. Results

The following section details measure results by research question and related hypotheses for the Centennial Care 2.0 Demonstration Waiver. This interim report provides results from the baseline period and first two years of the evaluation period. Details on the measure definitions and specifications can be found in Appendix C.

Results Summary

Findings for each measure are summarized generally by two criteria:

1. The measure directly addresses the hypothesis.
2. The measure does not directly address the hypothesis, and instead provides descriptive or contextual information.

Depending on the analytic approach utilized, measures that directly address the hypothesis can provide sufficient evidence to *support the hypothesis* or *fail to support the hypothesis*. If available data and/or the analytic approach used cannot draw these conclusions, a measure may neither support nor fail to support the hypothesis.

Measures that do not directly address the hypothesis but provide contextual information related to the hypothesis may be deemed *consistent with the hypothesis* or *inconsistent with the hypothesis*. Although the measure cannot provide direct evidence relating to the veracity of the hypothesis, the results may be in alignment with the hypothesis (i.e., consistent with the hypothesis) or not be in alignment with the hypothesis (i.e., inconsistent with the hypothesis).

Measures for which there are currently not enough data to draw a conclusion are classified as *N/A*.

Aim One: Continue the use of appropriate services by members to enhance member access to services and quality of care

Hypothesis 1: Continuing to expand access to Long-Term Support Services and Supports (LTSS) and maintaining the progress achieved through rebalancing efforts to serve more members in their homes and communities will maintain the number of members accessing Community Benefit (CB) services.

Research Question 1: Has the number of members accessing CB services been maintained year-over-year?

Number of Centennial Care Members Enrolled and Receiving CB Services (Measure 1)

Measure 1 assesses whether the number of members accessing CB services has been maintained. Table 5-1 shows the number of CB members remained fairly steady after increases in 2014 and 2015.

Table 5-1—Number of Centennial Care Members Enrolled and Receiving CB Services (Measure 1)

Year	Number of CB Members	Change From Previous Year	Percent Change From Previous Year
2013	3,363	-	-
2014	25,556	22,193	659.9%
2015	29,735	4,179	16.4%
2016	31,038	1,303	4.4%

Year	Number of CB Members	Change From Previous Year	Percent Change From Previous Year
2017	30,984	-54	-0.2%
2018	29,251	-1,733	-5.6%
2019	29,712	461	1.6%
2020	30,338	626	2.1%
2021	31,139	801	2.6%

The average change from the previous year from 2016 onward was less than 1 percent, with a notable decrease in 2018. However, this decrease was partially offset by increases in most years between 2016 and 2021, supporting the hypothesis that the number of beneficiaries accessing CB services has been maintained, following an increase shortly after the introduction of Centennial Care in 2014.

Measure 1 Conclusion: Supports the hypothesis

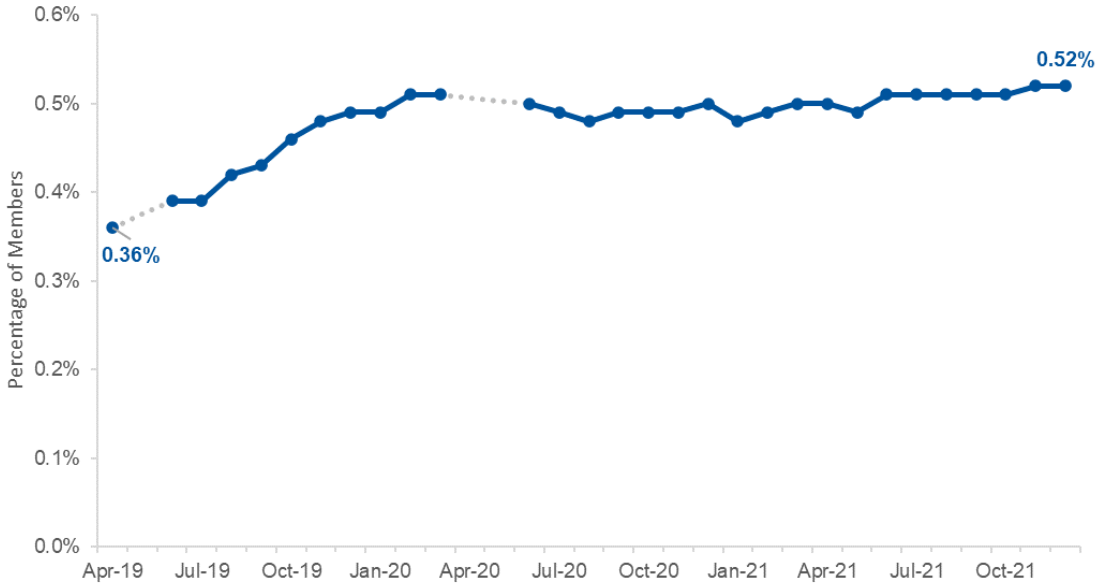
Hypothesis 2: Promoting participation in a health home will result in increased member engagement with a health home and increase access to integrated physical and behavioral healthcare in the community.

Research Question 1: Is there an increase in the number/percentage of members enrolled in a health home?

Percentage of Centennial Care Members Enrolled in a Health Home (Measure 2)

Measure 2 presents the number and percentage of Centennial Care members enrolled in a health home to determine if increased promotion in health home participation led to an increase in the percentage of Centennial Care members who are enrolled in a health home. To assess this measure, the percentage of Centennial Care members enrolled in managed care who are enrolled in a health home was calculated. Overall, the percentage rose from 0.36 percent in April 2019 to 0.52 percent in December 2021. Most of the increase occurred in 2019 when the percentage rose from 0.36 percent in April 2019 to 0.49 percent in December 2019. Starting in January 2020, the percentage remained steady between 0.48 percent and 0.52 percent through December 2021. No health home enrollment data were available for January 2019–March 2019, May 2019, and April 2020–May 2020. Figure 5-1 shows the monthly percentage of Centennial Care members enrolled in managed care who are enrolled in a health home. Table A-2 in Appendix A contains the number of Centennial Care members enrolled in a health home.

Figure 5-1—Percentage of Centennial Care Members Enrolled in a Health Home, 2019–2021 (Measure 2)



Measure 2 Conclusion: Supports the hypothesis

Research Question 2: Is the proportion of members engaged in a health home receiving any physical health (PH) services higher than those not engaged in a health home?

Number/Percentage of Health Home Members with at Least One (1) Claim for PH Service in the Calendar Year (Measure 3)

Measure 3 is evaluated through a difference-in-difference (DiD) analysis. For each evaluation year (2019-2021) the health home intervention group was matched with non-health home members and baseline rates from 2017 (prior to expansion of the Health Home Program) were used to compare against rates in the evaluation year. Due to changing populations across evaluation years, the number of members included in the baseline period will vary slightly.

Table 5-2 shows that during the 2017 baseline period, approximately 96 percent of health home and non-health home members had a claim (or encounter) for a PH service. During each evaluation year, the rate increased to nearly 100 percent among health home members while it dropped to approximately 91 to 92 percent among non-health home members, depending on the year. This suggests that enrollment in a health home contributed to a statistically significant increase in member utilization of PH services. Members in the health home group were matched to members in the non-health home group using a propensity score model which included member demographics, predominant county of residence during the evaluation year, and morbidities present at baseline (see Propensity Score-Based Matching Methodology for more information in Appendix A).

Table 5-2—Number/Percentage of Health Home Members With at Least One Claim for PH Service in the Calendar Year (Measure 3)

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change[2]	Health Home Impact (p-Value)
		Baseline	Evaluation Year		
2019	Health Home	96.2% N=2,227	99.9% N=2,227	3.7p.p.	7.9p.p. (<0.001)
	Non-Health Home	96.5% N=2,227	92.4% N=2,227	-4.2p.p.	
2020	Health Home	96.1% N=2,908	99.8% N=2,908	3.6p.p.	9.2p.p. (<0.001)
	Non-Health Home	96.3% N=2,908	90.7% N=2,908	-5.6p.p.	
2021	Health Home	96.2% N=3,165	99.5% N=3,165	3.3p.p.	8.7p.p. (<0.001)
	Non-Health Home	96.1% N=3,165	90.7% N=3,165	-5.4p.p.	

[1]Note: N represents the denominator count.
[2]p.p.=percentage point

Measure 3 Conclusion: Supports the hypothesis

Hypothesis 3: Enhanced care coordination supports integrated care interventions, which lead to higher levels of access to preventive/ambulatory health services.

Research Question 1: Is there an increase in Centennial Care members who have at least one claim for preventive/ambulatory care in a year?

Adults' Access to Preventive/Ambulatory Health Services (AAP) (Measure 4a)

To determine the impact that Centennial Care 2.0 had on the percentage of members receiving preventive/ambulatory care, Health Services Advisory Group, Inc. (HSAG) conducted an interrupted time series (ITS) analysis, controlling for seasonality and the peak coronavirus disease 2019 (COVID-19) public health emergency (PHE)-affected year (2020) on the following measures.[5-1]

- The percentage of members 20 years and older who had an ambulatory or preventive care visit
- The percentage of members 12 months–19 years of age who had a visit with a primary care practitioner (PCP), stratified by the following age groups:
  - 12–24 months
  - 25 months–6 years
  - 7–11 years
  - 12–19 years
- The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year

5-1 Model projections were calculated using all coefficients from the ITS regression except for the post-intervention indicator and the post-intervention time trend.

Table A-3 contains additional regression results.

Figure 5-2 through Figure 5-7 provide a comparison between the observed rates to the estimated counterfactual (in the absence of Centennial Care 2.0) rates from the ITS analysis. The dashed gray line represents the estimated counterfactual rate. The black line illustrates the national median, where available.

Figure 5-2 shows an overall downward trend in preventive visits throughout the baseline and evaluation periods, falling from a high of 78.5 percent in 2015 to 73.8 percent in 2021. The national median also exhibited a slight downward trend during the same period before falling in 2020 due to the COVID-19 PHE. The rate among New Mexico members remained consistently below the national median throughout the baseline and evaluation periods. Statistical testing results presented in Table 5-3 show that the decrease in the annual trend of 1.1 percentage points following Centennial Care 2.0 was not statistically significant. Similarly, the level change in 2019 at time of implementation was not statistically significant. Table A-3 contains additional regression results.

Figure 5-2—Adults' Access to Preventive/Ambulatory Health Services (AAP)—Centennial Care Population Observed Rates Compared to ITS Model Projections (Measure 4a)

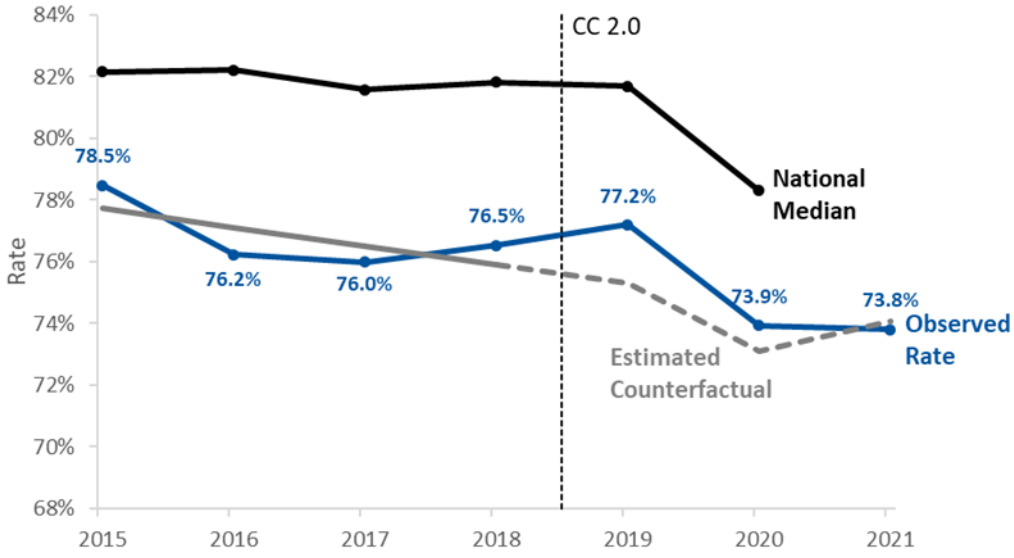


Table 5-3—Adults' Access to Preventive/Ambulatory Health Services (AAP)—Centennial Care Population Primary ITS Model Results[1] (Measure 4a)

Variable	Estimate[2]	p-Value
Intercept	77.7%	<0.001***
Pre- Centennial Care (CC) 2.0 annual trend	-0.6p.p.	0.307
Level change at implementation	3.0p.p.	0.236
Change in annual trend	-1.1p.p.	0.323

*p< 0.1, **p < 0.05, ***p<0.001

[1]Note: Full model results are presented in Appendix A.

[2]p.p. = percentage point

Measure 4a Conclusion: Neither supports nor fails to support the hypothesis

Children and Adolescents' Access to Primary Care Practitioners (CAP) (Measure 5a)

Due to differing measure specifications by age, results are reported by four separate age groups for children and adolescents' access to PCPs (CAP).

12–24 months

Figure 5-3 and Table 5-4 show that the rate of child primary care visits (ages 12-24 months) in the pre-Centennial Care 2.0 period steadily increased by 0.7 percent per year. However, the observed rates following Centennial Care 2.0 implementation in 2019 remained high in 2019 before falling in 2020 and 2021. Although no national data were available for 2020 and beyond due to the measure being retired, this decline is likely driven by the COVID-19 PHE. Even after controlling for the initial impacts of COVID-19 in 2020, the trend following Centennial Care 2.0 decreased by 2.3 percentage points per year, which is statistically significant at the 0.05 level. Since the COVID-19 PHE was officially still in effect beyond 2020 it is possible the observed decline in 2021 was partially driven by the PHE. Although every attempt was made to control for the impacts of the COVID-19 PHE, the precipitous and sustained drop in 2020 suggests that the PHE, rather than Centennial Care 2.0, had a significant and lasting impact on the access to care for children 12–24 months of age. Table A-4 in Appendix A contains additional regression results for children 12-24 months.

Figure 5-3—Children and Adolescents' Access to Primary Care Practitioners (CAP)—Centennial Care Population, Observed Rates Compared to ITS Model Projections, 12–24 Months (Measure 5a)

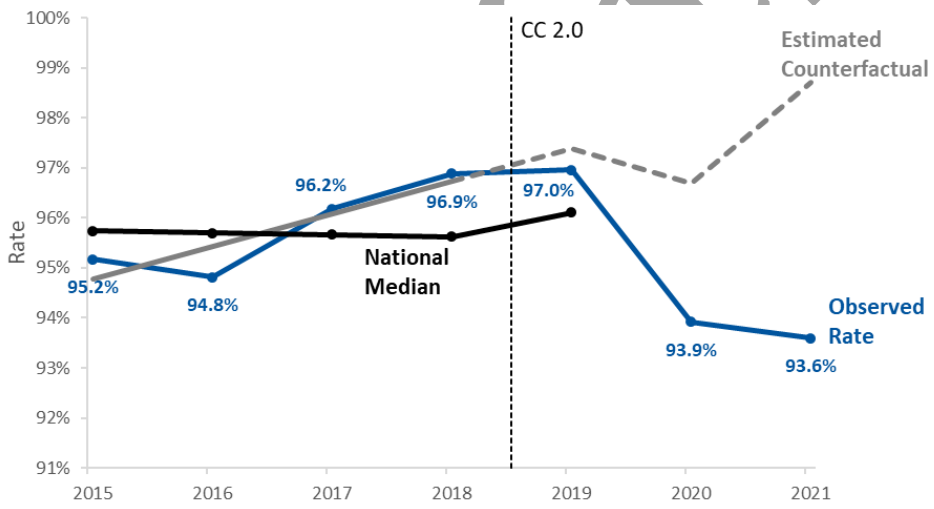


Table 5-4—Children and Adolescents' Access to Primary Care Practitioners (CAP)—Centennial Care Population, Primary ITS Model Results[1], 12–24 Months (Measure 5a)

Variable	Estimate[2]	p-Value
Intercept	94.8%	<0.001***
Pre-Centennial Care (CC) 2.0 annual trend	0.7p.p.	0.111
Level change at implementation	1.9p.p.	0.184
Change in annual trend	-2.3p.p.	0.034**

*p< 0.1, **p < 0.05, ***p<0.001
[1]Note: Full model results are presented in Appendix A.
[2]p.p.=percentage point

25 months–6 years

Similar to the rate of primary care visits among children 12–24 months, Figure 5-4 and Table 5-5 show that the rate among children ages 25 months to 6 years increased on average by 0.6 percentage points during the pre-Centennial Care 2.0 period. Although no national data were available for 2020 and beyond due to the measure being retired, the sharp decline starting in 2020 was almost certainly driven by the COVID-19 PHE. Even after controlling for the initial impacts of COVID-19 in 2020, the trend following Centennial Care 2.0 decreased by 3.9 percentage points per year, which is statistically significant at the 0.1 level. Since the COVID-19 PHE was officially still in effect beyond 2020 it is possible the observed decline in 2021 was partially driven by the PHE. Although every attempt was made to control for the impacts of the COVID-19 PHE, the precipitous drop in 2020 with only a small recovery in 2021 suggests that the PHE, rather than Centennial Care 2.0, had a significant and lingering impact on the access to care for children 25 months to 6 years of age. Table A-5 contains additional regression results for children aged 25 months – six years.

Figure 5-4—Children and Adolescents' Access to Primary Care Practitioners (CAP)—Centennial Care Population, Observed Rate Compared to ITS Model Projections, 25 Months–6 Years (Measure 5a)

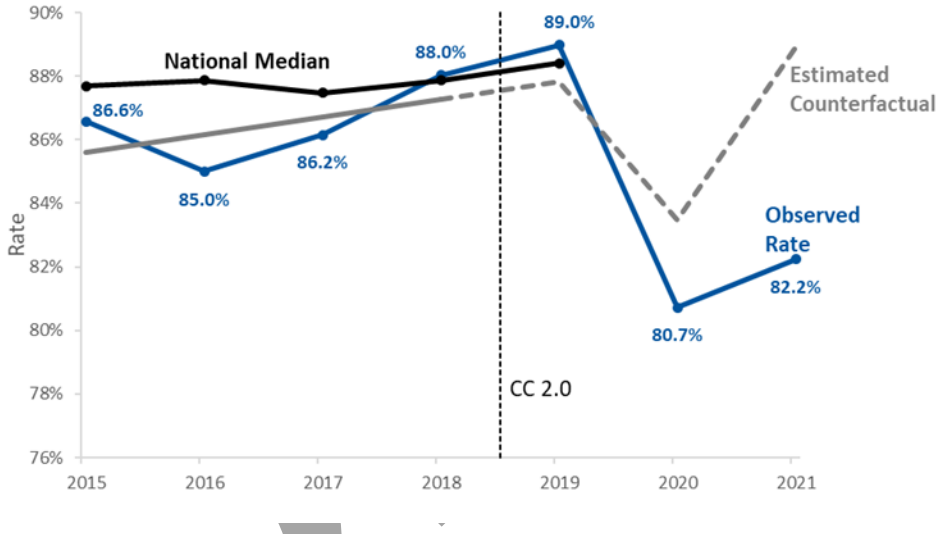


Table 5-5—Children and Adolescents' Access to Primary Care Practitioners (CAP)—CC Population, Primary ITS Model Results[1], 25 Months–6 Years (Measure 5a)

Variable	Estimate[2]	p-Value
Intercept	85.6%	<0.001***
Pre-CC 2.0 annual trend	0.6p.p.	0.433
Level change at implementation	5.1p.p.	0.154
Change in annual trend	-3.9p.p.	0.066*

*p< 0.1, **p < 0.05, ***p<0.001
[1]Note: Full model results are presented in Appendix A.
[2]p.p.=percentage point

7–11 years

Figure 5-5 and Table 5-6 show the rate of children's primary care visits among those ages 7–11 years had dropped for one year but began increasing until it had reached the national median during the pre-Centennial Care 2.0 period. The rate continued to increase into 2019 upon implementation of Centennial Care 2.0. However, the rate

fell in 2020 and fell further in 2021, likely due to the COVID-19 PHE, with a decrease in the trend of 2.5 percentage points per year. Although every attempt was made to control for the impacts of the COVID-19 PHE, the decrease that began in 2020 and continued into 2021 suggests that the PHE, rather than Centennial Care 2.0, had a significant and lingering impact on the access to care for children 7 to 11 years of age. Table A-6 contains additional regression results for children aged seven to 11 years.

Figure 5-5—Children and Adolescents' Access to Primary Care Practitioners (CAP)—Centennial Care Population, Observed Rate Compared to ITS Model Projections, 7–11 Years (Measure 5a)

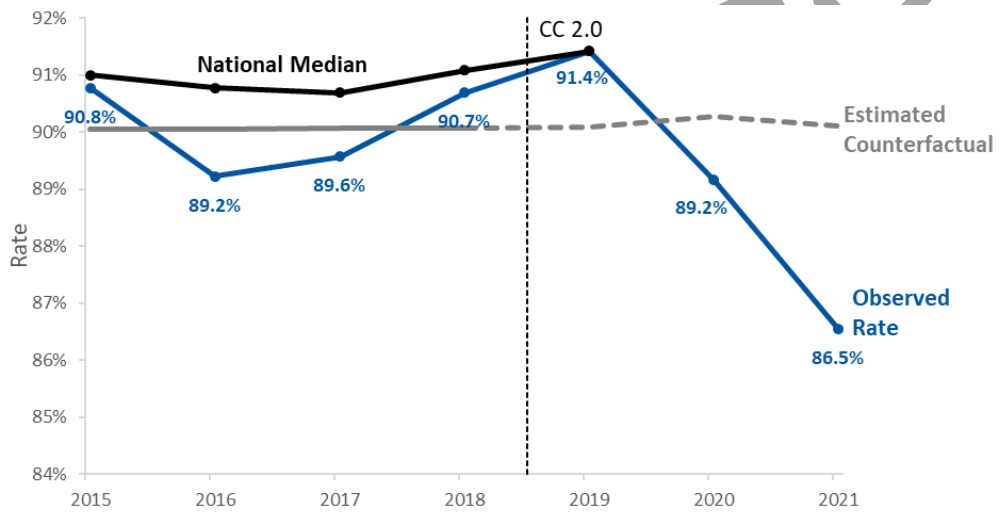


Table 5-6—Children and Adolescents' Access to Primary Care Practitioners (CAP)—Centennial Care Population, Primary ITS Model Results[1], 7–11 Years (Measure 5a)

Variable	Estimate[2]	p-Value
Intercept	90.0%	<0.001***
Pre-CC 2.0 annual trend	0.0p.p.	0.985
Level change at implementation	3.8p.p.	0.159
Change in annual trend	-2.5p.p.	0.093*

*p< 0.1, **p < 0.05, ***p<0.001
[1]Note: Full model results are presented in Appendix A.
[2]p.p.=percentage point

12–19 years

Similar to the rate of primary care visits among children ages 7–11 years, the rate among children and adolescents ages 12–19 years exhibited similar rates and trends, with a decrease in the trend of 2.3 percentage points per year in the post-Centennial Care 2.0 period relative to the pre-Centennial Care 2.0 trend as demonstrated in Figure 5-6 and Table 5-7. Although every attempt was made to control for the impacts of the COVID-19 PHE, the precipitous drop that began in 2020 and continued into 2021 suggests that the PHE, rather than Centennial Care 2.0, had a significant and lingering impact on the access to care for children 12 to 19 years of age. Table A-7 contains additional regression results for children aged 12 to 19 years.

Figure 5-6—Children and Adolescents' Access to Primary Care Practitioners (CAP)—Centennial Care Population, Observed Rate Compared to ITS Model Projections, 12–19 Years (Measure 5a)

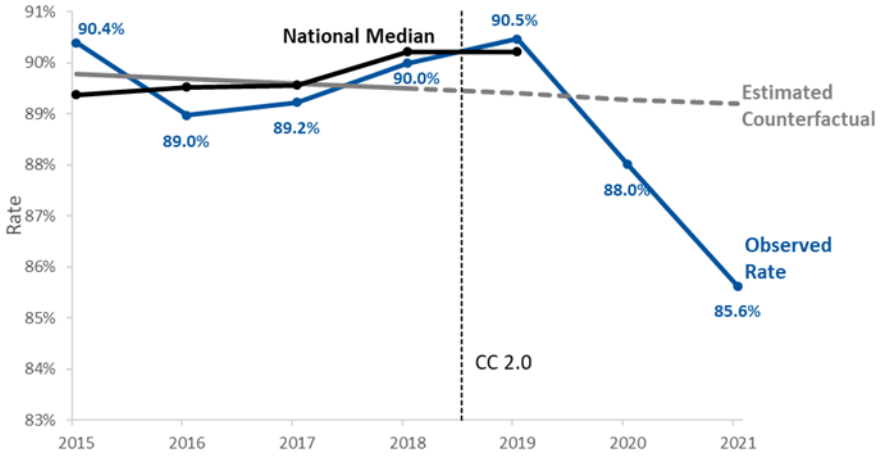


Table 5-7—Children and Adolescents' Access to Primary Care Practitioners (CAP)—Centennial Care Population, Primary ITS Model Results[1], 12–19 Years (Measure 5a)

Variable	Estimate[2]	p-Value
Intercept	89.8%	<0.001***
Pre-CC 2.0 annual trend	-0.1p.p.	0.811
Level change at implementation	3.4p.p.	0.141
Change in annual trend	-2.3p.p.	0.074*

*p< 0.1, **p < 0.05, ***p<0.001
[1]Note: Full model results are presented in Appendix A.
[2]p.p.=percentage point

Measure 5a Conclusion: Does not support the hypothesis.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) (Measure 6)

Figure 5-7 and Table 5-8 show that the rate of well child visits for children ages 3 to 6 remained below the national median throughout the baseline period, prior to implementation of Centennial Care 2.0. Table 5-8 shows that after controlling for the initial impacts of COVID-19 in 2020, there was no significant change in either the level or the trend of the rate following implementation of Centennial Care 2.0. The rate increased to 61.9 percent in 2019 before declining to 52.3 percent in 2020 and 59.4 percent in 2021. The observed rates in 2019 and 2020 were also higher than the projected rates, but the change in the level at implementation was not statistically significant. The drop in the rate during 2020 was likely the result of the COVID-19 PHE. The impact of the PHE may have held the rate down in 2021, however, insufficient data are available at this time to disentangle PHE impacts from the impact of Centennial Care 2.0. Table A-8 contains additional regression results for well-child visits.

Figure 5-7—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34), Observed Rates Compared to ITS Model Projections (Measure 6)

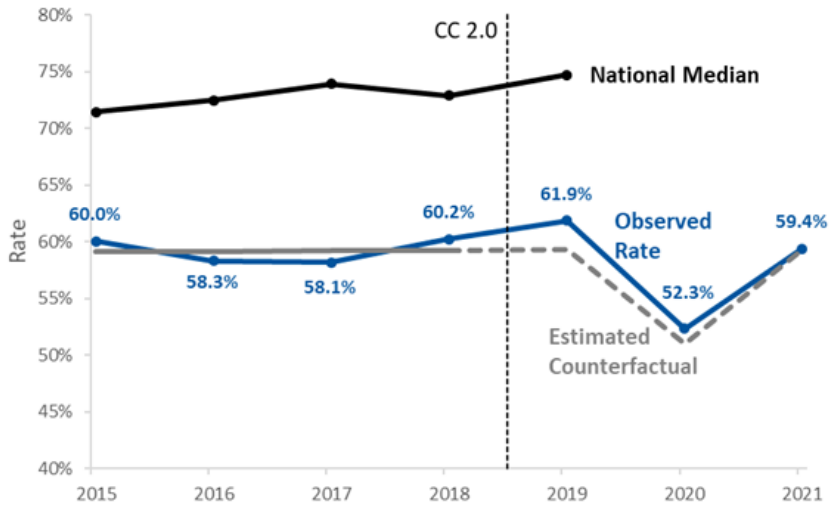


Table 5-8—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34), Primary ITS Model Results[1] (Measure 6)

Variable	Estimate[2]	p-Value
Intercept	59.1%	<0.001***
Pre-CC 2.0 annual trend	0.0p.p.	0.959
Level change at implementation	3.9p.p.	0.250
Change in annual trend	-1.3p.p.	0.375

*p< 0.1, **p < 0.05, ***p<0.001
[1]Note: Full model results are presented in Appendix A.
[2]p.p.=percentage point

Measure 6 Conclusion: Neither supports nor fails to support the hypothesis.

Research Question 2: Does engagement in a health home result in beneficiaries receiving more ambulatory/preventive health services?

Adults' Access to Preventive/Ambulatory Health Services (AAP)—Health Home Population (Measure 4b)

To assess the impact of the Health Home Program on rates of ambulatory/preventive health service visits, DiD analysis was used to evaluate the following measures:

- Adults' access to preventive/ambulatory health services (AAP)
- Children and adolescents' access to primary care practitioners (CAP)

Measures 4b and 5b were evaluated through a DiD analysis. For each evaluation year (2019–2021) the health home intervention group was matched with non-health home members, and baseline rates from 2017 (prior to expansion of the Health Home Program) were used to compare against rates in the evaluation year. Due to changing populations across evaluation years, the number of members included in the baseline period will vary slightly.

Rates of adults' access to preventive ambulatory health services increased significantly for those participating in a health home compared to the change in the non-health home group over the same time period. The change in rates among health home members was approximately 10 percent greater than expected given the change among non-health home members in each evaluation year. Overall, the rate increases ranged from 3.3 percentage points to 5.0 percentage points in the evaluation years for the health home group while the rate decreases ranged from 4.0 percentage points to 6.9 percentage points for the non-health home group (Table 5-9).

Table 5-9—Adults' Access to Preventive/Ambulatory Health Services (AAP)—Health Home Population (Measure 4b)

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change[2]	Health Home Impact (p-Value)
		Baseline	Evaluation		
2019	Health Home	90.0% *N=1,463*	94.9% *N=1,420*	5.0p.p.	9.0p.p. (<0.001)
	Non-Health Home	90.9% *N=1,492*	86.8% *N=1,292*	-4.0p.p.	
2020	Health Home	88.3% *N=1,784*	91.6% *N=1,787*	3.3p.p.	10.2p.p. (<0.001)
	Non-Health Home	89.8% *N=1,769*	82.9% *N=1,732*	-6.9p.p.	
2021	Health Home	89.3% *N=1,774*	93.3% *N=1,878*	3.9p.p.	10.8p.p. (<0.001)
	Non-Health Home	89.6% *N=1,737*	82.7% *N=1,858*	-6.9p.p.	

[1]Note: N represents the denominator count.
[2]p.p.=percentage point

Measure 4b Conclusion: Supports the hypothesis.

Children and Adolescents' Access to Primary Care Practitioners (CAP)—Health Home Population (Measure 5b)

Table 5-10 shows the rate of children and adolescents' access to PCPs increased among health home members compared to the change for the non-health home members between the baseline period and each evaluation year. These differences were significant for the 2020 and 2021 evaluation years. Health home participation impacted the rate by 1.3 percentage points in 2019, but that impact increased to 6.7 percentage points and 6.1 percentage points in 2020 and 2021, respectively. While the rate increases ranged from 1.2 percentage points to 2.8 percentage points between each baseline and evaluation year for the health home group, the decline in the rate of children and adolescents' access to PCPs declined for the non-health home ranged from 0.1 percentage points to 4.6 percentage points each year.

Table 5-10—Children and Adolescents' Access to Primary Care Practitioners (CAP)—Health Home Population (Measure 5b)

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change[2]	Health Home Impact (p-Value)
		Baseline	Evaluation		
2019	Health Home	95.4% *N=710*	96.5% *N=636*	1.2p.p.	1.3p.p. (0.380)
	Non-Health Home	93.9% *N=686*	93.8% *N=564*	-0.1p.p.	
2020	Health Home	95.0%	97.9%	2.8p.p.	6.7p.p.

Evaluation Year	Group	Regression Adjusted Rates Time Period[1] Baseline	Evaluation	Change[2]	Health Home Impact (p-Value)
		N=1,047	*N=944*		(<0.001)
	Non-Health Home	94.9% *N=1,053*	91.0% *N=900*	-3.9p.p.	
2021	Health Home	95.5% *N=1,301*	97.0% *N=1,115*	1.5p.p.	6.1p.p. (<0.001)
	Non-Health Home	93.8% *N=1,324*	89.2% *N=1,056*	-4.6p.p.	

[1]Note: N represents the denominator count. Although CAP was retired in HEDIS MY 2020, all CAP rates are generated using the HEDIS 2020 (MY 2019) specifications.
[2]p.p.=percentage point

Measure 5b Conclusion: Supports the hypothesis.

Hypothesis 4: Engagement in a health home and care coordination support integrative care interventions, which improve quality of care.

To assess the impact of the Health Home Program on quality of care, DiD analysis was used to evaluate the following measures:

- Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)
- Anti-depressant medication management (AMM) Effective Acute Phase Treatment
- Anti-depressant medication management (AMM) Effective Continuation Phase Treatment
- 7-day follow up after hospitalization for mental illness (FUH)
- 30-day follow up after hospitalization for mental illness (FUH)

Measures 7 through 11 were evaluated through a DiD analysis. For each evaluation year (2019–2021) the health home intervention group was matched with non-health home members and baseline rates from 2017 (prior to expansion of the Health Home Program) were used to compare against rates in the evaluation year. Due to changing populations across evaluation years, the number of members included in the baseline period will vary slightly.

Research Question 1: To what extent is health home engagement associated with improved disease management?

Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)—Health Home Population (Measure 7)

No statistically significant differences in the change in rates were observed between the health home and non-health home groups related to diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications. In 2019, rates for the health home group declined by 3.3 percent and increased by 3.0 percent for the non-health home group. Diabetes screening rates for members with schizophrenia or bipolar disorder who are using antipsychotic medications declined from baseline to 2020 for both the health home and non-health home group by 7.4 percentage points and 7.9 percentage points, respectively. Healthcare Effectiveness

Data and Information Set (HEDIS)®[5-2] benchmarks saw a similar decline of 5 percentage points from 2019 to 2020, indicating a possible COVID-19 impact. Rates remained steady between the baseline and evaluation periods for the 2021 health home and non-health home groups (Table 5-11).

Table 5-11—Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (Measure 7)

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change[2]	Health Home Impact (p-Value)
		Baseline	Evaluation		
2019	Health Home	79.8% *N=248*	76.6% *N=299*	-3.3p.p.	-6.3p.p. (0.306)
	Non-Health Home	79.9% *N=164*	82.9% *N=111*	3.0p.p.	
2020	Health Home	81.4% *N=279*	73.9% *N=345*	-7.4p.p.	0.4p.p. (0.876)
	Non-Health Home	83.5% *N=158*	75.7% *N=111*	-7.9p.p.	
2021	Health Home	80.7% *N=270*	81.7% *N=388*	1.0p.p.	1.8p.p. (0.754)
	Non-Health Home	82.7% *N=168*	81.9% *N=105*	-0.8p.p.	

[1]Note: N represents the denominator count.
[2]p.p.=percentage point

Measure 7 Conclusion: Neither supports nor fails to support the hypothesis.

Anti-Depressant Medication Management (AMM) Effective Acute Phase Treatment—Health Home Population (Measure 8)

The change in the percentage from baseline of health home members who remained on an antidepressant medication for at least 84 days was not statistically different from the non-health home group for any of the evaluation years. Table 5-12 show that while rates in 2019 declined for both groups, the health home group rate fell by 0.7 percentage points compared to 6.8 percentage points for the non-health home group. In 2020, the change in rates among health home members was approximately 6.5 percentage points less than expected given the change among non-health home members. The health home group saw a 10.4 percentage point increase from baseline to 2021 while the non-health home group saw an increase of 8.5 percentage points.

Table 5-12—Anti-Depressant Medication Management (AMM) Effective Acute Phase Treatment (Measure 8)

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change[2]	Health Home Impact (p-Value)
		Baseline	Evaluation		
2019	Health Home	41.4% *N=133*	40.6% *N=197*	-0.7p.p.	6.1p.p. (0.498)
	Non-Health Home	45.2% *N=146*	38.4% *N=73*	-6.8p.p.	
2020	Health Home	41.0% *N=173*	42.5% *N=259*	1.4p.p.	-6.5p.p. (0.411)
	Non-Health Home	41.6%	49.5%	7.9p.p.	

5-2 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change[2]	Health Home Impact (p-Value)
		Baseline	Evaluation		
		N=178	*N=103*		
2021	Health Home	41.2% *N=170*	51.6% *N=219*	10.4p.p.	1.9p.p. (0.811)
	Non-Health Home	48.2% *N=166*	56.7% *N=97*	8.5p.p.	

[1]Note: N represents the denominator count.
[2]p.p.=percentage point

Measure 8 Conclusion: Neither supports nor fails to support the hypothesis.

Anti-Depressant Medication Management (AMM) Effective Continuation Phase Treatment – Health Home Population (Measure 9)

Similar to Measure 8, Table 5-13 shows that the change in the percentage of health home members who remained on an antidepressant medication for at least 180 days was not statistically different from the non-health home group for any of the evaluation years. Directionality of the rate change was inconsistent across evaluation years for both groups. The health home group had a decrease in the change in rate in 2019 of 2.2 percentage points from the baseline year before having increases in the change in rates of 1.2 percentage points and 3.4 percentage points in 2020 and 2021 from the baseline, respectively. The non-health home group decreased by 8.9 percentage points and 4.9 percentage points from the baseline in 2019 and 2020, respectively. Rates increased from the baseline by 6.2 percentage points for the non-health home group in 2021.

Table 5-13—Anti-Depressant Medication Management (AMM) Effective Continuation Phase Treatment (Measure 9)

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change[2]	Health Home Impact (p-Value)
		Baseline	Evaluation		
2019	Health Home	24.1% *N=133*	21.8% *N=197*	-2.2p.p.	6.7p.p. (0.416)
	Non-Health Home	29.5% *N=146*	20.5% *N=73*	-8.9p.p.	
2020	Health Home	24.3% *N=173*	25.5% *N=259*	1.2p.p.	6.1p.p. (0.382)
	Non-Health Home	29.2% *N=178*	24.3% *N=103*	-4.9p.p.	
2021	Health Home	27.6% *N=170*	31.1% *N=219*	3.4p.p.	-2.8p.p. (0.685)
	Non-Health Home	24.7% *N=166*	30.9% *N=97*	6.2p.p.	

[1]Note: N represents the denominator count.
[2]p.p.=percentage point

Measure 9 Conclusion: Neither supports nor fails to support the hypothesis.

Research Question 2: Does health home engagement result in increased follow up after hospitalizations for mental illness?

7-Day Follow Up After Hospitalization for Mental Illness (FUH)—Health Home Population (Measure 10)

The rates of 7-day follow up after hospitalizations for mental illness either decreased or remained steady for each evaluation period. Overall, the change in rates among the health home group was higher than the change in rates in the non-health home group. The change in rates among health home members was 4.1 percentage points, 3.0 percentage points, and 4.4 percentage points higher than expected given the change among non-health home members in 2019, 2020, and 2021, respectively; however, these changes were not statistically significant. Although the health home impact is not statistically significant, the impact is positive in all evaluation years and thus weakly supports the hypothesis (Table 5-14).

Table 5-14—7-Day Follow Up After Hospitalizations for Mental Illness (FUH) (Measure 10)

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change[2]	Health Home Impact (p-Value)
		Baseline	Evaluation		
2019	Health Home	41.4% *N=210*	41.1% *N=384*	-0.3p.p.	4.1p.p. (0.587)
	Non-Health Home	32.1% *N=165*	27.7% *N=65*	-4.4p.p.	
2020	Health Home	44.2% *N=258*	39.7% *N=408*	-4.5p.p.	3.0p.p. (0.525)
	Non-Health Home	27.7% *N=191*	20.3% *N=79*	-7.5p.p.	
2021	Health Home	41.6% *N=245*	42.4% *N=484*	0.7p.p.	4.4p.p. (0.581)
	Non-Health Home	37.5% *N=184*	33.8% *N=65*	-3.7p.p.	

[1]Note: N represents the denominator count.
[2]p.p.=percentage point

Measure 10 Conclusion: Weakly supports the hypothesis.

30-Day Follow-Up After Hospitalization for Mental Illness (FUH)—Health Home Population (Measure 11)

Similar to Measure 10, Table 5-15 shows the change in the percentage of health home members with follow up within 30 days after hospitalization for mental illness was not statistically different from the non-health home group for any of the evaluation years. Only the non-health home group in 2019 had an increase in the rate from baseline; all other time periods evaluated for both groups decreased in the rate of 30-day follow-up after hospitalization for mental illness. In 2019, the change in rate was 7.1 percent lower for the health home group and in 2020 and 2021, the change in rate was 5.6 percent and 3.0 percent higher than the non-health home group.

Table 5-15—30-Day Follow Up After Hospitalization for Mental Illness (FUH) (Measure 11)

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change[2]	Health Home Impact (p-Value)
		Baseline	Evaluation		
2019	Health Home	67.6% *N=210*	63.5% *N=384*	-4.1p.p.	-7.1p.p. (0.381)
	Non-Health Home	57.0% *N=165*	60.0% *N=65*	3.0p.p.	
2020	Health Home	69.8% *N=258*	64.5% *N=408*	-5.3p.p.	5.6p.p. (0.517)
	Non-Health Home	47.6% *N=191*	36.7% *N=79*	-10.9p.p.	
2021	Health Home	69.4% *N=245*	65.9% *N=484*	-3.5p.p.	3.0p.p. (0.753)
	Non-Health Home	60.3% *N=184*	53.8% *N=65*	-6.5p.p.	

[1]Note: N represents the denominator count.
[2]p.p.=percentage point

Measure 11 Conclusion: Neither supports nor fails to support the hypothesis.

Hypothesis 5: Expanding member access to preventive care through the Centennial Home Visiting (CHV) Pilot Program and providing incentives through CR will encourage members to engage in preventive care services.

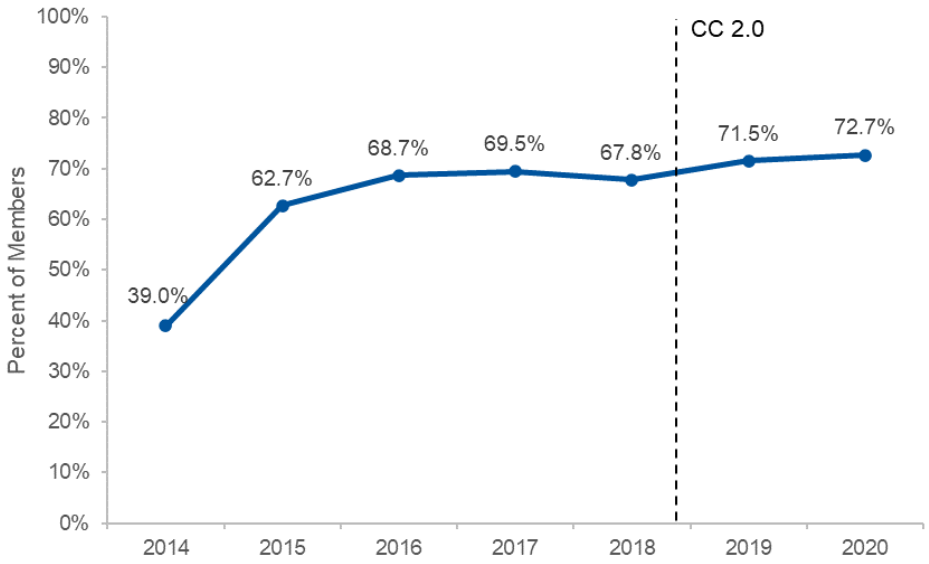
Research Question 1: Has the percentage of Centennial Care members participating in CR increased?

Centennial Rewards (CR) is a rewards program in which all Centennial Care members are enrolled. Participants earn points that can be used to purchase items by completing healthy activities, such as a prenatal care visit, flu shot, or HbA1c test. To participate, members must be engaged through multimedia communications and complete at least one healthy reward activity. To redeem rewards, members must complete a registration process including a health scan; about 30 percent of program participants redeem their rewards. The program was designed to control redemption costs by using gamification and Finity's "Register-to-Redeem" methodology similar to traditional loyalty programs (e.g., airline and credit card points programs.) The program is administered by Finity Communications, Inc.

Percentage of Centennial Care Members Participating in Centennial Rewards (CR) (Measure 12)

One goal of the Demonstration is to provide incentives to members to engage in preventive services by expanding CR participation. Figure 5-8 displays the percentage of Centennial Care members who participated in the CR program (i.e., members who were engaged through multimedia communications and completed at least one healthy reward activity) between 2014 and 2020. Overall, the CR participation rate nearly doubled during this period, increasing from 39.0 percent in 2014 to 72.7 percent in 2020. In addition, since the implementation of Centennial Care 2.0 in 2019, the CR participation rate increased each year, from a baseline rate of 67.8 percent in 2018 to 72.7 percent in 2020. While the CR participation rate increased substantially from 2014 to 2020, there is still room for participation to increase as better contact information becomes available and new reward activities for all members are added to the program.

Figure 5-8—Percentage of Centennial Care Members Participating in Centennial Rewards (CR) (Measure 12) [5-3]



Measure 12 Conclusion: Consistent with hypothesis.

Research Question 2: Are CR incentive-redeeming members likely to receive more preventive/ambulatory services on an annual basis than those who have not redeemed incentives in the 12-month period following the initial redemption?

Percentage of CR Participating Members with an Annual Preventive/Ambulatory Service (Measure 13)

Figure 5-9 and Table 5-16 display the percentage of CR participating members who were engaged in the program and completed a second preventive/ambulatory visit in the 12 months following an initial preventive/ambulatory visit between 2014 and 2020. Two groups are shown for comparison: members who redeemed CR incentives and members who did not redeem CR incentives. An interrupted time series analysis was conducted to test whether the rates changed following the implementation of Centennial Care 2.0 in 2019.

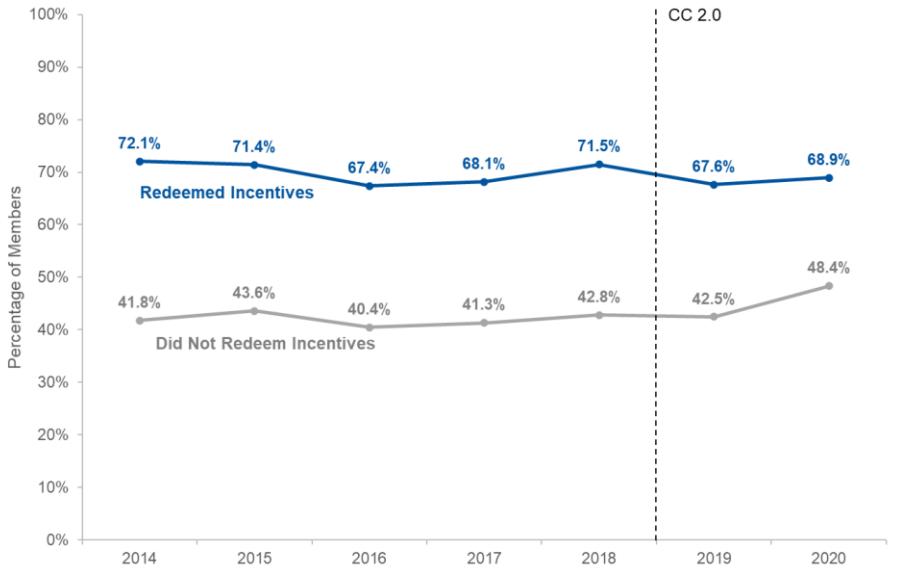
Table 5-16—Percentage of Members With a Second Preventive/Ambulatory Visit, 2014–2020 (Measure 13) [5-4]

Year	Redeemed Incentives	Did Not Redeem Incentives	Difference Between Member Groups[1]
2014	72.1%	41.8%	30.3p.p.
2015	71.4%	43.6%	27.8p.p.
2016	67.4%	40.4%	27.0p.p.
2017	68.1%	41.3%	26.8p.p.
2018	71.5%	42.8%	28.6p.p.
2019	67.6%	42.5%	25.2p.p.
2020	68.9%	48.4%	20.6p.p.

[1]p.p.=percentage points.

Figure 5-9—Preventive/Ambulatory Service Usage by Centennial Rewards Incentive Redemption, 2014–2020

5-3 Rates were provided by Finity Communications, Inc. and have not been independently verified or validated by HSAG.
5-4 Ibid.



Overall, CR incentive-redeeming members were consistently more likely to seek preventive/ambulatory services than members who did not redeem incentives; between 2014 and 2020, the difference between preventive/ambulatory service usage for members who redeemed incentives versus members who did not was 27 percentage points on average. However, since the implementation of Centennial Care 2.0, this gap has narrowed from 30.3 percentage points in 2014 to 20.6 percentage points in 2020. In addition, following the implementation of Centennial Care 2.0 in 2019, the rate of preventive/ambulatory service usage decreased by 4 percentage points for incentive-redeeming members (from 71.5 percent in 2018 to 67.6 percent in 2019) while it increased by 6 percentage points for non-redeeming members (from 42.8 percent in 2018 to 48.4 percent in 2020). Rates in 2020 were impacted by disruptions in access to care caused by the COVID-19 PHE.

Table 5-17—Estimated Difference in Interruption Effect on Treatment and Comparison Groups

	Average Rate 2014–2018	Average Rate 2019–2020	Level Change[1]	Difference in Level Change[1]	Slope Change	Difference in Slope Change
Redeemed Incentives	70.1%	68.3%	-1.1p.p.	-1.6p.p. (p=0.698)	1.7p.p.	-4.2p.p. (p=0.334)
Did not Redeem Incentives	42.0%	45.4%	0.5p.p.		5.9p.p.	

[1]p.p.=percentage points.

The ITS model indicates that, while the immediate effect of the interruption on the incentive redeeming group was a 1.1 percentage point decrease in the level and the long-term effect was a 1.7 percentage point increase in the slope, the differences between the incentive-redeeming group and non-redeeming group level change and slope change were not significantly different (Table 5-17). However, these results may not solely reflect the impact of Centennial Care 2.0 implementation, as rates in 2019 and 2020 were likely impacted by disruptions in access to care caused by the COVID-19 PHE.

Measure 13 Conclusion: Neither supports nor fails to support the hypothesis.

Research Question 3: Does use of CR encourage members to improve their health and make healthy choices?

Percent of CR Users Responding Positively on Satisfaction Survey to Question Regarding if the Program Helped to Improve Their Health and Make Healthy Choices (Measure 14)

Table 5-18 shows the percentage of CR user satisfaction survey respondents who answered yes to the questions, *Has the program helped you improve your health?* and *Do the rewards encourage you to make healthy choices?* Between 2018 and 2020, the percentage of respondents answering yes to these questions remained consistently high at above 90 percent. Because there are limited pre-Centennial Care 2.0 data and no comparison group, the results presented are descriptive in nature and no causal conclusions can be drawn.

Table 5-18—Percentage of Positive Satisfaction Survey Responses of Centennial Rewards Users, 2018–2020[5-5] (Measure 14)

Survey Question	2018	2019	2020
Has the program helped you improve your health?	93.9%	93.7%	93.8%
Do the rewards encourage you to make healthy choices?	96.8%	96.6%	96.6%

Measure 14 Conclusion: Insufficient data to draw a conclusion.

Research Question 4: Is the percentage of babies born with low birth weight (< 2,500 grams) to mothers participating in the Centennial Home Visiting (CHV) Pilot Program lower than the percentage of low-birth-weight babies born to Medicaid mothers who do not participate in the CHV Pilot Program?

Live Births Weighing Less Than 2,500 Grams (Low Birth Weight) (Measure 15)

The Centennial Home Visiting (CHV) Pilot Program was implemented to improve maternal and infant health outcomes. HSAG assessed data provided by the New Mexico Human Services Department (HSD) regarding deliveries among CHV and non-CHV program participants.

Table 5-19 shows the rate of low birthweight babies among CHV and non-CHV participating mothers.[5-6] Since the CHV Pilot Program began in 2019, rates for the CHV group were unavailable in 2018. Statistical analysis was conducted through logistic regression comparing the rate of low birthweight deliveries between CHV and non-CHV members for each year controlling for members' Chronic Illness and Disability Payment System (CDPS) risk scores.

The regression adjusted rate of low-birth weight babies among non-CHV members in 2018 was 4.6 percent but this rate increased to over 6 percent by 2020. Although there were few CHV members in each year, the regression adjusted rate of low birth weight deliveries was nearly triple the non-CHV group in 2019, which was statistically significant at the 0.05 level in 2019. The regression adjusted rates among the CHV group declined considerably throughout the study period, falling from 15.5 percent in 2019 to 4.9 percent in 2021, which was 1.6 percentage points lower than the non-CHV group.

5-5 Rates were provided by Finity Communications, Inc. and have not been independently verified or validated by HSAG

5-6 To control for differences in age and risk profile between the CHV and non-CHV group, statistical testing was conducted using logistic regression controlling for weighted risk score. Reported rates are derived from the model and therefore adjusted for mother's weighted risk score.

Table 5-19—Comparison of Low Birth Weight Deliveries Between CHV and Non-CHV Members

	CHV Members		Non-CHV		
Year	N[1]	Adjusted Rate	N[1]	Adjusted Rate	p-Value
2018	--	--	13,967	4.6%	--
2019	36	15.5%	14,014	5.7%	0.009**
2020	69	9.6%	13,556	6.4%	0.226
2021	72	4.9%	13,102	6.5%	0.553

*p< 0.1, **p < 0.05, ***p<0.001
[1] N represents the denominator count.

Measure 15 Conclusion: Does not support the hypothesis but trending favorably.

Aim Two: Manage the pace at which costs are increasing while sustaining or improving quality, services, and eligibility

Hypothesis 1: Incentivizing hospitals to improve health of members and quality of services and increasing the number of providers with value-based purchasing (VBP) contracts will manage costs while sustaining or improving quality.

Research Question 1: Has the number of providers with VBP contracts increased?

Total Number of Providers with VBP Contracts (Measure 16)

Measure 16 addresses Hypothesis 1 by assessing the number of providers with VBP contracts in the year prior to and the years following the Centennial Care 2.0 implementation. Although this measure does not directly address the hypothesis that costs will be managed or quality will be improved, this serves as a process measure to evaluate whether more providers have VBP contracts (under the implicit assumption that VBP contracts will manage costs or improve quality). For this reason, this measure cannot provide sufficient evidence regarding its support for the hypothesis.

Table 5-20 and Figure 5-10 display the total number of Centennial Care provider groups with VBP contracts between 2018 and 2021 for each managed care organization (MCO) and aggregated program wide. During this period, the number of provider groups with VBP contracts increased for individual MCOs and Centennial Care as a whole. In 2018, prior to the implementation of Centennial Care 2.0, a total of 145 provider groups had VBP contracts, which increased by 170 percent to 392 provider groups in 2021. The largest annual increase in program wide VBP provider groups, 73 percent, occurred between 2018 and 2019.

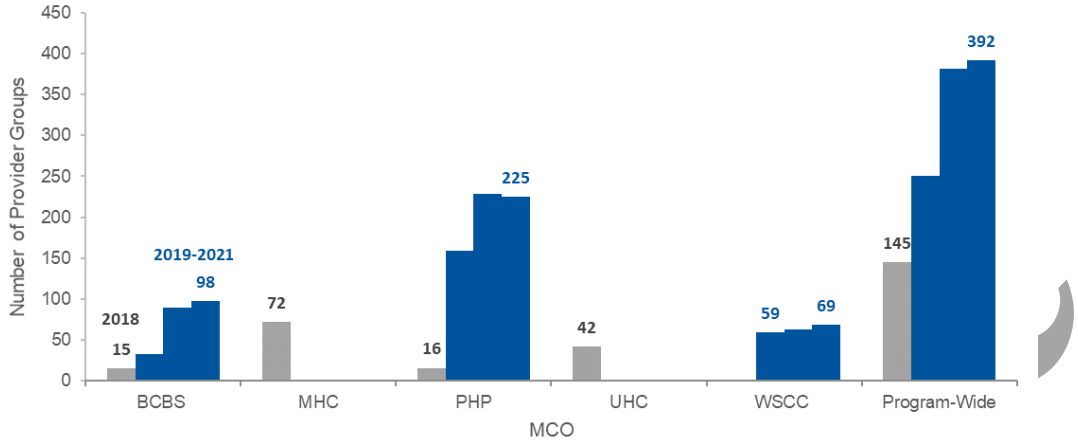
Table 5-20—Number of Provider Groups With VBP Contracts, 2018–2021 (Measure 16)

MCO	2018	2019	2020	2021
Blue Cross Blue Shield (BCBS)	15	33	90	98
Molina Healthcare of New Mexico, Inc. (MHC)	72	--	--	---
Presbyterian Health Plan (PHP)	16	159	228	225
UnitedHealthcare of New Mexico, Inc. (UHC)	42	--	--	-
Western Sky Community Care (WSCC)	--	59	63	69
Program-Wide	**145**	**251**	**381**	**392**

Note: -- is displayed for years in which an MCO was not contracted with Centennial Care.

Figure 5-10—Number of Provider Groups With VBP Contracts, 2018–2021

Blue bars represent years 2019–2021, after the implementation of Centennial Care 2.0.
Gray bars represent baseline values in 2018, prior to the implementation of Centennial Care 2.0.



Measure 16 Conclusion: Consistent with the hypothesis.

Research Question 2: Has the number of providers participating in VBP arrangements, who meet quality metric targets, increased?

Number/Percentage of Providers Meeting Quality Threshold (Measure 17)

Measure 17 assesses the percentage of providers with VBP contracts meeting quality metric targets. Table 5-21 display the percentage of providers with VBP contracts who reported quality metrics and met at least one quality metric target between 2019 and 2021 for each MCO and aggregated program wide. Overall, the percentage of provider groups meeting quality metric targets increased from 84.6 percent in 2019 to 85.7 percent in 2021. While the majority of provider groups met at least one quality metric target in all three years, provider groups across the Centennial Care Program met approximately 50 percent of quality metric targets on average (Table 5-22).

Note that the denominator for Measure 17 was originally intended to be all Centennial Care providers with VBP contracts. However, because not all Centennial Care 2.0-contracted VBP provider groups reported quality metrics, the denominator has been altered to be the total number of VBP provider groups who reported quality metrics in order to more accurately reflect the rate of providers meeting quality metrics. Because there were no data related to meeting quality targets prior to Centennial Care 2.0, results presented are descriptive in nature and no causal conclusions can be drawn.

Table 5-21—Percentage of Provider Groups With VBP Contracts Who Met the Quality Threshold, 2019–2021

MCO	Year	Number of Provider Groups Meeting at Least One Quality Metric Target	Total Number of Provider Groups Reporting Quality Metrics	Percentage
BCBS	2019	21	24	87.5%
	2020	23	27	85.2%
	2021	27	29	93.1%
PHP	2019	101	117	86.3%
	2020	101	124	81.5%
	2021	101	112	90.2%
WSCC	2019	21	28	75.0%
	2020	29	38	76.3%
	2021	34	48	70.8%
Program-Wide	**2019**	**143**	**169**	**84.6%**
	2020	**153**	**189**	**81.0%**
	2021	**162**	**189**	**85.7%**

Note: Only metrics with 10 or more attributed members are included.

Table 5-22—Average Percentage of Quality Metric Targets Met by Provider Groups, 2019–2021

MCO	Year	Average Percentage of Quality Metric Targets Met	Interquartile Range
BCBS	2019	34.5%	38.8%
	2020	33.0%	33.3%
	2021	43.9%	16.7%
PHP	2019	65.4%	50.0%
	2020	43.5%	36.8%
	2021	47.3%	38.1%
WSCC	2019	38.0%	58.9%
	2020	43.5%	70.0%
	2021	35.6%	60.0%
Program-Wide	**2019**	**56.5%**	**75.0%**
	2020	**42.0%**	**40.0%**
	2021	**43.8%**	**38.6%**

Note: Only metrics with 10 or more attributed members are included.

Measure 17 Conclusion: Insufficient data to draw a conclusion.

Research Question 3: Has the amount paid in VBP arrangements increased?

Percentage of Total Payments That Are for Providers in VBP Arrangements (Measure 18)

Table 5-23 shows the amount paid in VBP arrangements between 2017 and 2021 as a total dollar amount and a percentage of total healthcare expenditures, while Figure 5-11 shows the percentage paid in VBP arrangements as a percentage of total healthcare expenditures during the same period. Overall, the percentage of expenditures

attributed to VBP arrangements increased, from about 27 percent prior to the implementation of Centennial Care 2.0 to 62 percent in 2021. BCBS and PHP increased their VBP payments as a percentage of total expenditures during this period by 18 percent and 58 percent, respectively. WSCC's VBP payments declined from 36 percent of total expenditures in 2019 to 31 percent in 2021. While the largest increase in program-wide VBP payments occurred when Centennial Care 2.0 was implemented in 2019 (an increase from 27 percent of total expenditures in 2018 to 48 percent in 2019), VBP payments continued to increase in 2020 and 2021.

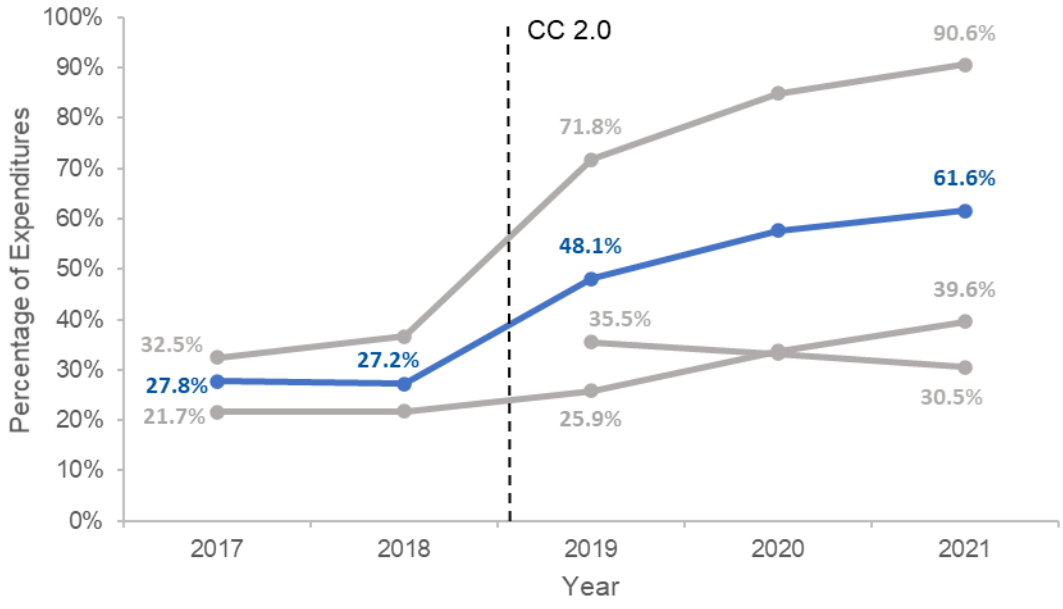
Table 5-23—Amount Paid in VBP Arrangements and Percentage of Total Healthcare Expenditures, 2017–2021 (Measure 18)

MCO	2017	2018	2019	2020	2021
BCBS	$142,867,926 (21.7%)	$155,099,593 (21.7%)	$359,402,770 (25.9%)	$498,356,927 (33.7%)	$555,148,255 (39.6%)
MHC	$154,810,895 (15.1%)	$155,412,079 (15.8%)	--	--	--
PHP	$247,460,730 (32.5%)	$288,290,867 (36.6%)	$1,033,496,822 (71.8%)	$1,347,642,959 (84.8%)	$1,287,303,731 (90.6%)
UHC	$243,629,551 (61.5%)	$150,381,151 (57.1%)	--	--	--
WSCC	--	--	$91,490,320 (35.5%)	$107,256,516 (33.2%)	$102,222,053 (30.5%)
Program-Wide	**$788,769,102 (27.8%)**	**$749,183,690 (27.2%)**	**$1,484,389,913 (48.1%)**	**$1,953,256,402 (57.6%)**	**$1,944,674,039 (61.6%)**

*Note: -- is displayed for years in which an MCO was not contracted with Centennial Care.

Figure 5-11—Percentage of Total Healthcare Expenditures Paid in VBP Arrangements, 2017–2021

The blue line represents the total for all MCOs.
Gray lines represent each individual MCO (only MCOs that contracted through 2021 are displayed).



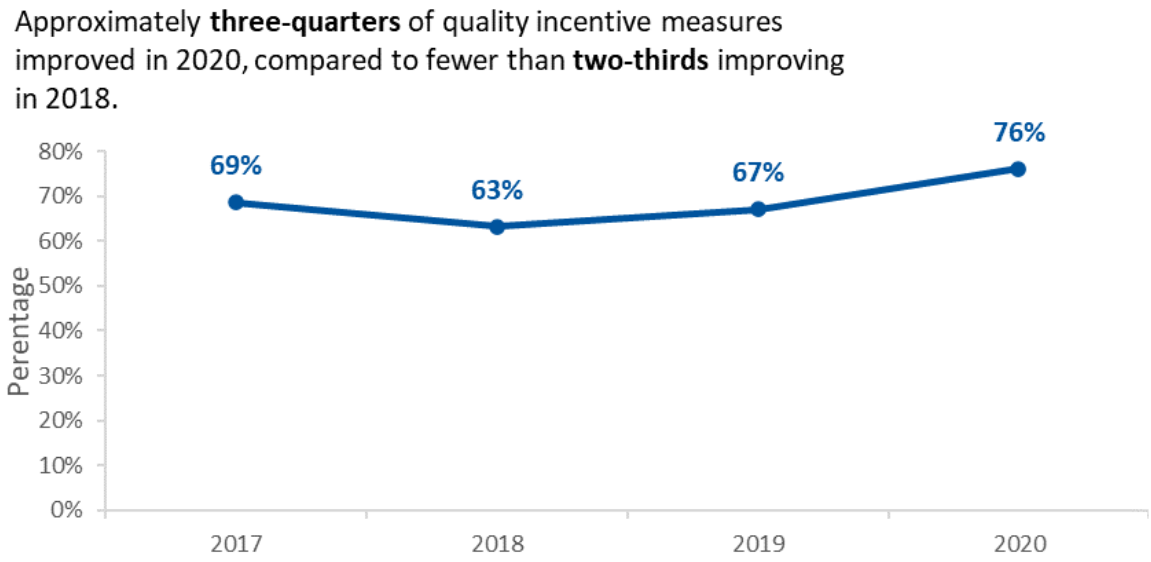
Measure 18 Conclusion: Supports the hypothesis.

Research Question 4: Has reported performance of Domain 1 measures in the Safety Net Care Pool (SNCP) Hospital Quality Improvement Program been maintained or improved?

Percentage of Qualified Domain 1 SNCP Hospital Quality Incentive Measures That Have Maintained or Improved Their Reported Performance Rates Over the Previous Year (Measure 19)

HSAG assessed the percentage of quality incentive measures that improved year-over-year. Data for 2017 through 2020 were supplied, covering two years prior to Centennial Care 2.0 and two years following implementation. Figure 5-12 below shows that the percentage generally increased following the implementation of Centennial Care 2.0 relative to the baseline rates in 2017 and 2018. Because there was no comparison group, results presented are descriptive in nature and neither support nor fail to support the hypothesis.

Figure 5-12—Percentage of Qualified Domain 1 SNCP Hospital Quality Incentive Measures That Have Maintained or Improved Their Reported Performance Rates Over the Previous Year (Measure 19)



Measure 19 Conclusion: Neither supports nor fails to support the hypothesis.

Do cost trends align with expected reimbursement and benefit changes?

The goal of the financial analysis of Centennial Care 2.0 is to compare the costs to the State for the programs covered under the 1115 Demonstration Waiver against the estimated expected costs had the 1115 Demonstration Waiver not been implemented. Expected expenditures were estimated based on changes in member demographics, population health condition-based risk score, and the medical cost price index (CPI).[5-7, 5-8] Total actual expenditure costs for providing care to members covered by the 1115 Demonstration Waiver were compared to the estimated expected expenditures which are calculated by applying annual demographic and

5-7 U.S. Bureau of Labor Statistics. CHRONIC ILLNESS AND DISABILITY PAYMENT SYSTEM (CDPS) Information and Overview. Available at https://www.bls.gov/cpi/tables/supplemental-files/home.htm. CDPS information available at: https://hwsph.ucsd.edu/research/programs-groups/cdps.html#Using-CDPS-Risk-Scores. Accessed on: Jun 9, 2022.

5-8 UC San Diego. Chronic Illness and Disability Payment System (CDPS). Available at: https://hwsph.ucsd.edu/research/programs-groups/cdps.html#Using-CDPS-Risk-Scores. Accessed on July 13, 2022.

inflation factors to the baseline costs for 2013. (See the Financial Analysis Trend and Cost Development Methodology section for additional details on adjustment factor development.) Note that the cost analyses do not refer to nor attempt to replicate the formal Budget Neutrality test required under the Section 1115 Demonstration Waiver program, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved.

Claims cost are calculated and analyzed at two levels:

- Per member per month (PMPM) basis by dividing the total expenditures by the total enrolled members for a given time period.
- Per utilizing member per month (PUMPM) basis which is calculated by dividing the total expenditures by the total members who utilized services during the review period.

Each of these measures is based on expenditures unadjusted for year-to-year demographic changes. Costs are reviewed on a PMPM or PUMPM basis to ensure comparability as the total number of members change over time.

Both unadjusted and adjusted expenditures and expenditure trends were reviewed. Adjustment involved normalizing expenditures to account for known changes such as demographics, health condition-based risk, and inflation. By making these adjustments, all known and quantifiable variations in each analysis period are removed, leading to a more accurate comparison across time periods.

Costs are normalized by dividing the unadjusted cost PMPM by the calculated area, age/gender, and health condition risk factors. Estimated counterfactual costs (estimated expenditures had the Demonstration Waiver not been implemented) were calculated by applying each normalization factor as well as including the annual medical CPI percentage from the U.S. Bureau of Labor Statistics.

To get a better understanding of how costs changed over time, several trend measures were developed.

- **Cumulative Unadjusted Trend from the Baseline:** Represents the total annual growth in the cost of care since 2013. The growth rate is calculated by comparing the annual PMPM for each year of the Demonstration to the 2013 baseline. For example, assume expenditures increased from $100.00 in 2013 to $104.00 in 2014, a trend increase of 4 percent; then to $106.08 from 2014 to 2015, a trend increase of 2 percent; then fell to $105.02 from 2015 and 2016, a trend decrease of 1 percent. The annual changes are multiplied together to determine the total cumulative trend. In this example the cumulative trend would be 5 percent.
- **Annualized Unadjusted Trend from the Baseline:** The average annual growth in cost of care between the baseline (2013) and each year of the Demonstration, adjusted to smooth the trend across the represented time period. (See the Methodology section for additional details.)
- **Annualized Normalized Trend from the Baseline:** Average annual growth in cost of care adjusted for known variances between years based on #2 above.
- **Year-Over-Year Unadjusted Trend:** Annual growth in cost of care from year to year.

Cost Per Member Trend (Measure 20)

The analysis contained here-in is based on the total actual expenditure costs for providing care to members covered by the 1115 Demonstration Waiver compared to the estimated expected expenditures calculated by applying annual demographic and inflation factors to the baseline costs for 2013. (See the Methodology section for additional details on adjustment factor development.) The cost analyses do not refer to nor attempt to replicate

the formal Budget Neutrality test required under the Section 1115 Demonstration Waiver program, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved.

Figure 5-13 displays the PMPM claim/encounter costs and total expenditures from the baseline in 2013 through 2021 for the capitated cost, actual incurred cost and the expected (counterfactual) costs. Both the actual and counterfactual costs and the actual and counterfactual PMPM costs increased from 2013 through 2021. Prior to 2018 the capitation cost is higher for both the PMPM and total expenditure than the actual incurred costs. The difference in the higher capitated costs is being driven by a large capitation rate paid to a single managed care organization that had the majority of the non-acute inpatient members. Beginning in 2018, the managed care organization with the highest capitation rate left the market. Capitation rate data, developed by the state's actuarial partners, utilized by HSAG are based on historical claims with any adjustments based on the expected financial impacts due to policy, provider reimbursement, and benefit changes. Since 2018, the capitation costs have shown minimal variance between the actual and capitated costs thereby suggesting the projected adjustments in the capitation rates have sufficiently accounted for the impact of financial changes due to policy, provider reimbursement, and benefit changes. Starting in 2021, capitation rates were slightly below the actual incurred costs to the MCO's, however, both have been less than the expected costs in the event that Centennial Care had not been implemented, including Centennial Care 2.0. The variance between the actual incurred costs and capitated costs may lead to higher future capitation rate increases. The gap between the actual and expected cost has also narrowed in 2021, however the cost to the State through the capitation arrangement is below both the actual and expected costs. Table A-9 and A-10 contain additional data points for PMPM costs and total costs

Figure 5-13—Per Member Per Month Cost and Total Cost

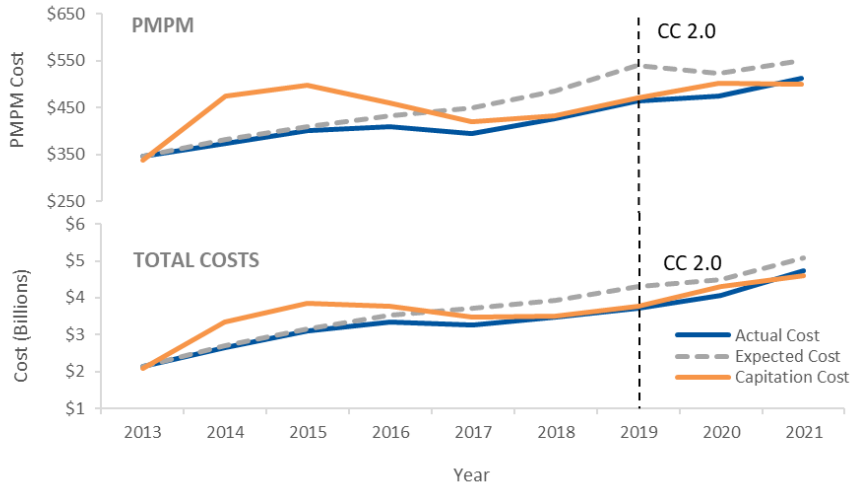
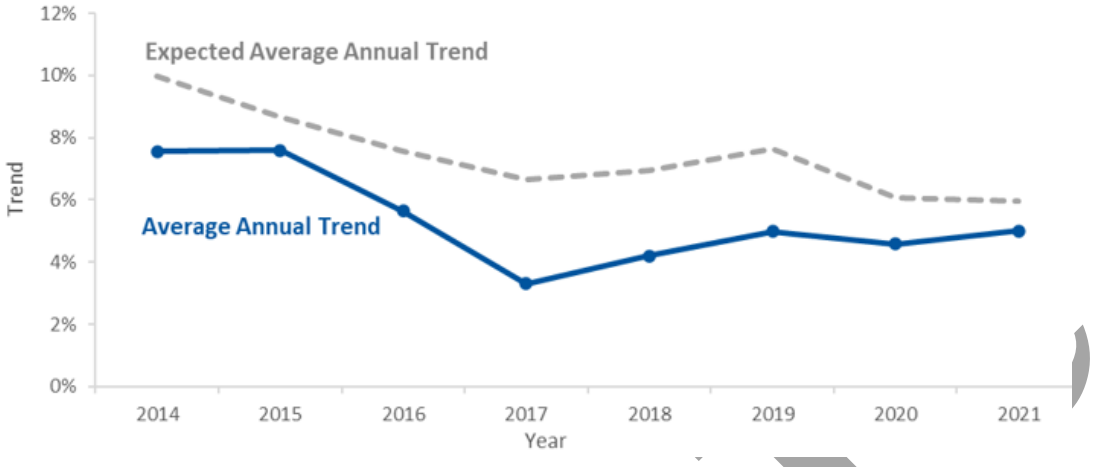


Figure 5-14 shows several trend calculations, based on changes from 2013 (not shown in the figure). The average annualized trend decreased throughout the life of the Centennial Care Demonstration, from the baseline of 7.2 percent to 4.1 percent. The average annualized trend has increased during Centennial Care 2.0, from 4.1 percent at the end of Centennial Care in 2018 to 5.7 percent in 2021 but has decreased from 7.2 percent in 2014.

Figure 5-14—Cost Per Member Trends



Changes to the demographics of the population also impacted the per member trends. With the expansion population growing throughout the Demonstration, the Medicaid program has seen a substantial decrease in the Temporary Assistance for Needy Families (TANF) population as a percentage of the total population. The average age of the TANF population has also increased from 11.4 years in 2013 to 15.4 years in 2021. The average age of the entire enrolled population during 2013 was 21.2 years; as of 2021, the average age has increased to 26.8 years. The growth of the expansion population has also led to a substantial shift in the distribution by population aid category and age. The population also saw an average annual increase in CDPS (version 6.5) condition-based risk scores of 2.5 percent. The member distribution by geographic region did not change substantially from 2013 to 2021.

Based on data from the U.S. Bureau of Labor Statistics, prices for medical care were 23.56 percent higher in 2021 compared to 2013 (a $23.56 difference in value per $100 of spending), indicating a medical care average inflation rate of 2.7 percent per year. The medical care inflation rate was greater than the overall annual inflation rate of 1.9 percent during this same period. The medical CPI is used to account for changes to cost due to inflationary factors. CPI does not account for New Mexico Medicaid-specific policy changes that had a fiscal impact. HSAG is not aware of any policy changes between 2019 and 2021 that had a fiscal impact that would have changed the analysis.

Employing the normalization process as described in the methodology section, factors were developed to quantify the change in risk, age-band/gender, area, and inflation from one Demonstration year to the next. These factors were then applied to the baseline period to calculate the expected average quarterly costs that are displayed in Figure 5-13 and the corresponding expected average quarterly trends in Figure 5-14. Table A-11 contains additional data for cost per member trends.

Table 5-24 shows the impacts of each of the known changes in the cost and demographic variables from 2013 to 2021. The annual impact of each known driver is applied to the PMPM claims cost from the baseline of 2013 to calculate the counterfactual claims PMPM. Both the average annual trend and the expected average annual trend decreased from the baseline period in 2013, to 2021 and the average annual trend is below the expected average annual trend for the same period. The calculated counterfactual claims trend incorporating all known external impacts was 6 percent, comparing this to the annualized paid claims trend of 6.0 percent achieved by the 1115 Demonstration Waiver, the program is currently achieving an estimated savings in claims cost of 0.9 percent, thereby supporting the hypothesis.

Table 5-24—Cost Per Member Trend Normalized Trend Walkdown (Measure 20)

Trend Component	2013 to 2021
Average Annual Normalized Trend	2.7%
Average Annual Aging Trend	0.6%
Average Annual Area Trend	-0.3%
Average Annual Risk Trend	2.5%
CPI Annual Trend 2013-2021	2.7%
Counterfactual Claims Trend	6.0%
Savings Below Expected Counterfactual	0.9%
Annualized Paid Claims Trend	5.0%

Measure 20 Conclusion: Supports the hypothesis.

Cost Per User Trend (Measure 21)

The analysis contained here-in is based on the total actual expenditure costs for providing care to members covered by the 1115 Demonstration Waiver compared to the estimated expected expenditures calculated by applying annual demographic and inflation factors to the baseline costs for 2018. (See the Methodology section for additional details on adjustment factor development.) The cost analyses do not refer to nor attempt to replicate the formal Budget Neutrality test required under the Section 1115 Demonstration Waiver program, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved.

Figure 5-15 displays the PUMPM claims costs and total expenditures from the baseline in 2013 through 2021 for the capitated cost, actual incurred cost and the expected (counterfactual) costs. A utilizing member month is any month in a calendar year during which a member incurred a claim or encounter. Prior to 2018 the capitation cost is higher for both the PMPM and total expenditure than the actual incurred costs. The difference in the higher capitated costs is being driven by a large capitation rate paid to a single managed care organization that had the majority of the non-acute inpatient members. Beginning in 2018, the managed care organization with the highest capitation rate left the market. Capitation rate data, developed by the state's actuarial partners, utilized by HSAG, are based on historical claims with any adjustments based on the expected financial impacts due to policy, provider reimbursement, and benefit changes. Since 2018, the capitation costs have shown minimal variance between the actual and capitated costs thereby suggesting the projected adjustments in the capitation rates have sufficiently accounted for the impact of financial changes due to policy, provider reimbursement, and benefit changes. Given that measure 21 is focused on utilizing members (i.e. members with at least one claim/encounter during the year), actual costs would be expected to be higher than capitated costs due to absence of non-utilizing members in the claims cost per month calculation. The capitation costs have come in lower than the counterfactual costs for 2021 while the actual costs are higher than the counterfactual costs in 2021. Table A-12 and A-13 contain additional data points.

Figure 5-15—Per Utilizing Member Per Month Cost and Total Cost

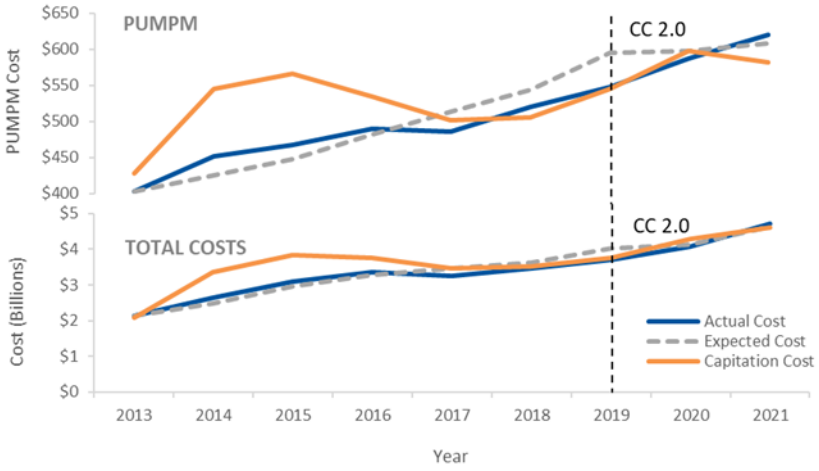
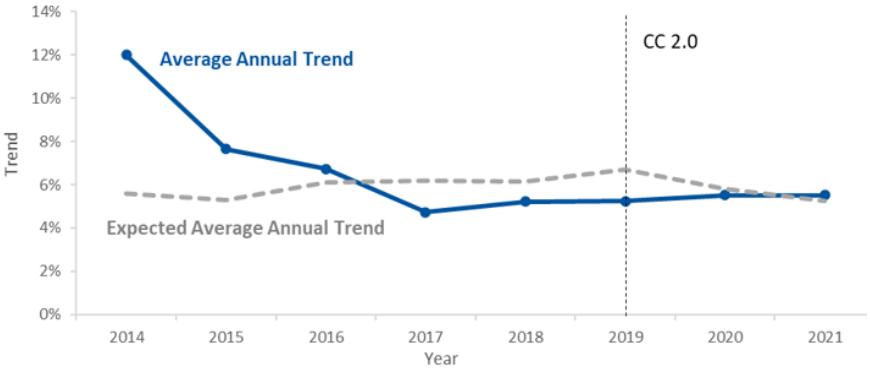


Figure 5-16 shows two trend calculations, based on changes from 2013 (not shown in figure). The average annualized trend decreased throughout the life of the Centennial Care 1.0 Demonstration, from the baseline of 11.6 percent to 5.2 percent. The average annualized trend has increased during Centennial Care 2.0, from 5.2 percent at the end of Centennial Care in 2018 to 5.5 percent in 2021 but has decreased from 11.6 percent in 2014. Table A-14 contains additional data for cost per utilizing member trends.

Figure 5-16—Cost Per Utilizing Member Trends



Changes to the demographics of the population also impacted the per utilizing member trends. The CDPS (version 6.5) condition-based risk score for the utilizing population was substantially higher than the enrolled population throughout calendar year 2014 to 2016 causing the average annual trend to be higher than the expected average annual trend for those years. The growth of the expansion population throughout the Demonstration has led to a substantial shift in the distribution by population aid category and age. The average age of the expansion population for utilizing members decreased from 44.4 in 2014 to 39.1 in 2021. The average age of the entire utilizing population during 2013 was 22.2 years; as of 2021, the average age had increased to 26.9 years. The member distribution by geographic region did not change substantially from 2013 to 2021.

Based on data from the U.S. Bureau of Labor Statistics, prices for medical care were 23.56 percent higher in 2021 compared to 2013 (a $23.56 difference in value per $100 of spending), indicating a medical care average inflation rate of 2.7 percent per year. The medical care inflation rate was greater than the overall annual inflation rate of 1.9

percent during this same period. The medical CPI is used to account for changes to cost due to inflationary factors. CPI does not account for NM Medicaid-specific policy changes that had a fiscal impact. HSAG is not aware of any policy changes between 2019 and 2021 that had a fiscal impact that would have changed the analysis.

Employing the normalization process as described in the methodology section, factors were developed to quantify the change in risk, age-band/gender, area, and inflation from one Demonstration year to the next. These factors were then applied to the baseline period to calculate the expected average quarterly costs that are displayed in Figure 5-15 and the corresponding expected average quarterly trends in Figure 5-16.

Table 5-25 shows the impacts of each of the known changes in the cost and demographic variables from 2013 to 2021. The annual impact of each known driver is applied to the PMPM claims cost from the baseline of 2013 to calculate the counterfactual claims PMPM. Both the average annual trend and the expected average annual trend decreased from the baseline in 2013, to 2021, and the average annual trend was higher than the expected average annual trend for the same period. The calculated counterfactual claims trend incorporating all known external impacts was 5.3 percent. The annualized paid claims trend achieved by the 1115 Demonstration Waiver was higher at 5.5 percent for the utilizing population, thereby this does not support the hypothesis.

Table 5-25—Cost Per User Trend Normalized Trend Walkdown (Measure 21)

Trend Component	2013 to 2021
Average Annual Normalized Trend	3.2%
Average Annual Aging Trend	0.3%
Average Annual Area Trend	0.0%
Average Annual Risk Trend	2.2%
CPI Annual Trend 2013-2021	2.7%
Counterfactual Claims Trend	5.3%
Costs Above Expected Counterfactual	0.2%
Annualized Paid Claims Trend	5.5%

Measure 21 Conclusion: Does not support the hypothesis.

Aim Three: Streamline processes and modernize the Centennial Care health delivery system through use of data, technology, and person-centered care

Hypothesis 1: The Demonstration will relieve administrative burden by implementing a continuous Nursing Facility Level of Care (NFLOC) approval with specific criteria for members whose condition is not expected to change over time.

Research Question 1: Has the number of continuous NFLOC approvals increased during the Demonstration?

Rate of continuous NF LOC approvals per 10,000 Nursing Facility (NF) Members Measure 22)

Rates of continuous NF LOC approvals have increased over time since the implementation of Centennial Care – particularly among Presbyterian Health Plan NF members, as shown below in Figure 5-17.[5-9]

From 2019 to 2021, Presbyterian Health Plan consistently reported the highest rates of NF LOC approvals among NF members. Over that timeframe, the rate steadily increased from 28.4 approvals per 10,000 NF members to 683.6 approvals per 10,000 NF members in Q4 2021. Though also increasing from 2019 to 2021, Blue Cross Blue Shield reported fewer than 57 continuous NF LOC approvals per 10,000 NF members for any given quarter during that period.

Figure 5-17—Number of Continuous NFLOC Approvals

Measure 22 Conclusion: Consistent with the hypothesis

5-9 Note: Data for Presbyterian Health Plan and Blue Cross Blue Shield from 2019-2021 was obtained from a summary report of open ended LTC spans. NF members were limited to those with home and community-based waivers, excluding waivers for medically fragile and developmentally disabled.

Hypothesis 2: The use of technology and continuous quality improvement (CQI) processes align with increased access to services and member satisfaction.

Research Question 1: Has the number of telemedicine providers increased during Centennial Care 2.0?

Number of Telemedicine Providers (Measure 23)

Table 5-26 and Figure 5-18 display the annual number of telemedicine providers between 2013 and 2021. The baseline number of providers from 2013 to 2018, prior to the implementation of Centennial Care 2.0, was 241 per year on average. In 2021 the number of providers was 8,722, suggesting a substantial increase following implementation of Centennial Care 2.0. However, the COVID-19 PHE beginning in 2020 had a substantial impact on the number of providers delivering care through telemedicine that cannot be isolated from the effects of the Demonstration, given the available data. The most accurate estimate of the impact of Centennial Care 2.0, is the number of telemedicine providers in 2019, during the first year of Centennial Care 2.0 and preceding the PHE; that number was 617, a 156 percent increase over the 2013–2018 average and a 55 percent increase over the previous year.

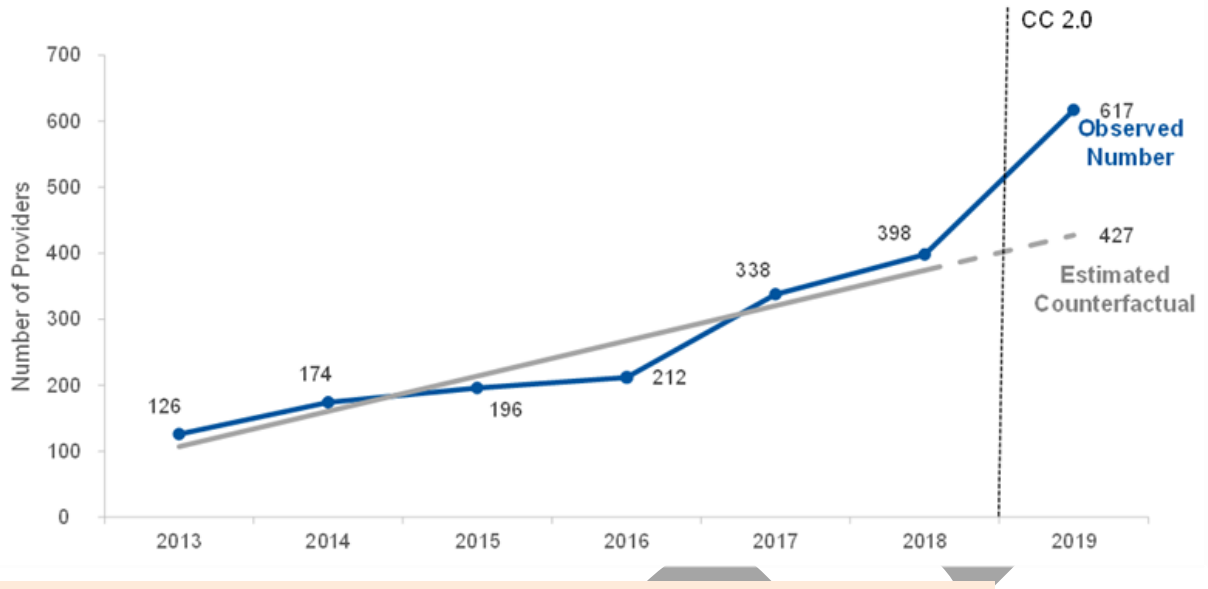
In addition, Table 5-26 shows the percentage difference between the actual and projected (i.e., estimated counterfactual) number of providers using a linear regression model of the baseline (2013–2018), along with the *p*-values associated with hypothesis testing of a difference between the actual and estimated counterfactual. Figure 5-18 shows the estimated counterfactual as a gray line. The 2019 count of providers was 44 percent higher than the estimated counterfactual, indicating an increase that could be due to the Demonstration. After the onset of COVID-19, the numbers of providers in 2020 and 2021 were about 1,800 percent and 1,500 percent higher than predicted, respectively.

Table 5-26—Number of Telemedicine Providers, 2013–2021 (Measure 23)

Year	Number of Providers	Year-Over-Year Change	Projected Number of Providers	Difference Between Actual and Projected (p-Value)
2013	126	--	--	--
2014	174	38%	--	--
2015	196	13%	--	--
2016	212	8%	--	--
2017	338	59%	--	--
2018	398	18%	--	--
2019	617	55%	427	44% (0.016)
2020	9,087	1,373%	481	1,789% (<0.001)
2021	8,722	-4%	534	1,533% (<0.001)

Note: "—" represents numbers that cannot be calculated or are not applicable.

Figure 5-18—Number of Telemedicine Providers, 2013–2021



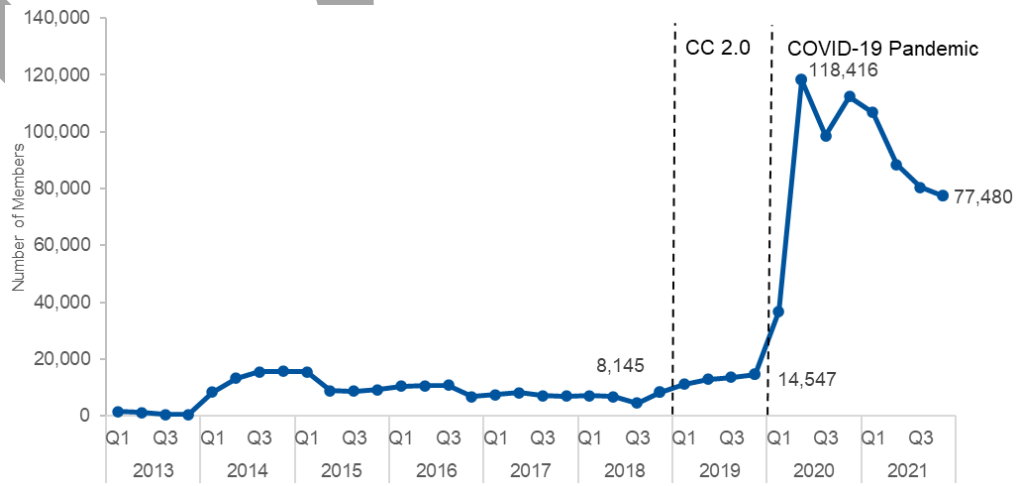
Measure 23 Conclusion: 2019 data are consistent with the hypothesis.

Research Question 2: Has the number of unduplicated members with a telemedicine visit increased during Centennial Care 2.0?

Number of Members Receiving Telemedicine Services (Measure 24)

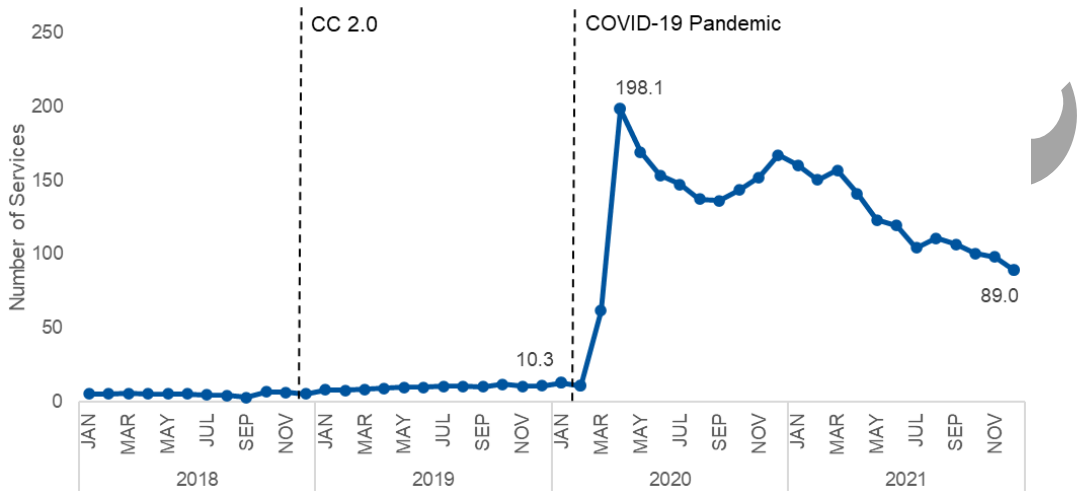
Figure 5-19 displays the quarterly number of members with a telemedicine visit between 2013 and 2021. The baseline number of members from 2013 to 2018, prior to the implementation of Centennial Care 2.0, was 8,109 per quarter on average. In 2019, prior to the start of the COVID-19 PHE, the quarterly average was 13,080 members, a 61 percent increase over the 2013–2018 quarterly average and a 95 percent increase over the 2018 quarterly average.

Figure 5-19—Number of Members With a Telemedicine Visit, 2013–2021



In 2020 and 2021, the total number of members utilizing telemedicine services increased dramatically. The significant growth in the utilization is most likely attributable to the PHE response with an average quarterly increase to approximately 90,000 members in 2020 and 2021. However, telemedicine utilization per thousand members also increased significantly from approximately 10-12 visits per thousand members in January and February 2020 to a peak of approximately 200 visits per thousand members in April 2020 (Figure 5-20), which suggests an increase in the proportion of members utilizing telemedicine services. By the end of 2021, utilization had decreased to approximately 100 visits per thousand members, still up significantly from pre-COVID levels.

Figure 5-20—Monthly Utilization of Telemedicine Services per 1,000 Members, 2018–2021



Measure 24 Conclusion: 2019 data are consistent with the hypothesis.

Research Question 3: Has member satisfaction increased during Centennial Care 2.0?

Consumer Assessment of Healthcare Providers and Systems (CAHPS)®[5-10] Health Plan Surveys are a set of standardized surveys that assess beneficiary experience with care. CAHPS surveys were administered by each MCO annually. To accurately evaluate changes in member experience following the implementation of Centennial Care 2.0, HSAG applied the results from each report to the previous year (e.g., 2019 member experience is reflected in the 2020 CAHPS report). HSAG used the results from these surveys to analyze three measures: member rating of health care, member rating of health plan, and member rating of personal doctor. Table 5-27 shows the positive responses for adult and pediatric members statewide for the three CAHPS survey questions analyzed. Statewide rates were calculated by weighting plan-specific rates by total enrollment each year. MCO-specific results are presented in the Appendix A for BCBS and PHP. As shown in Table 5-27, prior to the introduction of Centennial Care 2.0 in 2019, statewide rates remained relatively consistent across the three measures for adults and children, with satisfaction among children being higher than satisfaction among adults. BCBS and PHP rates, shown in the Appendix A (Table A-15 and A-16), followed a similar pattern.

5-10 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 5-27—Statewide Rates for CAHPS Survey Questions

	2014	2015	2016	2017	2018	2019	2019 Trend Model[1] Predicted	(P-value)
Member rating of health care (measure 25)								
Adult	73.8%	76.6%	72.8%	74.7%	71.0%	77.5%	71.9%	(0.008)
Child	85.4%	84.5%	86.6%	84.9%	84.8%	88.0%	85.1%	(0.254)
Member rating of health plan (measure 26)								
Adult	77.0%	79.5%	76.8%	76.4%	77.1%	78.2%	76.5%	(0.267)
Child	87.4%	86.5%	88.3%	86.6%	87.0%	87.2%	86.8%	(0.579)
Member rating of personal doctor (measure 27)								
Adult	81.5%	81.3%	81.5%	80.9%	80.9%	84.6%	80.5%	(0.103)
Child	87.3%	87.7%	89.7%	90.1%	89.3%	90.8%	90.7%	(0.845)

Note: Rates are provided by the MCOs and have not been independently validated by HSAG.
To accurately evaluate changes in member experience following the implementation of CC 2.0, HSAG applied the results from each report to the previous year (e.g., 2019 member experience is reflected in the 2020 CAHPS report).

[1]Actual vs projected shows the difference between observed rates during the evaluation period compared to the projected rate had the baseline trend continued.

Member Rating of Healthcare (Measure 25)

After the introduction of Centennial Care 2.0, member rating of health care increased across both the adult and child populations. As displayed in Table 5-27, adult members' rating of health care significantly increased from 71.0 percent in 2018 to 77.5 percent in 2019, 5.6 percentage points higher than the predicted value if the trend in the baseline period had continued. Pediatric member rating of health care also increased in 2019 compared to 2018 to 88.0 percent, 2.9 percentage points higher than the predicted value.

Measure 25 Conclusion: Supports the hypothesis.

Member Rating of Health Plan (Measure 26)

Member rating of health plan for adult and pediatric members also increased in 2019 after the introduction of Centennial Care 2.0. For both adult and pediatric members, the 2019 actual value was about 1 to 2 percentage points higher than the predicted value if the trend in the baseline period had continued as seen in Table 5-27.

Measure 26 Conclusion: Neither supports nor fails to support the hypothesis.

Member Rating of Personal Doctor (Measure 27)

Member rating of personal doctor for both adult and pediatric members increased in 2019 after the introduction of Centennial Care 2.0. As displayed in Table 5-27, adult members' satisfaction with their personal doctor increased from 80.9 percent in 2018 to 84.6 in 2019, greater than 4 percentage points higher than the expected value. The

rating of children's personal doctor remained relatively similar, increasing from 89.3 percent in 2018 to 90.8 percent in 2019, 0.1 percentage points higher than the expected value if the baseline trend had continued.

Measure 27 Conclusion: Neither supports nor fails to support the hypothesis.

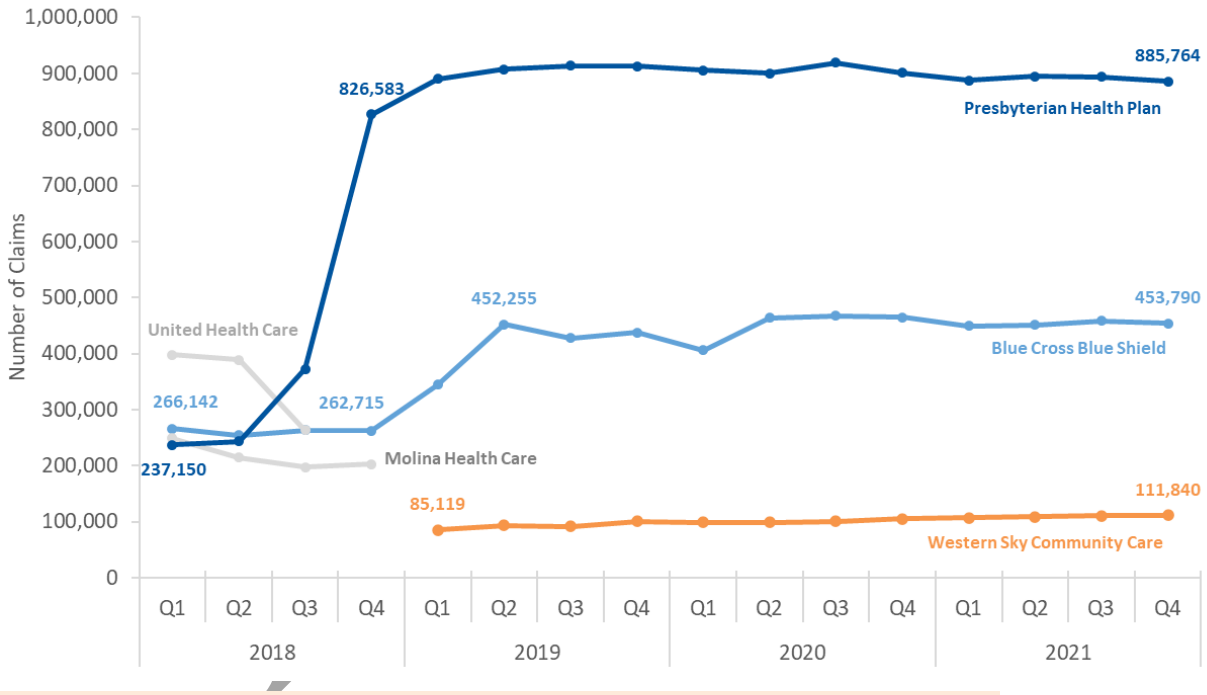
Hypothesis 3: Implementation of electronic visit verification (EVV) is associated with increased accuracy in reporting services rendered.

Research Question 1: Has the number of claims submitted through EVV increased?

Number of Submitted Claims Through EVV (Measure 28)

Figure 5-21 displays the number of claims submitted through EVV between 2018 and 2021 for each MCO. During this time period, PHP submitted the highest number of claims through EVV, beginning with 237,150 and 243,417 claims in quarter 1 (Q1) and Q2 2018 and jumping to 890, 451 claims in Q1 2019. BCBS experienced a similar increase from 262,715 claims in Q4 2018 and reaching 452,255 claims by Q2 2019. The number of claims submitted through EVV increased slightly from 85,119 claims in 2019 to 111,840 claims in 2021 for WSCC.

Figure 5-21—Number of Submitted Claims Through EVV (Measure 28)



Measure 28 Conclusion: Consistent with the hypothesis.

Research Question 2: Has the proportion of paid or unpaid hours retrieved due to false reporting decreased?

Percentage of Paid or Unpaid Hours Retrieved Due to False Reporting (Measure 29)

No plan reported having paid or unpaid hours for this measure, excluding PHP, which reported 86, 168, and 112 paid or unpaid hours retrieved due to false reporting for Q1 through Q3 2020, respectively. Because there were no data prior to Centennial Care 2.0 and limited data during the evaluation period with a high prevalence of zero

hours reported, results are descriptive in nature and cannot provide causal conclusions regarding hypothesis support.

Measure 29 Conclusion: Insufficient data to draw a conclusion.

Aim Four: Improved quality of care and outcomes for Medicaid beneficiaries With a SUD

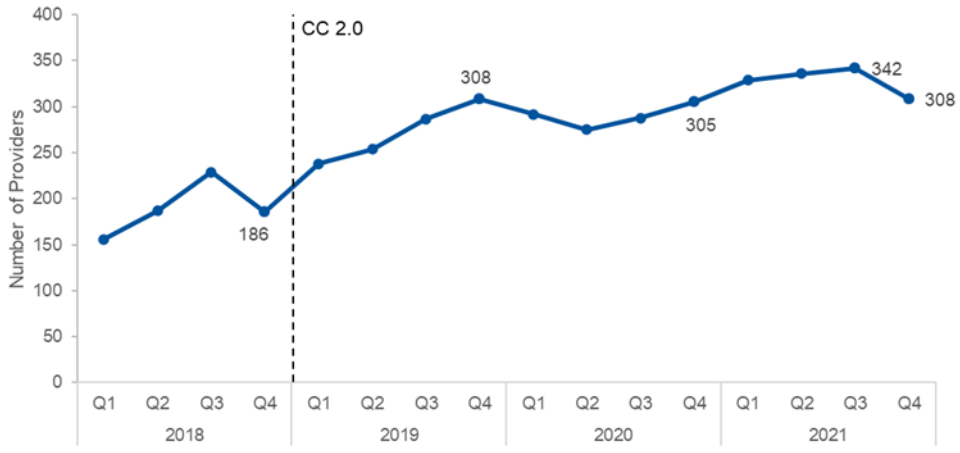
Hypothesis 1: The Demonstration will increase the number of providers that provide substance use disorder (SUD) screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for alcohol and other drug (AOD) dependence treatment.

Research Question 1: Did the number of behavioral health and physical health providers who screen beneficiaries for SUD increase?

Number of Providers Who Provide SUD Screening (Measure 30)

Figure 5-22 displays the quarterly number of Centennial Care providers who provided SUD screening between 2018 and 2021. Providers for this measure were identified using claims/encounter data. Overall, the quarterly average number of providers increased 73 percent during Centennial Care 2.0, from 190 providers per quarter in 2018 (prior to the Demonstration) to 329 providers per quarter in 2021. However, after reaching a peak of 342 providers in 2021 Q3, the number of providers decreased to 308 in Q4 2021. This decline may be due to insufficient data runout for Q4 but should be monitored to assess if the trend continues into 2022.

Figure 5-22—Quarterly Number of Providers Who Provided SUD Screening, 2018–2021



Measure 30 Conclusion: Supports the hypothesis.

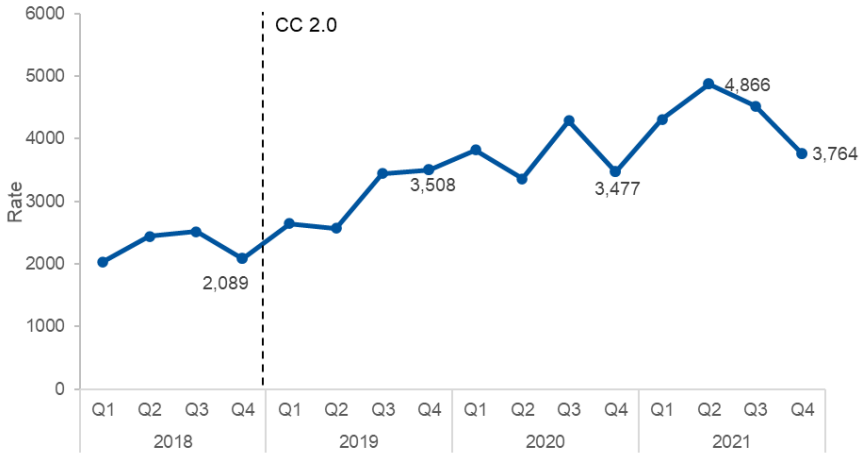
Research Question 2: Did the number of individuals screened for SUD increase?

Number of Individuals Screened for SUD (Measure 31)

Figure 5-23 displays the quarterly number of Centennial Care members who were screened for SUD between 2018 and 2021. Members for this measure were identified using claims/encounter data. Overall, the quarterly average number of members increased 92 percent during Centennial Care 2.0, from an average of 2,270 members

per quarter in 2018 (prior to the Demonstration) to 4,367 members per quarter in 2021. However, after reaching a peak of 4,866 total members in Q2 2021, the number of members decreased each quarter to 3,764 in Q4 2021. This decline may be due to in part to a resurgence of the COVID-19 PHE in the second half of 2021, and/or incomplete Q4 data and should be monitored to assess if the trend continues into 2022 with additional data run-out.

Figure 5-23—Quarterly Number of Members Screened for SUD, 2018–2021



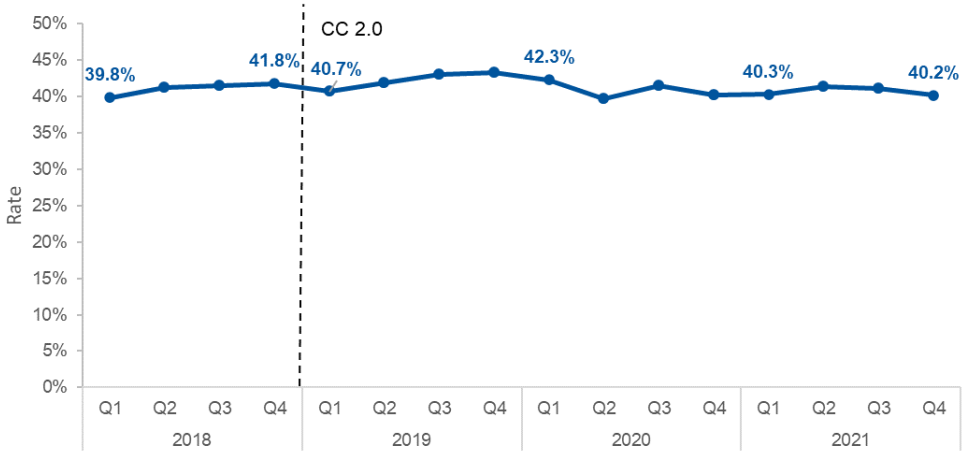
Measure 31 Conclusion: Supports the hypothesis.

Research Question 3: Has the percentage of individuals with a SUD who received any SUD related service increased?

Percentage of Individuals with a SUD Diagnosis Who Received Any SUD Service During the Measurement Year (Measure 32)

Measure 32 assesses the percentage of individuals with a SUD who received any SUD-related service using claims/encounter data. Figure 5-24 displays that this percentage remained steady each quarter between 2018 and 2021. There was no appreciable increase in the percentage of members with a SUD diagnosis receiving SUD services following the implementation of Centennial Care 2.0 in 2019.

Figure 5-24—Percentage of Members Diagnosed With a SUD Who Received SUD Services, 2018–2021



Measure 32 Conclusion: Does not support the hypothesis.

Research Question 4: Did the percentage of individuals who initiated AOD abuse and dependence treatment increase?

Initiation of AOD Abuse or Dependence Treatment (IET) (Measure 33)

Measure 33 uses claims/encounter data to assess the percentage of individuals initiating AOD abuse or dependence treatment through a comparison of projected rates covering a two-year baseline period (2017–2018) to each evaluation year (2019–2021).[5-11]

Figure 5-25 and Table 5-28 show that the observed rates fell below the projected rates had the baseline trend continued into the Centennial Care 2.0 Demonstration period. This difference was statistically significant as shown by the small p-values (e.g., all below 0.05) in Table 5-28. This is primarily driven by a short baseline period within which to estimate a counterfactual trend, with an increase in rates between 2017 and 2018, which led to estimated counterfactual rates that are likely too high. The national median as illustrated by the black line in Figure 5-25 showed a very similar pattern and supports the hypothesis of an inflated estimated counterfactual. While these findings suggest that rates during Centennial Care 2.0 fell below what was expected, the Centennial Care 2.0 rates tracked alongside national trends.

5-11 Technical specifications for measure calculation cover a measurement period of one year; as such quarterly rates to support an interrupted time series analysis could not be calculated in a manner to compare against national benchmarks.

Figure 5-25—Initiation of AOD Abuse or Dependence Treatment (IET) (Measure 33)

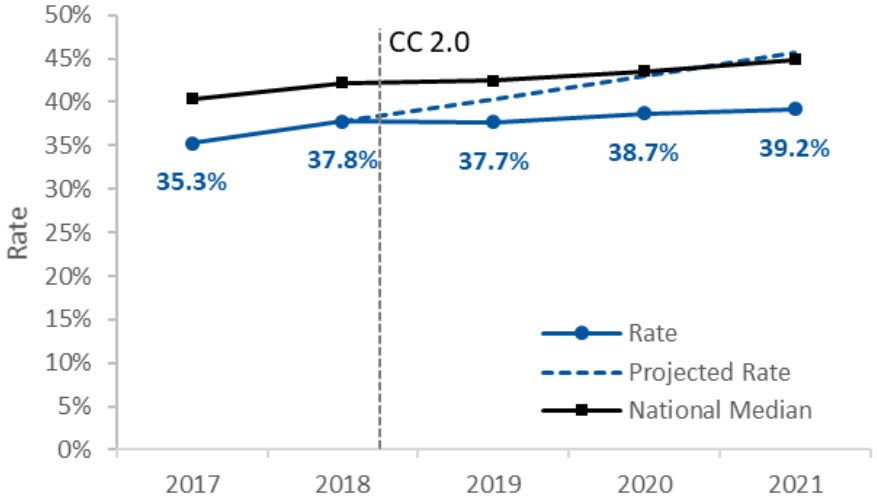


Table 5-28—Initiation of AOD Abuse or Dependence Treatment (IET) (Measure 33)

Year	Denominator	Rate	Projected Rate	p-Value
2017	27,850	35.3%	--	--
2018	26,706	37.8%	--	--
2019	27,596	37.7%	40.4%	<0.001
2020	27,411	38.7%	43.0%	<0.001
2021	31,241	39.2%	45.7%	<0.001

Note: "—" represents numbers that cannot not calculated or are not applicable.

Measure 33 Conclusion: Does not support the hypothesis but trending favorably.

Hypothesis 2: The Demonstration will increase peer support services which will result in more individuals engaging in and retained in AOD abuse and dependence treatment.

Four measures were calculated using claims/encounter data to assess whether peer support services increased the number of individuals engaging and remaining in AOD abuse and dependence treatment. One measure used an ITS approach (Measure 34) and three were evaluated using a DiD approach (Measures 35, 36, and 37).

The DiD approach compared the change in rates among a group receiving peer support services against those not receiving peer support services. Baseline rates from 2018 (prior to the Centennial Care 2.0 Demonstration) were used to compare against rates in the evaluation year. Due to changing populations across evaluation year, the number of members included in the baseline period will vary slightly. To control for systematic differences in profiles between the two groups, HSAG controlled for members' baseline risk score in the DiD models.

Research Question 1: Has the percentage of individuals with a SUD diagnosis who received peer support services increased?

Percentage of Individuals with a SUD Diagnosis Who Received Peer Support (Measure 34)

Figure 5-26 compares the observed rate to the estimated counterfactual rate (the rate in the absence of the SUD elements of Centennial Care 2.0) from an interrupted time series analysis controlling for seasonality and peak COVID-19-affected quarters (Q2 2020 through Q1 2021). The dotted gray line represents the estimated

counterfactual had Centennial Care 2.0 not been implemented. The interrupted time series analysis also produces predicted results for the post-intervention period, which are not shown on Figure 5-26, but are discussed below in Table 5-29.

Figure 5-26—Percentage of Individuals With a SUD Diagnosis who Received Peer Support, Observed Rates Compared to ITS Model Projections (Measure 34)

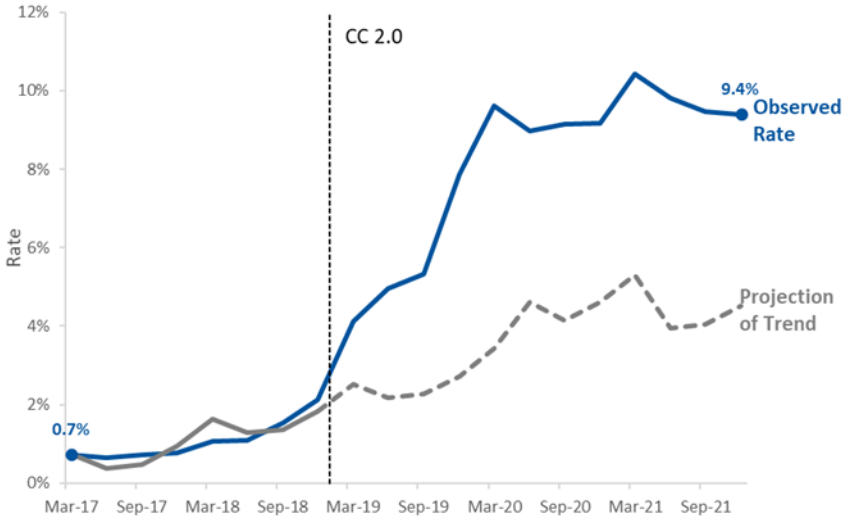


Table 5-29 presents key statistical results from the interrupted time series analysis after accounting for the trends during the baseline and evaluation periods, seasonality, and the peak COVID-19-affected quarters (full model results can be found in Appendix A). The results show that the percentage of individuals with a SUD diagnosis who received peer support increased significantly by 2.8 percentage points upon implementation of Centennial Care 2.0 in Q1 2019. While the trend in the rate increased by 0.3 percentage points per quarter following the implementation of Centennial Care 2.0 relative to the trend in the baseline period, this difference was not statistically significant. The results are consistent with a small but significant increase in the percentage of individuals with a SUD diagnosis receiving peer support occurring shortly after the implementation of Centennial Care 2.0; however, outside of that jump in rate in Q1 2019, the broader trend in the measure did not change significantly. Table A-17 and A-18 contain additional regression results.

Table 5-29—Percentage of Individuals With a SUD Diagnosis Who Received Peer Support, Primary ITS Results[1]

Variable	Estimate[2]	p-Value
Intercept	0.7%	0.317
Pre-CC 2.0 quarterly trend	0.2p.p.	0.199
Level change at implementation	2.8 p.p.	0.014**
Change in quarterly trend	0.3 p.p.	0.169

*p< 0.1, **p < 0.05, ***p<0.001
[1]Note: Full model results are presented in Appendix A.
[2]p.p.=percentage point.

Measure 34 Conclusion: Supports the hypothesis.

Research Question 2: Does receiving peer support increase the percentage of individuals engaged in AOD abuse and dependence treatment?

Engagement of AOD Abuse or Dependence Treatment (IET) (Measure 35)

Measure 35 was evaluated using a DiD model to compare changes in rates between the baseline period (2018) and each evaluation year among a peer support group and non-peer support group.

As displayed in Table 5-30, the rate of individuals receiving peer support and engaging in AOD abuse and dependence treatment increased by over 7 percentage points relative to the comparison group in each evaluation year. These increases were statistically significant at the 0.05 level. These results demonstrate that individuals receiving peer support had a significantly higher likelihood of engaging in AOD abuse and dependence treatment in each demonstration year compared to those not receiving peer support services. Moreover, these results represent meaningful changes, from approximately 23 percent to over 26 percent in each year, an equivalent change from the 90th national percentile to over the 95th percentile. The rates for the peer support group in each evaluation year are approximately double that of the non-peer support group, after controlling for differences in members' baseline risk scores.

Table 5-30—Engagement of AOD Abuse or Dependence Treatment (IET) (Measure 35)

		Regression Adjusted Rates			
		Time Period[1]			Peer Support Impact
Evaluation Year	Group	Baseline	Evaluation	Change[2]	(p-Value)
2019	Peer Support	23.5% *N=231*	32.9% *N=692*	9.3p.p.	11.2 p.p. (0.002)
	Non-Peer Support	17.5% *N=26,475*	15.6% *N=25,690*	-1.8 p.p.	
2020	Peer Support	23.0% *N=231*	27.3% *N=860*	4.2 p.p.	7.0 p.p. (0.025)
	Non-Peer Support	17.2% *N=26,475*	14.4% *N=22,599*	-2.8 p.p.	
2021	Peer Support	23.4% *N=231*	26.8% *N=1,377*	3.4 p.p.	7.3 p.p. (0.010)
	Non-Peer Support	17.4% *N=26,475*	13.5% *N=23,595*	-3.9 p.p.	

[1]Note: N represents the denominator count.
[2]p.p.=percentage point

Measure 35 Conclusion: Supports the hypothesis.

Research Question 3: Does receiving peer support increase the treatment tenure for individuals receiving AOD abuse and dependence treatment?

Average Length of Stay (ALOS) (Measure 36)

Members in AOD abuse and dependence treatment receiving peer support had a longer tenure of treatment than members not receiving peer support, even after controlling for differences in risk score at baseline. However, this effect appeared to decrease over time as displayed in Table 5-31. For the 2019 evaluation group, peer support members increased their average treatment tenure by 119 days between the baseline and evaluation year relative to the non-peer support comparison group. Although this effect decreased for the 2020 evaluation group, the estimated impact of 38 days remained statistically significant. For the 2021 evaluation group, members receiving

peer support increased treatment tenure by 19 days between the baseline and evaluation year relative to the comparison group; however, this impact was not statistically significant at a standard level.

Table 5-31—Average Length of Stay (Days) (Measure 36)

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change	Peer Support Impact (p-Value)
		Baseline	Evaluation		
2019	Peer Support	232 *N=135*	341 *N=460*	109	119 (<0.001)
	Non-Peer Support	94 *N=12,285*	85 *N=11,856*	-10	
2020	Peer Support	230 *N=135*	250 *N=960*	19	38 (<0.001)
	Non-Peer Support	93 *N=12,285*	75 *N=11,636*	-18	
2021	Peer Support	230 *N=135*	232 *N=1,076*	2	19 (0.100)
	Non-Peer Support	93 *N=12,285*	76 *N=11,694*	-17	

[1]Note: N represents the denominator count.

Measure 36 Conclusion: Supports the hypothesis.

Research Question 4: Does receiving peer support increase the treatment tenure for medication assisted treatment (MAT) for opioid use disorder (OUD)?

Continuity of Pharmacotherapy for OUD (Measure 37)

Analysis of Measure 37 utilizing claims/encounter data shows that after Centennial Care 2.0, the percentage of members with continuity of pharmacotherapy for OUD increased significantly among the peer support group compared to the change in the comparison group over the same time period as displayed in Table 5-32. Between the baseline period and each evaluation year, the peer support group increased by 17.7 percent to 22.5 percent, while the non-peer support comparison group remained relatively unchanged after controlling for members' baseline risk scores. These differences are statistically significant at the 0.05 level.

Table 5-32—Continuity of Pharmacotherapy for OUD (Measure 37)

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change[2]	Peer Support Impact (p-Value)
		Baseline	Evaluation		
2019	Peer Support	20.9% *N=51*	38.6% *N=361*	17.7p.p.	17.4p.p. (0.022)
	Non-Peer Support	27.3% *N=11,196*	27.6% *N=11,937*	0.3p.p.	
2020	Peer Support	19.1% *N=51*	41.6% *N=2,130*	22.5p.p.	22.9p.p. (0.002)
	Non-Peer Support	25.9% *N=11,196*	25.5% *N=11,402*	-0.5p.p.	
2021	Peer Support	18.8% *N=51*	38.2% *N=4,028*	19.5p.p.	19.9p.p. (0.005)
	Non-Peer Support	25.6% *N=11,196*	25.2% *N=10,395*	-0.4p.p.	

Evaluation Year	Group	Regression Adjusted Rates			
		Time Period[1]		Change[2]	Peer Support Impact (p-Value)
		Baseline	Evaluation		

[1]Note: N represents the denominator count.
[2]p.p.=percentage point

Measure 37 Conclusion: Supports the hypothesis.

Hypothesis 3: The Demonstration will improve access to a comprehensive continuum of SUD care which will result in decreased utilization of ED and inpatient hospitalization and SUD inpatient readmissions.

Research Question 1: Has the continuum of services available for individuals with a SUD expanded in terms of which services are available?

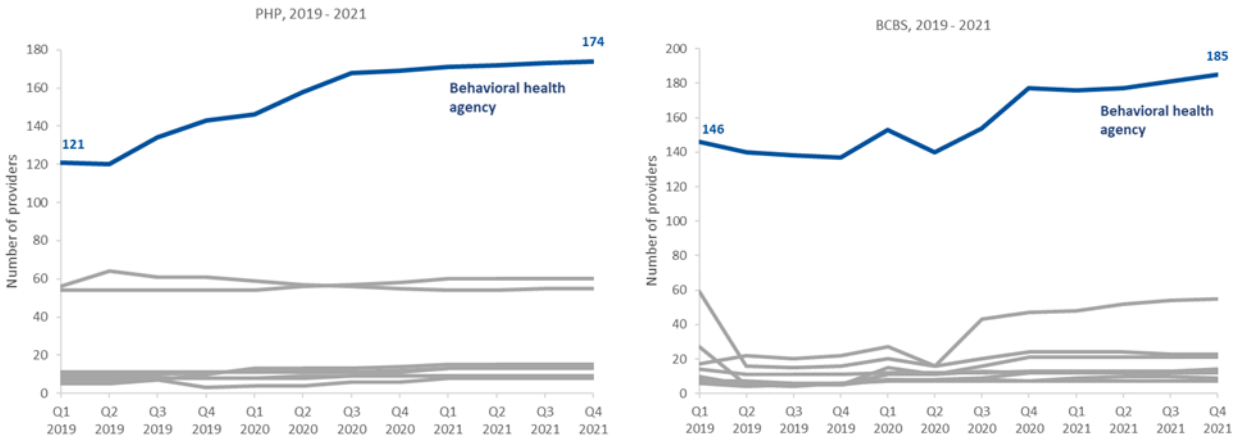
Continuum of Services Available (Measure 38)

This measure aims to answer the question of whether the continuum of services available for individuals with a SUD has expanded in terms of which services are available using MCO reports. Data for this measure were reported by individual MCOs (BCBS, PHP, and WSCC). Only data post-Centennial Care 2.0 was available and therefore a comparison of facilities and services post-Centennial Care 2.0 to pre-Centennial Care 2.0 nor a definitive conclusion on whether there was an expansion of services as a result of the demonstration can be made. However, there are some notable trends in the number of providers reported by facility type as displayed in Table 5-33.

Table 5-33—Number of Providers Reported Across All MCOs During Q4 2021

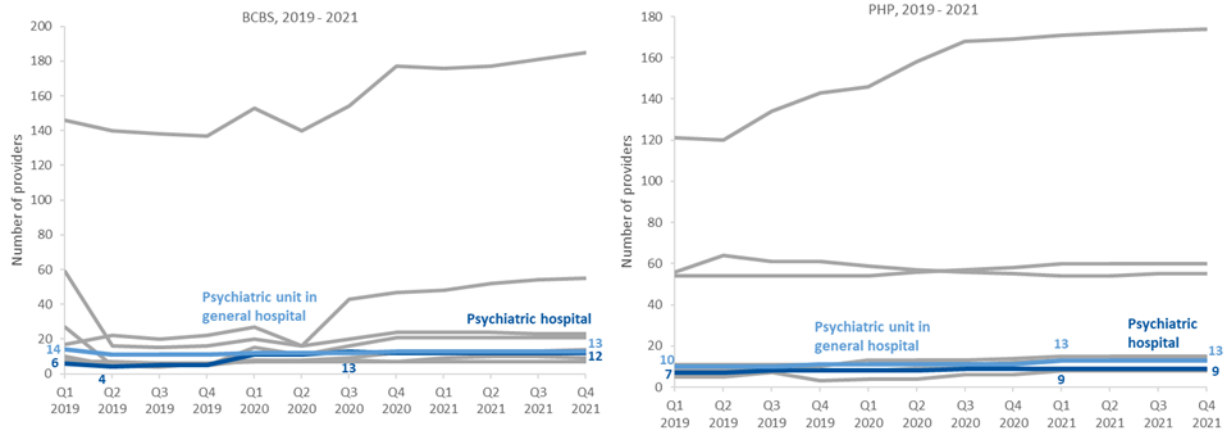
Facility Type	Number of Providers
Accredited Residential Facility (ARTC) - Juvenile, BH	24
Accredited Residential Facility (ARTC) - Adult, SUD	15
Behavioral Health Agency	553
Community Mental Health Center	36
Core Service Agency (CSA)	97
FQHC/RHC providing BH Services	250
Hospital, Psychiatric	28
Hospital, Psychiatric Unit in General Hospital	31
IHS or 638 Tribal Facility providing BH Services	116
OTC/Methadone Clinic	40
Residential Treatment Center, Joint Commission Certified	17
Residential Treatment Center, Non-Joint Commission Certified	9
Treatment Foster Care I (TFC I)	26
Treatment Foster Care II (TFC II)	9
Psychiatric Emergency Services	0
Accredited Residential Facility (ARTC)	24
Residential Non-Joint Commission Group Home (GH)	0
Rural Health Centers	0
School Based Health Services	0

As shown in Figure 5-27, BCBS reported 146 providers in Q1 2019 compared to 185 providers in Q4 2021, an approximately 27 percent increase. PHP reported an increase of 43.8 percent, from 121 providers in Q1 2019 to 174 providers by the end of 2021.Figure 5-27—Number of Behavioral Health Agency Providers, 2018–2021, PHP and BCBS



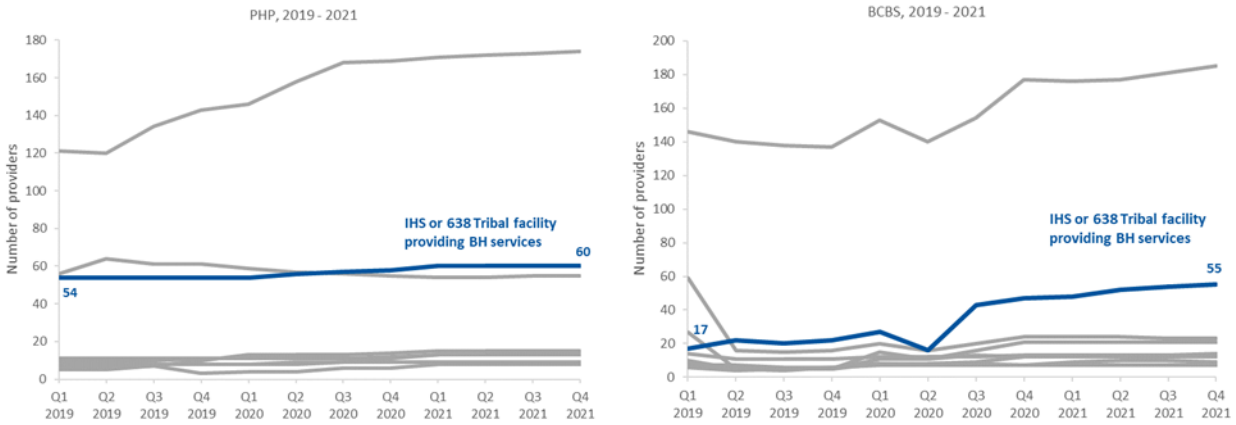
As shown in Figure 5 28, BCBS psychiatric units in a general hospital reported 14 providers in Q1 2019 and remained steady thereafter. Psychiatric hospital facilities reported four providers in Q2 2019; this number increased to 13 in Q3 2020 and remained steady at 12 from Q4 2020 through 2021. PHP psychiatric hospitals and psychiatric units in general hospitals reported seven and 10 providers, respectively, in 2019, and increased to nine and 13 providers, respectively, in 2021.

Figure 5-28—Number of Psychiatric Unit Providers, 2018–2021, PHP and BCBS



BCBS IHS or 638 Tribal Facilities providing behavioral health services showed an increase in the number of providers in the latter half of 2020 and 2021 (Figure 5-29). PHP IHS or 638 Tribal Facilities providing behavioral health services increased by approximately 11.1 percent, starting at 54 providers in 2019 and increasing to 60 providers by the end of 2021.

Figure 5-29—Number of Tribal Facility Providers, 2018–2021, PHP and BCBS



PHP ARTCs demonstrated a slight increase in the number of providers from seven providers in 2019 to 15 providers in 2021 (Figure 5-30)

Figure 5-30—Number of Accredited Residential Facility Providers, 2018–2021, PHP

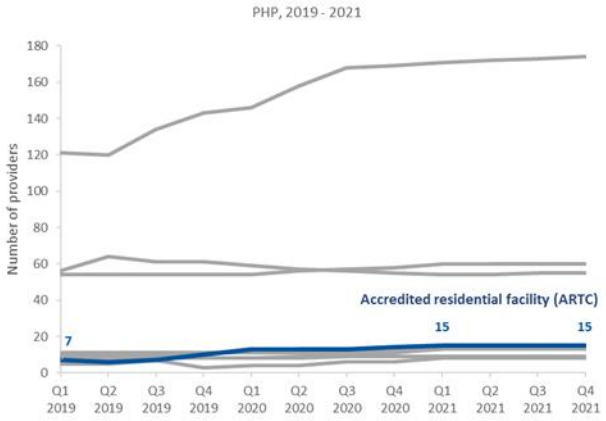


Figure 5-31 shows that during the Centennial Care 2.0 period, WSCC behavioral health agencies exhibited an approximately 27 percent increase in the number of providers during this period; 152 providers were reported in Q1 2019, dropped to 125 providers the following quarter, then increased to 194 providers by the end of 2021. Joint Commission-certified residential treatment centers also showed evidence of expansion, with eight providers reported in Q1 2019 and gradually expanding to 17 providers in the last quarter of 2020 (Figure 5-32).

Figure 5-31—Number of Behavioral Health Agency Providers, 2019–2021, WSCC

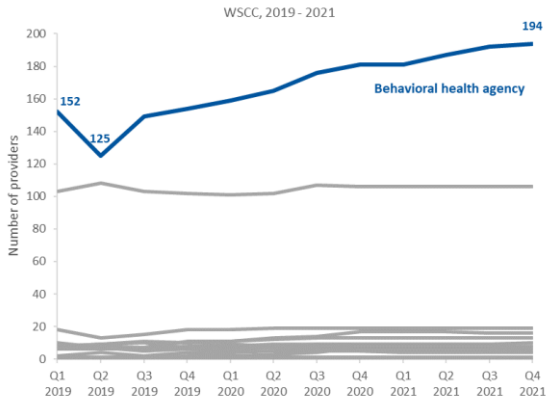
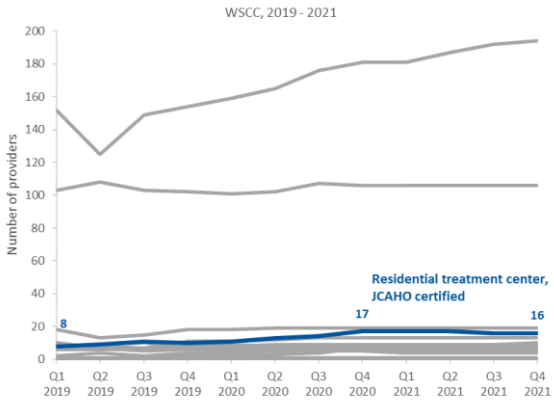
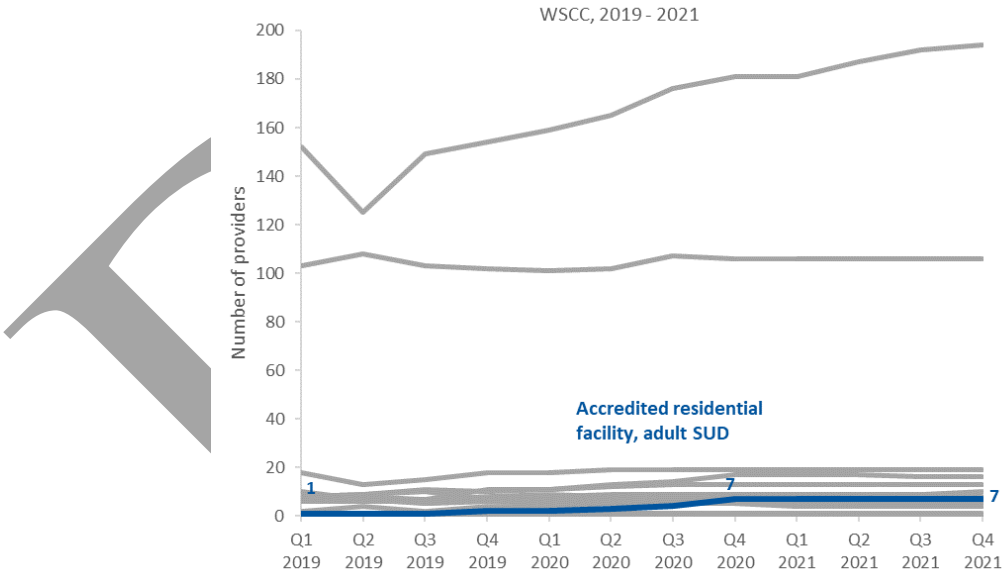


Figure 5-32—Number of Residential Treatment Center, Joint Commission Certified Providers, 2019–2021, WSCC



Accredited residential facilities for adult SUD also grew from one provider in the Q1 2019 to seven providers by the last quarter of 2020 and through 2021 (Figure 5 33).

Figure 5-33—Number of Accredited Residential Facility, Adult SUD Providers, 2019–2021, WSCC



Although the number of behavioral health *facilities* associated with each MCO has generally increased during the evaluation period, HSAG could not reliably identify a significant increase in the number and variety of different *services* following the implementation of Centennial Care 2.0 in 2019, which is the focus of the research question. Despite this, the expansion of the number of facilities for available services is consistent with the hypothesis.

Measure 38 Conclusion: Neither supports nor fails to support the hypothesis.

Research Question 2: Has capacity for ambulatory SUD services increased?

Number of Providers and Capacity for Ambulatory SUD Services (Measure 39)

Measure 39 uses claims/encounter data to assess the provider capacity for ambulatory SUD services by estimating the projected capacity among all providers covering SUD services throughout the Centennial Care 2.0 approval period. MCOs supplied HSAG with lists of providers who offered SUD services between 2018 and 2021. Because of the change in plan composition in 2019, only two plans (BCBS and PHP) provided data for 2018. WSCC began providing data in 2019.

To estimate changes in provider capacity following the Centennial Care 2.0 Demonstration using exclusively the provider lists supplied by the MCOs and administrative claims/encounter data, HSAG calculated the average provider Medicaid panel size in the year prior to Centennial Care 2.0 (2018) and used this to estimate maximum Medicaid panel size for new providers going forward. HSAG then analyzed the actual panel size in each year of the Demonstration (2019–2021) and compared the actual to the projected. This comparison was done separately for existing providers (i.e., those who had been providing SUD services in 2018) and new providers (i.e., those who had *not* provided SUD services in 2018).

Differences between actual and projected panel sizes may arise for a variety of reasons. Among the new provider group, lower panel sizes than projected may be a result of reluctance of providers to take on a large number of Medicaid members, saturation of the Medicaid market, or providers operating in geographic areas with few Medicaid members. Higher-than-projected panel sizes may be a result of pent-up demand or new providers operating in geographic areas with few providers and/or a high concentration of Medicaid members.

Table 5-34 shows that in 2018, SUD providers saw an average of 191 Medicaid members. In 2019, existing providers saw an average of 214, suggesting these providers were taking on more Medicaid patients than the year prior; however, among the new provider group, the average panel size was only 72. Although the root cause of this discrepancy is unclear,[5-12] it does suggest that added capacity of new SUD providers did not correspond to a proportional increase in the number of members served. Similarly, new providers only saw an average of 84 members in 2020 and 94 in 2021. Meanwhile, existing providers saw an average of 184 members in 2020 (a decline compared to the previous two years, but likely driven by the COVID-19 PHE, and 198 members in 2021.

Table 5-34— Number of Providers and Capacity for Ambulatory SUD Services (Measure 39)

Year	Provider Group	Number of Providers	Average Panel Size	Total Panel Size	Projected Capacity	Percent of Projected Capacity
2018	All providers	5,381	191	1,026,771	N/A	N/A
2019	Existing providers	5,035	214	1,078,221	960,749	112%
2019	New providers	3,965	72	285,639	756,578	38%
2020	Existing providers	5,311	184	978,130	1,013,414	97%
2020	New providers	4,350	84	366,012	830,042	44%
2021	Existing providers	4,957	198	983,575	945,866	104%
2021	All providers	5,826	94	549,849	1,111,683	49%
2019	**All providers**	**9,000**	**152**	**1,363,860**	**1,717,327**	**79%**

5-12 This discrepancy could be a result of new providers coming from MCOs that no longer operated in 2019 and thus switched which MCOs they accepted.

2020	All providers	9,661	139	1,344,142	1,843,456	73%
2021	All providers	10,783	142	1,533,424	2,057,549	75%

Analysis shows that providers who had been supplying SUD services for Medicaid members in 2018 (either for BCBS or PHP) had generally maintained or increased their capacity during Centennial Care 2.0. However, SUD providers who had not contracted with BCBS or PHP in 2018 had a much smaller panel size from 2019–2021, suggesting the capacity added was less than half of the projected capacity (between 38 percent and 49 percent). Because of incomplete data prior to Centennial Care 2.0, it is unclear whether the smaller panel size among providers who were not contracted with BCBS or PHP in 2018 would have been expected in the event these providers had similarly small panel sizes in 2018 under a plan that had left Centennial Care in 2019. However, while the realized capacity is less than expected due to smaller panel sizes, the potential capacity as measured by the number of Medicaid members who could receive services from the expanded number of providers has increased substantially. The available data were insufficient to determine whether the smaller panel sizes for new providers are due to decisions by the new providers to see fewer Medicaid patients than previous providers, or if there are external reasons, such as a satiated demand for services. In any event, the number of providers and the number of members receiving services have expanded since the implementation of Centennial Care 2.0, and the evidence supports the hypothesis.

Measure 39 Conclusion: Supports the hypothesis.

Research Question 3: Has the utilization of emergency departments (EDs) by individuals with SUD decreased?

Figure 5-34 through Figure 5-38 compare the observed rate to projections from an ITS analysis controlling for seasonality and peak COVID-19-affected quarters (Q2 2020 through Q1 2021). The dotted gray line represents the predicted rate had the baseline trend (solid gray line) continued into the evaluation period.

Percentage of ED Visits of Individuals With SUD Diagnoses (Measure 40)

Figure 5-34 shows that the projected rates from the ITS model track closely with the observed rates calculated using claims/encounter data. This suggests there were minimal changes in the percentage of ED visits that were from members with a SUD diagnosis following the start of Centennial Care 2.0 in 2019.

Figure 5-34—Percentage of ED Visits of Individuals With SUD Diagnoses, Observed Rates Compared to ITS Model Projections (Measure 40)

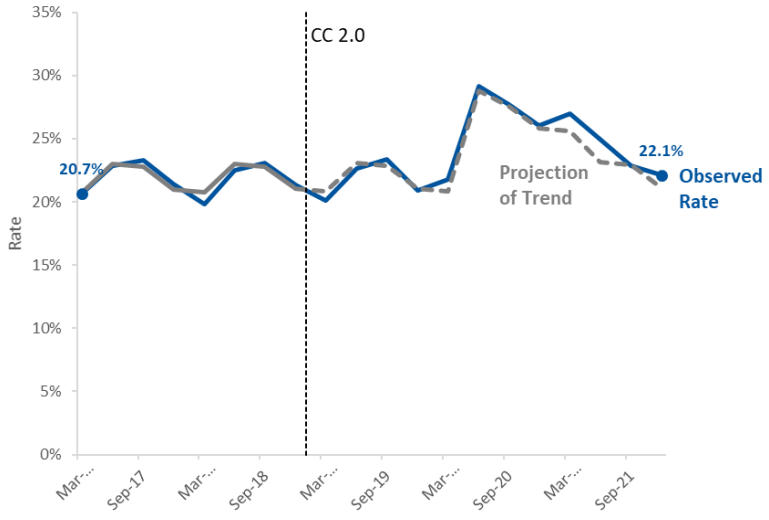


Table 5-35 corroborates the findings illustrated in Figure 5-34. The results show that the percentage of ED visits from individuals with a SUD diagnosis did not substantively change upon implementation of Centennial Care 2.0 in Q1 2019, after controlling for seasonality and peak COVID-19 PHE-affected quarters. While the trend in the rate increased by 0.1 percentage points per quarter following the implementation of Centennial Care 2.0 relative to the trend in the baseline period, this difference was not statistically significant. Tables A-19 and A-20 contain additional regression results.

Table 5-35—Percentage of ED Visits of Individuals With SUD Diagnoses, Primary ITS Model Results[1] (Measure 40)

Variable	Estimate	p-Value
Intercept	20.7%	<0.001 ***
Pre-CC 2.0 quarterly trend	0.0%	0.928
Level change at implementation	-0.4%	0.553
Change in quarterly trend	0.1%	0.341

*p< 0.1, **p < 0.05, ***p<0.001
[1]Note: Full model results are presented in Appendix X.

Measure 40 Conclusion: Neither supports nor fails to support the hypothesis.

Research Question 4: Has the utilization of inpatient hospital settings for SUD-related treatment decreased?

Percentage of Inpatient Admissions for SUD-Related Treatment (Measure 41)

Similar to Measure 40, Figure 5-35 shows that the projected rates from the ITS model track closely with the observed rates. This suggests there were minimal changes in the percentage of inpatient (IP) admissions for SUD related treatment following the start of Centennial Care 2.0 in 2019. Furthermore, although rates were generally increasing over time, there was not a substantive increase in the rate beyond what might be expected from historical seasonality and trends during the COVID-19 PHE when substance usage was increasing.

Figure 5-35—Percentage of Inpatient Admissions for SUD-Related Treatment, Observed Rates Compared to ITS Model Projections (Measure 41)

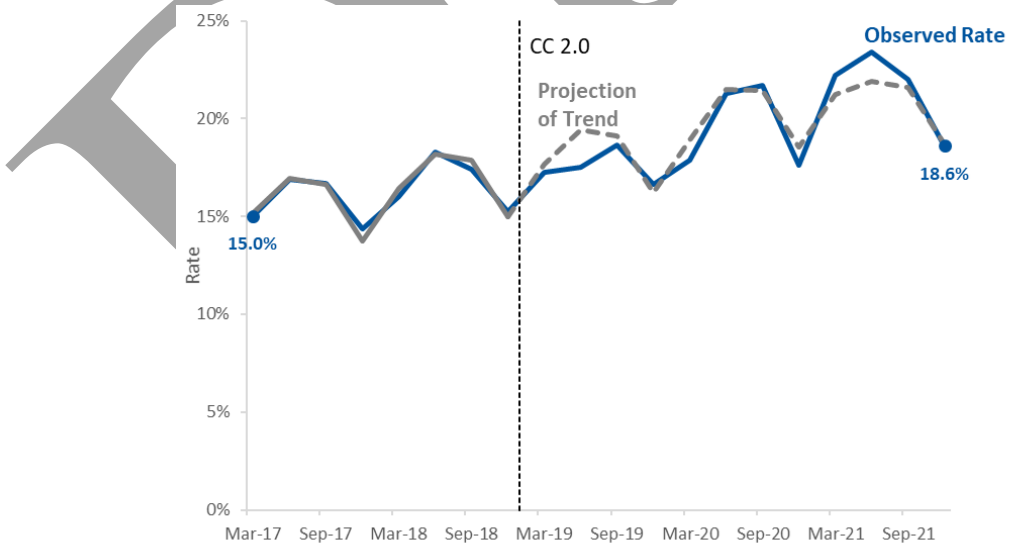


Table 5-36 shows that, although there was a significant upward trend during the pre-intervention period of 0.3 percent per quarter, this trend continued generally unchanged into the Centennial Care 2.0 period (increasing by

0.1 percentage points, which was not statistically significant). The average rate after implementation declined by 1.1 percent but was not statistically significant. Tables A-21 and A-22 contain additional regression results.

Table 5-36—Percentage of Inpatient Admissions for SUD-Related Treatment, Primary ITS Model Results[1] (Measure 41)

Variable	Estimate	p-Value	
Intercept	15.2%	<0.001	***
Pre-CC 2.0 quarterly trend	0.3%	0.039	**
Level change at implementation	-1.1%	0.201	
Change in quarterly trend	0.1%	0.345	

*p< 0.1, **p < 0.05, ***p<0.001
[1]Note: Full model results are presented in Appendix A.

Measure 41 Conclusion: Neither supports nor fails to support the hypothesis.

Research Question 5: Has the utilization of inpatient hospital settings for withdrawal management decreased?

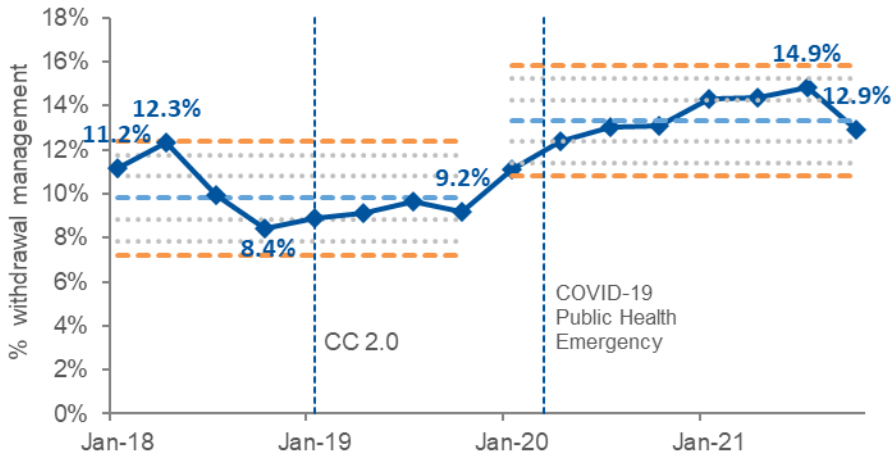
Percentage of Inpatient Admissions of Individuals With a SUD for Withdrawal Management (Measure 42)

Measure 42 uses claims/encounter data to assess whether inpatient admissions for withdrawal management decreased. A statistical process control chart was used to assess variation over time in this measure.

Figure 5-36 shows that the percentage of inpatient admissions of individuals with a SUD for withdrawal management increased steadily beginning in Q1 2020, shifting the average by approximately 3 percentage points from 10 percent to 13 percent (a 30 percent relative increase).

During Q1 of the baseline year (2018), 11.2 percent of individuals with a SUD had an inpatient admission for withdrawal management; this increased to 12.3 percent in Q2, before dropping to 8.4 percent by Q4. In 2019, the rate remained steady around 9.2 percent, before gradually increasing to 14.9 percent by Q3 2021. In the last quarter of 2021, the rate began to decline again to around 12.9 percent.

Figure 5-36—Percentage of Inpatient Admissions of Individuals With a SUD for Withdrawal Management, 2018–2021 (Measure 42)



Measure 42 Conclusion: Does not support the hypothesis.

Research Question 6: Have inpatient SUD readmissions decreased for individuals with SUD diagnoses?

7-Day and 30-Day Inpatient and Residential SUD Readmission Rates (Measure 43)

Figure 5 37 shows that the projected rate of 7-day SUD readmissions was higher than the observed rates following Centennial Care 2.0; however, as shown in Table 5-37, these differences were not statistically significant. While both the level change at implementation and the change in quarterly trend declined (by 0.7 percentage points and 0.2 percentage points, respectively), these changes were not statistically significant.

Figure 5-37—7-Day Inpatient and Residential SUD Readmission Rates, Observed Rates Compared to ITS Model Projections (Measure 43)

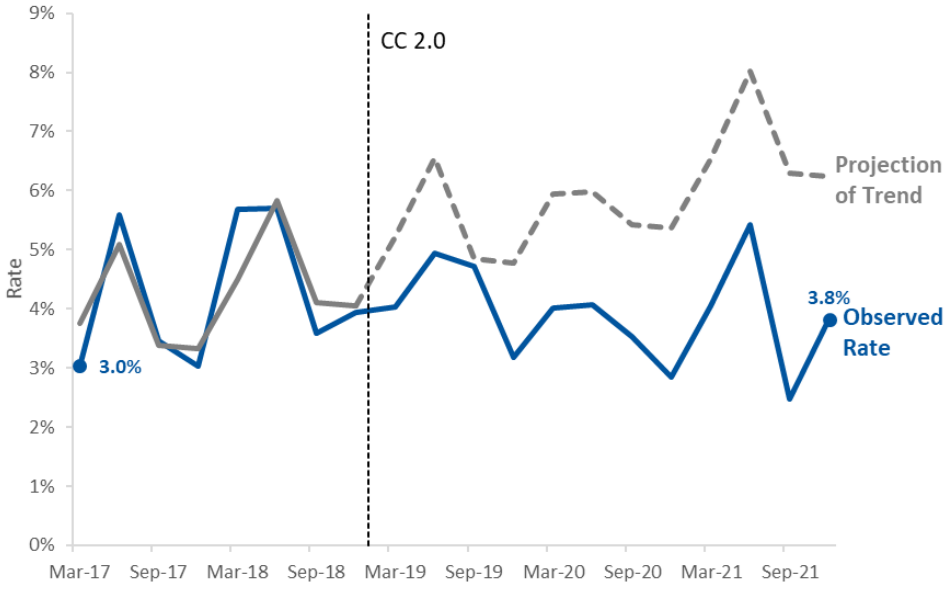


Table 5-37—7-Day Inpatient and Residential SUD Readmission Rates, Primary ITS Model Results[1] (Measure 43)

Variable	Estimate[2]	p-Value
Intercept	3.8%	<0.001***
Pre-CC 2.0 quarterly trend	0.2p.p.	0.152
Level change at implementation	-0.7p.p.	0.324
Change in quarterly trend	-0.2p.p.	0.156

*p< 0.1, **p < 0.05, ***p<0.001
[1]Note: Full model results are presented in Appendix A.
[2]p.p.=percentage point

Figure 5-38 shows that the projected rate of 30-day SUD readmissions was higher than the observed rates following Centennial Care 2.0, which had begun to decline. The quarterly trend prior to Centennial Care 2.0 was an increase of 0.5 percent per quarter, whereas afterwards, the trend changed by a decline of 0.7 percentage points (to an overall decline of 0.2 percentage points per quarter). Table 5-38 demonstrates this change in the trend was statistically significant, suggesting that the start of Centennial Care 2.0 in Q1 2019 led to a reversal of the upward trend in 30-day SUD-related readmission rates.

Figure 5-38—30-Day Inpatient and Residential SUD Readmission Rates, Observed Rates Compared to ITS Model Projections (Measure 43)

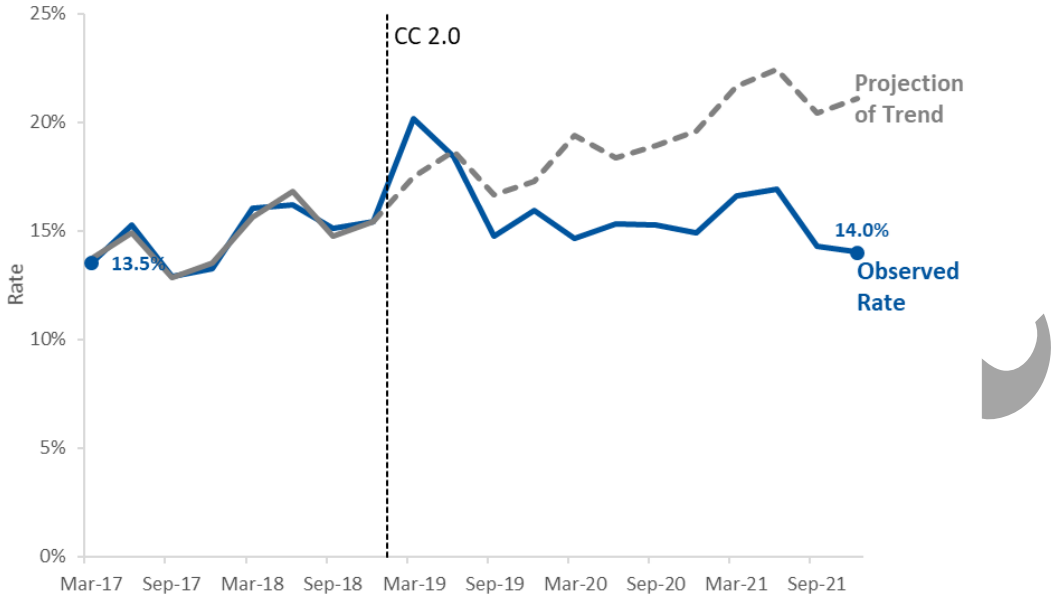


Table 5-38—30-Day Inpatient and Residential SUD Readmission Rates, Primary ITS Model Results[1] (Measure 43)

Variable	Estimate[2]	p-Value
Intercept	13.7%	<0.001***
Pre-CC 2.0 quarterly trend	0.5p.p.	0.022**
Level change at implementation	1.2p.p.	0.254
Change in quarterly trend	-0.7p.p.	0.004**

*p< 0.1, **p < 0.05, ***p<0.001
[1]Note: Full model results are presented in Appendix A.
[2]p.p.=percentage point

Although the results of 7-day readmissions were not statistically significant, both coefficients of interest from the ITS (level change at implementation and change in quarterly trend) were in the favorable direction of reducing rates. Evaluating 30-day readmissions, ITS results suggest that Centennial Care 2.0 stabilized and slightly reversed an increasing trend in the rate. Tables A-23 through A-26 contain additional regression results for this measure.

Measure 43 Conclusion: Supports the hypothesis.

Research Question 7: Have increasing trends in total cost of care been slowed for individuals with SUD diagnoses?

The goal of the financial analysis of Centennial Care 2.0 is to compare the costs to the State for the programs covered under the 1115 Demonstration Waiver against the estimated expected costs had the 1115 Demonstration Waiver not been implemented. Expected expenditures were estimated based on changes in member

demographics, population health condition-based risk score, and the medical CPI.[5-13,5-14] The medical CPI is used to account for changes to cost due to inflationary factors. CPI does not account for NM Medicaid-specific policy changes that had a fiscal impact. HSAG is not aware of any policy changes between 2019 and 2021 that had a fiscal impact that would have changed the analysis. Using claims/encounter data, total actual expenditure costs for providing care to members covered by the 1115 Demonstration Waiver were compared to the estimated expected expenditures which are calculated by applying annual demographic and inflation factors to the baseline costs for 2013. (See the Financial Analysis Trend and Cost Development Methodology section for additional details on adjustment factor development.) Note that the cost analyses do not refer to nor attempt to replicate the formal Budget Neutrality test required under the Section 1115 Demonstration Waiver program, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved.

Claims cost are calculated and analyzed at two levels:

- PMPM basis by dividing the total expenditures by the total member months for the total enrolled members for a given time period.
- PUMPM basis which is calculated by dividing the total expenditures by the total member months for the total members who utilized services during the review period.

Each of these measures is based on expenditures unadjusted for year-to-year demographic changes. Costs are reviewed on a PMPM or PUMPM basis to ensure comparability as the total number of members change over time.

Both unadjusted and adjusted expenditures and expenditure trends were reviewed. Adjustment involved normalizing expenditures to account for known changes such as demographics, health condition-based risk, and inflation. By making these adjustments, all known and quantifiable variations in each analysis period are removed, leading to a more accurate comparison across time periods.

Costs are normalized by dividing the unadjusted cost PMPM by the calculated area, age/gender, and health condition risk factors. Estimated counterfactual costs (estimated expenditures had the Demonstration Waiver not been implemented) were calculated by applying each normalization factor as well as including the annual medical CPI percentage from the U.S. Bureau of Labor Statistics.

To get a better understanding of how costs changed over time, several trend measures were developed.

- **Cumulative Unadjusted Trend from the Baseline**: Represents the total annual growth in the cost of care since 2013. The growth rate is calculated by comparing the annual PMPM for each year of the Demonstration to the 2013 baseline. For example, assume expenditures increased from $100.00 in 2013 to $104.00 in 2014, a trend increase of 4 percent; then to $106.08 from 2014 to 2015, a trend increase of 2 percent; then fell to $105.02 from 2015 and 2016, a trend decrease of 1 percent. The annual changes are multiplied together to determine the total cumulative trend. In this example the cumulative trend would be 5 percent.
- **Annualized Unadjusted Trend from the Baseline**: The average annual growth in cost of care between the baseline (2013) and each year of the Demonstration, adjusted to smooth the trend across the represented time period. (See the Methodology section for additional details.)

5-13 U.S. Bureau of Labor Statistics. Available at https://www.bls.gov/cpi/tables/supplemental-files/home.htm. Accessed on: Jun 9, 2022.

5-14 UC San Diego. Chronic Illness and Disability Payment System (CDPS). Available at: https://hwsph.ucsd.edu/research/programs-groups/cdps.html#Using-CDPS-Risk-Scores. Accessed on July 13, 2022.

- **Annualized Normalized Trend from the Baseline**: Average annual growth in cost of care adjusted for known variances between years based on #2 above.
- **Year-Over-Year Unadjusted Trend**: Annual growth in cost of care from year to year.

Total and PMPM Cost (Medical, Behavioral and Pharmacy) for Members With a SUD Diagnosis (Measure 44)

Two measures are used to assess Research Question 7 for Hypothesis 3: Have increasing trends in total cost of care been slowed for individuals with SUD diagnoses? The analysis of these measures is based on the total actual expenditure costs for providing care to SUD diagnosed members covered by the 1115 Demonstration Waiver compared to the estimated expected expenditures calculated by applying annual demographic and inflation factors to the baseline costs for 2018. (See the Methodology section for additional details on adjustment factor development.) The cost analyses do not refer to nor attempt to replicate the formal Budget Neutrality test required under the Section 1115 Demonstration Waiver program, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved.

Figure 5-39 displays the per member per month costs and total expenditures from the baseline Q1 2018 through the Q4 2021 for the actual incurred cost and the expected (counterfactual) costs for members with a SUD diagnosis. All of the actual and counterfactual total costs and the capitated, actual, and counterfactual PMPM costs increased from Q1 2018 through Q4 2021. Table A-29 contains additional data.

Figure 5-39—Per Member Per Month Cost and Total Cost for Members with SUD Diagnosis

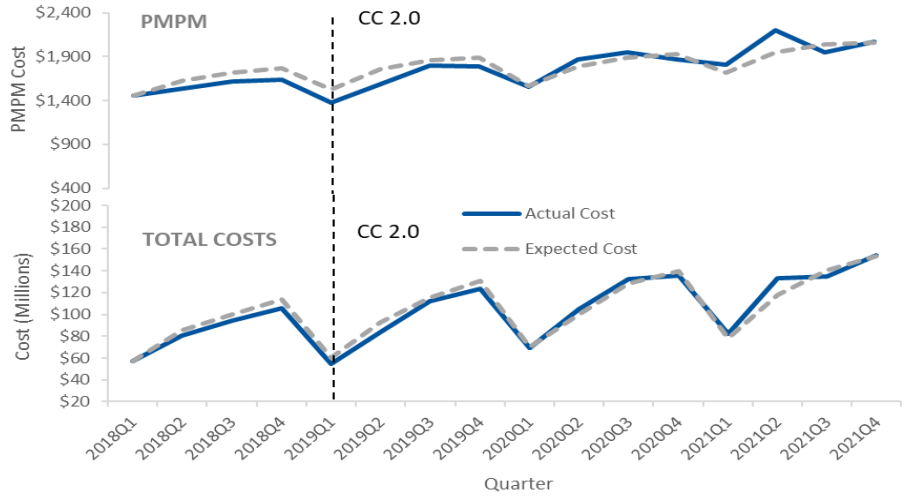
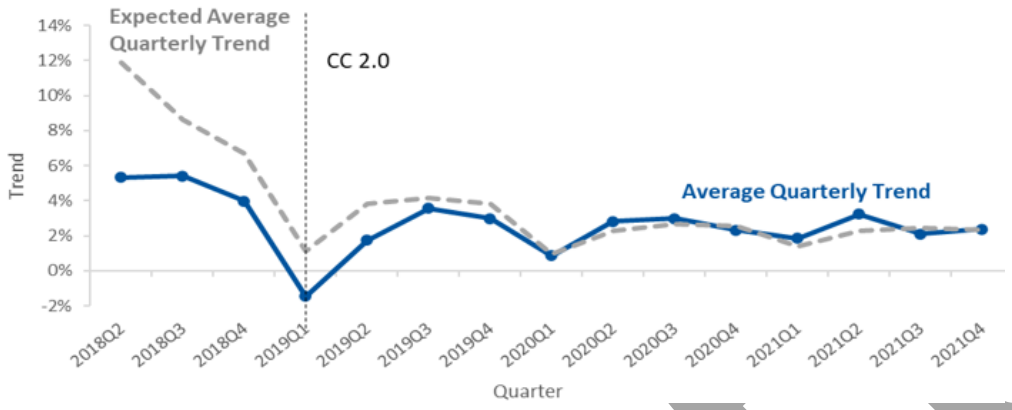


Figure 5-40 shows two trend calculations based on changes from Q1 2018 (not shown in figure). The average quarterly trend decreased throughout the review period, from the baseline of 5.3 percent in Q2 2018 to 2.4 percent in Q4 2021.

Figure 5-40—Cost Per Member Trends for Members with SUD Diagnosis



Changes to the demographics of the SUD diagnosed population also impacted the per member trends. Members were flagged and included in the SUD diagnosed population based on the first month in a calendar year and any subsequent enrolled months. SUD diagnosed flags were reset January 1 each calendar year in the analysis. Over the entire review period of Q1 2018 through Q4 2021, most members with a SUD diagnosis fell in the expansion population, followed by the TANF population. The average age of the expansion population for a member with a SUD diagnosis increased from 36.8 in Q1 2018 to 38.8 in Q4 2021. The average age of the TANF population for a member with a SUD diagnosis increased slightly from 30.2 in Q1 2018 to 30.8 in Q4 2021. The population also saw an average quarterly increase in CDPS (version 6.5) condition-based risk scores relative to the baseline of Q1 2018, resulting in an increase of 1.3 percent. The member distribution by geographic region did not change substantially from 2018 to 2021.

Based on data from the U.S. Bureau of Labor Statistics, prices for medical care were 8.37 percent higher in 2021 compared to 2018 (an $8.37 difference in value per $100 of spending), indicating a medical care average inflation rate of 2.7 percent per year. The medical care inflation rate was slightly greater than the overall annual inflation rate of 2.6 percent during this same period. The medical CPI is used to account for changes to cost due to inflationary factors. CPI does not account for NM Medicaid-specific policy changes that had a fiscal impact. HSAG is not aware of any policy changes between 2019 and 2021 that had a fiscal impact that would have changed the analysis.

Employing the normalization process as described in the methodology section, factors were developed to quantify the change in risk, age-band/gender, area, and inflation from one Demonstration year to the next. These factors were then applied to the baseline period to calculate the expected average quarterly costs that are displayed in Figure 5-41 and the corresponding expected average quarterly trends in Figure 5-42. Table A-30 contains additional data.

Measure 44 focuses on a subset of the population utilizing services analyzed in Measure 21. Therefore, the higher utilizing member cost trends are not outside of normal expectations as the costs are limited a select subset of the population, members who have had a SUD diagnosis.

Table 5-39 shows the impacts of each of the known changes in the cost and demographic variables from Q1 2018 to Q4 2021. The quarterly impact of each known driver was applied to the PMPM claims cost from the baseline of Q1 2018 to calculate the counterfactual claims PMPM. The calculated counterfactual claims trend incorporating changes for risk, age-band/gender, area, and inflation was 2.3 percent. The quarterly paid claims trend achieved by the 1115 Demonstration Waiver was slightly higher at 2.4 percent. The hypothesis related to this measure is not directly related to costs, therefore this measure is not strictly applicable to this hypothesis.

Table 5-39—Total and PMPM Cost (Medical, Behavioral, and Pharmacy), for Members with SUD Diagnosis Normalized Trend Walkdown (Measure 44)

Trend Component	Q1 2018 to Q4 2021
Average Quarterly Normalized Trend	1.1%
Average Quarterly Aging Trend	0.1%
Average Quarterly Area Trend	0.1%
Average Quarterly Risk Trend	1.3%
CPI Quarterly Trend 2018-2021	0.6%
Counterfactual Claims Trend	2.3%
Costs Above Expected Counterfactual	0.1%
Quarterly Paid Claims Trend	2.4%

Measure 44 Conclusion: N/A

Total and PMPM Cost (Medical, Behavioral and Pharmacy) for Members With a SUD Diagnosis by Source of Care (Measure 45)

Figure 5- displays the breakdown by source of care for per member per month costs and total expenditures from Figure 5-41 in measure 44. Data are displayed below for the baseline from Q1 2018 through Q4 2021 for the actual incurred cost and the expected (counterfactual) costs for both SUD and non-SUD claims costs for members with a SUD diagnosis broken out by source of care. Both the total costs and the PMPM costs increased from Q1 2018 through Q4 2021, with the exception of the pharmacy PMPM, which decreased slightly. Tables A-31 through A-40 contains specific data points for each source of care.

Figure 5-43—Per Member Per Month Cost and Total Cost for Members with SUD Diagnosis by Source of Care

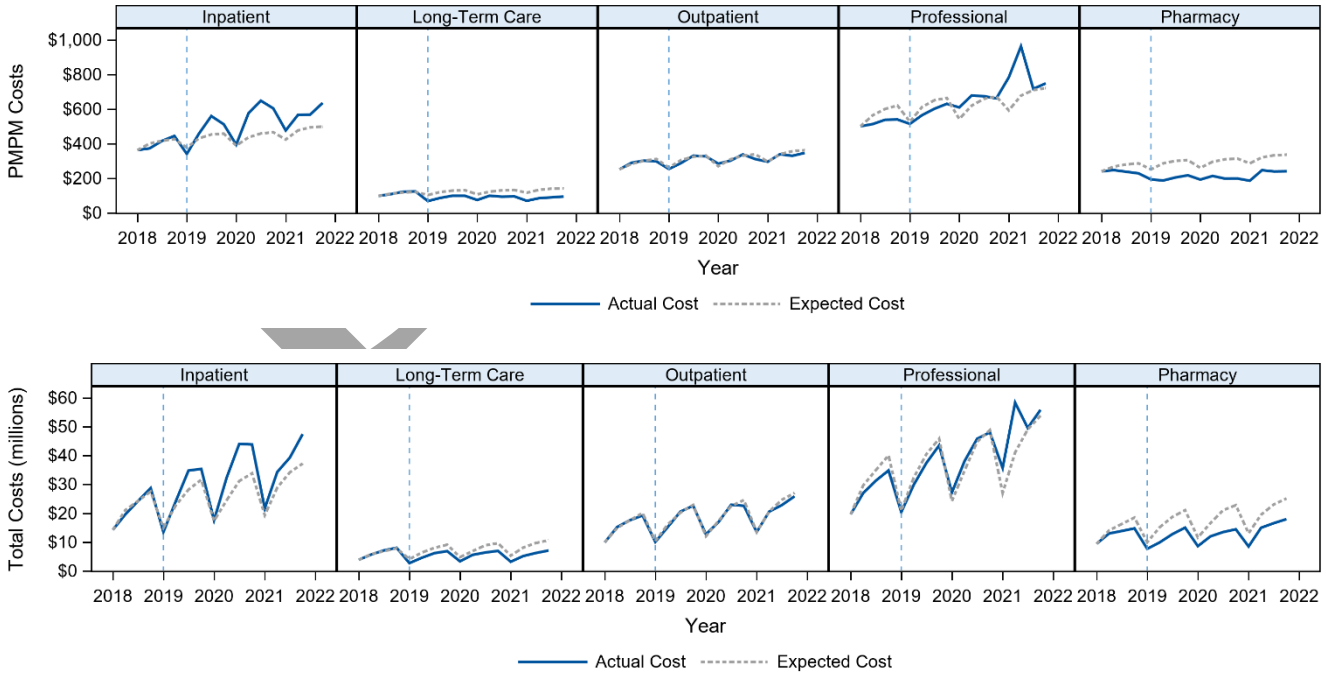
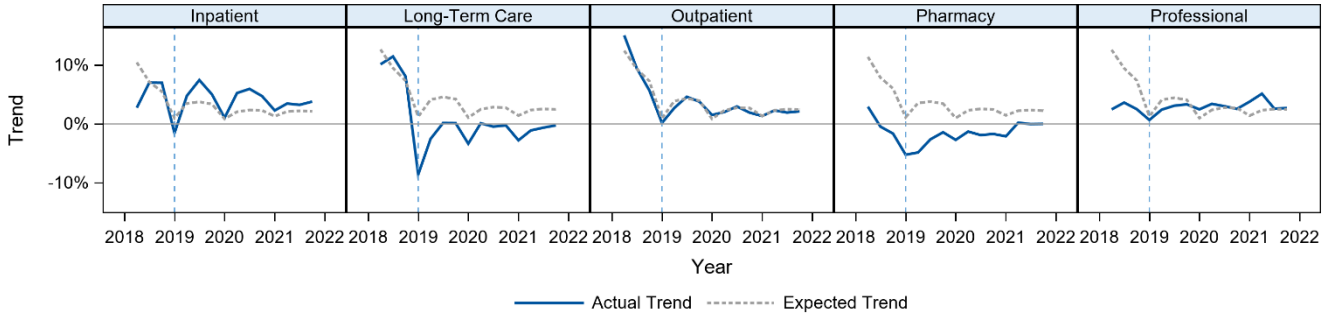


Figure 5-44 shows two trend calculations for the PMPM actual and expected cost outlined in Figure 5-43 based on changes from Q1 2018 for each source of care. The weighted combination of these trends by their respective expenditures equates to the total trend displayed in Figure 5-42 in measure 44.

Figure 5-44—Percentage Change in Annual PMPM Costs for Members with SUD Diagnosis by Source of Care



Based on data from the U.S. Bureau of Labor Statistics, prices for medical care were 8.37 percent higher in 2021 compared to 2018 (an $8.37 difference in value per $100 of spending), indicating a medical care average inflation rate of 2.7 percent per year. The medical care inflation rate was slightly greater than the overall annual inflation rate of 2.6 percent during this same period. The medical CPI is used to account for changes to cost due to inflationary factors. CPI does not account for NM Medicaid-specific policy changes that had a fiscal impact. HSAG is not aware of any policy changes between 2019 and 2021 that had a fiscal impact that would have changed the analysis.

Employing the normalization process as described in the methodology section, factors were developed to quantify the change in risk, age-band/gender, area, and inflation from one Demonstration year to the next. These factors were then applied to the baseline period to calculate the expected average quarterly costs that are displayed in Figure 5-43 and the corresponding expected average quarterly trends in Figure 5-44.Tables A-41 through A-45 contain specific data points for each source of care.

For inpatient and professional sources of care, the average quarterly trends in Q4 2021 are higher than the average quarterly trends in Q1 2018 and are also higher than the expected average quarterly trends. For long-term care and pharmacy sources of care, the average quarterly trends in Q4 2021 are lower than the average quarterly trends in Q1 2018 and are also lower than the expected average quarterly trends. For outpatient source of care, the average quarterly trends in Q4 2021 are lower than the average quarterly trends in Q1 2018 and are equal to the expected average quarterly trend.

Table 5-40 shows the quarterly paid claims trends from Q1 2018 to Q4 2021 by source of care and to the total calculated in measure 44. The hypothesis related to this measure is not directly related to costs, therefore this measure is not strictly applicable to this hypothesis.

Table 5-40—Total and PMPM Cost (Medical, Behavioral, Pharmacy), for Members with SUD Diagnosis by SUD Source of Care, Source of Care Comparison to Total (Measure 45)

Source of Care	Quarterly Paid Claims Trend
Inpatient	3.8%
Long Term Care	-0.2%
Outpatient	2.1%
Professional	2.7%
Pharmacy	0.0%
Total	2.4%

Measure 45 Conclusion: N/A

Research Question 8: Have SUD costs for individuals with SUD diagnoses changed proportionally as expected with increased identification and engagement in treatment?

Total and PMPM Cost for SUD Services for Members With a SUD Diagnosis (Measure 46)

Two measures are used to assess Research Question 8 for Hypothesis 3: Have SUD costs for individuals with SUD diagnoses changed proportionally as expected with increased identification and engagement in treatment? The analysis of these measures is based on the total actual expenditure costs for providing care to SUD diagnosed members covered by the 1115 Demonstration Waiver compared to the estimated expected expenditures calculated by applying annual demographic and inflation factors to the baseline costs for 2018. (See the Methodology section for additional details on adjustment factor development.) The cost analyses do not refer to nor attempt to replicate the formal Budget Neutrality test required under the Section 1115 Demonstration Waiver program, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved.

Figure 5-45 displays the per member per month costs and total expenditures from the baseline Q1 2018 through Q4 2021 for the capitated cost, actual incurred cost and the expected (counterfactual) costs for SUD services for members with a SUD diagnosis. All of the actual and counterfactual total costs and the actual and counterfactual PMPM costs increased from Q1 2018 through Q4 2021. Table A-46 contains specific data points for each time period.

Figure 5-45—Per Member Per Month Cost and Total Cost for SUD Services for Members with SUD Diagnosis

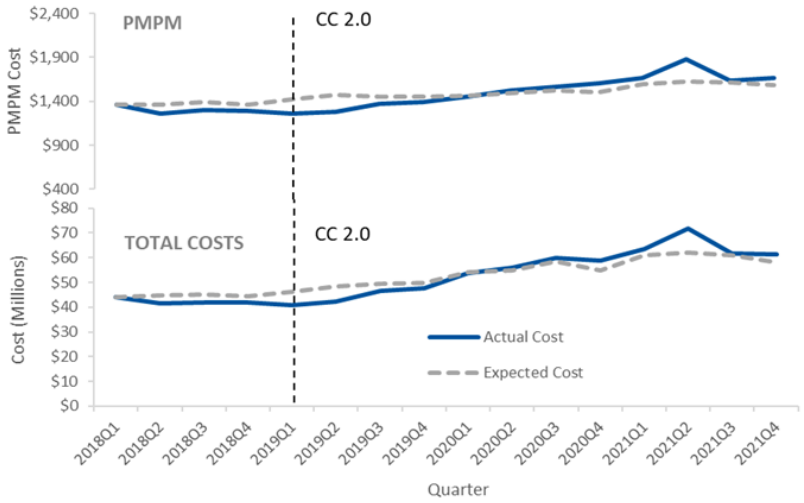
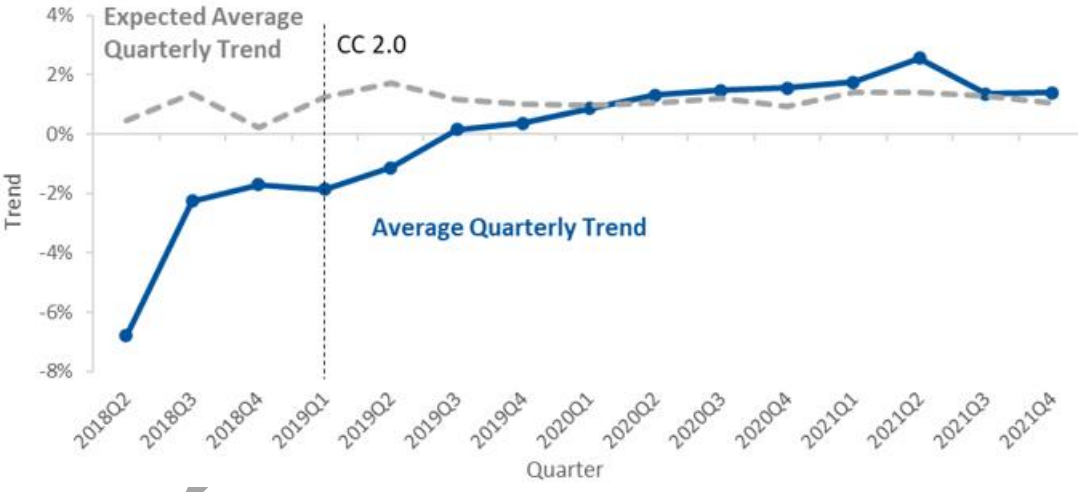


Figure 5-46 shows two trend calculations based on changes from Q1 2018. The average quarterly trend is less than or close to the expected quarterly trend from the beginning of 2018 through Q1 2020 and Q3 2021. The average quarterly trend was greater than the expected quarterly trend Q2 of 2020 through Q2 of 2021 and Q4 2021. The average quarterly trend increased during Centennial Care 2.0, from -1.9 percent in the beginning of 2019 to 1.4 percent at the end of 2021.

Figure 5-46—Cost Per Member Trends for SUD Services for Members with SUD Diagnosis



Changes to the demographics of the SUD diagnosed population also impacted the per member trends. Over the entire review period of Q1 2018 through Q4 2021, most members with a SUD service fell in the expansion population, followed by the TANF population. The average age of the expansion population for a SUD service for a member with a SUD diagnosis has increased from 36.4 in Q1 2018 to 37.8 in Q4 2021. The average age of the TANF population for a SUD service for a member with a SUD diagnosis increased from 30.2 in Q1 2018 to 32.3 in Q4 2021. The average quarterly CDPS (version 6.5) condition-based risk for the population only increased slightly at 0.2 percent from 2018 to 2021. The member distribution by geographic region did not change substantially from 2018 to 2021.

Based on data from the U.S. Bureau of Labor Statistics, prices for medical care were 8.37 percent higher in 2021 compared to 2018 (an $8.37 difference in value per $100 of spending), indicating a medical care average inflation rate of 2.7 percent per year. The medical care inflation rate was slightly greater than the overall annual inflation rate of 2.6 percent during this same period. The medical CPI is used to account for changes to cost due to inflationary factors. CPI does not account for NM Medicaid-specific policy changes that had a fiscal impact. HSAG is not aware of any policy changes between 2019 and 2021 that had a fiscal impact that would have changed the analysis.

Employing the normalization process as described in the methodology section, factors were developed to quantify the change in risk, age-band/gender, area, and inflation from one Demonstration year to the next. These factors were then applied to the baseline period to calculate the expected average quarterly costs that are displayed in Figure 5-45 and the corresponding expected average quarterly trends in Figure 5-46. Additional data points can be found in Table A-47.

Measure 46 focuses on a subset of the population utilizing services analyzed in Measure 44. Therefore, the higher utilizing member cost trends are not outside of normal expectations as the costs are limited a select subset of the population, members who have had a SUD diagnosis.

Table 5-41 shows the impacts of each of the known changes in the cost and demographic variables from Q1 2018 to Q4 2021. The quarterly impact of each known driver is applied to the PMPM claims cost from the baseline of Q1 2018 to calculate the counterfactual claims PMPM. The calculated counterfactual claims trend incorporating changes for risk, age-band/gender, area, and inflation was 1.0 percent. The actual quarterly paid claims trend achieved by the 1115 Demonstration Waiver was slightly higher at 1.4 percent, meaning after adjusting for measurable demographic changes, the actual costs increased more than predicted costs. The hypothesis related to this measure is not directly related to costs, therefore this measure is not strictly applicable to this hypothesis.

Table 5-41—Total PMPM Cost for SUD Services for Members with SUD Diagnosis Normalized Trend Walkdown (Measure 46)

Trend Component	Q1 2018 to Q4 2021
Average Quarterly Normalized Trend	1.7%
Average Quarterly Aging Trend	0.0%
Average Quarterly Area Trend	0.0%
Average Quarterly Risk Trend	0.2%
CPI Quarterly Trend 2018-2021	0.6%
Counterfactual Claims Trend	1.0%
Costs Above Expected Counterfactual	0.4%
Quarterly Paid Claims Trend	1.4%

Measure 46 Conclusion: N/A

Total and PMPM Cost for SUD Services by Type of Care (IP, OP, RX, etc.) (Measure 47)

Figure 5-47 displays breakdown by source of care for the per member per month costs and total expenditures from Figure 5-45 in measure 46. Data is displayed below for the baseline in Q12018 through Q4 2021 for the actual incurred cost and the expected (counterfactual) costs for SUD services for members with a SUD diagnosis broken out by source of care. Both the total costs and the PMPM costs increased from Q1 2018 through Q4 2021, except Long-Term Care PMPM and Pharmacy PMPM sources of care, which decreased. Table A-48 through A-57 contains specific data points for each source of care.

Figure 5-47—Per Member Per Month Cost and Total Cost for SUD Services for Members with SUD Diagnosis, by Source of Care

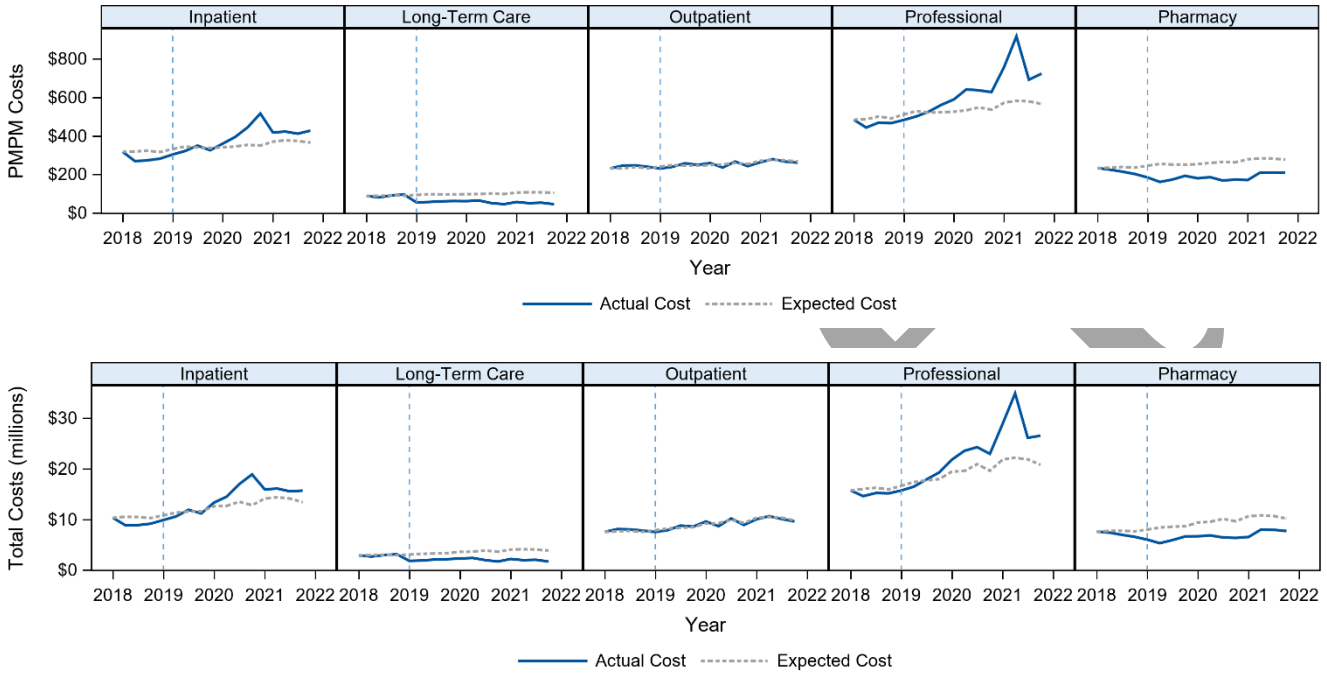
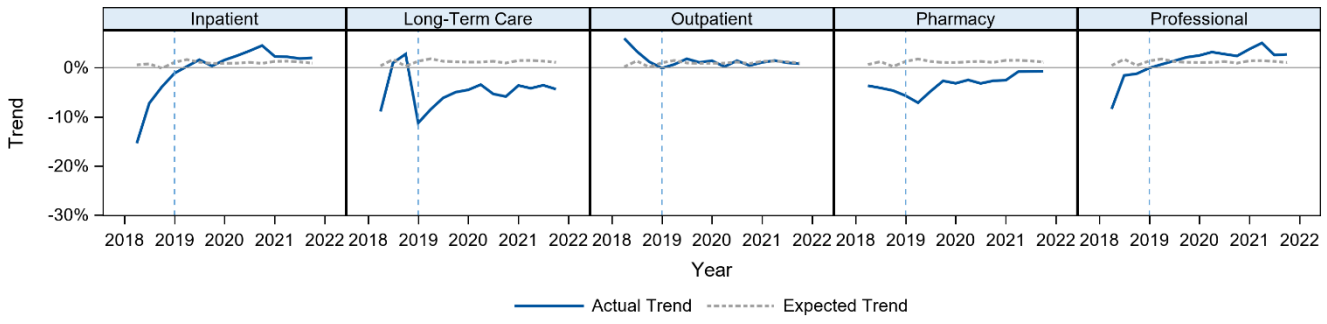


Figure 5-48 shows two trend calculations for the PMPM actual and expected cost outlined in Figure 5-47 based on changes from Q1 2018 (not shown in figure) for each source of care. The weighted combination of these trends by their respective expenditure equates to the total trend displayed in Figure 5-46 from measure 46. The average quarterly trends increased for all sources of care during Centennial Care 2.0. The average quarterly trends were less than the expected quarterly trends during Centennial Care 2.0 for Long-Term Care and Pharmacy but were greater than the expected quarterly trends for Inpatient, Outpatient, and Professional sources of care. Table A-58 through A-62 contain data points for each source of care.

Figure 5-48—Percentage Change in Annual PMPM Costs for SUD Services for Members with SUD Diagnosis, by Source of Care



Based on data from the U.S. Bureau of Labor Statistics, prices for medical care were 8.37 percent higher in 2021 compared to 2018 (an $8.37 difference in value per $100 of spending), indicating a medical care average inflation rate of 2.7 percent per year. The medical care inflation rate was slightly greater than the overall annual inflation

rate of 2.6 percent during this same period. The medical CPI is used to account for changes to cost due to inflationary factors. CPI does not account for NM Medicaid-specific policy changes that had a fiscal impact. HSAG is not aware of any policy changes between 2019 and 2021 that had a fiscal impact that would have changed the analysis.

Employing the normalization process as described in the methodology section, factors were developed to quantify the change in risk, age-band/gender, area, and inflation from one Demonstration year to the next. These factors were then applied to the baseline period to calculate the expected average quarterly costs that are displayed in Figure 5-41 and the corresponding expected average quarterly trends in Figure 5-42. Table A-30 contains additional data.

For all sources of care, inpatient, long-term care, outpatient, pharmacy, and professional, the average quarterly trends in Q4 2021 are higher than the average quarterly trends in Q1 2018. The average quarterly trends for inpatient and professional sources of care are also higher than the expected average quarterly trends (based on the population and CPI changes but excluding any policy changes outside of the waiver). The average quarterly trends for long-term care and pharmacy sources of care are lower than the expected average quarterly trends. The average quarterly trend for outpatient source of care is equal to the expected average quarterly trend.

Table 5-42 shows the comparison of the average quarterly paid claims trends from Q1 2018 to Q4 2021 by source of care and to the total. The hypothesis related to this measure is not directly related to costs, therefore this measure is not strictly applicable to this hypothesis.

Table 5-42—Total and PMPM Cost for SUD Services by Type of Care (IP, OP, RX, etc.) Source of Care Comparison to Total (Measure 47)

Source of Care	Quarterly Paid Claims Trend
Inpatient	2.0%
Long Term Care	-4.4%
Outpatient	0.8%
Professional	2.7%
Pharmacy	-0.7%
Total	1.4%

Measure 47 Conclusion: N/A

Hypothesis 4: The Demonstration will increase the number of individuals with fully delegated care coordination which includes screening for co-morbid conditions, which will result in increased utilization of physical health services.

Research Question 1: Has the percentage of individuals diagnosed with a SUD receiving care coordination increased?

Percentage of Individuals Diagnosed With a SUD Receiving Care Coordination (Measure 48)

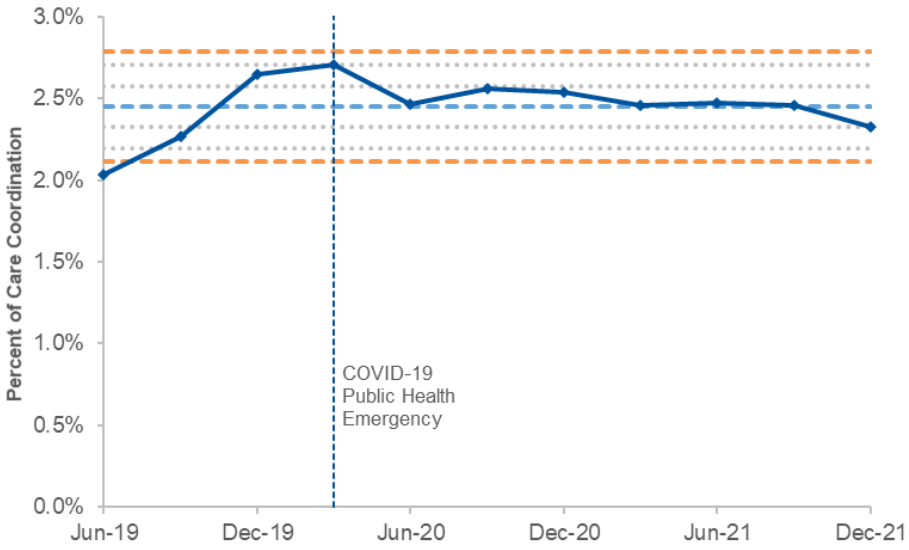
Hypothesis 4 states that an increase in the number of members with fully delegated care coordination (i.e., participation in a health home) will result in an increased utilization of physical health services. Research question 1 examines whether the percentage of individuals with a SUD diagnosis receiving care coordination increased.

Due to limitations in the health home enrollment data, HSAG could only examine members receiving care coordination on or after April 2019. This precludes an interrupted time series analysis as described in the evaluation design plan or a pre-test/post-test design.

A statistical process control chart was used to assess variation over time in this measure.

Figure 5-41 shows the percentage of members with a SUD diagnosis enrolled in a health home remained steady at approximately 2.5 percent following an initial increase in 2019. The dashed orange control limits indicate the expected range of quarterly variation. No evidence of special cause variation was detected—that is, there was no consistent shift or trend in the rate, nor were there outlying data points, with the possible exception of Q2 2019; however, this could be driven in part by incomplete health home enrollment data.[5-15]

Figure 5-41—Percentage of Individuals Diagnosed with a SUD Receiving Care Coordination (Measure 48)



Measure 48 Conclusion: Does not support the hypothesis.

Research Question 2: Has the number of individuals with a SUD receiving preventive health care increased?

Percentage of Individuals With a SUD Receiving Preventive/Ambulatory Health Services (Measure 49)

Figure 5-42 and Table 5-43 show that the observed rates would appear above the projected rates had the baseline trend continued into the Centennial Care 2.0 Demonstration period. The rates after Centennial Care 2.0 fluctuated between 87 percent and 89 percent and were higher than what was projected from the baseline trend.

5-15 Health home enrollment for May 2019 was not available. HSAG imputed a member's enrollment for this month if the member was 1) enrolled in a health home during both April and June 2019, and 2) enrolled in Centennial Care in May 2019.

Figure 5-42—Percentage of Individuals With a SUD Receiving Preventive/Ambulatory Health Services (Measure 49)

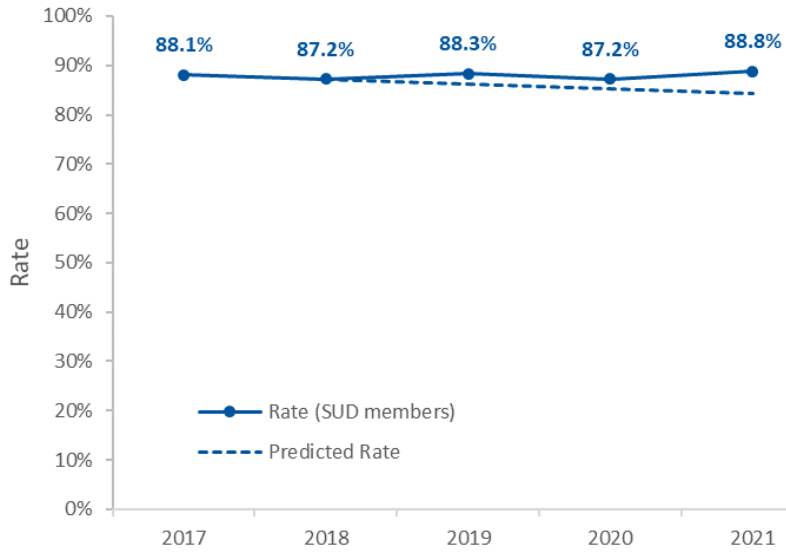


Table 5-43—Percentage of Individuals With a SUD Receiving Preventive/Ambulatory Health Services (Measure 49)

Year	N	Rate	Predicted Rate	p-Value
2017	38,125	88.1%	--	--
2018	38,054	87.2%	--	--
2019	41,144	88.3%	86.3%	<0.001
2020	44,293	87.2%	85.4%	0.006
2021	49,685	88.8%	84.4%	<0.001

Measure 49 Conclusion: Supports the hypothesis.

Hypothesis 5: The Demonstration will increase use of naloxone, MAT, and enhanced monitoring and reporting of opioid prescriptions through the prescription monitoring program, which will result in fewer overdose deaths due to opioid use.

Research Question 1: Has there been an expansion of naloxone distribution and training?

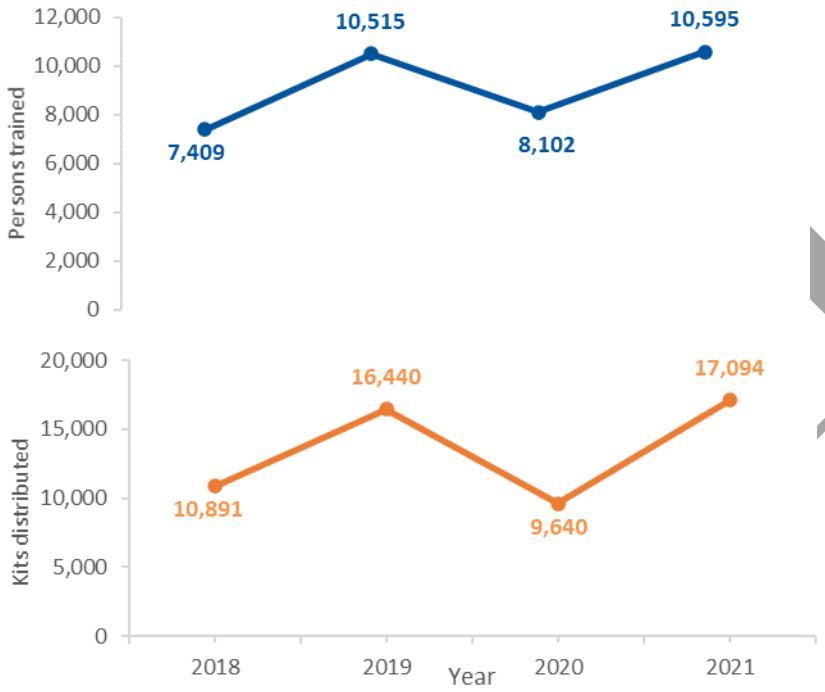
Number of Naloxone Training and Kit Distributions (Measure 50)

Figure 5-43 shows the number of persons receiving overdose (OD) prevention training and the number of naloxone kit distribution from 2018 to 2021. While there is evidence of an increase in OD prevention training and naloxone distributions after 2018, this may be conflated with the effects of a new 2019 policy requiring providers to prescribe an opioid antagonist with each opioid prescription[5-16]. The number of persons receiving training and kit distributions increased from 7,409 and 10,891 in 2018 to 10,515 and 16,440 in 2019, respectively. However, in 2020, the number decreased to 8,102 and 9,640, respectively; this decrease is likely due to the COVID-19 PHE

5-16 casetext. N.M. Stats. 24-2D-7. 2019. Available at: https://casetext.com/statute/new-mexico-statutes-1978/chapter-24-health-and-safety/article-2d-pain-relief/section-24-2d-7-requirements-for-health-care-providers-who-prescribe-distribute-or-dispense-opioid-analgesics. Accessed on: Aug 25, 2022.

and the need to adjust training mediums from in-person to online instruction. . In 2021, the number greatly increased again to 10,595 and 17,094, respectively.

Figure 5-43—Number of Persons Receiving OD Prevention Training and Naloxone Kits Distributed, 2018–2021



Measure 50 Conclusion: Does not support the hypothesis.

Research Question 2: Has the number of MAT providers increased?

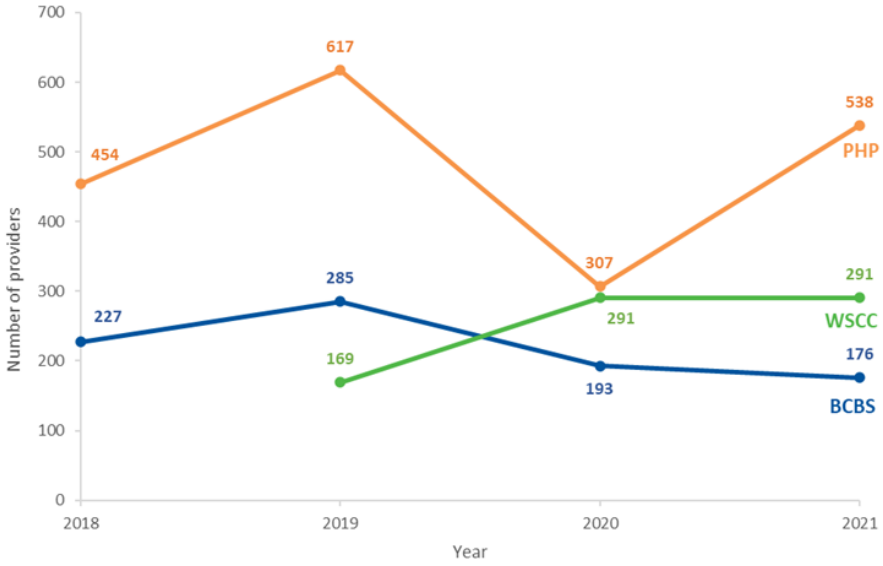
Number of MCO Network MAT Providers (Measure 51)

Table 5-44 and Figure 5-45 show the number of MAT providers by MCO from 2018 to 2021. For BCBS, the number of MAT providers in 2018 was 277, which increased to 285 in 2019 before declining to 176 in 2021. The greatest number of MAT providers for PHP was in 2019, with 617 providers, and lowest in 2020, with 307 providers. WSCC increased the number of MAT providers from 169 in 2019 to 291 in 2020. In 2021, the number remained steady.

Table 5-44—Number of MCO Network MAT Providers, 2018–2021

Plan	2018	2019	2020	2021
BCBS	227	285	193	176
PHP	454	617	307	538
WSCC	NA	169	291	291

Figure 5-44— Number of MCO Network MAT Providers, 2018–2021



Measure 51 Conclusion: Does not support the hypothesis.

Research Question 3: Has the number of individuals with a SUD receiving MAT increased?

Percentage of Individuals Diagnosed With a SUD with MAT Claims (Measure 52)

Figure 5-45 compares the observed rate to predictions from an ITS analysis controlling for seasonality and peak COVID-19-affected quarters (Q2 2020 through Q1 2021). The dotted gray line represents the predicted rate had the baseline trend (solid gray line) continued into the evaluation period.

Figure 5-45—Percentage of Individuals Diagnosed With a SUD With MAT Claims, Observed Rates Compared to ITS Model Projections (Measure 52)

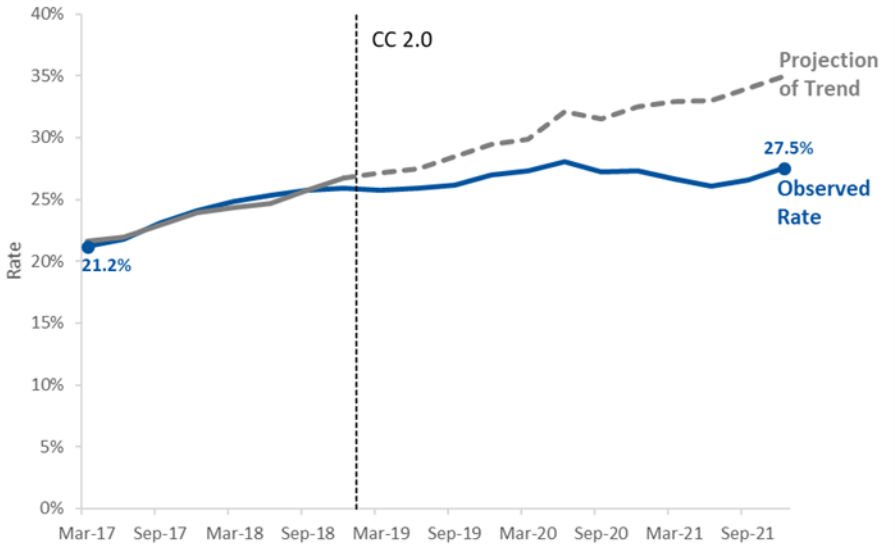


Figure 5-45 shows the projected rates were higher than the observed rates following the start of Centennial Care 2.0 and a leveling out of the observed rates. Table 5-45 shows this change in the trend was statistically significant, from a pre-Centennial Care 2.0 trend of increasing by 0.7 percentage points per quarter, to a trend of only 0.1 percentage points (a decline of 0.6 percentage points, indicated by the variable: change in quarterly trend). This illustrates that the rate of members with a SUD receiving claims for MAT declined relative to what was projected during the Centennial Care 2.0 period (i.e., a leveling out of rates instead of a continued increase). Tables A-27 and A-28 include additional regression results.

Table 5-45—Percentage of Individuals Diagnosed With a SUD With MAT Claims, Primary ITS Model Results[1] (Measure 52)

Variable	Estimate[2]	p-Value
Intercept	21.6%	<0.001***
Pre-CC 2.0 quarterly trend	0.7p.p.	<0.001***
Level change at implementation	-0.3p.p.	0.634
Change in quarterly trend	-0.6p.p.	<0.001***

*p< 0.1, **p < 0.05, ***p<0.001
[1]Note: Full model results are presented in Appendix A.
[2]p.p.=percentage point

Measure 52 Conclusion: Does not support the hypothesis.

Research Question 4: Is there evidence of enhanced policies and practices related to the prescription monitoring program, real time prescription monitoring program updates, member/provider lock-in programs, and limits/edits at pharmacy points-of-sale?

Number of Policy and Procedure Manual References (Measure 53)

Measure 53 aims to determine if there is any evidence of enhanced policies and practices related to the prescription monitoring program, real time prescription monitoring program updates, member/provider lock-in programs, and limits/edits at pharmacy points-of-sale. To assess this measure, data were obtained on the number of providers who made at least one request to the Prescription Monitoring Program (PMP). According to the New Mexico Board of Pharmacy, the mission of the PMP is to "provide practitioners, pharmacists, and other authorized users the ability to review a patient's-controlled substance prescription history and assist in the prevention of diversion, abuse, misuse, and drug overdose deaths associated with controlled substance prescriptions."[5-17] Only providers who are required to submit 10 or more PMP reports are included in this measure.

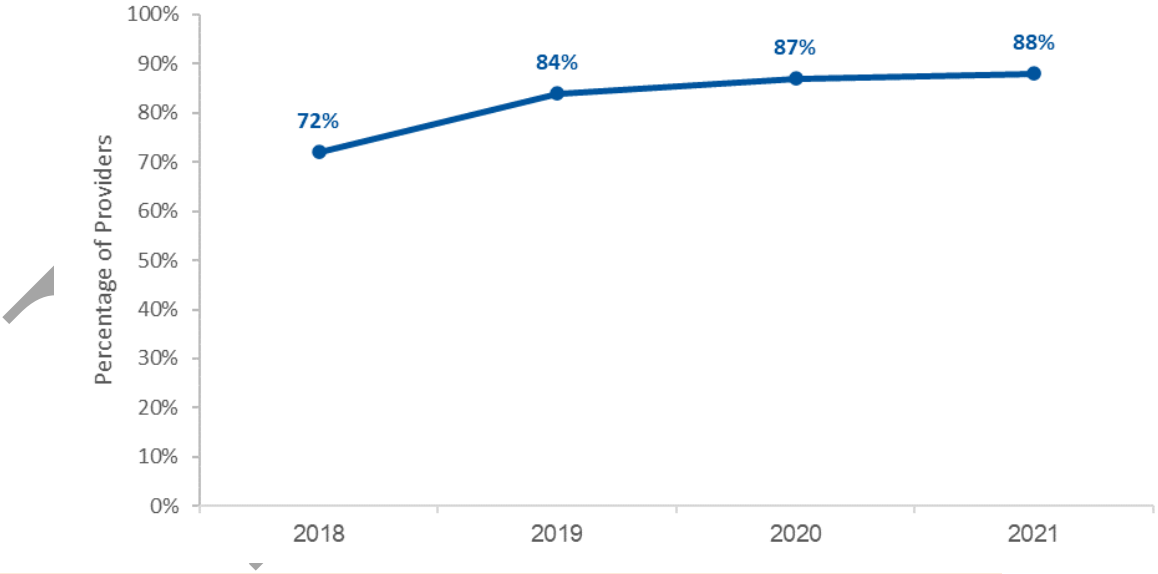
Overall, there is some evidence of an increasing proportion of providers making a request to the PMP. As seen in Figure 5-46, the overall percentage of providers making a request increased from 72 percent in 2018 to 88 percent in 2021. The largest increase can be seen prior to the implementation of Centennial Care 2.0 between 2018 and 2019 in which the percentage jumped from 72 percent to 84 percent. The upward trend somewhat stagnated after the start of Centennial Care 2.0, with only an increase from 84 percent in 2019 to 88 percent in 2021. Table 5-46 provides a breakdown of the number and percentage of specific provider types who made a request to the PMP.

5-17 New Mexico Board of Pharmacy. The New Mexico Prescription Monitoring Program (PMP). Available at: https://www.nmpmp.org/. Accessed on: June 9, 2022.

Table 5-46—Providers Using the PMP, 2018–2021 (Measure 53)

Provider Type	2018	2019	2020	2021
Dentists	7 (14%)	2 (8%)	7 (33%)	9 (26%)
Osteopaths	91 (62%)	113 (84%)	115 (87%)	104 (90%)
Podiatrists	22 (48%)	17 (52%)	25 (69%)	29 (74%)
Doctors of Medicine (MDs)	1120 (72%)	1122 (84%)	1107 (87%)	1082 (88%)
Nurse Midwives	5 (50%)	6 (67%)	4 (67%)	2 (67%)
Nurse Practitioners	566 (79%)	670 (89%)	708 (90%)	793 (90%)
Physician Assistants	225 (75%)	229 (85%)	206 (89%)	214 (91%)
Pharmacist Clinicians	8 (89%)	7 (78%)	5 (63%)	9 (90%)
Prescribing Psychologists	34 (89%)	33 (87%)	35 (83%)	36 (92%)
Unknown	2 (100%)	1 (100%)	2 (67%)	1 (33%)
Total	**2,080 (72%)**	**2,200 (84%)**	**2,214 (87%)**	**2,279 (88%)**

Figure 5-46—Percentage of Providers Using the PMP, 2018–2021



Measure 53 Conclusion: Supports the hypothesis.

Research Question 5: Is there a decrease in the number of deaths due to overdose?

Rate of Deaths Due to Overdose (Measure 54)

Measure 54 assesses whether there has been a decrease in the number of deaths due to overdose following the Centennial Care 2.0 Demonstrations increased use of naloxone, MAT, and enhanced monitoring and reporting of

opioid prescriptions through the PMP. To answer this question, the statewide and Medicaid cause-specific death rates from overdose and the overdose proportionate mortality rates were calculated for 2018–2021 and are displayed in Table 5-47.

The cause-specific death rate associated with overdose deaths within the New Mexico Medicaid population has been rising, from 42.8 per 100,000 New Mexico Medicaid recipients in 2018 to 60.7 per 100,000 New Mexico Medicaid recipients in 2021, a 41.8 percent increase. Similarly, the cause-specific death rate associated with overdose deaths statewide has been steadily increasing, from 25.7 per 100,000 New Mexico residents in 2018 to 38.2 per 100,000 New Mexico residents in 2020, a 48.6 percent increase, as displayed in Table 5-48 and Figure 5-47. Although a slight dip was seen from 2020 to 2021, data for these years are preliminary and therefore subject to change.

Table 5-47—New Mexico Statewide Overdose Cause-Specific Death Rates, 2018–2021

	2018	2019	2020	2021
NM Total Deaths from Overdose	537	601	801**	770**
NM Population*	2,092,434	2,092,454	2,097,021	2,115,877
Cause-Specific Death Rate per 100,000 NM Residents	25.7	28.7	38.2	36.4

* Population totals for 2018-2020 represent five-year American Community Survey estimates. Population totals for 2021 are derived from the NM Census Bureau Quick Facts which utilizes the Population Estimates Program (PEP).
** Overdose deaths for New Mexico are preliminary for 2020 and 2021.

Table 5-48—New Mexico Medicaid Overdose Cause-Specific Death Rates, 2018–2021

	2018	2019	2020	2021
NM Medicaid Deaths from Overdose	356	373	519	567
NM Medicaid Population	832,599	824,026	869,330	933,884
Cause-Specific Death Rate per 100,000 NM Medicaid Members	42.8	45.3	59.7	60.7

Figure 5-47—Overdose Cause-Specific Death Rates per 100k Individuals, 2018–2021

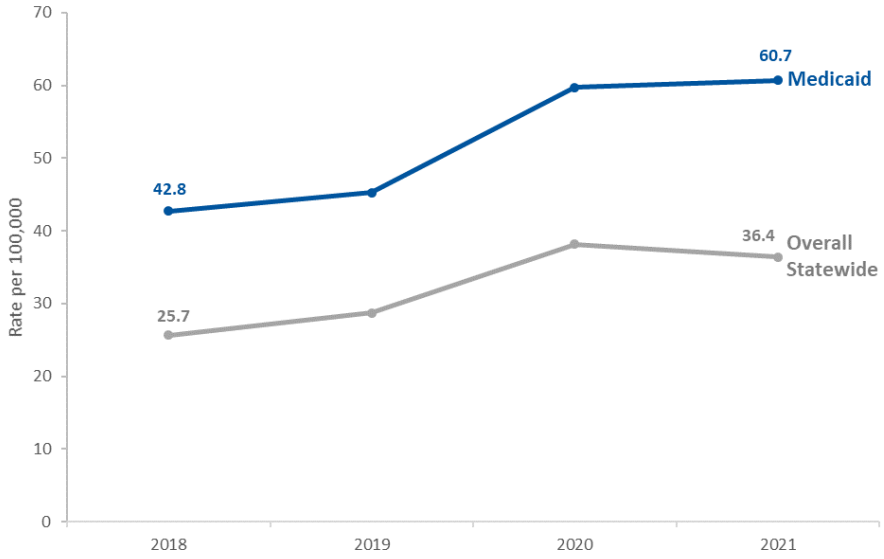
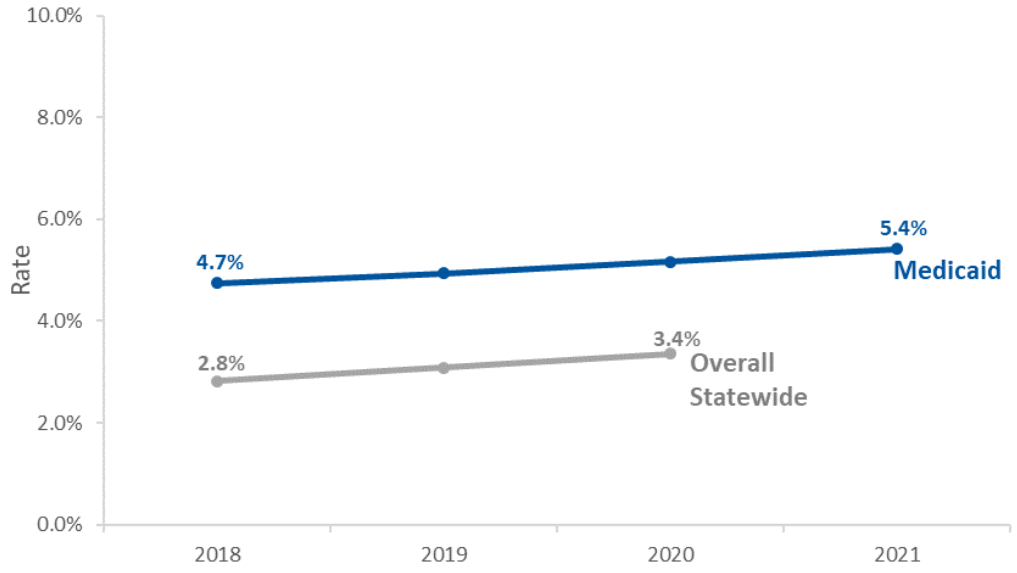


Table 5-49 and Figure 5-48 demonstrate that the overdose proportionate mortality in the New Mexico Medicaid population increased from 4.7 percent in 2018 to 5.4 percent in 2021. The overdose proportionate mortality in New Mexico statewide increased from 2.8 percent in 2018 to 3.4 percent in 2020. Total deaths statewide in New Mexico are not yet available for 2021. While the overdose proportionate mortality was higher among the Medicaid population, the rate trended similarly to the overall statewide population, increasing 0.5 and 0.6 percentage points between 2018 and 2020 for the Medicaid population and statewide population, respectively.

Table 5-49—Overdose Proportionate Mortality, 2018–2021

	2018	2019	2020	2021
NM Total Deaths from Overdose	537	601	801**	770**
Total NM Deaths	19,023	19,521	23,842	N/A
Percentage of Statewide Deaths Attributable to Overdose	2.8%	3.1%	3.4%	
NM Medicaid Deaths from Overdose	356	373	519	567
NM Medicaid Total Deaths	7,508	7,554	10,044	10,478
Percentage of Medicaid Deaths Attributable to Overdose	4.7%	4.9%	5.2%	5.4%

Figure 5-48—Overdose Proportionate Mortality, 2018–2021



Measure 54 Conclusion: Does not support the hypothesis.

6. Conclusions

Of the four aims associated with the Demonstration Waiver, Aim One and Aim Two are supported by the results of the analyses. Aim Three is generally supported by the analyses; however, no conclusions could be drawn for two of the three associated hypotheses. The results for Aim Four are mixed. Table 6-1 provides results for each measure, hypothesis, and aim. Note, results of "NS/FS" are given for measure that neither support nor fail to support the hypothesis. This finding may arise through two primary reasons:

1. Results were not statistically significant, or
2. Results were mixed in terms of their support

Table 6-1—Summary of Results by Measure, Hypothesis, and Aim

Measure Number	Measure Name	Measure Supports Hypothesis
Aim One: Continue the use of appropriate services by members to enhance member access to services and quality of care		
Hypothesis 1: Continuing to expand access to Long-Term Support Services and Supports (LTSS) and maintaining the progress achieved through rebalancing efforts to serve more members in their homes and communities will maintain the number of members accessing Community Benefit (CB) services.		
1	Number of Centennial Care members enrolled and receiving CB services	Yes
Hypothesis 2: Promoting participation in a health home (HH) will result in increased member engagement with a health home and increase access to an integrated physical and behavioral health care community.		
2	Number/Percentage of Centennial Care members enrolled in a health home	Yes
3	Number/Percentage of Health Home members with at least one (1) claim for physical health (PH) service in the calendar year	Yes
Hypothesis 3: Enhanced care coordination supports integrated care interventions, which lead to higher levels of access to preventive/ambulatory health services.		
4a	Adults' access to preventive/ambulatory health services (AAP)[1]	NS/FS
5a	Children and adolescents' access to primary care practitioners (CAP) [1]	No
6	Well-child visits in the third, fourth, fifth, and sixth years of life (W34)	NS/FS
4b	Adults' access to preventive/ambulatory health services (AAP) – HH population	Yes
5b	Children and adolescents' access to primary care practitioners (CAP) – HH population	Yes
Hypothesis 4: Engagement in a health home and care coordination support integrative care interventions, which improve quality of care.		
7	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD) – HH population	NS/FS
8	Anti-depressant medication management (AMM) Effective Acute Phase Treatment – HH population	NS/FS
9	Anti-depressant medication management (AMM) Effective Continuation Phase Treatment – HH population	NS/FS
10	7-day follow up after hospitalization for mental illness (FUH) – HH population	Yes
11	30-day follow up after hospitalization for mental illness (FUH) – HH population	NS/FS
Hypothesis 5: Expanding member access to preventive care through the Centennial Home Visiting (CHV) pilot program and providing incentives through Centennial Rewards (CR) will encourage members to engage in preventive care services.		
12	Percentage of CC members participating in CR	Consistent[2]

Measure Number	Measure Name	Measure Supports Hypothesis
13	Percentage of CR participating members with an annual preventive/ambulatory service	NS/FS
14	Percent of CR users responding positively on satisfaction survey to question regarding if the program helped to improve their health and make healthy choices	—[3]
15	Live births weighing less than 2,500 grams (low birth weight)	No
Aim Two: Manage the pace at which costs are increasing while sustaining or improving quality, services, and eligibility		
Hypothesis 1: Incentivizing hospitals to improve health of members and quality of services and increasing the number of providers with value-based purchasing (VBP) contracts will manage costs while sustaining or improving quality.		
16	Number of provider groups with VBP contracts	Consistent
17	Number/percentage of providers meeting quality threshold	—
18	Percentage of total payments that are for providers in VBP arrangements	Yes
19	Percentage of qualified Domain 1 safety net care pool (SNCP) Hospital Quality Incentive measures that have maintained or improved their reported performance rates over the previous year	NS/FS
20	Cost per member trend	Yes
21	Cost per user trend	No
Aim Three: Streamline processes and modernize the Centennial Care health delivery system through use of data, technology, and person-centered care		
Hypothesis 1: The Demonstration will relieve administrative burden by implementing a continuous Nursing Facility Level of Care (NFLOC) approval with specific criteria for members whose condition is not expected to change over time.		
22	Number of continuous NFLOC approvals	Consistent
Hypothesis 2: The use of technology and continuous quality improvement (CQI) processes align with increased access to services and member satisfaction.		
23	Number of telemedicine providers	Consistent
24	Number of members receiving telemedicine services	Consistent
25	Member rating of health care	Yes
26	Member rating of health plan	NS/FS
27	Member rating of personal doctor	NS/FS
Hypothesis 3: Implementation of electronic visit verification (EVV) is associated with increased accuracy in reporting services rendered.		
28	Number of submitted claims through EVV	Consistent
29	Percentage of paid or unpaid hours retrieved due to false reporting	—
Aim Four: Improved quality of care and outcomes for Medicaid beneficiaries with SUD		
Hypothesis 1: The Demonstration will increase the number of providers that provide substance use disorder (SUD) screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for alcohol and other drug (AOD) abuse and dependence treatment.		
30	Number of providers who provide SUD screening	Yes
31	Number of individuals screened for SUD	Yes
32	Percentage of individuals with a SUD diagnosis who received any SUD service during the measurement year	No
33	Initiation of AOD Abuse or Dependence Treatment (IET)	No

Measure Number	Measure Name	Measure Supports Hypothesis
Hypothesis 2: The Demonstration will increase peer support services which will result in more individuals engaging in and retained in AOD dependence treatment.		
34	Percentage of individuals with a SUD diagnosis who received peer support	Yes
35	Engagement of AOD Abuse or Dependence Treatment (IET)	Yes
36	Average Length of Stay (ALOS)	Yes
37	Continuity of Pharmacotherapy for opioid use disorder (OUD)	Yes
Hypothesis 3: The Demonstration will improve access to a comprehensive continuum of SUD care which will result in decreased utilization of emergency department (ED) and inpatient hospitalization and SUD inpatient readmissions.		
38	Continuum of services available	NS/FS
39	Number of providers and capacity for ambulatory SUD services	Yes
40	Percentage of ED visits of individuals with SUD diagnoses	NS/FS
41	Percentage of Inpatient admissions for SUD-related treatment	NS/FS
42	Percentage of Inpatient admissions of individuals with a SUD for withdrawal management	No
43	7- and 30-day inpatient and residential SUD readmission rates	Yes
44	Total and per member per month (PMPM) cost (medical, behavioral, and pharmacy) for members with a SUD diagnosis	N/A[4]
45	Total and PMPM cost (medical, behavioral, and pharmacy) for members with a SUD diagnosis by SUD source of care	N/A
46	Total and PMPM cost for SUD services for members with a SUD diagnosis	N/A
47	Total and PMPM cost for SUD services by type of care (inpatient [IP], outpatient [OP], prescription [RX], etc.)	N/A
Hypothesis 4: The Demonstration will increase the number of individuals with fully delegated care coordination which includes screening for co- morbid conditions, which will result in increased utilization of physical health services.		
48	Percentage of individuals diagnosed with a SUD receiving care coordination	No
49	Percentage of individuals with a SUD receiving preventive/ambulatory health services (AAP)	Yes
Hypothesis 5: The Demonstration will Increase use of naloxone, medication assisted treatment (MAT), and enhanced monitoring and reporting of opioid prescriptions through the prescription monitoring program, which will result in fewer overdose deaths due to opioid use.		
50	Number of naloxone training and kit distributions	No
51	Number of managed care organization (MCO) network MAT providers	No
52	Percentage of individuals diagnosed with a SUD with MAT claims	No
53	Number of policy and procedure manual references	Yes
54	Rate of deaths due to overdose	No

[1]To concisely evaluate the Health Home Program, results for Measures 4b and 5b (health home-specific measures) are presented after Measure 6.

[2]Consistent = The measure does not directly address the hypothesis, but provides contextual information on the hypothesis.

[3]— = Insufficient data to draw a conclusion.

[4]N/A = The measure is not directly connected to the hypothesis, but provides critical program information.

*The following abbreviations are used in the measure descriptions—ALOS: Average Length of Stay; AOD: alcohol and other drugs; CB: Community Benefit; CC: Centennial Care; CR: Centennial Rewards; ED: emergency department; EVV: electronic visit verification; HH: health home; IP: inpatient; NCQA: National Committee for Quality Assurance; NFLOC: nursing facility level of care; MAT: medication assisted treatment; MCO: managed care organization; OP: outpatient; OUD: opioid use disorder; PH: physical health; PMPM: per member per month; RX: prescription; SNCP: safety net care pool; SUD: substance use disorder; VBP: value-based purchasing

Aim One

For Aim One, the analytic results provide strong support for both Hypothesis 1 (the number of members accessing Community Benefit [CB] services will be maintained) and Hypothesis 2 (member engagement with health homes and access to integrated physical and behavioral healthcare communities will increase). The analysis provides weaker support for Hypothesis 3 (enhanced care coordination supports integrated care interventions, leading to higher levels of access to preventive/ambulatory health services) and Hypothesis 4 (engagement in a health home and care coordination support integrative care interventions, which improve quality of care), with inconclusive results for several measures across these four hypotheses. One measure (Measure 5a) does not support its hypothesis (Hypothesis 3). The analyses are mixed with regard to support for Hypothesis 5 (expanding member access to and incentives for preventive care through the Centennial Rewards program, and expanded member access to preventive services through the Centennial Home Visiting [CHV] Pilot Program). The only conclusive measure, Measure 15, which is related to the Centennial Home Visiting program failed to support the hypothesis. Measures evaluating the Centennial Rewards program, 12 -14, were mixed, with one measure consistent with the hypothesis, but data and methodological limitations prevent drawing conclusions regarding the efficacy of the CR program. HSAG will work with HSD and Finity to develop more informative and robust measures for the evaluation of the program for the Summative Evaluation Report.

Aim Two

For the six measures associated with Aim Two and its only hypothesis (providing incentives to hospitals to improve the health of members and quality of services, and increasing the number of providers with value-based purchasing [VBP] contracts will manage costs while sustaining or improving quality), two measures support the hypothesis, one measure fails to support the hypothesis, one measure is inconclusive, with an additional measure consistent with hypothesis-related processes. Strikingly, the results of the two financial measures were split. The analysis of Measure 20 (*Cost Per Member Trend*) found member cost trends to be less than what would have been expected in the absence of Centennial Care 2.0 (the counterfactual), but the gap between the estimated counterfactual and actual cost trends has been closing. The analysis for Measure 21 (*Cost Per User Trend*) found that since the implementation of Centennial Care 2.0, the cost trend has increased while the expected trend has decreased. This suggests the costs are increasing at an accelerated rate compared to what is expected..

Aim Three

The analysis supports the hypothesis that the use of technology and continuous quality improvement (CQI) processes align with increased access to services and member satisfaction (Hypothesis 2). Three of the five measures either support the hypothesis or are consistent with the hypothesis, both in terms of the expanded use of telemedicine services, even prior to the COVID-19 public health emergency (PHE), and increased member satisfaction ratings. Analysis of members with continuous Nursing Facility Level of Care (NFLOC) approval is consistent with the conclusion that the Demonstration will relieve administrative burden by implementing a continuous NFLOC approval with specific criteria for members whose condition is not expected to change over time (Hypothesis 1). However, no conclusions could be drawn to support that the implementation of electronic visit verification (EVV) is associated with increased accuracy in reporting services rendered (Hypothesis 3). Two of the measures associated with the Aim had insufficient data from which to draw conclusions. Measure 28 (*Number of Submitted Claims Through EVV*), which is associated with Hypothesis 3, demonstrates that EVV has been implemented and is being utilized, but the measure as defined is not sufficient to measure the impacts of EVV implementation.

Aim Four

The COVID-19 PHE had a significant impact on outcomes and performance throughout the health care system, including both the rates of substance use disorders (SUD) and the availability of treatment for SUD. Despite this impact, SUD treatment for the Centennial Care 2.0 population appeared to remain relatively robust. Results from measure 32 show a minimal decline in the percentage of members with an SUD who received SUD services following the PHE in Q2 2020. Similarly, results from measure 34 show a sustained increase in the percentage of individuals with an SUD diagnosis receiving peer support (however, it is not certain whether the increasing trend prior to the PHE would have continued but-for the PHE). Where possible, HSAG employed statistical controls in an attempt to capture the impact of the COVID-19 on measured outcomes (measures 34, 35, 36, 37, 40, 41, 43, and 52).

The results suggest that the increase in peer support services resulted in more individuals engaging in and being retained in alcohol and other drugs (AOD) dependence treatment (Hypothesis 2) with the analysis results indicating that all four measures associated with the hypothesis support the hypothesis.

Two of the six non-financial measures associated with the hypothesis that the Demonstration will improve access to a comprehensive continuum of SUD care resulting in decreased utilization of emergency department (ED) and inpatient hospitalization and SUD inpatient readmissions (Hypothesis 3) support the hypothesis. The *Number of Providers and Capacity for Ambulatory SUD Services* (Measure 39) and the *7- and 30-Day Inpatient and Residential SUD Readmission Rates* (Measure 43) both support the hypothesis. The analysis results for Measure 42 (*Percentage of Inpatient Admissions of Individuals with a SUD for Withdrawal Management*) did not support Hypothesis 3, and the remaining non-financial measures were inconclusive.

Four financial measures are associated with Hypothesis 3; however, they do not connect directly to the hypothesis, which does not contain an explicit financial or cost element. Generally, the financial measures showed trends similar to or less than the estimated counterfactual over the course of Centennial Care 2.0, but with a sharp spike early in 2021 and continuing to increase through 2021. The analysis of Measure 44 found that the total and per member per month (PMPM) cost, including medical, behavioral, and pharmacy, for members with a SUD diagnosis tracked closely to the estimated counterfactual. Early in the Centennial Care 2.0 period costs were below the estimated counterfactual, but the analysis shows costs spiking early in 2021, possibly due to the release of pent-up demand from the COVID-19 PHE. The analysis of *Total and PMPM Costs (Medical, Behavioral, and Pharmacy) for Members with a SUD Diagnosis by SUD Source of Care* (Measure 45) found that inpatient and outpatient costs were close to the estimated counterfactual. Both long term care (LTC) and pharmacy costs were less than the estimated counterfactual. Professional claims were close to the estimated counterfactual until a spike in costs in early 2021. The *Total and PMPM Cost for SUD Services for Members with a SUD Diagnosis* (Measure 46) have generally been below the estimated counterfactual but have been increasing relative to the estimated counterfactual with a sharp increase in early in 2021, which may again be due to a release of pent-up demand from the COVID-19 PHE. Analysis of the total and PMPM costs for SUD services by type of care showed similar results to those described for Measure 45 above.

Both Hypothesis 1 and Hypothesis 4 were evenly split, with half the measures providing support for the associated hypothesis. Two measures (Measures 30 and 31) supported the hypothesis that the Demonstration will increase the number of providers that provide SUD screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for AOD dependence treatment (Hypothesis 1). Measure 32 (*Percentage of Individuals with a SUD Diagnosis Who Received Any SUD Service During the Measurement Year*) did not support the hypothesis. While the results of Measure 33 (*Initiation of AOD Abuse or Dependence Treatment [IET]*) did not support the hypothesis, the measure is trending favorably and may provide support for the hypothesis in the Summative Evaluation Report.

Results from Measure 49 (*Percentage of Individuals with a SUD Receiving Preventive/Ambulatory Health Services*) support the hypothesis that the Demonstration will ultimately result in increased utilization of physical health services among members receiving fully delegated care coordination (Hypothesis 4). Conversely, the results of the analysis of the *Percentage of Individuals Diagnosed with a SUD Receiving Care Coordination* (Measure 48) did not support the hypothesis that the Demonstration will increase the number of individuals with fully delegated care coordination.

Generally, the results of the analysis do not support Hypothesis 5 (the Demonstration will increase use of naloxone, medication assisted treatment [MAT], and enhanced monitoring and reporting of opioid prescriptions through the prescription monitoring program, resulting in fewer overdose deaths due to opioid use). Only the results of Measure 53 (*Number of Policy and Procedure Manual References*) provide support for the hypothesis. All other analysis results for measures associated with the hypothesis (Measures 50, 51, 52, and 54) did not support the hypothesis. However, it should be noted that the self-reported data may have reflected the impact of the COVID-19 PHE as managed care organizations (MCOs) addressed the urgent elements of the PHE. Likewise, the increase in the number of overdose deaths during 2020 and 2021 may be more indicative of secondary impacts of the COVID-19 PHE than the performance of the Demonstration Waiver.

7. Interpretations, and Policy Implications, and Interactions with Other State Initiatives

Interpretations

Analysis suggests that at this point in the Demonstration, the State is meeting Aim One and Aim Two. Aim Three is being met to the extent that conclusions could be drawn from the available data. As additional data become available, it is expected that a more nuanced picture around Aim Three can be drawn. Health Services Advisory Group, Inc. (HSAG) will work with the State to explore additional data sources or additional measures that will ensure a more complete picture of Aim Three performance for the Summative Evaluation Report. As of this Interim Evaluation Report, the results for Aim Four are mixed. However, several aspects of Aim Four have been substantially impacted by the coronavirus disease 2019 (COVID-19) public health emergency (PHE). HSAG believes that as additional data become available and the impacts of the PHE diminish, the performance of the program should be separable from PHE impacts, allowing for a more refined analysis of the diagnosis and treatment of substance use disorder (SUD) elements of Centennial Care 2.0.

Peer support services represent the most notable success emerging from the interim evaluation analyses. The number of individuals with a SUD diagnosis increased during Centennial Care 2.0 and all peer support services performance measures have shown improvement against declines for individuals not enrolled in peer support services. The peer support services performance improvements continued against the backdrop of the COVID-19 PHE, which appears to have substantially impacted other elements of Aim Four, to improve the quality of care and outcomes for Medicaid beneficiaries with SUDs.

Health homes were moderately successful, although the PHE clearly had an impact. Health home enrollment continued to grow at a moderate rate; however, the results of only four of the 11 outcome/utilization measures (3, 4b, 5b, and 10) support the associated hypotheses and aims. Results for other health home measures were generally mixed and not statistically significant.

Among the full Centennial Care 2.0 population, access to PCPs and preventive care (Measures 4a, 5a, and 6) all showed improvement in 2019, followed by sharp declines beginning in 2020. While statistical methods were applied to control for the impacts of the COVID-19 PHE, it is probable that due to the scale of the PHE, standard statistical methods are insufficient.

The financial analyses suggest the cost of care has been below or around the estimated costs had the Centennial Care 2.0 not been implemented (the counterfactual) until early calendar year (CY) 2021, at which time costs began to increase substantially. If the CY 2021 trend continues, costs of care are likely to exceed the estimated counterfactual cost of care. It is possible that the increases in costs of care in CY 2021 resulted from the release of pent-up demand during the PHE. Data for subsequent years to be included in the Summative Evaluation Report should provide additional insight into the extent of the PHE impact on costs of care.

Telehealth services greatly expanded due to the COVID-19 PHE; however, it is worth noting that the number of telemedicine providers and the number of members receiving telemedicine services both increased in 2019, prior to the COVID-19 PHE.

The SUD portion of the Demonstration has also been impacted by the COVID-19 PHE. Several of the measures for which analysis results failed to support their associated hypotheses showed some degree of improvement in 2019 before declining in 2020, including:

- Percentage of individuals with a SUD diagnosis who received any SUD service during the measurement year.
- Percentage of individuals diagnosed with a SUD receiving care coordination
- Number of naloxone training and kit distributions
- Number of managed care organization (MCO) network medication-assisted treatment (MAT) providers

However, there were other SUD-related measures that were analyzed where the 2019 results did not show improvement from previous years:

- Percentage of inpatient admissions of individuals with a SUD for withdrawal management (2019 rates trended upward [lower rates are better], with the PHE period trending slightly higher than the 2019 trend)
- Percentage of individuals diagnosed with a SUD with MAT claims (2019 was lower than the estimated counterfactual, with a further decrease beginning in 2020)
- Overdose proportionate mortality, which is a part of Measure 54 and looks at the difference between the statewide and Medicaid overdose mortality rates (the difference between the statewide and Medicaid rate remained stable across all years)
- Overdose cause-specific death rates per 100k individuals, which is a part of Measure 54 (the rate increased in 2020, but the difference between the statewide and Medicaid rate widened starting in 2020)

The introduction of Accredited Adult Residential Treatment Centers (AARTCs) and Crisis Triage Centers (CTCs) in 2021 also contributed to changes in the rates in 2021 compared to previous years.

While the analysis results generally suggest that the Centennial Rewards program encourages members to engage in preventive care services, the measures for the program lack a valid comparison group or sufficient historical data to reliably assess the impact of the program. HSAG will work with the New Mexico Human Services Department (HSD) and Finity to develop more informative and robust measures for the evaluation of the program for the Summative Evaluation Report.

Policy Implications

The COVID-19 PHE has added layers of complexity to program evaluations, with only a few elements not impacted by the pandemic. Even with the most significant impacts confined mainly to 2020, lingering PHE impacts were identified through 2021. Due to the unprecedented nature of the PHE, very little research is available to reliably predict the trajectory of PHE impacts beyond those accompanying the shutdown and restrictions in 2020. Separating the impacts of the Demonstration Waiver from those of the PHE will be facilitated by the availability of additional data to identify and control for the trajectory of the PHE and its impacts on the program. If out-of-state data are available and feasible for the summative report (e.g., through Transformed Medicaid Statistical Information System [T-MSIS]) then a comparison group may be constructed for some measures, improving the ability to control for the effects of the PHE on the implementation of the Demonstration.

There are likely PHE impacts that have not yet been fully realized, particularly around service needs that were postponed during the PHE and any resurgences of the virus. These impacts will likely continue to impact Demonstration Waivers for several years. The financial analyses suggest that during the PHE, states faced fiscal pressures responding to the PHE. However, states may still face fiscal pressures from the demand for services as well as lingering health impacts from COVID-19 on their populations.

Despite the impact of the PHE, peer support services appeared to lead to improved outcomes. The results of the analyses suggest that connections with peers provides robust support for individuals with SUD, even in the face of

an unprecedented PHE. Additional research should be encouraged and disseminated regarding other ways in which peer support services may be leveraged to improve member health and appropriate service utilization within a Medicaid program.

Interactions With Other State Initiatives

New Mexico has implemented multiple strategies to reduce opioid misuse and dependence, including expanding the SUD continuum of care (which includes extending Screening, Brief Intervention, and Referral to Treatment [SBIRT] to primary care, community health centers, and urgent care facilities), allowing increased stays in institutions for mental diseases (IMDs) from 15 to 30 days for beneficiaries with a SUD diagnosis with a transition to community-based SUD treatment in place afterwards. HSD also created the Office of Substance Abuse Prevention (OSAP) and the New Mexico Opioid Crisis State Targeted Response Grant.[7-1]

The combination of these activities throughout the State and from various funding sources represents a concerted effort in New Mexico to reduce the impact of opioid misuse and addiction. While this report has identified some improvements in SUD-related measures, these results cannot be disentangled to isolate and attribute a specific portion of the change to each source. It is likely the concerted efforts of all of these approaches have produced the observed results.

Background on Other State Initiatives

State Initiatives

HSD operated several programs, initiatives, and grants outside of Centennial Care 2.0 to provide care for its members. One such grant, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), is the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant.[7-2] The goal of the grant is to provide integrated physical and behavioral healthcare to 795 consumers in the State of New Mexico affected by a SUD or mental illness (MI) and having a chronic physical health condition. The grant was approved for five years, beginning in 2019 and ending in 2023. Through the grant, behavioral health and primary care providers meet regularly and discuss patient needs while providing prevention-based services to members with a SUD or MI. Additionally, a large portion of the grant was directed to increasing the workforce capacity of Community Health Workers (CHWs) and Certified Peer Support Workers (CPSWs). CHWs and CPSWs engage SUD or MI patients in health promotion activities and is to be completed by training CHWs and CPSWs on health promotion Evidence-Based Practices (EBPs) and integrating CHWs and CPSWs into care coordination teams.[7-3]

HSD developed numerous SUD health information technology (HIT) initiatives, including a prescription drug monitoring program (PDMP). As of September 2021, approximately 87 percent of providers consulted the PDMP before prescribing medications.[7-4] Additionally, HSD implemented an emergency department (ED) information exchange (EDIE) in health homes to assist CHWs in identifying barriers to care and promoting care coordination

7-1 Details of these programs can be found in the *Background on Other State Initiatives* section below.

7-2 Centennial Care 2.0 Demonstration. Section 1115 Annual Report, Demonstration Year: 6. Available at: http://nmhsd-old.sks.com/uploads/files/Public%20Information/Centennial%20Care/Quarterly%20Progress%20Reports/2019%20Quarter%20Reports/2020%20Quarterly%20Reports/DY6%20Annual%20CMS%20Monitoring%20Report_FINAL(1).pdf. Accessed on Apr. 25, 2022.

7-3 Substance Abuse and Mental Health Services Administration. SM-17-008 Individual Grant Awards 2018. Available at: https://www.samhsa.gov/grants/awards/2018/SM-17-008. Accessed on Apr. 27, 2022.

7-4 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 8, Quarter 3. Available at: https://www.hsd.state.nm.us/wp-content/uploads/NM_1115-DY8Q3_CMS-Quarterly-Monitoring-Report_20211228.pdf. Accessed on April 25, 2022.

prior to discharge. The EDIE is an electronic platform that tracks high-risk patients and high utilizers of the ED. ED providers receive real-time notifications and insights when a high-risk patient checks into the ED and case managers can identify high utilizers who require additional patient needs through the EDIE.[7-5] All health homes were registered with the EDIE and received training.

HSD tracked the number of providers who received training on pain management techniques through Project Extension for Community Healthcare Outcomes (ECHO). Although the number of trainings provided dropped due to COVID-19PHE, enrollment remained high through the option to participate in virtual trainings. In addition to its provider tracking, Project ECHO continues to share best practice treatment protocols to improve healthcare and education in rural and underserved communities.[7-6] Project ECHO New Mexico programs include education on topics such as MAT, opioid use disorder (OUD), and Medicaid quality improvement, which is also a requirement for provider licensing.

HSD and the MCOs worked together on the drug utilization review (DUR) committee to develop a monitoring program for controlled substances. The committee met quarterly to discuss accomplishments regarding monitoring parameters and gather input from the MCOs regarding improving the support for the clinicians' review of a member's history of controlled substance prescriptions from the PDMP.[7-7]

HSD collaborated with the MCOs to reduce non-emergent ED visits through the Low Acuity Non-Emergent (LANE) Care initiative. Each MCO utilized a different strategy to address reducing non-emergent visits. Blue Cross Blue Shield of New Mexico (BCBS) monitored member utilization of ED visits. Presbyterian Health Plan (PHP) worked with providers to encourage members to engage with preventive services and maintain their health instead of relying on emergency services. Western Sky Community Care (WSCC) performed outreach and addressed care needs with members who had more than three ED visits within 30 days or members who had a mental health or SUD related ED visit. Through the Community Paramedicine Program, paramedics engaged with members who had unreliable transportation or were located in rural areas to reduce non-emergent ED visits by providing basic primary care to members in their own homes. Paramedics also helped encourage and deliver communication between members and their primary care provider.[7-8]

HSD created a new department called OSAP within the Behavioral Health Services Division which focused on improving and maximizing New Mexico's substance abuse prevention system and ultimately reduced alcohol, tobacco, and other drug abuse. OSAP coordinated grants and other projects across the State to help achieve HSD's goals.[7-9]

HSD also manages the New Mexico Opioid Crisis State Targeted Response Grant (Opioid STR). The goals of the Opioid STR are to 1) increase the number of people receiving OUD treatment; 2) increase the number of people receiving OUD recovery services; 3) increase the number of providers providing MAT; 4) increase the number of trained OUD prevention and treatment providers; and 5) decrease the rate of opioid misuse, opioid overdoses, and opioid-related deaths. The Opioid STR grant funds are also used for the training and distribution of Narcan

7-5 Your Guide to PreManage ED (aka EDIE): The Technology Platform for New Mexico's ER is for Emergencies Project. Available at: https://www.nmhanet.org/files/Documents/PreManage-ED9-16.pdf. Accessed on May 9, 2022.

7-6 The University of New Mexico. ECHO's Lasting Impact in New Mexico. Available at: https://hsc.unm.edu/echo/where-we-work/new-mexico.html. Accessed on June 13, 2022.

7-7 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 8, Quarter 3. Available at: https://www.hsd.state.nm.us/wp-content/uploads/NM_1115-DY8Q3_CMS-Quarterly-Monitoring-Report_20211228.pdf. Accessed on April 25, 2022.

7-8 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 8, Quarter 3. Available at: https://www.hsd.state.nm.us/wp-content/uploads/NM_1115-DY8Q3_CMS-Quarterly-Monitoring-Report_20211228.pdf. Accessed on April 25, 2022.

7-9 New Mexico Prevention. Available at: http://www.nmprevention.org/index.html. Accessed on April 25, 2022.

(naloxone) to first responders across the State and for the training of health care providers to provide MAT to people with OUD.[7-10]

MCO Initiatives

In addition to the statewide initiatives led by HSD, MCOs also developed and lead their own organization specific initiatives to support their members. Table 7-1 provides a high-level summary of key MCO initiatives.

Table 7-1 — MCO Initiatives

MCO	Initiative	Program Description
BCBS	Behavioral Health Care Coordination Community Outreach	Performed outreach to members to assist with medication compliance.[7-11]
	Alexa Echo Dot Pilot	Utilized Alexa Echo Dots to help members remember to complete specific health-related tasks.[7-12]
	Peer Support Worker Outreach Initiatives	20 peer support workers (PSWs) who had previously experienced a SUD or mental health condition worked to connect with members and act as a model towards recovery.[7-13]
	Target of emergency room (ER) usage for those members diagnosed with substance abuse, while utilizing the work of recovery support assistants (RSA) (certified peers)	RSAs and Transition of Care (TOC) staff utilized the EDIE to identify members at risk of future ED visits and provide support and services to discourage further ED usage.[7-14]
	Telehealth Grant Program Update	Awarded funds to providers to develop or expand telehealth services.[7-15]
PHP	Diabetes Prevention Program	Partnered with Good Measures to develop The Path for Wellness Diabetes Prevention Program aimed at reducing members' risk of developing Type 2 diabetes.[7-16]

7-10 New Mexico Prevention. Opioid Crisis Targeted Response Grant (Opioid STR) Available at: http://www.nmprevention.org/Opioid-STR.html. Accessed on July 9, 2022.

7-11 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 8, Quarter 2. Available at: https://www.hsd.state.nm.us/wp-content/uploads/NM_1115-DY8Q2_CMS-Quarterly-Monitoring-Report_20210827.pdf. Accessed on April 25, 2022.

7-12 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 6, Quarter 1. Available at: http://nmhsd-old.sks.com/uploads/files/Public%20Information/Centennial%20Care/Centennial%20Care%202.0/DY6Q1_Progress%20Report_FINAL.pdf. Accessed on April 25, 2022.

7-13 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 6, Quarter 2. Available at: http://nmhsd-old.sks.com/uploads/files/DY6Q2_CMS%20Monitoring%20Report_FINAL.pdf. Accessed on April 25, 2022.

7-14 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Annual Report, Demonstration Year 7. Available at: https://www.hsd.state.nm.us/wp-content/uploads/DY7_CMS-Annual-Monitoring_To-CMS.pdf. Accessed on April 25, 2022.

7-15 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 6, Quarter 3. Available at: http://nmhsd-old.sks.com/uploads/files/Public%20Information/Centennial%20Care/Quarterly%20Progress%20Reports/2019%20Quarter%20Reports/DY6Q3_CMS%20FINAL.pdf. Accessed on April 25, 2022.

7-16 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 6, Quarter 3. Available at: http://nmhsd-old.sks.com/uploads/files/Public%20Information/Centennial%20Care/Quarterly%20Progress%20Reports/2019%20Quarter%20Reports/DY6Q3_CMS%20FINAL.pdf. Accessed on April 25, 2022.

MCO	Initiative	Program Description
WSCC	Pay for Performance to Increase Pediatric Appointments	Negotiated with a large medical provider group to agree upon a pay-for-performance (P4P) arrangement for pediatric care and contracted with a vendor that facilitates the P4P program.[7-17]
	MyStrength Initiative	Developed an online virtual mental health club program that provides tools for members to implement a healthier lifestyle.[7-18]
	Improving Adherence to Antidepressants	A pharmacy team was developed to identify members at risk of running out of medication and helped members obtain a new prescription.[7-19]
	Telehealth for behavioral health (BH) follow-up after acute inpatient psychiatric discharges	Contracted with Teambuilders, a BH agency, to provide telehealth assessment services within seven days post discharge from an inpatient mental health stay.[7-20]
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Outreach	Identified providers serving members who were prescribed antipsychotics but had not completed a glucose or lipid test in the past year. Educational outreach was performed to the providers with noncompliant members.[7-21]
	Expanding Access for Native American Members	Collaborated with tribal governments, tribal facilities, and external providers to expand services to tribal entities.[7-22]
	Assisting Tribal Communities	Provided COVID-19 care packages, back-to-school backpacks, and provider language assistance posters, a resource used to reduce language barriers in health care clinics, to tribal communities.[7-23]

COVID-19 Initiatives

Effective March 15, 2020, two days after the President of the United States declared COVID-19 a national emergency, states were able to request the use of Section 1135 waivers. Section 1135 waivers were granted to

7-17 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 6, Quarter 1. Available at: http://nmhsd-old.sks.com/uploads/files/Public%20Information/Centennial%20Care/Centennial%20Care%202.0/DY6Q1_Progress%20Report_FINAL.pdf. Accessed on April 25, 2022.

7-18 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 6, Quarter 3. Available at: http://nmhsd-old.sks.com/uploads/files/Public%20Information/Centennial%20Care/Quarterly%20Progress%20Reports/2019%20Quarter%20Reports/DY6Q3_CMS%20FINAL.pdf. Accessed on April 25, 2022.

7-19 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 7, Quarter 2. Available at: http://nmhsd-old.sks.com/uploads/files/Public%20Information/Centennial%20Care/Quarterly%20Progress%20Reports/2019%20Quarter%20Reports/2020%20Quarterly%20Reports/DY7%20Q2%20CMS%20Monitoring%20Report_FINAL.pdf. Accessed on April 25, 2022.

7-20 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 8, Quarter 1. Available at: https://www.hsd.state.nm.us/wp-content/uploads/DY8_Q1_CMS-Monitoring-Report_To-CMS.pdf. Accessed on April 25, 2022.

7-21 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 8, Quarter 3. Available at: https://www.hsd.state.nm.us/wp-content/uploads/NM_1115-DY8Q3_CMS-Quarterly-Monitoring-Report_20211228.pdf. Accessed on April 25, 2022.

7-22 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 7, Quarter 1. Available at: http://nmhsd-old.sks.com/uploads/files/Public%20Information/Centennial%20Care/Quarterly%20Progress%20Reports/2019%20Quarter%20Reports/2020%20Quarterly%20Reports/DY7Q1_CMS%20Monitoring%20Report_FINAL.pdf. Accessed on April 25, 2022.

7-23 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 7, Quarter 3. Available at: http://nmhsd-old.sks.com/uploads/files/Public%20Information/Centennial%20Care/Quarterly%20Progress%20Reports/2019%20Quarter%20Reports/2020%20Quarterly%20Reports/DY7_CMS%20Monitoring%20Report_To%20CMS.pdf. Accessed on April 25, 2022.

states through the authority of Section 1135 of the Social Security Act, which permits the United States Health and Human Services Secretary to temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure sufficient care and services are provided during a PHE.[7-24] On March 19, 2022, New Mexico submitted a Section 1135 waiver request.[7-25] New Mexico's request included permission for the State to suspend prior authorizations and extend existing authorizations to ensure that all medically necessary emergency care was covered. The removal of prior-authorization requirements ensured members were able to receive care throughout the PHE when proper documentation would not be feasible. The Section 1135 waiver request allowed payments to facilities for services provided in alternative settings. This allowed providers to provide care outside of their typical setting, including in an unlicensed facility. As a result, care could be provided in locations such as temporary shelters, ensuring that all medically necessary emergency care needed could be provided. The Centers for Medicare & Medicaid Services (CMS) approved the request for the Section 1135 waiver on March 23, 2020.[7-26]

In addition to the Section 1135 waiver, HSD issued various flexibilities and expansions in coverage and benefits. On May 6, 2020, HSD issued Special COVID-19 letter of direction (LOD) #6—Care Coordination and Other In-Home Services and Community Benefits to the MCOs, modifying the requirements for care coordination and in-home services and community benefits.[7-27] LOD #6 allowed the MCOs to waive the requirement that care coordination visits be in person, thereby shifting care coordination services to operate through telephonic or virtual visits. Telehealth was further expanded in Special COVID-19 LOD #13—Telehealth Services, later repealed and replaced by Special COVID-19 LOD #13-1, during the COVID-19 PHE, when HSD directed MCOs to notify providers that all possible services should be rendered via telehealth and activated new billing codes to encourage the use of telephonic or e-visits instead of in-person care for certain providers. Other providers were directed to use the same codes and rates as face-to-face care when billing for services.[7-28] The LOD included instructions on how physical health, behavioral health, applied behavior analysis, skilled nursing, and dental providers should bill for services rendered telephonically or through telehealth e-visits. The prior authorizations waived through the Section 1135 waiver were further supplemented through Special COVID-19 LOD #9—COVID-19 Special Requirement for Prior Authorization and Cost-Sharing, later repealed and replaced by Special COVID-19 LOD #9-1, through which HSD waived prior authorizations for members seeking treatment or COVID-19 testing and extended the existing prior authorizations for all other non-COVID-19 related services.[7-29] All modifications allowed through these LODs were retroactively effective on March 11, 2020, and remain valid for the duration of the PHE.

In addition to making modifications to the Medicaid system, HSD unveiled a phone application (app) called NMConnect, allowing users to access behavioral health professionals 24/7. The app was created as a new feature

7-24 Centers for Medicare & Medicaid Services. 1135 Waivers. Available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers. Accessed on Apr. 27, 2022.

7-25 New Mexico Human Services Department. 1135 Waiver Request. Available at: https://nmmedicaid.portal.conduent.com/static/PDFs/NM%201135%20Waiver.pdf. Accessed on Apr. 27, 2022.

7-26 Centers for Medicare & Medicaid Services. Section 1135 Waiver Flexibilities – New Mexico Coronavirus Disease 2019. Available at: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/entry/54032. Accessed on Apr. 27, 2022.

7-27 New Mexico Human Services Department. Special COVID-19 Letter of Direction #6. Available at: https://nmmedicaid.portal.conduent.com/static/PDFs/Special%20COVID19%20LOD6%20Coordination%20and%20Other%20In-Home%20Services%20Community%20Benefits.pdf. Accessed on Apr. 27, 2022.

7-28 New Mexico Human Services Department. Special COVID-19 Letter of Direction #13. Available at: https://nmmedicaid.portal.conduent.com/static/PDFs/COVIDLOD__Telehealth.pdf. Accessed on Apr. 27, 2022.

7-29 New Mexico Human Services Department. Special COVID-19 Letter of Direction #9. Available at: https://nmmedicaid.portal.conduent.com/static/PDFs/Special%20COVID19%20LOD9%20Prior%20Authorizations%20and%20Cost%20Sharing.pdf. Accessed on Apr. 27, 2022.

of the standard crisis line that existed prior to the app's release.[7-30] The app was launched in April 2020 as a tool to help combat mental health distress caused by the COVID-19 PHE as well as other mental health concerns unrelated to COVID-19.[7-31]

In April 2021, HSD formed a COVID-19 workgroup focused on increasing the COVID-19 vaccination rate in New Mexico. Participants included representative from 18 organizations including HSD, the New Mexico Department of Health, the Public Education Department, Centennial Care MCOs and professional societies including the New Mexico Nurse Practitioner Council, the New Mexico Pediatric Society, the New Mexico Medical Society and the New Mexico Pharmacists Association. The workgroup met regularly to analyze COVID-19 vaccination data, discuss developments in COVID-19 vaccines, identify and resolve barriers and to disseminate information to the organizations and their members.

MCO COVID-19 Initiatives

In addition to the statewide COVID-19 initiatives led by the State, MCOs also developed and led their own organization-specific COVID-19 initiatives to support their members. Table 7-2 provides a high-level summary of key MCO initiatives.

Table 7-2—MCO COVID-19 Initiatives

MCO	Initiative	Program Description
BCBS	GotShots! Campaign and Healthify	Facilitated care coordination activities to encourage vaccination and COVID-19 education.[7-32]
PHP	Food Insecurity Initiative for COVID-19 Positive Members	Monitored members through Clinical Data Integration data and provided 14 days' worth of meals to members testing positive for COVID-19.[7-33]
WSCC	1, 2, 3 Eyes on Me	Partnered with New Mexico Appleseed, a poverty advocacy organization, to host events targeted at members who had barriers to care due to the COVID-19 PHE, providing assistance in registering for a COVID-19 vaccine along with direct needs resources personal to the members' care needs.[7-34]

7-30 New Mexico Crisis and Access Line. NMConnect. Available at: https://nmmedicaid.portal.conduent.com/static/PDFs/Announcing%20the%20NMConnect%20mobile%20app.pdf. Accessed on Apr. 27, 2022.

7-31 The State of New Mexico. New Mexico Unveils App for Behavioral Health Support. Available at: https://www.newmexico.gov/2020/04/14/new-mexico-unveils-app-for-behavioral-health-support/. Accessed on Apr. 27, 2022.

7-32 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 8, Quarter 3. Available at: https://www.hsd.state.nm.us/wp-content/uploads/NM_1115-DY8Q3_CMS-Quarterly-Monitoring-Report_20211228.pdf. Accessed on April 25, 2022. .

7-33 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 7, Quarter 3. Available at: http://nmhsd-old.sks.com/uploads/files/Public%20Information/Centennial%20Care/Quarterly%20Progress%20Reports/2019%20Quarter%20Reports/2020%20Quarterly%20Reports/DY7_CMS%20Monitoring%20Report_To%20CMS.pdf. Accessed on April 25, 2022.

7-34 Centennial Care 2.0 Demonstration. Section 1115 Demonstration Quarterly Report, Demonstration Year: 8, Quarter 3. Available at: https://www.hsd.state.nm.us/wp-content/uploads/NM_1115-DY8Q3_CMS-Quarterly-Monitoring-Report_20211228.pdf. Accessed on April 25, 2022.

8. Lessons Learned and Recommendations

Previous sections in this Interim Evaluation Report provide background on the Centennial Care 2.0 Medicaid 1115 Demonstration Waiver; a description of the evaluation research questions, hypotheses, measures, data sources and methodology; results; conclusions; and interpretation. This section of the Interim Evaluation Report presents lessons learned from the evaluation and recommendations for future improvements.

Peer Support

Despite the coronavirus disease 2019 (COVID-19) public health emergency (PHE), the analysis results suggested that peer support services were effective at getting more individuals with substance use disorder (SUD) to initiate alcohol and other drug (AOD) abuse or dependence treatment, increase the tenure of treatment, and maintain the continuity of pharmacotherapy for opioid use disorder (OUD).

Recommendations

- Continue to encourage peer support enrollment.
- Consider ways to expand peer support services to help improve other SUD-related measures that are a part of Aim 4.

COVID-19 PHE Impacts

The interim evaluation report analysis results have identified areas where the PHE has produced delayed impacts that began to manifest in 2021. There may be additional future impacts from the PHE, particularly around the release of pent-up demand for services.

Recommendation

- Anticipate and prepare for delayed PHE impacts, particularly around the costs of care. While the costs of care do not reflect current state expenditures, the costs of providing care borne by the managed care organizations (MCOs) are good predictors of the direction of future capitation rates, which will eventually impact State expenditures.

Centennial Rewards Performance Measures

The measures used to evaluate the Centennial Rewards Program are insufficient to rigorously evaluate the efficacy of the program. The current measures and methods do not provide adequate control for participant self-selection bias, inasmuch as members who are more involved with their health care and likely to receive preventive service may be more likely to participate in the program as they know they will receive rewards for behaviors they would have exhibited even if not enrolled in the program.

Recommendation

- In collaboration with Finity and Health Services Advisory Group, Inc. (HSAG), develop additional measures that meet one of the following criteria:

- A valid comparison group can be identified consisting of members who are similar in measure characteristics, such as gender, age, chronic health conditions, and general health risk-adjustment scores that will facilitate a difference-in-differences (DiD), or similar, analysis.
- Sufficient data are available prior to the implementation of the Centennial Rewards that will allow for an interrupted time series (ITS) analysis or with robust and valid comparison group(s) available for DiD.

Aim Three, Hypothesis Three

Aim 3, Hypothesis 3 states that "Implementation of electronic visit verification (EVV) is associated with increased accuracy in reporting services rendered" and has two associated measures. The first measure (Measure 28: *Number of submitted claims through EVV*) is a process measure that only measures the extent to which EVV is being used and provides no information on the effect of expanding EVV use. The second measure (Measure 29: *Percentage of paid or unpaid hours retrieved due to false reporting*), due to its self-reported nature, provided very little information from which to evaluate the impact of the expansion of EVV on the accuracy of reporting services rendered.

Recommendation

- If an equivalent level of data-reporting for Measure 29 is expected to continue, the New Mexico Human Services Department (HSD) should consider working with the MCOs and HSAG to identify robust measures of the accuracy of the reporting of services rendered.

[RESERVED for APPENDIX C: State Public Notices]

[RESERVED for APPENDIX D: Summary of Stakeholder Feedback and State Response]

Appendix E: Current Centennial Care Eligibility Groups

- Mandatory and optional State Plan groups described below derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived and as described in the current 1115 Waiver Standard Terms and Conditions.
- Table 1 describes the mandatory State Plan populations included in Centennial Care;
- Table 2 describes the optional State Plan populations included in Centennial Care; and
- Table 3 below, describes the beneficiary eligibility groups who are made eligible for benefits by virtue of the expenditure authorities expressly granted in this demonstration (i.e. the 217-like group).

Table 1. Mandatory State Plan Populations

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
Parents/Caretaker Relatives	Low Income Families (1931) 42 CFR §435.110	No	TANF and Related
Transitional Medical Assistance	Families with 12 month extension due to earnings 3. §408(a)(11)(A) 1. §1931(c)(2) 1. §1925 1. §1902(a)(52) and 1902(e)(1)	No	TANF and Related
Extension due to Spousal Support	Families with 4 month extension due to increased collection of spousal support 1. §408(a)(11)(B) 1. §1931(c)(1) 42 CFR §435.115	No	TANF and Related
Pregnant Women	Consolidated group for pregnant women 1. §§1902(a)(10)(A)(i)(III) and (IV) 1. §§1902(a)(10)(A)(ii)(I), (IV) and (IX) 1. §1931(b) and (d) 42 CFR §435.116	No	TANF and Related
Children under Age 19	Consolidated group for children under age 19 1. §§1902(a)(10)(A)(i)(III), (IV), (VI) and (VII) 1. §§1902(a)(10)(A)(ii)(IV) and (IX) 1. §1931(b) and	No	TANF and Related

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
	(d) 42 CFR §435.118		
Continuous Eligibility for Hospitalized Children	Children eligible under 42 CFR §435.118 receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay §1902(e)(7) 42 CFR §435.172	No	TANF and Related
Deemed Newborns	Newborns deemed eligible for one year §1902(e)(4) 42 CFR §435.117	No	TANF and Related
Adoption Assistance and Foster Care Children	Children receiving IV-E foster care or guardianship maintenance payments or with IV-E adoption assistance agreements – §1902(a)(10)(i)(I) – §473(b)(3) 42 CFR §435.145	No	TANF and Related
Former Foster Care Children	Former foster care children under age 26 not eligible for another mandatory group 1902(a)(10)(A)(i)(IX) 42 CFR §435.150	No	TANF and Related
Adult group	Non-pregnant individuals age 19 through 64 with income at or below 133% FPL 1902(a)(10)(A)(i)(VIII) 42 CFR §435.119	No	VIII Group
Aged, Blind, and Disabled	Individuals receiving SSI cash benefits 1902(a)(10)(A)(i)(II) Disabled children no longer eligible for SSI benefits because of a change in the definition of disability	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals under age 21 eligible for Medicaid in the month they apply for SSI 1902(a)(10(A)(i)(II)(cc)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Disabled individual whose earning exceed SSI substantial gainful activity level 1902(a)(10)(A)(i)(II) 1619(a)	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
Aged, Blind, and Disabled	Individuals receiving mandatory State supplements 42 CFR §435.130	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Institutionalized individuals continuously eligible for SSI in December 1973 42 CFR §435.132 Blind and disabled individuals eligible for SSI in December 1973 42 CFR §435.133	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals who would be eligible for SSI except for the increase in OASDI benefits under Public Law 92-336 42 CFR §435.134	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals ineligible for SSI because of requirements inapplicable in Medicaid 42 CFR §435.122	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Disabled widows and widowers Early widows/widowers 1634(b) 42 CFR §435.138	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Individuals who become ineligible for SSI as a result of OASDI cost-of- living increases received after April 1977 42 CFR §435.135	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	1939(a)(5)(E) Disabled adult children 1634(c).	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Disabled individuals whose earnings are too high to receive SSI cash 1619(b).	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
	Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not		SSI Medicaid only (if not eligible for Medicare)

A. Mandatory Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?	D. MEG for Budget Neutrality
Aged, Blind, and Disabled	exceed 300% of the SSI income standard 1902(a)(10)(A)(ii)(V) 1905(a) 42 CFR §435.236.	NF LOC: Included PACE: Excluded ICFMR: Excluded	SSI Dual (if eligible for Medicare)

Table 2. Optional State Plan Populations

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on Centennial Care 2.0?	D. MEG for Budget Neutrality
Optional Targeted Low Income Children	Optional group for uninsured children under age 6 1902(a)(10)(A)(ii)(XIV) 42 CFR §435.229. Note: If sufficient Title XXI allotment is available as described under STC 84, uninsured individuals in this eligibility group are funded through the Title XXI allotment. Insured individuals in this eligibility group are funded through Title XIX, and if Title XXI funds are exhausted as described in STC 85, then all individuals in this eligibility group are funded through Title XIX.	No	If Title XIX: TANF and Related If Title XXI: MCHIP Children
Optional Reasonable Classification of Children	Optional group for children under age 19 not eligible for a mandatory group §§1902(a)(10)(A)(ii)(I) and (IV) 42 CFR §435.222.	No	TANF and Related
Independent Foster Care Adolescents	Individuals under age 21 who were in foster care on their 18th birthday 1902(a)(10)(A)(ii)(XVII) 42 CFR §435.226.	No	TANF and Related

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on Centennial Care 2.0?	D. MEG for Budget Neutrality
Out-of-State Former Foster Care Children	Individuals under age 26 who were in foster care in a state other than New Mexico or tribe in such other state when they aged out of foster care 1902(a)(10)(A)(ii)(XX) 42 CFR §435.218.	No	TANF and Related
Aged, Blind, and Disabled	Working disabled Individuals 1902(A)(10)(A)(ii)(XIII).	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Aged, Blind, and Disabled	Working disabled Individuals 1902(A)(10)(A)(ii)(XIII).	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Institutionalized Individuals	Individuals who would be eligible for SSI cash if not in an institution 1902(a)(10)(A)(ii)(IV) 1905(a) 42 CFR §435.211.	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Breast and Cervical Cancer Program	Uninsured individuals under 65 screened and found to need treatment for breast or cervical cancer 1902(a)(10)(A)(ii)(XVIII) 42 CFR §435.213.	No	TANF and Related

A. Optional Medicaid Eligibility Groups in State Plan	B. Description Statutory/ Regulatory Citations	C. Limitations on Centennial Care 2.0?	D. MEG for Budget Neutrality
Home- and Community- Based 1915(c) Waivers that are continuing outside the demonstration (217 group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR §435.217, 435.236 and 435.726 and section 1924 of the Act, through the State's 1915(c) Developmentally Disabled waiver.	1915(c) waiver services are not provided through Centennial Care 2.0	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Home- and Community- Based 1915(c) Waivers that are continuing outside the demonstration (217 group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR §435.217, 435.236 and 435.726 and section 1924 of the Act, through the State's 1915(c) Medically Fragile waiver.	1915(c) waiver services are not provided through Centennial Care 2.0	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Home- and Community- Based 1915(c) Waivers that were transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who would only be eligible in an institution in the same manner as specified under 42 CFR §435.217, 435.236 and 435.726 and section 1924 of the Social Security Act, if the State had not eliminated its 1915(c) AIDS, Colts, and Mi Via-NF waivers.	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)
Home- and Community- Based 1915(c) Waivers that are continuing outside of the demonstration (217 group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR §435.217, 435.236 and 435.2276 and section 1924 of the Act.	No	SSI Medicaid only (if not eligible for Medicare) SSI Dual (if eligible for Medicare)

Table 3. Demonstration Expansion Populations

A. Expansion Medicaid Eligibility Group	B. Description Statutory/ Regulatory Citations	C. Standards and Methodologies	D. Limitations on inclusion in Centennial Care 2.0?	E. MEG for Budget Neutrality
Home- and Community-Based 1915(c) Waivers that were transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who would only be eligible in an institution in the same manner as specified under 42 CFR §435.217, 435.236 and 435.726 and section 1924 of the Social Security Act, if the State had not eliminated its 1915(c) AIDS, Colts, and Mi Via-NF Waivers.	Income test: 300% of Federal Benefit Rate with NF LOC determination. Resource test: $2000	No	**SSI Medicaid only (if not eligible for Medicare)** **SSI Dual (if eligible for Medicare)**
Home- and Community-Based 1915(c) Waivers that were transitioned into the demonstration (217-like group)	Individuals whose eligibility is determined using institutional eligibility and post eligibility rules for individuals who are eligible as specified under 42 CFR §435.217, 435.236 and 435.2276 and section 1924 of the Act.	Income test: 300% of Federal Benefit Rate with NF LOC determination. Resource test: $2000	No	**SSI Medicaid only (if not eligible for Medicare)** **SSI Dual (if eligible for Medicare)**

Table 4: Limited Benefit Group Enrollees

A. Limited Benefit Medicaid Eligibility Group	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?
Individuals eligible for family planning services only (category 029)	Individuals whose coverage is limited under section 42 CFR §435.214 is expanded to include COVID-19 vaccine and vaccine administration whose coverage is limited under section 6008 of the Family First Coronavirus Response Act (FFCRA).	These are FFS individuals with limited benefits.
Pregnancy Related Services (category 301)	Individuals whose coverage is limited under section 42 CFR §435.4 is expanded to include COVID-19 vaccine and vaccine administration whose coverage is limited under section 6008 of the Family First Coronavirus Response Act (FFCRA).	Yes, in CC 2.0 with limited benefits.
COVID-19 Testing Group (category 085;Federal Match 8)	Individuals whose coverage is limited/authorized through the Families First Coronavirus Response Act (FFCRA) is expanded to include COVID-19 vaccine and vaccine administration whose coverage is limited	These are FFS individuals with limited benefits.

A. Limited Benefit Medicaid Eligibility Group	B. Description Statutory/ Regulatory Citations	C. Limitations on inclusion in Centennial Care 2.0?
	under section 6008 of the Family First Coronavirus Response Act (FFCRA).	
Emergency Medical Services for aliens (EMSA) (category 085;Federal Match 4)	Individuals whose coverage is limited under section 42 CFR §440.255 is expanded to include COVID-19 vaccine and vaccine administration whose coverage is limited under section 6008 of the Family First Coronavirus Response Act (FFCRA).	These are FFS individuals with limited benefits.

Appendix F: Centennial Care Current Benefits

Table 1 describes the current non-CB services, including services available under the ABP. Table 2 lists the CB services. Table 3 lists the services available only through Centennial Care.

Table 1: Centennial Care Non-Community Benefit Services

Service	Medicaid State Plan	ABP Services
Accredited Residential Treatment Center Services	X	X Age limited
Applied Behavior Analysis (ABA)	X	X Age Limited
Adult Psychological Rehabilitation Services	X	X
Ambulatory Surgical Center Services	X	X
Anesthesia Services	X	X
Assertive Community Treatment Services	X	X
Bariatric Surgery	X	X Lifetime limit
Behavior Management Skills Development Services	X	X Age Limited
Behavioral Health Professional Services: outpatient behavioral health and substance abuse services	X	X
Cancer Clinical Trials	X	X
Case Management	X	
Comprehensive Community Support Services	X	X
Day Treatment Services	X	X Age limited
Dental Services	X	X
Diagnostic Imaging and Therapeutic Radiology Services	X	X
Dialysis Services	X	X
Durable Medical Equipment and Supplies	X	X Limits apply
Emergency Services (including emergency department visits, psychiatric ER, and ground/air ambulance services)	X	X
Experimental or Investigational Procedures, Technology or Non-Drug Therapies61	X	X
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	X	X Age Limited
EPSDT Personal Care Services	X	X Age Limited
EPSDT Private Duty Nursing	X	X Age Limited

[61] Experimental and investigational procedures, technologies or therapies are only available to the extent specified in MAD 8.325.6.9 or its successor regulation.

Service	Medicaid State Plan	ABP Services
EPSDT Rehabilitation Services	X	X Age Limited
Family Planning	X	X
federally Qualified Health Center Services	X	X
Hearing Aids and Related Evaluations	X	
Home Health Services	X	X Limits apply
Hospice Services	X	X
Hospital Inpatient (including Detoxification services and medical/surgical care)	X	X
Hospital Outpatient	X	X
Inpatient Hospitalization in Freestanding Psychiatric Hospitals	X	X
Inpatient Rehabilitative Facilities	X	X Skilled nursing or acute rehab facility only
Intensive Outpatient Program Services	X	X
Immunizations	X	X
IV Outpatient Services	X	X
Diagnostic Labs, X-Ray and Pathology	X	X
Labor/Delivery and Inpatient Maternity Services	X	X
Medication Assisted Treatment for Opioid Dependence	X	X
Midwife Services	X	X
Multi-Systemic Therapy Services	X	
Non-Accredited Residential Treatment Centers and Group Homes	X	X Age limited
Nursing Facility Services	X	X
Nutritional Services	X	
Occupational Therapy Services	X	X Limits apply
Outpatient Hospital based Psychiatric Services and Partial Hospitalization	X	X
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital	X	X
Outpatient Health Care Professional Services	X	X
Outpatient Surgery	X	X
Prescription Drugs	X	X
Primary Care Services	X	X
Physical Therapy	X	X Limits apply

Service	Medicaid State Plan	ABP Services
Physician Visits	X	X
Podiatry Services	X	X Limits apply
Pre- and Post-Natal Care	X	X
Pregnancy Termination Procedures	X State-funded	X State-funded
Preventive Services	X	X
Prosthetics and Orthotics	X	X Limits apply
Psychosocial Rehabilitation Services	X	X
Radiation Therapy and Chemotherapy	X	X
Radiology Facilities	X	X
Rehabilitation Option Services (Psycho social rehab)	X	X Limits apply
Rehabilitation Services Providers	X	X Limits apply
Reproductive Health Services	X	X
Rural Health Clinics Services	X	X
School-Based Health Center Services	X	X
Smoking Cessation Services	X	X
Specialist Visits	X	X
Speech and Language Therapy	X	X Limits apply
Swing Bed Hospital Services	X	X
Telemedicine Services	X	X
Tot-to-Teen Health Checks	X	X Age Limited
Organ and Tissue Transplant Services	X	X Lifetime limit
Transportation Services (medical)	X	X
Treatment Foster Care	X	X Age Limited
Treatment Foster Care II	X	X Age Limited
Treatment of Diabetes	X	X
Urgent Care Services/Facilities	X	X
Vision Care Services	X	X Only for eye injury or disease; routine vision care not covered

Table 2: Centennial Care Current Community Benefit Services

Service Description	ABCB	SDCB
Adult Day Health	X	
Assisted Living	X	
Behavioral Support Consultation	X	X
Community Transition (community reintegration members only)	X	
Customized Community Supports		X
Emergency Response	X	X
Employment Supports	X	X
Environmental Modifications ($5,000 every 5 years)	X	X
Home Health Aide	X	X
Self-Directed Personal Care Services		X
Nutritional Counseling	X	X
Personal Care Services (Consumer Directed and Consumer Delegated)	X	X
Private Duty Nursing Services for Adults (RN or LPN)	X	X
Related Goods (phone, internet, printer etc...)		X
Respite	X	X
Skilled Maintenance Therapy Services (occupational, physical and speech therapy)	X	X
Specialized Therapies (acupuncture, biofeedback, chiropractic, cognitive rehabilitation therapy, Hippotherapy, massage therapy, Naprapathy, Native American Healers)		X
Non-Medical Transportation		X
Start-Up Goods		X

Table 3 – Services Available to Centennial Care Members Only

Service Description
Family Support
Behavioral Health Respite
Recovery Services
Community Interveners for the Deaf and Blind

Appendix G: Turquoise Care Community Benefit Limits

I. Adult Day Health (ABCB)

Adult Day Health services provide structured therapeutic, social and rehabilitative services designed to meet the specific needs and interests of members by the care plans incorporated into the care plan.

Adult Day Health Services are provided by a licensed adult day-care, community-based facility that offers health and social services to assist members to achieve optimal functioning. Private Duty nursing services and skilled maintenance therapies (physical, occupational and speech) may be provided within the Adult Day Health setting and in conjunction with the Adult Day Health services but would be reimbursed separately from reimbursement for Adult Day Health services.

II. Assisted Living (ABCB)

Assisted Living is a residential service that provides a homelike environment which may be in a group setting, with individualized services designed to respond to the individual needs as identified by and incorporated in the care plan.

Core services provide assistance to the member in meeting a broad range of activities of daily living including; personal support services (homemaker, chore, attendant services, meal preparation), and companion services; medication oversight (to the extent permitted under State law), 24-hour, on-site response capability to meet scheduled or unpredictable member's needs andto provide supervision, safety, and security. Services also include social and recreational programming. Coverage does not include 24-hour skilled care or supervision or the cost of room or board. Nursing and skilled therapy services are incidental, rather than integral to, the provision of assisted living services. Services provided by third parties must be coordinated with the assisted living provider.

Limits or Exclusions: The following services will not be provided to members in Assisted Living facilities: Personal Care, Respite, Environmental Modifications, Emergency Responseor Adult Day Health. The Assisted Living Program is responsible for all of these services at the Assisted Living Facility.

III. Behavior Support Consultation (ABCB and SDCB)

Behavior Support Consultation is the provision of assessment, treatment, evaluation and follow- up services to assist the member, parents, family enrollees and/or primary caregivers with copingskills which promote maintaining the member in a home environment.

Behavior Support Consultation: 1) informs and guides the member's providers with the services and supports as they relate to the member's behavior and his/her medically fragile condition; 2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to

interfering behavior and potentially reducing interfering behavior(s); 3) supports effective implementation based on a functional assessment; 4) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the member and his/her service and support providers. Based on the member'scare plan, services are delivered in an integrated/natural setting or in a clinical setting.

IV. Community Transition Services (ABCB)

Community Transition Services are one-time set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement (excluding assisted living facilities) to a living arrangement in a private residence where the person is directlyresponsible for his or her own living expenses. Allowable expenses are determined by the MCO based on the state's criteria outlined in these STCs and in 8.308.12.13.D.NMAC, and are monitored by the state to ensure the expenses are reasonable. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- Services necessary for the individual's health and safety such as but not limited to, pest eradication and one-time cleaning prior to occupancy; and
- Moving expenses.

Limits or Exclusions: Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. Community Transition Services are limited to $4,000 per person every five years. Deposits for Assisted Living Facilities are limited to a maximum of $500. In order to be eligible for this service, the person must have a NF stay of at least 90 days prior to transition to the community.

V. Customized Community Supports (SDCB)

Customized Community Supports include participation in community congregate day programs and centers that offer functional meaningful activities that assist with acquisition, retention or improvement in self-help, socialization and adaptive skills. Customized Community Supports may include day support models. Customized Community Supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings.

VI. Emergency Response (ABCB and SDCB)

Emergency Response services provide an electronic device that enables a member to secure helpin an emergency at home and avoid institutionalization. The member may also wear a portable

"help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when a "help" button is activated. The response center is staffed by trained professionals. Emergency response services include: installing, testing and maintaining equipment; training members, caregivers and first responders on use of the equipment; twenty-four (24) hour monitoring for alarms; checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.; and reporting member emergencies and changes in the member's condition that may affect service delivery. Emergencycategories consist of emergency response and emergency response high need.

VII. Employment Supports (ABCB and SDCB)

Employment Supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted. The job coach provides training, skill development, and employer consultation that a member may require while learning to perform specific work tasks on the job; co-worker training; job site analysis; situational and/or vocational assessments and profiles; education of the member and co-workers on rights and responsibilities; and benefits counseling. The service must be tied to a specific goal specified in the member's care plan.

Job development is a service provided to members by skilled staff. The service has five components: 1) job identification and development activities; 2) employer negotiations; 3) job restructuring; 4) job sampling; and 5) job placement.

Employment Supports will be provided by staff at current or potential work sites. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by members receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Limits or Exclusions: Payment shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program. FFP cannot be claimed to defray expenses associated with starting up or operating a business.

VIII. Environmental Modifications (ABCB and SDCB)

Environmental Modification services include the purchase and/or installation of equipment and/or making physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance his/her level of independence.
Adaptations include the installation of ramps and grab-bars; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing); turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and

mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light-activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating/cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems and/or signaling devices.

All services shall be provided in accordance with applicable federal, state, and local building codes. Excluded are those adaptations or improvements to the home that are of general utility andare not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction/remodeling services, provide administrative and technical oversight of construction projects, provide consultation to family enrollees, providers and contractors concerning environmental modification projects to the member's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

Limits or Exclusions: Environmental Modification services are limited to five thousand dollars ($6,000) every five (5) years. Additional services may be requested if a member's health and safety needs exceed the specified limit.

IX. Home Health Aide (ABCB and SDCB)

Home Health Aide services provide total care or assist a member in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampoo (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniquesand ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake. The Home Health Aide services assist the member in a manner that promotes an improved qualityof life and a safe environment for the member. Home Health Aide services can be provided outside the member's home. State plan Home Health Aide services are intermittent and provided primarily on a short-term basis; whereas, Home Health Aide services are provided hourly, for members who need this service for a long term basis. Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home Health Aides perform an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulationand exercise, household services essential to health care at home, assisting with medications that are normally self-administered, reporting changes in patient conditions and needs, and completingappropriate records. Home health aide services must be provided under the supervision of a registered nurse or other appropriate professional staff. Must make a supervisory visit to the member's residence at least every two weeks to observe and determine whether goals are being met. Home Health Aide Services must be provided by a state licensed Home Health Agency under the supervision of a registered nurse.

X. Non-Medical Transportation (SDCB)

Non-Medical Transportation services enable SDCB members to travel to and from community services, activities and resources as specified in the SDCB care plan.

Limits or Exclusions: Limited to 75 miles radius of the member's home. Non-Medical Transportation is limited to $1,000 per year. Not a covered service for minors.

XI. Nutritional Counseling (ABCB and SDCB)

Nutritional Counseling services include assessment of the member's nutritional needs, development and/or revision of the member's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritionalplan. Nutritional counseling must be provided by a state licensed dietician.

XII. Personal Care Services (ABCB and SDCB)

Personal Care Services (PCS) provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). There are two delivery models for ABCB and one for SDCB as follows:

Agency-Based Community Benefit:

1. Consumer delegated PCS allows the member to select the PCS agency to perform all PCS employer related tasks. The agency is responsible for ensuring PCS is delivered to the member in accordance with the care plan.
2. Consumer directed PCS allows the member to oversee his or her own PCS delivery, and requires the member to work with his or her PCS agency who then acts as a fiscal intermediary agency.

Self-Directed Community Benefit:

1. The member has employer authority and directly hires PCS caregivers or contracts with an agency.

XIII. Private Duty Nursing for Adults (ABCB and SDCB)

Private Duty Nursing services include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability for members who are twenty-one (21) years of age or older with intermittent or extended direct nursing care in the member's home. Services include medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance.

Limits or Exclusions*:* All services provided under Private Duty nursing require the skills of a Licensed Registered Nurse or a Licensed Practical Nurse under written physician's order in accordance with the New Mexico Nurse Practice Act, Code of federal Regulation for Skilled Nursing.

XIV. Related Goods (SDCB)

Related goods are equipment, supplies or fees and memberships, not otherwise provided through under Medicaid. Related goods must address a need identified in the member's care plan (including improving and maintaining the member's opportunities for full membership in the community) and meet the following requirements: be responsive to the member's qualifying condition or disability; and/or accommodate the member in managing his/her household; and/or facilitate activities of daily living; and/or promote personal safety and health; and afford the member an accommodation for greater independence; and advance the desired outcomes in the member's care plan; and decrease the need for other Medicaid services. Related goods will be carefully monitored by health plans to avoid abuses or inappropriate use of the benefit.
The member receiving this service does not have the funds to purchase the related good(s) or the related good(s) is/are not available through another source. These items are purchased from the member's individual budget.

Limits or Exclusions: Experimental or prohibited treatments and goods are excluded. Related goods are limited to $2,000 per person per care plan year.

XV. Respite (ABCB and SDCB)

Respite services are provided to members unable to care for themselves that are furnished on a short-term basis to allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite careis furnished at home, in a private residence of a respite care provider, in a specialized foster care home, in a hospital or NF or an ICF/IDD meeting the qualifications for provider certification. When respite care services are provided to a member by an institution, that individual will not be considered a resident of the institution for purposes of demonstration eligibility. Respite care services include: medical and non-medical health care; personal care bathing; showering; skin care; grooming; oral hygiene; bowel and bladder car; catheter and supra-pubic catheter care; preparing or assisting in preparation of meals and eating; as appropriate, administering enteral feedings; providing home management skills; changing linens; making beds; washing dishes; shopping; errands; calls for maintenance; assisting with enhancing self-help skills; promoting useof appropriate interpersonal communication skills and language; working independently without constant supervision/observation; providing body positioning, ambulation and transfer skills; arranging for transportation to medical or therapy services; assisting in arranging health care needs and follow-up as directed by primary care giver, physician, and case manager, ensuring thehealth and safety of the member at all times.

Limits or Exclusions: Respite services are limited to a maximum of 300 hours annually per care plan year.

XVI. Skilled Maintenance Therapy Services (ABCB and SDCB)

Skilled maintenance therapy services include Physical Therapy (PT), Occupational Therapy (OT)or Speech and Language Therapy (SLT) for individuals twenty-one years and older. These services are an extension of therapy services provided for acute and temporary conditions that areprovided with the expectation that the individual will improve significantly in a reasonable and generally predictable period of time. Skilled Maintenance Therapy services are provided to adults

with a focus on maintenance, community integration, socialization and exercise, or enhance support and normalization of family relationships. Services in this category include:

Physical Therapy

Physical Therapy services promote gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include: professional assessment(s), evaluation(s) and monitoring for therapeutic purposes; physical therapy treatments and interventions; training regarding PT activities, use of equipment and technologies or any other aspect of the individual's physical therapy services; designing, modifying or monitoring use of related environmental modifications;designing, modifying, and monitoring use of related activities supportive to the care plan goals and objectives; and consulting or collaborating with other service providers or family enrollees, as directed by the member. Physical Therapy services must be providedby a state licensed physical therapist.

Occupational Therapy Services

OT services promote fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. Specific services may include: teaching of daily living skills; development of perceptual motor skills and sensory integrative functioning; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment; use of specifically designed crafts and exercise to enhance function; training regarding OT activities; and consulting or collaborating with other service providers or family enrollees, as directed by the member. Occupational Therapy services must be provided by a state licensed occupational therapist.

Speech Language Therapy

SLT services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology, and/or prevent progressive disabilities. Specific services may include: identification of communicative or oropharyngeal disorders and delays in the development of communication skills; prevention of communicative or oropharyngeal disorders and delays in the development of communication skills; development of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the member's environment to meet his/her needs; training regarding SLT activities; and consulting or collaborating withother service providers or family enrollees, as directed by the member. Speech Language Therapy services must be provided by a state licensed speech and language pathologist.

Limits or Exclusions: A signed therapy referral for treatment must be obtained from the member's primary care physician. The referral must include frequency, estimated durationof therapy, and treatment/procedures to be rendered.

XVII. Specialized Therapies (SDCB)

Specialized Therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A member may include specialized therapies in his/her care plan when the services enhance opportunities to achieve inclusion in community activities and avoid institutionalization. Services must be related to the member's disability or condition, ensure the member's health and welfare in the community, supplement rather than replace the member's natural supports and other community services for which the member may be eligible, and prevent the member's admission to institutional services. Experimental or investigational procedures, technologies or therapies and those services covered as a Medicaid state plan benefit are excluded. Services in this category include:

Acupuncture

Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits. Acupuncture services providers must be licensed by the NM Board of Acupuncture and Oriental Medicine.

Biofeedback

Biofeedback uses visual, auditory or other monitors to feed back to members' physiological information of which they are normally unaware. This technique enables a member to learn how to change physiological, psychological and behavioral responses forthe purposes of improving emotional, behavioral, and cognitive health and performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

Chiropractic

Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis, for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health. Chiropractic services providers must be licensed by the NM Board of Chiropractic Examiners.

Cognitive Rehabilitation Therapy

Cognitive rehabilitation therapy services are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or

establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or toteach compensatory strategies to overcome specific cognitive problems. Cognitive Rehabilitation Therapy providers must have a license or certification with the appropriate specialized training, clinical experience and supervision, and their scope of practice must include Cognitive Rehabilitation Therapy.

Hippotherapy

Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for members with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the member use cognitive functioning, especially for sequencing and memory. Members with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and for individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production. Hippotherapy providers must havea state license in physical therapy, occupational therapy, or speech therapy, and their scopeof practice must include Hippotherapy.

Massage Therapy

Massage therapy is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a member's ability to be more independent in the performance of ADL living; thereby, decreasing dependency upon others to perform or assist with basic daily activities.

Naprapathy

Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body

function. Naprapathy providers must have a state license in Naprapathy.

Native American Healers

Native American Healers are a covered benefit under the self-directed community benefit. These services are subject to the $2,000 annual specialized therapies limits. These services may also be a value added service provided by the MCO, for which the MCO does not receive FFP for these services. There are twenty-two sovereign Tribes, Nations and Pueblos in New Mexico, as well as numerous Native American individuals who come from many other tribal backgrounds. Native American healing therapies encompass a widevariety of culturally-appropriate therapies that support members in their communities by addressing their physical and emotional health. Treatments may include dance, song, plantmedicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel. This form of therapy may be provided by community-recognized medicine men and women and others as healers, mentors and advisors to members, and provides opportunities for members to remain connected with their communities. The communal support provided by this type of healing can reduce pain and stress and improve quality of life.

Limits and Exclusions: Specialized therapies are limited to $2,000 annually.

Appendix H: Substance Use Disorder Continuum of Care

I. ASAM Level 0.5 Early Intervention

Screening, Brief Intervention, and Referral to Treatment (SBIRT) – New Mexico was part of the first cohort of states selected to receive SBIRT funding. In August 2013, SAMHSA awarded NMwith a new five year, $10 million grant to implement SBIRT at selected locations. SBIRT services integrate BH within primary care and community health care settings. Each medical partner site universally screens adult patients 18 years old or over at least annually to identify those at-risk of or those having a substance use disorder and offers brief intervention, brief treatment, and appropriate referral as needed. The following are the seven NM SBIRT medical partner sites and locations: White Sands Family Medical Practice, Alamogordo; Aspen Medical Center, Santa Fe; Christus St. Vincent Entrada Contenta, Santa Fe; Christus St. Vincent Family Medicine Center, Santa Fe; First Nations Community Health Source Zuni Clinic, Albuquerque; Santa Fe Indian Hospital, Santa Fe; University of New Mexico Hospital, Albuquerque. As of September 2017, 37,536 screens were conducted with 34,092 individuals screened. Grant fundingends July 30, 2018.

II. ASAM Level 1 Outpatient

This is a covered Medicaid benefit, covering a wide range of services including assessment, treatment plan development, individual and group therapy, crisis intervention, pharmacological management, suboxone induction, and methadone maintenance.

III. ASAM Level 2.1 Intensive Outpatient

This is a covered Medicaid benefit. Intensive outpatient (IOP) services are provided through an integrated multi-disciplinary approach or through coordinated, concurrent services with MH providers. The intent is to not exclude consumers with co-occurring disorders. IOP is availablefor adults with SUD or COD that meet ASAM patient placement criteria for Level II Intensive Outpatient Treatment.

IV. ASAM Level 2.5 Partial Hospitalization Services

Defined in the ASAM criteria as 20 or more hours of clinically intensive programming per week for multidimensional instability not requiring 24-hour care. This is currently a covered benefit forMH but not SUD. The state is currently revising the rule on partial hospitalization to include SUDas a covered benefit.

V. ASAM Level 3 Adult Residential Treatment

This is currently not a covered Medicaid benefit. SUD services at 11 adult residential treatment centers (RTCs) are state-funded. $7.2 million was spent in CY16, with a projection of close to $8million for CY17. A recent survey of eleven RTC providers showed 199 beds, with 126 for men and 73 for women, far less than what is needed. Nine of ten responding providers use ASAM admission criteria. Only two of ten are CARF accredited, but others are in process. The planned state plan amendment to include adult RTCs in the Medicaid program would enable important transitions of care within the SUD continuum to produce better outcomes for Medicaid members.

VI. Educational and Prevention Efforts

Naloxone Pharmacy Technical Assistance -New Mexico's Office of Substance Abuse Prevention (OSAP) has contracted with the Southwest CARE Center under the Opioid STR grant to provide technical assistance to NM pharmacies reimbursed by Medicaid to dispense naloxone for 100 pharmacy trainings over the two-year grant period, to be completed by September 2018.
Opioid treatment training – the Opioid STR grant supports training on MAT, including buprenorphine, to increase the availability of qualified staff and programs to address the needs ofpeoples with OUD and improve access to services.

Prescription drug monitoring – New Mexico's Office of Substance Abuse Prevention (OSAP) received SAMHSA's Strategic Prevention Framework for Prescription Drugs (SPF Rx), which provides $371,616 award per year for five years beginning September 1, 2016. The purpose of the grant is to raise awareness about the dangers of sharing medications, and promote collaboration between states, pharmaceutical and medical communities to understand the risks of over- prescribing to youth and adults; bring prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and users in a targeted community of high need; and promote increased incorporation of Prescription Monitoring Program (PMP) data into state and community level needs assessments and strategic plans.

Training on Medical Detoxification – Medically managed inpatient detoxification is a Medicaid reimbursable service if provided in general hospital settings. Standardized evidence-based protocols are available to systematically guide medically managed detoxification, but too often this has not been part of regular practice among general hospitalists and nurses in NM. To improve capacity, through CBHTR, New Mexico's Human Services Department supports trainingin evidence-based, medically-managed detoxification in community hospitals throughout the state.

Underage Drinking and Prescription Drug Abuse - New Mexico's Office of Substance Abuse Prevention (OSAP) was awarded a SAMHSA grant of $1.68 annually for 5 years ($8 million total) beginning October 2015 to address underage drinking and youth prescription drug abusethrough targeted strategic planning for selected New Mexico communities. Implementation ofevidence based strategies began August 2017.

PAX Good Behavior Game – PAX is an evidence-based practice that teaches students self- regulation, self-control, and self-management. Long-term outcomes include reduced need for special education services, reductions in drug and alcohol addictions, serious violent crime, suicide contemplations and attempts, and initiation of sexual activity; and increases in high schoolgraduation rates and college attendance. The Human Services Department, Behavioral Health Services Division, funded a pilot project in 2016 to train 172 teachers in PAX, reaching 3,329 students. A 2017 RFA is expected to extend the reach to an additional 139 elementary school teachers. The STR will build on SGF efforts to expand PAX to 12 tribal schools.

VII. Opioid Treatment Services

Defined as daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder. OTS is a Medicaid funded service. New Mexico's Human Services Department approves licensing of Opioid Treatment Programs (OTPs). Currently there are 19 Opioid Treatment Programs, serving approximately 5,800 patients. There is a high concentration of OTPs in Albuquerque, NM's largest population center; thus, the Opioid STR grant (above) is providing training to expand OTCcapacity throughout the state.

VIII. Utilization of Buprenorphine

State direction to MCOs to cover buprenorphine in any formulation for the treatment of OUD without requiring a prior authorization.

IX. Behavioral Health Investment Zones

The state has developed and funded two Investment Zones in counties with high rates of OUD: Rio Arriba County has implemented county-wide Pathways care coordination system; McKinley County has renovated the Gallup Detox center, converted an old hospital into a SUD RTC.

X. Programs for Justice-Involved Individuals

Through state general funds, New Mexico supports a range of programs for adult substance abuse offenders and their families, from jail diversion to treatment to reentry, aftercare and recovery planning. Funding supports district courts, county alternative sentencing programs, and other community providers of services for justice-involved individuals.

XI. Recovery Support Services

New Mexico's Office of Peer Recovery and Engagement (OPRE) is developing and delivering trainings with a special focus on OUD for certified peer support specialists who can work in regional hubs to provide recovery services. One of our peer-run recovery agencies will have dedicated staff trained to support local agencies and providers in implementing MAT for OUD. In addition, Medicaid covers the following recovery services: Comprehensive Community Support Services, Behavioral Management Skills Development, Adaptive Skills Building, Psychosocial Rehab, Family Support Services, Recovery Services, and BH Respite Services.

XII. Supportive Housing

NM has a number of supportive housing programs (Crisis Housing, Move-in Assistance and Eviction Prevention, Oxford House, Linkages Permanent Supportive Housing, Special Needs Housing, SAMHSA Permanent Supportive Housing Grant) that provide a continuum of supportfor individuals with behavioral health issues (SUD, SMI, and COD), from Crisis Housing to Transitional Housing to Permanent Supportive Housing. Some programs allow a primary SUD diagnosis, while others require primary SMI diagnosis. A combination of state funds and federalgrants supports these housing programs. Medicaid covers certain supportive housing services through CCSS.

XIII. Collaborative Efforts

The state continues to have strong collaboration and partnership with Counties & Municipalities to provide better coordinated behavioral health services: The January 2017 New Mexico Association of Counties (NMAC) Conference showcased BH innovations in the counties of McKinley, Rio Arriba, Bernalillo, and Dona Ana; June 2017 conference: Opioid crisis & increased access to naloxone in detention centers; 2018: Crisis triage and Emergency DepartmentInformation Exchange (EDIE). In addition, Bernalillo County approved 1/8 GRT ($16 million) to fund behavioral health services in Albuquerque and Bernalillo County.

Appendix I: Demonstration Evaluation Quarterly Monitoring Reports from Q1 and Q2, 2022

New Mexico Human Services Department
Centennial Care 2.0 1115 Waiver Evaluation

Quarterly Monitoring Report (STC 114)

Evaluation Findings and Activities	
Quarter 1 (Q1) 2022	**Accomplishments** The New Mexico Human Services Department (HSD) and Health Services Advisory Group, Inc. (HSAG) continued to work together to: • Collect the Medicaid Management Information System (MMIS), value-based purchasing (VBP), health home, low-birth weight, financial, and managed care organization (MCO) data. • Finalized the outline for the interim evaluation report based on the Centers for Medicare & Medicaid Services (CMS) guidance.
	Potential Challenges and Solutions During this reporting period, HSD and HSAG have not encountered any evaluation or technical challenges.
	Activities In Progress HSAG continued performing data validation and gap analysis on all data extracts. In addition, HSAG continued the development of SAS®1 programming code for the performance measure calculations, as well as finalizing the cost-effectiveness and budget neutrality analytic plan. In addition, the evaluator began drafting non-results sections of the interim evaluation report.
	COVID-19 Impacts HSD and HSAG continued discussions on the impacts of the coronavirus disease 2019 (COVID-19) pandemic on the waiver demonstration. Began analyses on the increased use of telemedicine by beneficiaries begin, HSAG presented preliminary results on the patterns in the data and began discussing with HSD potential impacts related to COVID and other initiatives. As additional analyses are preformed, HSAG will discuss with HSD to determine how the impacts may affect the evaluation and will explore statistical and other methods to control for the COVID-19 impact in the evaluation.

[1] SAS® is a registered trademark of the SAS Institute Inc.

Preliminary Evaluation Findings

To-date, HSAG has completed preliminary analyses for 18 evaluation measures. Preliminary results presented in this section are organized by demonstration aim and hypothesis. *These results are preliminary and subject to change upon finalization and may not represent the final results in the Interim Evaluation Report.*

PRELIMINARY CONCLUSIONS

Overall, preliminary evidence on measures evaluated to-date **supports** their respective hypotheses, with 11 out of 18 measures supporting their hypothesis, with only three not supporting the hypothesis.

Table 1—Preliminary Analysis Summary

Preliminary Conclusion	Number of Measures
Supports the hypothesis	11
Does not support the hypothesis	2
Neither supports nor fails to support	2
N/A	3

Table 2—Measures Included in This Quarterly Report

Number	Measure Name
1	Number of Centennial Care (CC) members enrolled and receiving Community Benefit (CB) services
2	Number/percentage of Centennial Care members enrolled in a Health Home
12	Percentage of CC members participating in Centennial Rewards (CR)
14	Percent of CR users responding positively on satisfaction survey to question regarding if the program helped to improve their health and make healthy choices
16	Total number of providers with Value Based Purchasing (VBP) contracts
18	Percentage of total payments that are for providers in VBP arrangements
22	Number of continuous nursing facility level of care (NFLOC) approvals
23	Number of telemedicine providers
24	Number of members receiving telemedicine services
25	Member rating of health care
26	Member rating of health plan
27	Member rating of personal doctor
28	Number of submitted claims through electronic visit verification (EVV)
29	Percent of paid or unpaid hours retrieved due to false reporting
30	Number of providers who provide substance use disorder (SUD) screening
31	Number of individuals screened for SUD
32	Percentage of individuals with a SUD diagnosis who received any SUD service during the measurement year
48	Percentage of individuals diagnosed with SUD receiving care coordination

Aim One: Continue the use of appropriate services by members to enhance member access to services and quality of care.

Hypothesis 1: Continuing to expand access to LTSS and maintaining the progress achieved through rebalancing efforts to serve more members in their homes and communities will maintain the number of members accessing community benefit (CB) services

Measure 1—Number of Centennial Care members enrolled and receiving CB services

Table 3 shows the number of community benefit members remained fairly steady after an initial increase in 2014 and 2015.

Table 3—Year-over-Year Change in Community Benefits

Year	Number of CB Members	YoY Change	YoY Percent

2013	3,363	-	-
2014	25,556	22,193	660%
2015	29,735	4,179	16%
2016	31,038	1,303	4%
2017	30,984	-54	0%
2018	29,251	-1,733	-6%
2019	29,712	461	2%
2020	30,338	626	2%
2021	31,139	801	3%

The average year-over-year (YoY) change from 2016 and onward is less than one percent, supporting the hypothesis that the number of beneficiaries accessing CB services has been maintained, following an increase shortly after the introduction of CC 1.0 in 2014.

Preliminary Conclusion: Supports the hypothesis

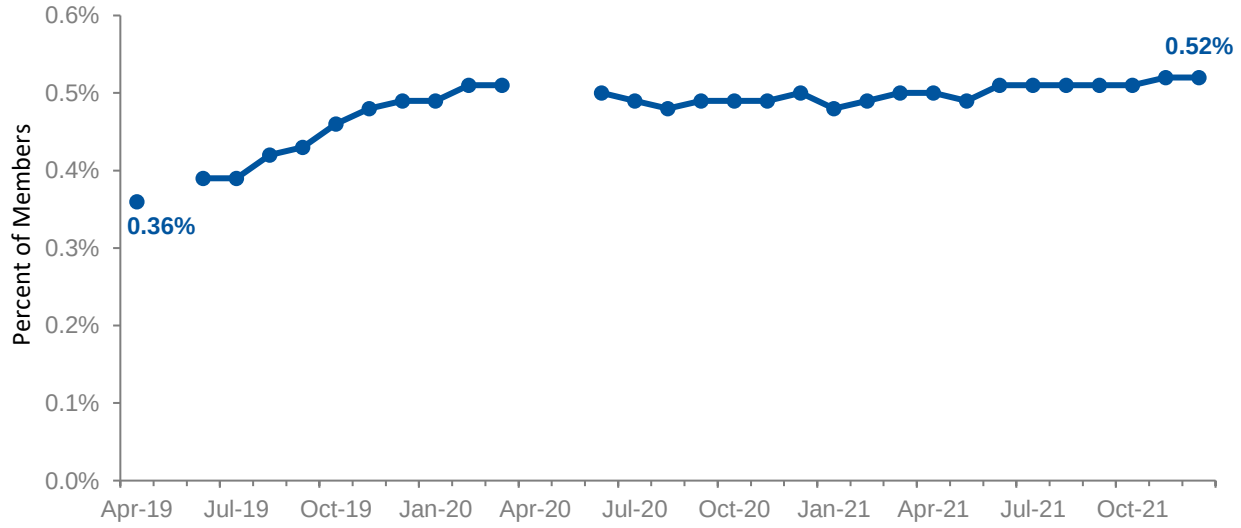
Hypothesis 2: Promoting participation in a Health Home will result in increased member engagement with a Health Home and increase access to integrated physical and behavioral health care in the community

Measure 2— Number/percentage of Centennial Care members enrolled in a Health Home

Measure 2 seeks to determine if increased promotion of Health Home participation has led to an increase in the percentage of Centennial Care members who are enrolled in a Health Home. To assess this measure, the percentage of Centennial Care members enrolled in managed care who are enrolled in a Health Home was generated.

Overall, the percentage rose from 0.36 percent in April 2019 to 0.52 percent in December 2021. Most of the increase occurred in 2019 where the percentage rose from 0.36 percent in April 2019 to 0.49 percent in December 2019. Starting January 2020, the percentage hovered between 0.48 percent and 0.52 percent until December 2021. No Health Home enrollment was available for January 2019–March 2019, May 2019, and April 2020–May 2020. Figure 1 shows the monthly percentage of Centennial Care members enrolled in managed care who are enrolled in a Health Home.

Figure 1—Centennial Care Members Enrolled in a Health Home



Preliminary Conclusion: Supports the hypothesis

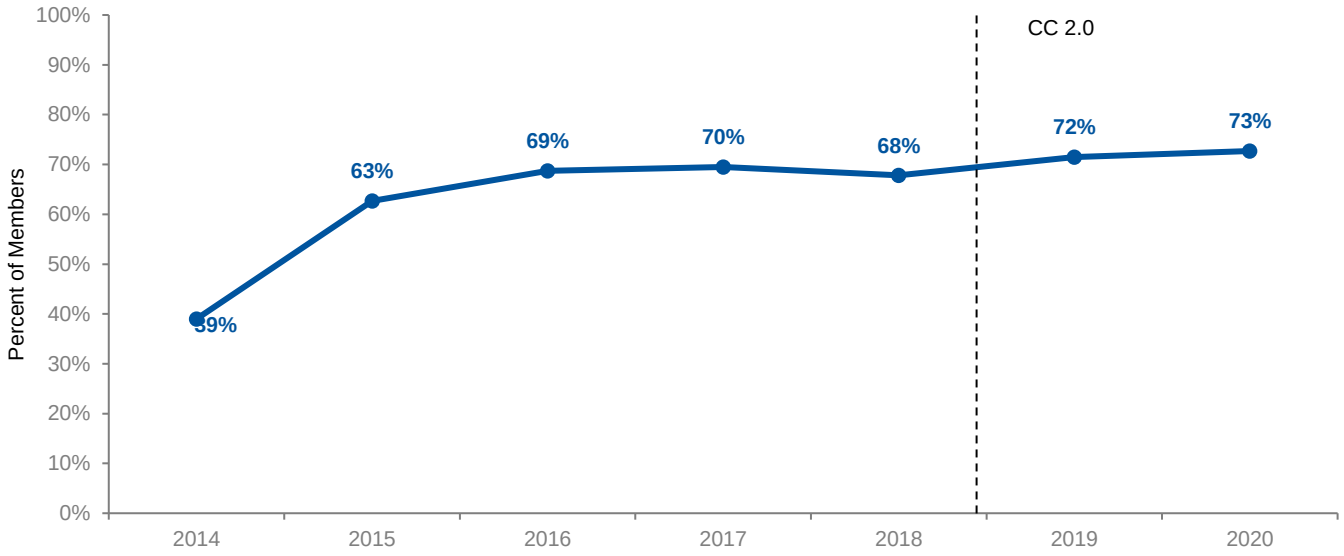
Hypothesis 5: Expanding member access to and incentives for preventative care through the CHV pilot program and CR will encourage members to engage in preventative care services

Measure 12—Percentage of CC members participating in Centennial Rewards (CR)

Centennial Rewards (CR) is a rewards program in which all Centennial Care members are enrolled. Participants earn points that can be used to purchase items by completing healthy activities, such as a prenatal care visit, flu shot, or HbA1c test. Members must complete a registration process and health scan to redeem rewards; about 30 percent of program participants redeem their rewards. The program is administered by Finity Communications, Inc.

One goal of the demonstration is to provide incentives to members to receive preventative services by expanding CR participation. Figure 2 displays the percentage of Centennial Care members who participated in the CR program (i.e., members who were engaged through multimedia communications and completed at least one healthy reward activity) between 2014 and 2020. Overall, the CR participation rate nearly doubled during this period, increasing from 39.0 percent in 2014 to 72.7 percent in 2020. In addition, since the implementation of Centennial Care 2.0 in 2019, the CR participation rate increased each year, from a baseline rate of 67.8 percent in 2018 to 72.7 percent in 2020. While the CR participation rate increased significantly from 2014 to 2020, there is still room for improvement, with a little over 25 percent of Centennial Care members opting not to participate in the CR program.

Figure 2—Centennial Rewards Participation Rate, 2014–2020[1]



[1] Rates were provided by Finity and have not been independently verified or validated by HSAG.

Preliminary Conclusion: Supports the hypothesis

Measure 14: Does use of CR encourage members to improve their health and make healthy choices?

Table 4 shows the percentage of CR user satisfaction survey respondents who answered yes to the questions "Has the program helped you improve your health?" and "Do the rewards encourage you to make healthy choices?". Between 2018 and 2020, the percentage of respondents answering yes to these questions remained consistently high at above 90 percent. Because there is limited pre-CC 2.0 data and no comparison group, the results presented are descriptive in nature and neither support nor fail to support the hypothesis.

Table 4—Percentage of Positive Satisfaction Survey Responses of Centennial Rewards Users, 2018–2020[1]

Survey Question	2018	2019	2020
Has the program helped you improve your health?	93.9%	93.7%	93.8%
Do the rewards encourage you to make healthy choices?	96.8%	96.6%	96.6%

[1]Rates were provided by Finity and have not been independently verified or validated by HSAG.

Preliminary Conclusion: Neither supports nor fails to support

Aim Two: Manage the pace at which costs are increasing while sustaining or improving quality, services, and eligibility.

Hypothesis 1: Incentivizing hospitals to improve health of members and quality of services and increasing the number of providers with VBP contracts will manage costs while sustaining or improving quality

Measure 16: Has the number of providers with VBP contracts increased?

Table 5 and

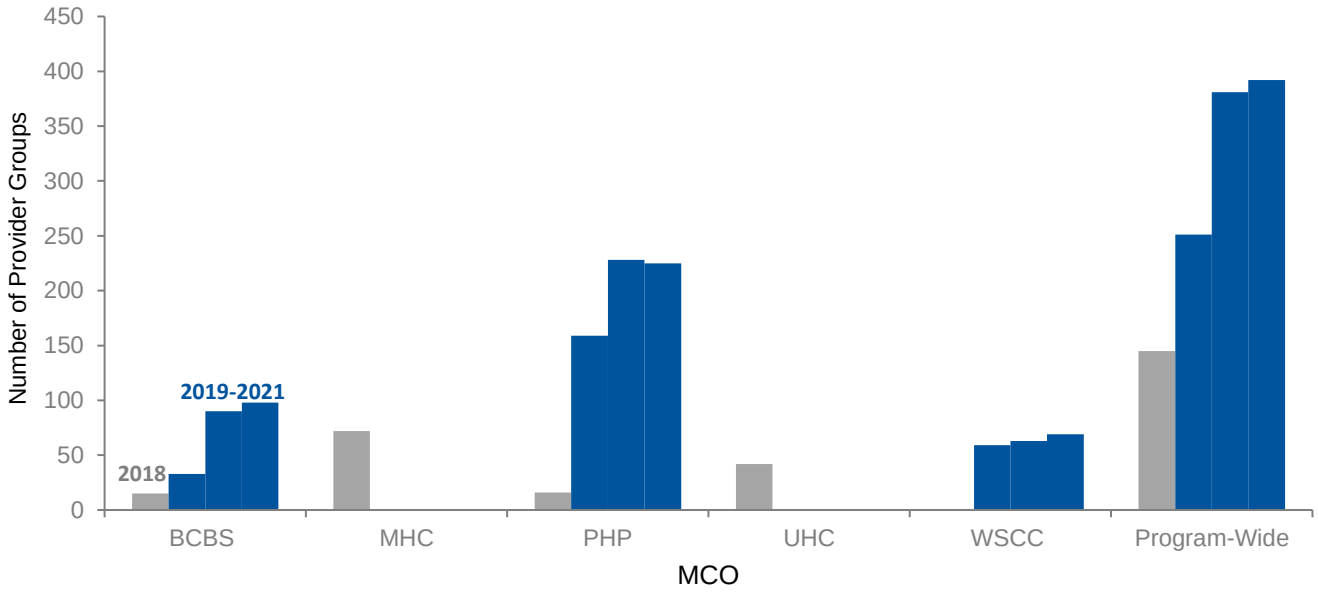
Figure 3 display the total number of Centennial Care provider groups with VBP contracts between 2018 and 2021 for each MCO and aggregated program wide. During this period, the number of provider groups with VBP contracts increased for MCOs and Centennial Care as a whole. In 2018, prior to the implementation of Centennial Care 2.0, there were a total of 145 provider groups with VBP contracts, which increased by 170 percent to 392 provider groups in 2021. The largest annual increase in program wide VBP provider groups, 73 percent, occurred between 2018 and 2019.

Table 5—Number of Provider Groups with VBP Contracts, 2018–2021

MCO	2018	2019	2020	2021
Blue Cross Blue Shield (BCBS)	15	33	90	98
Molina Healthcare of New Mexico, Inc. (MHC)	72	--	--	---
Presbyterian Health Plan (PHP)	16	159	228	225
UnitedHealthcare of New Mexico, Inc. (UHC)	42	--	--	--
Western Sky Community Care (WSCC)	--	59	63	69
Program-Wide	**145**	**251**	**381**	**392**

Note: -- indicates years in which an MCO was not contracted with Centennial Care.

Figure 3—Number of Provider Groups with VBP Contracts, 2018–2021



Preliminary Conclusion: Supports the hypothesis

Measure 18: Has the number of providers participating in VBP arrangements, who meet quality metric targets, increased?

Table 6 shows the amount paid in VBP arrangements between 2017 and 2021 as a total dollar amount and a percentage of total health care expenditures, while

Figure 4 shows the percentage paid in VBP arrangements as a percentage of total health care expenditures during the same period. Overall, the percentage of expenditures attributed to VBP arrangements increased, from about 27 percent prior to the implementation of Centennial Care 2.0 to 62 percent in 2021. BCBS and PHP increased their VBP payments as a percentage of total expenditures during this period by 18 percent and 58 percent, respectively. WSCC's VBP payments declined from 36 percent of total expenditures in 2019 to 31 percent in 2021. While the largest increase in program wide VBP payments occurred when Centennial Care 2.0 was implemented in 2019 (an increase from 27 percent of total expenditures in 2018 to 48 percent in 2019), VBP payments continued to increase in 2020 and 2021.

Table 6—Amount Paid in VBP Arrangements and Percentage of Total Health Care Expenditures, 2017–2021

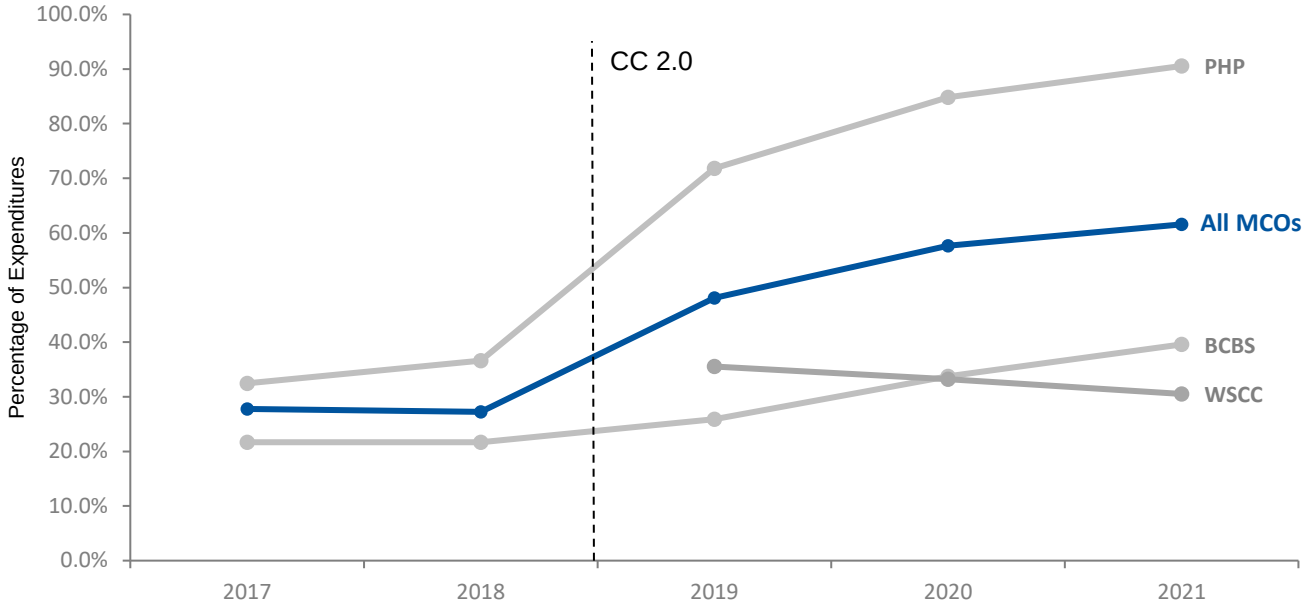
MCO	2017	2018	2019	2020	2021
BCBS	$142,867,926 (21.7%)	$155,099,593 (21.7%)	$359,402,770 (25.9%)	$498,356,927 (33.7%)	$555,148,255 (39.6%)
MHC	$154,810,895 (15.1%)	$155,412,079 (15.8%)	--	--	--
PHP	$247,460,730 (32.5%)	$288,290,867 (36.6%)	$1,033,496,822 (71.8%)	$1,347,642,959 (84.8%)	$1,287,303,731 (90.6%)
UHC	$243,629,551 (61.5%)	$150,381,151 (57.1%)	--	--	--
WSCC	--	--	$91,490,320 (35.5%)	$107,256,516 (33.2%)	$102,222,053 (30.5%)
Program-Wide	**$788,769,102 (27.8%)**	**$749,183,690 (27.2%)**	**$1,484,389,913 (48.1%)**	**$1,953,256,402 (57.6%)**	**$1,944,674,039 (61.6%)**

Note: -- indicates years in which an MCO was not contracted with Centennial Care.

Figure 4—Percentage of Total Health Care Expenditures Paid in VBP Arrangements, 2017–2021

The blue line represents the total for all MCOs.

Gray lines represent each individual MCO (only MCOs that contracted through 2021 are displayed).



Note: the dashed line represents the implementation of Centennial Care 2.0 in 2019.

Preliminary Conclusion: Supports the hypothesis

Aim Three: Streamline processes and modernize the Centennial Care health delivery system through use of data, technology, and person-centered care.

Hypothesis 1: The Demonstration will relieve administrative burden by implementing a continuous Nursing Facility Level of Care (NFLOC) approval with specific criteria for members whose condition is not expected to change over time.

Measure 22—Number of continuous NFLOC approvals

Only data for 2019 was reported to-date. For 2019, Presbyterian Health Plan consistently reported the most continuous NFLOC approvals. Blue Cross Blue Shield and Western Sky Community Care reported very few continuous NFLOC approvals for any given quarter in 2019. Because no pre-intervention data are available, the results presented are descriptive in nature and no conclusions can be drawn.

Table 7—Number of Continuous NF LOC Approvals, 2019

MCO	Q1	Q2	Q3	Q4
Blue Cross Blue Shield	NR	NR	NR	NR
Presbyterian Health Plan	259	364	391	71
Western Sky Community Care	NR	NR	NR	NR

NR=Not Reportable (value suppressed due to low cell counts resulting in potentially identifiable information).

Preliminary Conclusion: N/A

Hypothesis 2: The use of technology and continuous quality improvement (CQI) processes align with increased access to services and member satisfaction

Measure 23—Has the number of telemedicine providers increased During Centennial Care 2.0?

Preliminary analysis shows the number of telemedicine providers increased 44 percent in the first year of the CC 2.0 demonstration above what was expected had the pre-CC 2.0 trend continued. This suggests the evidence supports the hypothesis. Measurement of telemedicine providers during the second year of the demonstration, CY 2020, was confounded by the COVID-19 public health emergency (PHE) which saw a wide-spread and necessary shift towards telemedicine. Conclusions for 2020 and 2021 are unreliable due to this confounding factor. Table 8 shows the number of telemedicine providers massively increased following the PHE.

Table 8—Number of Telemedicine Providers, 2013–2021

Year	Number of Providers	Year-Over-Year Change	Projected Number of Providers	Difference Between Actual and Projected (P-Value)
2013	126	--	--	--
2014	174	38%	--	--
2015	196	13%	--	--
2016	212	8%	--	--
2017	338	59%	--	--
2018	398	18%	--	--
2019	617	55%	427	44% (0.0160)
2020	9,087	1,373%	481	1,789% (<0.0001)
2021	8,722	-4%	534	1,533% (<0.0001)

Preliminary Conclusion: 2019 data supports the hypothesis

Measure 24—Has the number of members with a telemedicine visit increased during Centennial Care 2.0?

The baseline number of members from 2013 to 2018, prior to the implementation of CC 2.0, was 8,109 per quarter on average. In 2019, prior to the start of the COVID-19 pandemic, the quarterly average was 13,080 members, a 61 percent increase over the 2013–2018 quarterly average and a 95 percent increase over the 2018 quarterly average. The COVID-19 public health emergency response led to an increase in average unemployment in the state and nationwide. An expansion of Medicaid eligibility and job losses increased the population eligible for benefits since the initial outbreak of COVID-19 in the United States. In 2020 and 2021, the total number of members utilizing telemedicine services increased dramatically. The significant growth in the utilization is most likely attributable to the public health emergency response with an average quarterly increase to approximately 90,000 members in 2020 and 2021. However, telemedicine utilization per thousand members also increased significantly from approximately 10–12 visits per thousand members in January and February 2020 to a peak of approximately 200 visits per thousand members in April 2020 (Figure 6), which suggests an increase in the proportion of members utilizing telemedicine services. By the end of 2021, utilization had decreased to approximately 100 visits per thousand members, still up significantly from pre-COVID levels. Conclusions for 2020 and 2021 are unreliable due to this confounding factor.

Figure 5—Number of Telehealth Visits, 2013-2021

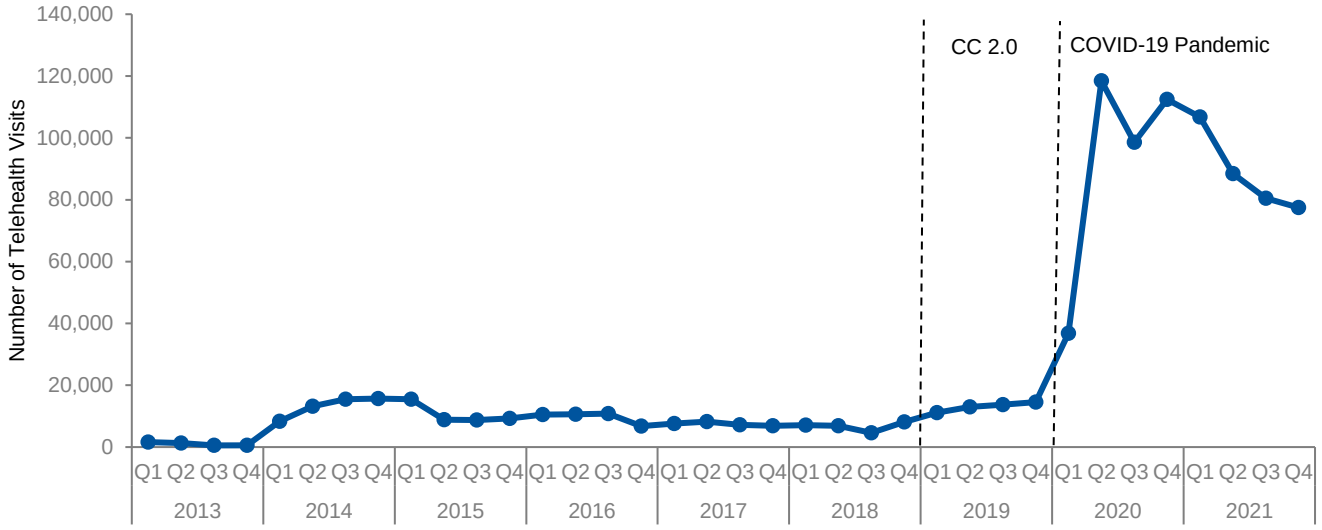
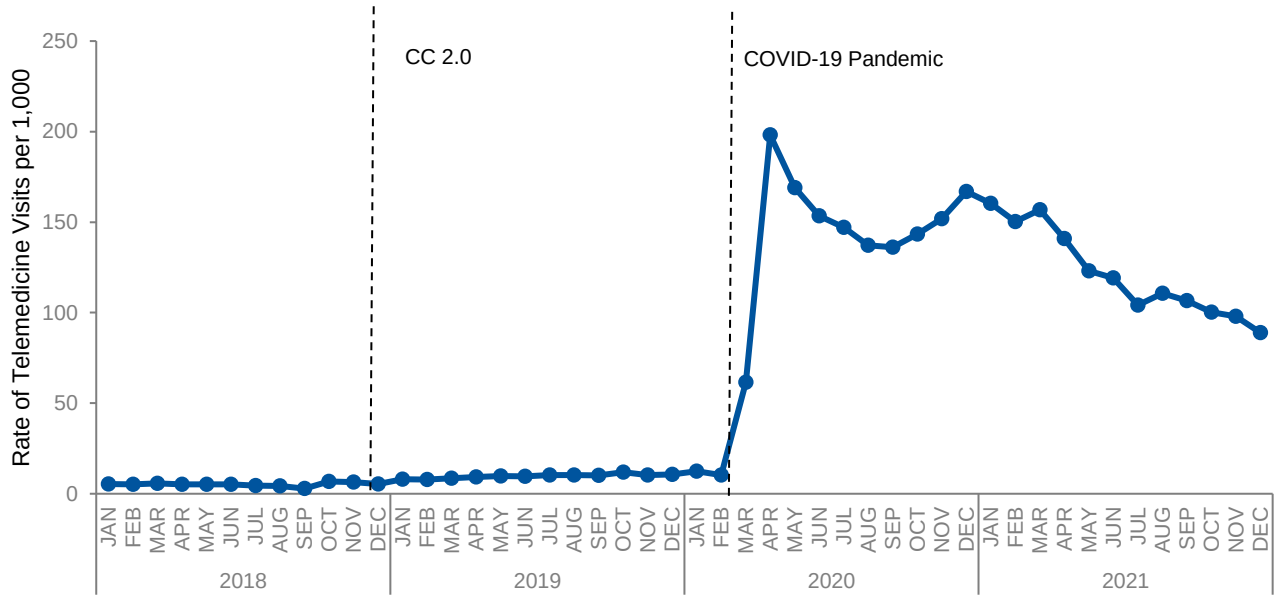


Figure 6 details the number of members receiving telemedicine services monthly following the implementation of CC 2.0 and the impact of the COVID-19 PHE. As shown, the number of members increased slightly in 2019 and early 2020 until lock-down efforts triggered a shift to telemedicine beginning in March 2020.

Figure 6—Telemedicine Visits per 1,000 Members, 2018-2021



Preliminary Conclusion: 2019 data supports the hypothesis

Measure 25—Member rating of health care; Measure 26—Member rating of health plan; Measure 27—Member rating of personal doctor

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Surveys are a set of standardized surveys that assess beneficiary perspectives on care. CAHPS surveys were administered by each MCO annually. HSAG used the results from these surveys to analyze three measures: member rating of health care, member rating of health plan, and

member rating of personal doctor. Table 9 shows the positive responses for adult and pediatric members statewide for the three CAHPS survey questions analyzed.[2] Statewide rates were calculated by weighting plan-specific rates by total enrollment each year. MCO-specific results are presented in the appendix for BSBC and PHP. As shown in Table 9, prior to the introduction of Centennial Care 2.0 in 2019, statewide rates remained relatively consistent across the three measures for adults and children, with satisfaction among children being higher than satisfaction among adults. BCBS and PHP rates, shown in the appendix, followed a similar pattern.

Table 9—Statewide Rates for CAHPS Survey Questions

	2014	2015	2016	2017	2018		2019 Trend Model[1] 2019	Predicted	(P-value)
Member rating of health care									
Adult	73.8%	76.6%	72.8%	74.7%	71.0%		77.5%	71.9%	(0.008)
Child	85.4%	84.5%	86.6%	84.9%	84.8%		88.0%	85.1%	(0.254)
Member rating of health plan									
Adult	77.0%	79.5%	76.8%	76.4%	77.1%		78.2%	76.5%	(0.267)
Child	87.4%	86.5%	88.3%	86.6%	87.0%		87.2%	86.8%	(0.579)
Member rating of personal doctor									
Adult	81.5%	81.3%	81.5%	80.9%	80.9%		84.6%	80.5%	(0.103)
Child	87.3%	87.7%	89.7%	90.1%	89.3%		90.8%	90.7%	(0.845)

Note: Rates are provided by the MCOs and have not been independently validated by HSAG.

[1]Actual vs projected shows the difference between observed rates during the evaluation period compared to the projected rate had the baseline trend continued.

Measure 25—Member rating of health care

After the introduction of Centennial Care 2.0, member rating of health care increased across both the adult and child populations. Table 9 shows adult members' rating of health care significantly increased from 71.0 percent in 2018 to 77.5 percent in 2019, 5.6 percentage points higher than the predicted value if the trend in the baseline period had continued. Pediatric member rating of health care also increased in 2019 compared to 2018 to 88.0 percent, 3.1 percentage points higher than the predicted value.

Preliminary Conclusion: Supports the hypothesis

Measure 26—Member rating of health plan

Member rating of health plan for adult and pediatric members also increased in 2019 after the introduction of Centennial Care 2.0. For both adult and pediatric members, the 2019 actual value was about 1 to 2 percentage points higher than the predicted value if the trend in the baseline period had continued.

Preliminary Conclusion: Supports the hypothesis

Measure 27—Member rating of personal doctor

Member rating of personal doctor for both adult and pediatric members increased in 2019 after the introduction of Centennial Care 2.0. Adult members' satisfaction of their personal doctor increased from 80.9 percent in 2018 to 84.6 in 2019, nearly 4 percentage points higher than the expected value. The rating of children's personal doctor remained relatively similar,

[2] Each measure reflects the percentage of members responding with a high rating defined as 8, 9, or 10 on a scale between 0 and 10.

increasing from 89.3 percent in 2018 to 90.8 percent in 2019, 0.1 percentage points higher than the expected value if the baseline trend had continued.

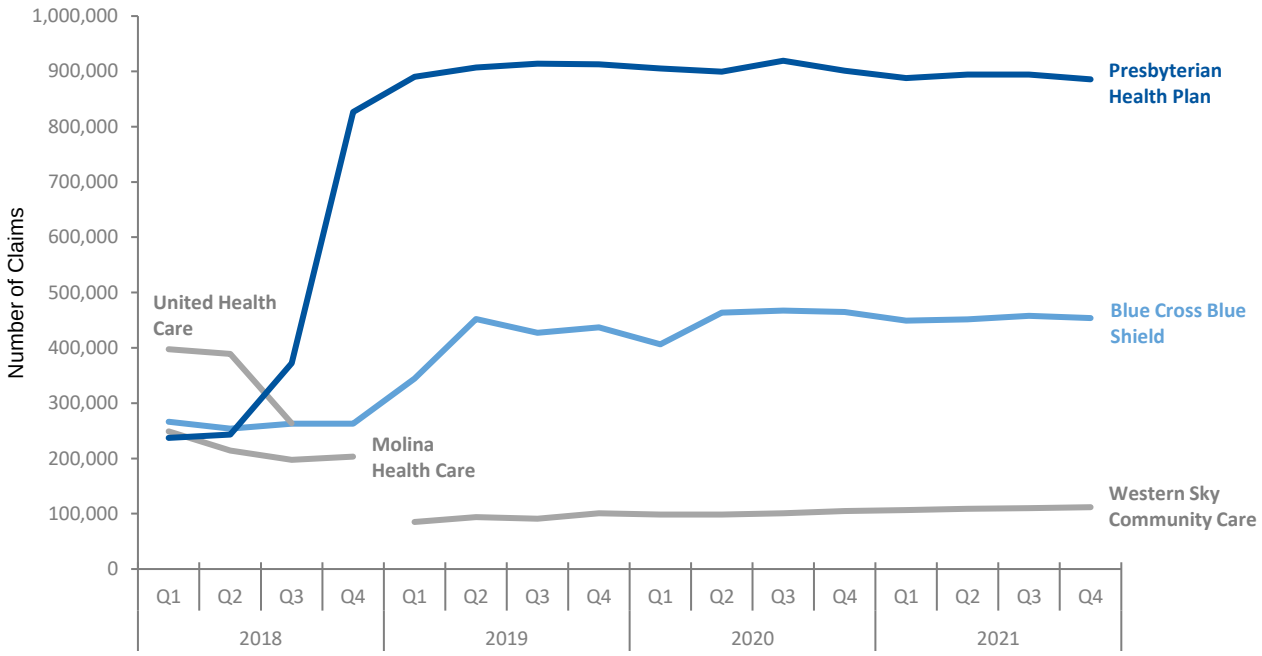
Preliminary Conclusion: Neither supports nor fails to support

Hypothesis 3: Implementation of electronic visit verification (EVV) is associated with increased accuracy in reporting services rendered.

Measure 28—Number of claims submitted through EVV

Figure 7 displays the number of claims submitted through EVV between 2018 and 2021 for each MCO. During this time period, **Presbyterian Health Plan** submitted the highest number of claims through EVV, beginning with 237,150 and 243,417 claims in Q1 and Q2 of 2018 and jumping to 890, 451 claims in quarter 1 of 2019. **Blue Cross Blue Shield** experienced a similar increase from 262,715 claims in Q4 2018 and reaching 452,255 claims by Q2 of 2019. The number of claims submitted through EVV increased slightly from 85,119 claims in 2019 to 111,840 claims in 2021 for Western Sky Community Care.

Figure 7—Number of Submitted Claims Through EVV



Preliminary Conclusion: N/A

Measure 29—Percent of paid or unpaid hours retrieved due to false reporting

No MCO except for Presbyterian Health Plan reported having any paid or unpaid hours retrieved due to false reporting. PHP reported 86, 168 and 112 paid or unpaid hours retrieved due to false reporting for Q1 through Q3 of 2020.

Preliminary Conclusion: N/A

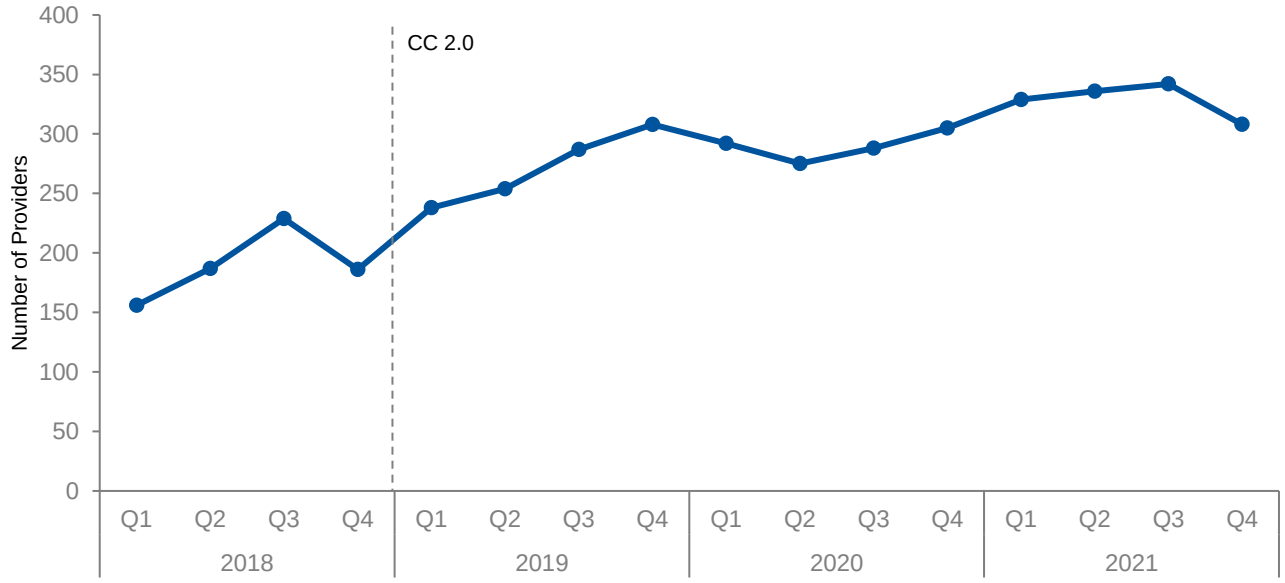
Aim Four: Improved quality of care and outcomes for Medicaid beneficiaries with SUD.

Hypothesis 1: The demonstration will increase the number of providers that provide SUD screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for alcohol and other drug (AOD) dependence treatment.

Measure 30—Number of providers who provide SUD screening

HSAG assessed the number of providers who had a claim for SUD screening by quarter. Overall, the quarterly average number of providers increased 73 percent during CC 2.0, from 190 providers per quarter in 2018 (prior to the demonstration) to 329 providers per quarter in 2021. However, after reaching a peak of 342 providers in 2021 Q3, the number of providers decreased to 308 in 2021 Q4. This decline may be due to incomplete Q4 data but should be monitored to assess if the trend continues into 2022.

Figure 8—Number of Providers Offering SUD Screening, 2018-2021

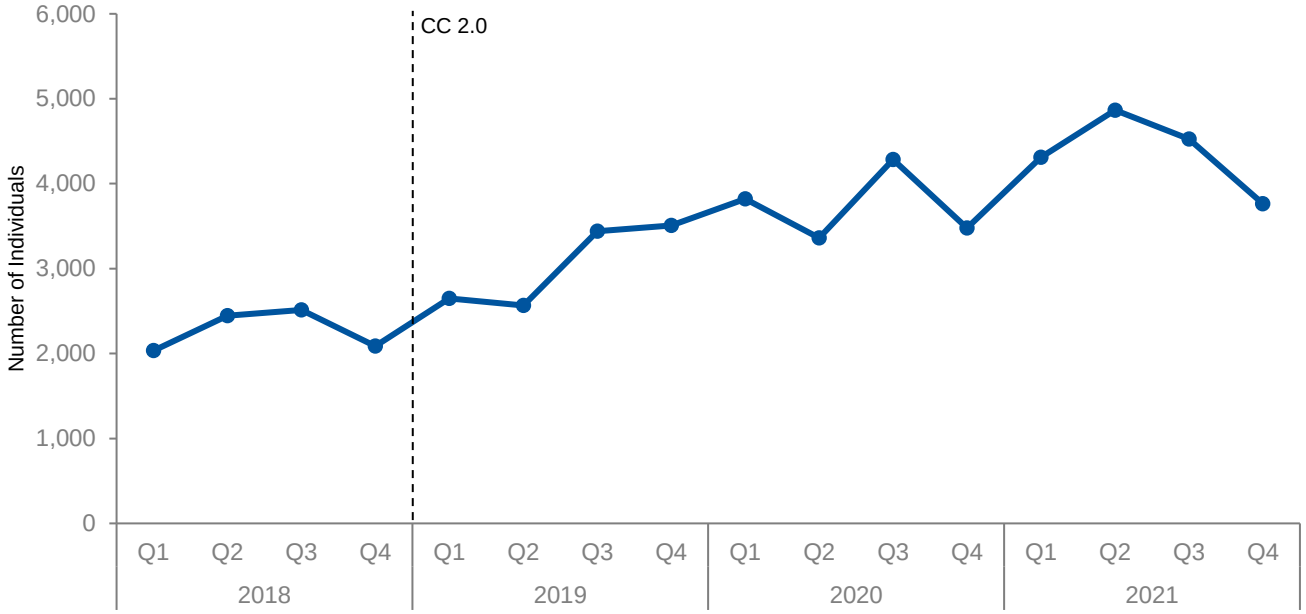


Preliminary Conclusion: Supports the hypothesis

Measure 31—Number of individuals screened for SUD

HSAG assessed the number of individuals who had a claim for SUD screening by quarter. Overall, the quarterly average number of members increased by 92 percent during CC 2.0, from 2,270 members per quarter in 2018 (prior to the demonstration) to 4,367 members per quarter in 2021. However, after reaching a peak of 4,866 total members in 2021 Q2, the number of members decreased each quarter to 3,764 in 2021 Q4. This decline may be due to incomplete Q4 data but should be monitored to assess if the trend continues into 2022.

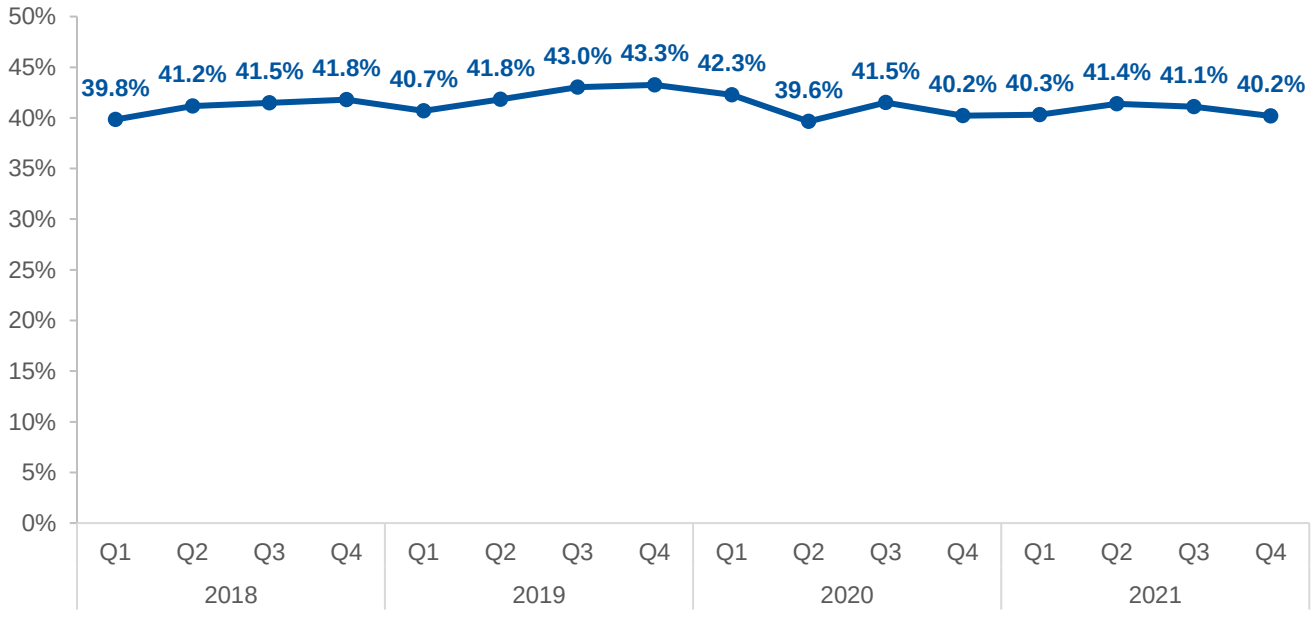
Figure 9—Number of Individuals Screened for SUD, 2018-2021



Preliminary Conclusion: Supports the hypothesis

Measure 32: Has the percentage of individuals with SUD who received any SUD related service increased?

The hypothesis for Measure 32 is that the demonstration will increase the number of providers that provide SUD screening, which will result in an increase in the percentage of individuals who initiate treatment for AOD dependence. The percentage of members with a SUD diagnosis who received SUD services each quarter between 2018 and 2021 **remained effectively flat**, ranging between 39.6 percent and 43.3 percent with an average quarter-over-quarter change of only 0.1 percent.



Preliminary Conclusion: Does not support the hypothesis

Hypothesis 4: The Demonstration will Increase the number of individuals with fully delegated care coordination which includes screening for co- morbid conditions, which will result in increased utilization of physical health services.

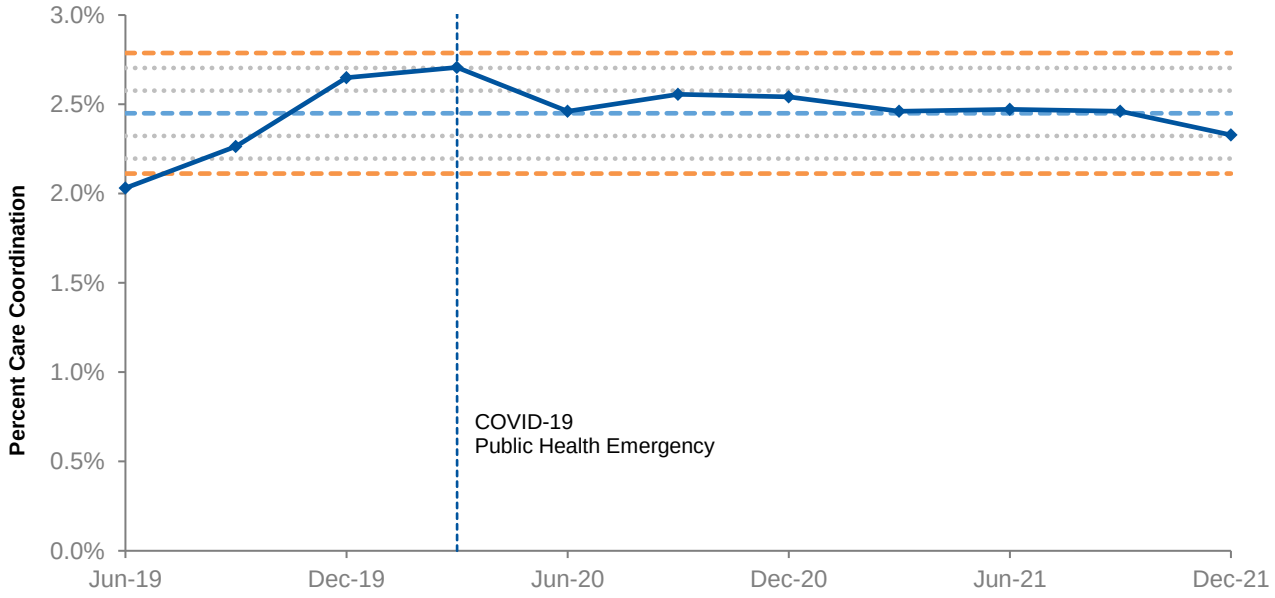
Measure 48—Percentage of individuals diagnosed with SUD receiving care coordination

Hypothesis 4 states that an increase in the number of members with fully delegated care coordination (i.e., participation in a Health Home) will result in an increased utilization of physical health services. Research question 1 examines whether the percentage of individuals with an SUD diagnosis receiving care coordination increased.

Due to limitations in the Health Home enrollment data, HSAG could only examine members receiving care coordination on or after April 2019. This precludes an interrupted time series analysis as described in the evaluation design plan or a pre-test/post-test design.

A statistical process control chart was used to assess variation over time in this measure. Figure 11 shows the percentage of members with an SUD diagnosis enrolled in a Health Home remained steady at approximately 2.5 percent following an initial increase in 2019. The dashed orange control limits indicate the expected range of quarterly variation. No evidence of special cause variation was detected—that is, there was no consistent shift or trend in the rate, nor were there outlying data points, with the possible exception of Q2 2019; however, this could be driven in part by incomplete Health Home enrollment data.[3]

Figure 10—Percentage of Members with an SUD Enrolled in a Health Home



Preliminary Conclusion: Does not support the hypothesis

[3] Health Home enrollment for May 2019 was not available. HSAG imputed a member's enrollment for this month if they were: 1) enrolled in a Health Home during both April and June 2019, and 2) enrolled in Centennial Care in May 2019.

New Mexico Human Services Department
Centennial Care 2.0 1115 Waiver Evaluation

Quarterly Monitoring Report (STC 114)

Evaluation Findings and Activities	
Quarter 2 (Q2) 2022	**Accomplishments** The New Mexico Human Services Department (HSD) and Health Services Advisory Group, Inc. (HSAG) continued to work together to: • Finalize data validation and gap analysis on all data extracts. • Finalize definitions of terms used in measure specifications to ensure complete and accurate analyses. • Develop the interim evaluation report results and non-results sections. • Review and revise the Background and Interpretations, and Policy Implications, and Interactions with Other State Initiatives in advance of the interim evaluation report submission. • Review the Medicaid Management Information System (MMIS), value-based purchasing (VBP), telemedicine, Health Home, Centennial Rewards, low-birth weight, financial, and managed care organization (MCO) data. • Determine appropriate methods for identifying low birth weight deliveries and finalize data query of HSD's systems.
	Performance Metrics HSAG finalized the SAS®[1] programming code for the performance measure calculations. HSAG also worked on the calculations, statistical modeling, and analysis of performance measures. To-date, HSAG has performed calculations for 50 measures.
	Budget Neutrality and Financial Reporting Requirements HSAG continued working on the cost-effectiveness analysis for the interim evaluation report. (The interim evaluation report cost effectiveness analyses are not the same as the formal budget neutrality tests required under the Section 1115 Waiver Demonstration program.)
	Potential Challenges and Solutions During this reporting period, HSD and HSAG have not encountered any evaluation or technical challenges.
	Activities in Progress HSAG continued performing and finalizing analyses. In addition, HSAG began drafting the interim evaluation report. HSAG worked to develop and finalize the non-results sections, including the Background, Evaluation Questions and Hypotheses, Methodology, and

[1] SAS® is a registered trademark of the SAS Institute Inc.

Evaluation Findings and Activities	
	Interpretations, and Policy Implications, and Interactions with Other State Initiatives sections as well as the results section of the report. HSAG and HSD collaborated on developing the review process to be used for finalizing the interim evaluation report for submission to the Centers of Medicare & Medicaid Services (CMS).
	COVID-19 Impacts HSD and HSAG continued discussions on the impacts of the coronavirus disease 2019 (COVID-19) pandemic on the demonstration waiver. In addition, HSAG utilized a range of methodologies in measure analyses to control for COVID-19 impacts on the demonstration results. Specifically, HSAG utilized indicator variables where possible as statistical controls to account for time periods impacted by COVID-19. These were employed primarily in interrupted time series (ITS) analyses. A difference-in-differences approach used on certain measures with an identifiable comparison group and pre-intervention data (i.e., Health Home measures and measures related to peer support services) can control for the impact of COVID-19 on the intervention group. Assuming COVID-19 impacted both groups equally, the impact of COVID-19 on the intervention group would be removed through the inclusion of the comparison group. More precisely, the changes in the comparison group due to COVID-19 are removed from the changes in the intervention group, thus "netting out" the impact of COVID-19 on the intervention group. Measures utilizing other types of analytic approaches cannot easily account for the impact of COVID-19 and results are synthesized to caveat potential impacts.

Preliminary Evaluation Findings

To-date, HSAG has completed preliminary analyses for 50 evaluation measures. Preliminary conclusions presented in this section are organized by demonstration aim and hypothesis. ***These conclusions are preliminary and subject to change upon finalization and may not represent the final results in the Interim Evaluation Report.*** Findings for each measure are summarized in

Table 1 and Table 2.

Depending on the analytic approach utilized, measures that directly address the hypothesis can provide sufficient evidence to *support the hypothesis* or *fail to support the hypothesis*. If available data and/or the analytic approach used cannot draw these conclusions, a measure may neither support nor fail to support the hypothesis.

Measures that do not have sufficient evidence to support or fail to support the hypothesis were deemed inconclusive. These measures may provide contextual information related to the hypothesis. Although the measure cannot provide direct evidence relating to the veracity of the hypothesis, the results may be in alignment with the hypothesis. Other measures that did not have sufficient data from which to draw a conclusion were unable to be calculated.

PRELIMINARY CONCLUSIONS

Overall, preliminary evidence on measures evaluated to-date either support, weakly support, or are consistent with their respective hypotheses, with 24 out of 50 measures supporting, weakly supporting or consistent with their hypothesis, with eight failing to support the hypothesis and two failing to support the hypothesis but trending in the favorable direction. Additionally, 12 out of 50 measures neither supported or failed to support the hypothesis and four measures had insufficient data from which to draw a conclusion.

Table 1—Preliminary Analysis Summary

Preliminary Conclusion	Number of Measures
Supports the hypothesis	18
Consistent with the hypothesis	5
Weakly supports the hypothesis	1
Neither supports nor fails to support the hypothesis	12
Does not support the hypothesis but trending favorably	2
Does not support the hypothesis	8
Insufficient data to draw a conclusion	4

Table 2—Measure Results Summary

Measure Number	Measure Name	Measure Supports Hypothesis
Aim One: Continue the use of appropriate services by members to enhance member access to services and quality of care		
Hypothesis 1: Continuing to expand access to Long-Term Support Services (LTSS) and maintaining the progress achieved through rebalancing efforts to serve more members in their homes and communities will maintain the number of members accessing community benefit (CB) services.		
1	Number of Centennial Care members enrolled and receiving CB services	Yes
Hypothesis 2: Promoting participation in a Health Home will result in increased member engagement with a Health Home and increase access to integrated physical and behavioral health care community.		
2	Number/Percentage of Centennial Care members enrolled in a Health Home	Yes
3	Number/Percentage of Health Home members with at least 1 claim for PH service in the calendar year	Yes
Hypothesis 3: Enhanced care coordination supports integrated care interventions, which lead to higher levels of access to preventative/ambulatory health services.		
4a	Adults' access to preventive/ambulatory health services (AAP)	Inconclusive
5a	Children and adolescents' access to primary care practitioners (CAP)	No
6	Well-child visits in the third, fourth, fifth, and sixth years of life (W34)	Inconclusive
4b	Adults' access to preventive/ambulatory health services (AAP) – HH population	Yes
5b	Children and adolescents' access to primary care practitioners (CAP) – HH population	Yes
Hypothesis 4: Engagement in a Health Home and care coordination support integrative care interventions, which improve quality of care.		
7	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD) – HH population	Inconclusive
8	Anti-depressant medication management (AMM) Effective Acute Phase Treatment – HH population	Inconclusive
9	Anti-depressant medication management (AMM) Effective Continuation Phase Treatment – HH population	Inconclusive
10	7-day follow up after hospitalizations for mental illness (FUH) – HH population	Yes
11	30-day follow up after hospitalizations for mental illness (FUH) – HH population	Inconclusive
Hypothesis 5: Expanding member access to and incentives for preventative care through the CHV pilot program and CR will encourage members to engage in preventative care services.		
12	Percentage of CC members participating in CR	Yes
13	Percentage of CR participating members with an annual preventive/ambulatory service	Inconclusive

Measure Number	Measure Name	Measure Supports Hypothesis
14	Percent of CR users responding positively on satisfaction survey to question regarding if the program helped to improve their health and make healthy choices	—
15	Live births weighing less than 2,500 grams (low birth weight)	No
Aim Two: Manage the pace at which costs are increasing while sustaining or improving quality, services, and eligibility		
Hypothesis 1: Incentivizing hospitals to improve health of members and quality of services and increasing the number of providers with value-based purchasing (VBP) contracts will manage costs while sustaining or improving quality.		
16	Total number of providers with VBP contracts	Yes
17	Number/percentage of providers meeting quality threshold	—
18	Percentage of total payments that are for providers in VBP arrangements	Yes
19	Percentage of qualified Domain 1 SNCP Hospital Quality Incentive measures that have maintained or improved their reported performance rates over the previous year	Inconclusive
20	Cost per member trend	TBD
21	Cost per user trend	TBD
Aim Three: Streamline processes and modernize the Centennial Care health delivery system through use of data, technology, and person-centered care		
Hypothesis 1: The Demonstration will relieve administrative burden by implementing a continuous Nursing Facility Level of Care (NFLOC) approval with specific criteria for members whose condition is not expected to change over time.		
22	Number of continuous NFLOC approvals	—
Hypothesis 2: The use of technology and CQI processes align with increased access to services and member satisfaction.		
23	Number of telemedicine providers	Yes
24	Number of members receiving telemedicine services	Yes
25	Member rating of health care	Yes
26	Member rating of health plan	Yes
27	Member rating of personal doctor	Inconclusive
Hypothesis 3: Implementation of electronic visit verification (EVV) is associated with increased accuracy in reporting services rendered.		
28	Number of submitted claims through EVV	Yes
29	Percent of paid or unpaid hours retrieved due to false reporting	—
Aim Four: Improved quality of care and outcomes for Medicaid beneficiaries with SUD		
Hypothesis 1: The demonstration will increase the number of providers that provide substance use disorder (SUD) screening, which will result in an increase in the number of individuals screened and the percentage of individuals who initiate treatment for alcohol and other drug (AOD) dependence treatment.		
30	Number of providers who provide SUD screening	Yes
31	Number of individuals screened for SUD	Yes
32	Percentage of individuals with a SUD diagnosis who received any SUD service during the measurement year	No
33	Initiation of AOD Abuse or Dependence Treatment (IET)	No
Hypothesis 2: The demonstration will increase peer support services which will result in more individuals engaging in and retained in AOD Dependence Treatment.		
34	Percentage of individuals with a SUD diagnosis who received peer support	Yes
35	Engagement of AOD Abuse or Dependence Treatment (IET)	Yes
36	Average Length of Stay (ALOS)	Yes
37	Continuity of Pharmacotherapy for OUD	Yes

Measure Number	Measure Name	Measure Supports Hypothesis
Hypothesis 3: The Demonstration will improve access to a comprehensive continuum of SUD care which will result in decreased utilization of ED and inpatient hospitalization and SUD inpatient readmissions.		
38	Continuum of services available	Inconclusive
39	Number of providers and capacity for ambulatory SUD services	Yes
40	Percentage of ED visits of individuals with SUD diagnoses	Inconclusive
41	Percentage of Inpatient admissions for SUD related treatment	Inconclusive
42	Percentage of Inpatient admissions of individuals with SUD for withdrawal management	No
43	7- and 30-day inpatient and residential SUD readmission rates	Yes
44	Total and PMPM cost (medical, behavioral and pharmacy) for members with SUD diagnosis	TBD
45	Total and PMPM cost (medical, behavioral and pharmacy) for members with SUD diagnosis by SUD source of care	TBD
46	Total and PMPM cost for SUD services for members with SUD diagnosis	TBD
47	Total and PMPM cost for SUD services by type of care (IP, OP, RX, etc.)	TBD
Hypothesis 4: The Demonstration will Increase the number of individuals with fully delegated care coordination which includes screening for co- morbid conditions, which will result in increased utilization of physical health services.		
48	Percentage of individuals diagnosed with SUD receiving care coordination	No
49	Percentage of individuals with SUD receiving preventive/ambulatory health services (AAP)	Yes
Hypothesis 5: The Demonstration will Increase use of naloxone, MAT and enhanced monitoring and reporting of opioid prescriptions through the prescription monitoring program, which will result in fewer overdose deaths due to opioid use.		
50	Number of naloxone training and kit distributions	No
51	Number of MCO network MAT providers	No
52	Percentage of individuals diagnosed with SUD with MAT claims	No
53	Number of policy and procedure manual references	Yes
54	Rate of deaths due to overdose	No

Note: TBD = Analysis is ongoing, and a conclusion has not been determined. — = Insufficient data to draw a conclusion. In order to concisely evaluate the Health Home program, results for measures 4b and 5b (Health Home-specific measures) are presented after measure 6.

ALOS: Average Length of Stay; AOD: alcohol and other drugs; CB: community benefit; CC: Centennial Care; CDC: Centers for Disease Control and Prevention; CMS: Centers for Medicare & Medicaid Services; CR: centennial rewards; ED: emergency department; EVV: electronic visit verification; HH: Health Home; IP: inpatient; NCQA: National Committee of Quality Assurance; NFLOC: nursing facility level of care; NQF: National Quality Forum; MAT: medication assisted treatment; MCO: managed care organization; OP: outpatient; OUD: opioid use disorder; PH: physical health; PMPM: per member per month; RX: prescription; SNCP: safety net care pool; SUD: substance use disorder; USC: University of Southern California; VBP: value-based purchasing