DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 29, 2026

Alanna Dancis
Interim Medicaid Director
New Mexico Health Care Authority
P.O. Box 2348
Sante Fe, NM 87504-2348

Dear Director Dancis:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Centennial Care 2.0 Summative Evaluation Report, which is required by the Special Terms and Conditions (STCs), specifically STC #129 "Summative Evaluation Report" of New Mexico's section 1115 demonstration, "Centennial Care 2.0" (Project No: 11-W-00285/6). The demonstration was approved on January 1, 2019, and effective through June 30, 2024, and this Summative Evaluation Report covers the same time period. CMS determined that the Evaluation Report, submitted on January 9, 2026 is in alignment with the CMS-approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state's Summative Evaluation Report.

Through the application of a rigorous evaluation methodology, New Mexico's Centennial Care 2.0 was operationally and financially successful, particularly in expanding value-based payment, slowing healthcare spending growth, strengthening care coordination, and modernizing Medicaid delivery systems. While the demonstration achieved significant operational and delivery system improvements, evidence of consistent improvements in health outcomes and member experience was mixed.

The evaluation underscores the importance of sustaining successful delivery system reforms while strengthening their impact on health outcomes and member experience as New Mexico builds upon these achievements under Turquoise Care. By embedding continuous quality improvement and rigorous evaluation within Turquoise Care, New Mexico has the opportunity to serve as a national leader in advancing evidence-based Medicaid innovation.

The approved Summative Evaluation Report may now be posted to the state's Medicaid website. CMS will also post the Summative Evaluation Report on Medicaid.gov.

We appreciated our partnership on the New Mexico State Centennial Care 2.0 and look forward to our continued partnership with the ongoing New Mexico section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

Digitally signed by DANIELLE DALY -S
Date: 2026.06.29 12:23:50 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Matthew Burriss, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

State of New Mexico Health Care Authority

Medicaid Section 1115 Demonstration Waiver—Centennial Care 2.0

Summative Evaluation Report

December 2025

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Executive Summary

The Centers for Medicare & Medicaid Services (CMS) approved the New Mexico Health Care Authority's (HCA's) Section 1115 Demonstration Waiver renewal application, Centennial Care 2.0, on December 14, 2018, effective January 1, 2019, through December 31, 2023.[1] On September 5, 2023, Centennial Care 2.0 received a temporary extension through December 31, 2024.[2] However, the demonstration was formally terminated on July 25, 2024, with the approval of its successor, Turquoise Care.[3]

Centennial Care 2.0 supported five unique aims:

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

Pursuant to the Centennial Care 2.0 Special Terms and Conditions (STCs), HCA contracted with an independent evaluator to conduct a comprehensive evaluation of the demonstration.[4] This evaluation ensured compliance with Section 1115 Demonstration Waiver requirements; informed State and federal decision making about the program's efficacy; and supported the development of clinically appropriate, fiscally responsible, and effective Medicaid demonstration programs. This report presents the Centennial Care 2.0 Summative Evaluation Report, evaluating the complete demonstration period, from January 1, 2019, through June 30, 2024.[5]

Results

The independent evaluation of Centennial Care 2.0 assessed a range of programs and populations to identify successes, challenges, and opportunities for future improvement. The following section summarizes the successes and challenges related to each of the demonstration's five aims.

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1 Centers for Medicare & Medicaid Services. CMS Extension Approval. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-appvl-ltr-12142018.pdf. Accessed on: Aug 12, 2025.

2 Centers for Medicare & Medicaid Services. Demonstration Approval – Temporary Extension. Available at: nm-centennial-care-appvl-12152023.pdf. Accessed on: Aug 12, 2025.

3 Centers for Medicare & Medicaid Services. Demonstration Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-extn-aprvl-07252024.pdf. Accessed on: Aug 12, 2025.

4 Centers for Medicare & Medicaid Services. Demonstration Approval – Temporary Extension. Available at: nm-centennial-care-appvl-12152023.pdf. Accessed on: Aug 12, 2025.

5 The period from July 1, 2024, through July 25, 2024, will be included in the Turquoise Care evaluation period and is not included in this Centennial Care 2.0 Summative Evaluation Report.

Table 1—Aim One Key Findings

Successes
• Member access to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) personal care services (PCS) improved, as the percentage of members who received and the number of EPSDT PCS delivered per utilizing member increased during Centennial Care 2.0. • Members enrolled in a Health Home (HH) had higher rates of physical health care and preventive visits. – The percentage of HH members with a physical health (PH) claim increased compared to similar non-HH members. – HH adult member rates of access to preventive/ambulatory health services and child rates of access to primary care providers (PCPs) increased compared to similar non-HH members. • High-fidelity wraparound (HFW) program implementation under Centennial Care 2.0 authority was reported to be a generally smooth and effective process. • Low birth weight (LBW) deliveries among members participating in Centennial Home Visiting (CHV) declined throughout Centennial Care 2.0.
Challenges
• Adult rates of access to preventive/ambulatory health services and child rates of access to PCPs decreased overall throughout Centennial Care 2.0. • Initial HFW provider education requirements did not align with providers' actual education levels, delaying provider enrollment in the HFW program. • Anti-depressant medication management and diabetes screenings for members with schizophrenia or bipolar disorder who used antipsychotic medications generally exhibited lower changes in rates among HH members compared to non-HH members.

Table 2—Aim Two Key Findings

Successes
• The number of providers with value-based purchasing (VBP) contracts and the percentage of payments through VBP increased during Centennial Care 2.0. • Results for cost metrics, cost per member trend, and cost per user trend indicated that Centennial Care 2.0 achieved an estimated savings in claims costs compared to expected costs.
Challenges
• There were no challenges associated with Aim Two.

Table 3—Aim Three Key Findings

Successes
• The number of continuous nursing facility level of care (NFLOC) approvals increased throughout Centennial Care 2.0. • The number of telemedicine providers and number of members who received telemedicine services increased after the implementation of Centennial Care 2.0 (and prior to the start of the COVID-19 PHE).
Challenges
• Adult and child member satisfaction with personal doctor decreased relative to the baseline trend. • The number of claims submitted through electronic visit verification (EVV) increased at a slower rate than the baseline trend.

Table 4—Aim Four Key Findings

Successes
• The number of providers who offered SUD screening increased during Centennial Care 2.0. • The percentage of SUD members who utilized peer support services increased. Peer support members had higher rates of continuity of pharmacotherapy for opioid use disorder (OUD) and higher engagement and longer retention in alcohol and other drug (AOD) dependence treatment than non-peer support members. • The percentage of members with an SUD who had a preventive/ambulatory visit increased during Centennial Care 2.0 relative to the baseline trend. • The number of naloxone kits distributed, individuals who received overdose prevention training, and providers who utilized the prescription monitoring program (PMP) increased throughout Centennial Care 2.0.
Challenges
• The percentage of SUD members who received any SUD-related service decreased compared to the baseline trend. • SUD member emergency department (ED) utilization and SUD inpatient (IP) readmissions remained stable during Centennial Care 2.0 and did not significantly decrease as hypothesized. • IP hospitalization among members with an SUD increased during Centennial Care 2.0 relative to the baseline trend. • Overdose deaths among the Medicaid population increased at a higher rate than statewide.

Table 5—Aim Five Key Findings[6]

Successes
• Despite no SMI/SED services being implemented through Centennial Care 2.0, the average length of stay (LOS) for Institutions for Mental Diseases (IMDs) and all stays, as well as SMI/SED identification and treatment remained stable.
Challenges
• No implementation plan was approved as of the conclusion of Centennial Care 2.0. As a result, the State did not implement SMI/SED service changes.

Conclusions

The analysis suggests that Centennial Care 2.0 met the goals of Aims One, Two, and Three, as demonstrated by the following:

- Continued members' use of appropriate services, evidenced by enrollment of the intended population in the HFW program and increased access to services among members enrolled in HHs or participating in the Centennial Rewards (CR) program.
- Effective management of the pace at which costs increased while sustaining quality.

[6] Following the approval of the SMI/SED authority on March 28, 2023, HCA collaborated with CMS to develop and receive approval for an implementation plan; however, no implementation plan was approved until July 10, 2025, one year following the conclusion of Centennial Care 2.0. As a result, the State did not implement SMI/SED service changes until August 1, 2025.
Centers for Medicare & Medicaid Services. NM Approval Letter SMI SED IP. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-turquoise-care-appvl-07102025.pdf. Accessed on: Aug 12, 2025.

- Streamlined processes and modernization of the Centennial Care 2.0 healthcare delivery system, demonstrated by an increase in the number of telemedicine providers and utilizing members, as well as an increase in continuous NFLOC approvals.

Results for Aim Four, focused on members with SUD, were mixed. While SUD provider availability increased, improvements in member outcomes were limited. Improvements in quality of care for SMI/SED members under Aim Five were not expected, as CMS did not approve the SMI/SED implementation plan during the Centennial Care 2.0 demonstration period.

Recommendations

The evaluation identified several successes attributed to Centennial Care 2.0, along with key lessons learned and recommendations for the future. To close gaps in care and reporting, HCA should collaborate with providers and CMS to:

- **Utilize the Care Coordination Infrastructure**: Ensure communication among care coordination teams, particularly between care coordinators and pharmacists, if applicable, to support monitoring of members' use of anti-depressant medications.
- **Manage HH Participant Tracking**: Establish and maintain consistent, automated processes to accurately track HH participant enrollment and engagement.
- **Ensure Accurate Program Requirements**: Review the concordance between provider education requirements and actual providers' education level in advance of finalizing program and policy language.
- **Implement Programs in a Timely Manner**: Ensure timely development and approval of Section 1115 Demonstration Waiver implementation plans, including those for SMI/SED programs, to reduce potentially foregone care and improve evaluation completeness.

1. Background

The Centers for Medicare & Medicaid Services (CMS) approved the New Mexico Health Care Authority's (HCA's) Section 1115 Demonstration Waiver renewal application, Centennial Care 2.0, on December 14, 2018, effective January 1, 2019, through December 31, 2023.[1-1] On September 5, 2023, Centennial Care 2.0 received a temporary extension through December 31, 2024.[1-2] However, Centennial Care 2.0 was formally terminated on July 25, 2024 with the approval of its successor, Turquoise Care.[1-3] The following section outlines the history and implementation of Centennial Care 2.0, including its goals and the demographics of members impacted, in accordance with the Special Terms and Conditions (STCs).[1-4]

Historical Background of New Mexico's Section 1115 Demonstration Waiver

New Mexico aimed to transform lives through its Medicaid program by providing high quality services to improve the security of and promote the independence of its citizens. Throughout New Mexico's Medicaid program, the State employed federal waivers to test new covered populations and delivery methods.

New Mexico's Medicaid program utilized a fee-for-service (FFS) model until 1997 when the State legislature mandated the implementation of a managed care program and HCA requested Section 1915(b) Waiver authority to provide medical and social services under managed care.[1-5] On July 1, 1997, HCA implemented the Salud! Program, covering approximately 65 percent of the State Medicaid population, to improve the quality of and access to care while making cost-effective use of State and federal funds. The Children's Health Insurance Program (CHIP) and other Medicaid safety net programs for children were combined into a single program, New MexiKids.

New Mexico's Medicaid program was administered under several 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 members with acquired immunodeficiency syndrome (AIDS), autism, intellectual and developmental disabilities (IDD), and those deemed medically fragile. Operating multiple waivers created administrative burden, siloed care, and comprised an increasing portion of the State budget. HCA applied for a single Section 1115 Demonstration Waiver on April 25, 2012, to streamline its Medicaid program.[1-6] CMS

1-1 Centers for Medicare & Medicaid Services. CMS Extension Approval. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-appvl-ltr-12142018.pdf. Accessed on: Aug 12, 2025.

1-2 Centers for Medicare & Medicaid Services. Demonstration Approval – Temporary Extension. Available at: nm-centennial-care-appvl-12152023.pdf. Accessed on: Aug 12, 2025.

1-3 Centers for Medicare & Medicaid Services. Demonstration Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-extn-aprvl-07252024.pdf. Accessed on: Aug 12, 2025.

1-4 Centers for Medicare & Medicaid Services. Demonstration Approval – Temporary Extension. Available at: nm-centennial-care-appvl-12152023.pdf. Accessed on: Aug 12, 2025.

1-5 New Mexico Health Care Authority. New Mexico 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: Aug 12, 2025.

1-6 Centers for Medicare & Medicaid Services. Waiver Request (04/25/12). Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-waiver-req-04252012.pdf. Accessed on: Aug 12, 2025.

approved the application and authorized Centennial Care on July 12, 2013, for the period of January 1, 2014, through December 31, 2018.[1-7] The goals of Centennial Care were to:[1-8]

- Ensure that Medicaid members 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 followed four guiding principles:[1-9]

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

Prior to Centennial Care, New Mexico's Medicaid program was administratively complex, operating 12 distinct waivers and an FFS program, and contracting with seven managed care organizations (MCOs). Six MCOs provided physical health (PH) care or long-term services and supports (LTSS), while behavioral health (BH) care was provided through the statewide BH MCO. The program costs increased from 12 percent of the State's budget in 2012 to 16 percent in 2013.[1-10] Centennial Care streamlined administration by incorporating most waivers and reducing contracted MCOs from seven to four, to control increasing costs.

Simultaneous to Centennial Care implementation in January 2014, New Mexico expanded Medicaid to cover adults ages 19–64 years up to 138 percent of the federal poverty level (FPL) under the Affordable Care Act

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1-7 Centers for Medicare & Medicaid Services. Approval Letter (07/12/13). Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-appvl-ltr-07122013.pdf. Accessed on: Aug 12, 2025.

1-8 Centers for Medicare & Medicaid Services. CMS Approved Evaluation Design. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-aprvl-04232024.pdf. Accessed on: Aug 12, 2025.

1-9 Centers for Medicare & Medicaid Services. CMS Approved Evaluation Design (08/18/2017). Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-appvd-eval-dsgn-revised-08182017.pdf. Accessed on: Aug 12, 2025.

1-10 New Mexico Health Care Authority. Application for Renewal. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-pa.pdf. Accessed on: Aug 12, 2025.

(ACA). Medicaid expansion increased the enrollment of low-income adults by nearly 600 percent, and by 85 percent for CHIP members.[1-11] By July 2024, total New Mexico Medicaid enrollment was 783,431 members.[1-12]

Demonstration Background

On December 14, 2018, CMS approved HCA's request to renew New Mexico's Section 1115 Demonstration Waiver, Centennial Care, under the name Centennial Care 2.0. This renewal covered a five-year period from January 1, 2019, through December 31, 2023.[1-13] Centennial Care 2.0 continued the original program's goals and objectives, including administrative simplification, care coordination, benefit and delivery system payment reforms, and member engagement.

Centennial Care 2.0 initially supported four aims. On March 28, 2023, CMS approved an amendment for the State to receive federal financial participation (FFP) for members with serious mental illness (SMI) and serious emotional disturbance (SED) staying in Institutions for Mental Diseases (IMDs), FFP for improvements to HCBS, and the implementation of the high-fidelity wraparound (HFW) intensive care coordination benefit.[1-14] On April 23, 2024, CMS approved a revised Evaluation Design that incorporated this amendment, adding a fifth evaluation aim.[1-15] This Summative Evaluation Report evaluates the program's five 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**: Improved quality of care and outcomes for Medicaid members with substance use disorder (SUD).
- **Aim Five**: Improved quality of care and outcomes for Medicaid beneficiaries with SMI/SED.[1-16]

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

1-11 Ibid.

1-12 Centers for Medicare & Medicaid Services. Medicaid & CHIP in New Mexico. Available at: https://www.medicaid.gov/state-overviews/stateprofile.html?state=New-Mexico. Accessed on: Aug 12, 2025.

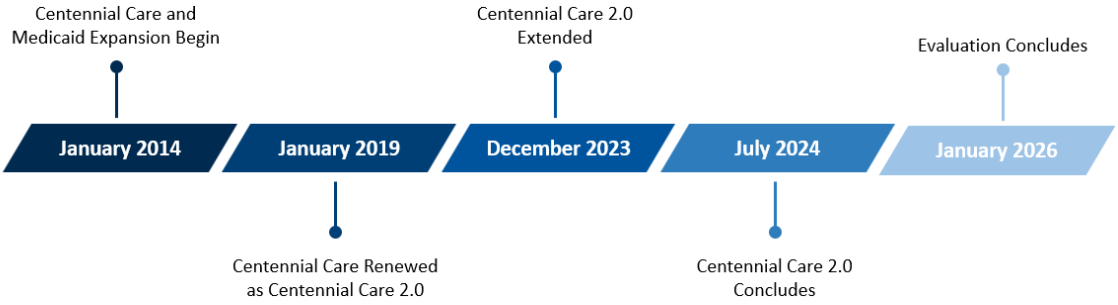
1-13 Centers for Medicare & Medicaid Services. CMS Extension Approval. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-appvl-ltr-12142018.pdf. Accessed on: Aug 12, 2025.

1-14 Centers for Medicare & Medicaid Services. CMS Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-ca1.pdf. Accessed on: Aug 12, 2025.

1-15 Centers for Medicare & Medicaid Services. CMS Approved Evaluation Design. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-aprvl-04232024.pdf. Accessed on: Aug 12, 2025.

1-16 CMS approved the SMI/SED program on March 28, 2023; however, the implementation plan was not approved until July 10, 2025, effective August 1, 2025. As such, SMI/SED service changes were not implemented during Centennial Care 2.0. Centers for Medicare & Medicaid Services. NM Approval Letter SMI SED IP. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-turquoise-care-appvl-07102025.pdf. Accessed on: Aug 21, 2025.

Figure 1-1—Timeline of Key Events



Administrative Simplification

Centennial Care reduced the complexity of New Mexico's Medicaid program by incorporating its previous 12 federal waivers and reducing the number of MCOs, each providing a full array of integrated care services. Centennial Care 2.0 further simplified the Medicaid program, increasing efficiency and reducing costs.

Care Coordination

Centennial Care provided members with a central point of contact for resources and services to improve health outcomes to promote care coordination for high needs members. MCOs were required to conduct a health risk assessment (HRA) with new members and those with conditions requiring high levels of care who were not engaged in care coordination. The HRA determined whether members required a comprehensive needs assessment (CNA) and targeted care coordination services through the development of a comprehensive care plan (CCP). HCA directed MCOs to focus on several populations throughout the duration of Centennial Care, including members diagnosed with a traumatic brain injury (TBI) or a developmental disability (DD), justice involved members, American Indian/Alaska Native (AI/AN) members, and children in State custody. HCA directed MCOs to increase their transition of care services for members transitioning from an inpatient (IP) or nursing facility who may be in need of Community Benefits (CB).

Additionally, HCA directed MCOs to transition members to delegated care coordination using either a full delegation or shared functions model for select populations such as perinatal, Comprehensive Addiction and Recovery Act (CARA) members, certified community behavioral health clinics (CCBHCs), and primary care payment reform. Under the full delegation model, value-based purchasing (VBP) arrangements were required, in which providers were paid based on the health outcomes of their patients and the quality of services rendered. In the shared functions model, MCOs retained some care coordination functions and allowed other care coordination activities to be conducted by a partner organization.

Health Homes (HHs) were also implemented through Centennial Care. HHs provided fully delegated care coordination and services to children and adults with chronic BH conditions. These services included PH and BH services, long-term care (LTC), housing assistance, transportation support, and other social services. HHs were initially implemented in two pilot counties (Curry and San Juan) in April 2016. As of December 2023, there were

12 HHs operating statewide.[1-17] In addition to implementing and expanding HHs as a care coordination model, Centennial Care 2.0 expanded patient-centered medical homes (PCMHs) to create a focus on integrated patient-centered care driven by providers through delegated arrangements.

HCA also 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, a residential or institutional facility, an IP stay, or a nursing facility. HCA and MCOs created VBP initiatives to support successful transitions. Centennial Care 2.0 encouraged partnerships between MCOs and community agencies to expand successful programs that targeted high needs populations. Such partnerships included Project Extension for Community Healthcare Outcomes (ECHO), wellness centers, paramedicine agencies, community health workers, and leveraging use of the Emergency Department (ED) Information Exchange (EDIE).[1-18]

Benefit and Delivery System

With the implementation of Centennial Care, members received integrated healthcare through a single MCO. Additionally, Centennial Care expanded access to HCBS for LTSS members, who previously required a waiver slot. The program also increased funding to help LTSS members remain in their homes rather than transitioning to institutional settings.

HCA further improved benefit management under Centennial Care 2.0 by aligning self-directed community benefits (SDCB) and agency-based community benefits (ABCB). To ensure members received care at the right time and place, HCA provided items that encouraged SDCB members to self-manage and allowed one-time start-up goods for members who transitioned from ABCB to SDCB. Additionally, HCA established cost limits for certain services, such as nonmedical transportation and specialized therapies for members in the SDCB model to ensure sustainability.

HCA collaborated with the New Mexico Department of Health (DOH), New Mexico Children, Youth, and Families Department (CYFD), and New Mexico Early Childhood Education & Care Department (ECECD) to increase prenatal, postpartum, and early childhood development services through the Centennial Home Visiting (CHV) Pilot Program.[1-19] CHV began in 2019 under Centennial Care 2.0 as a home visiting payment method that previously existed through the Nurse Family Partnership (NFP) and Parents as Teachers (PAT) evidence-based models. NFP required enrollment prior to 28 weeks gestation and continued until the child was 2 years old, providing prenatal and postpartum nursing assessments, breastfeeding support and education, and screening and education initiatives for domestic violence and home safety. PAT enrollment was required before delivery and continued until the child was 5 years old, providing support services, education, and assistance with referrals. CHV was implemented in Bernalillo, Curry, Roosevelt, and Taos counties before CMS approved an amendment on February 7, 2020, that expanded services statewide.[1-20] The Early Childhood Education and Care Department

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1-17 Centers for Medicare & Medicaid Services. Annual Monitoring Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-anul-mntrng-jan-dec-2023.pdf. Accessed on: Aug 12, 2025.

1-18 New Mexico Health Care Authority. Application for Renewal. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-pa.pdf. Accessed on: Aug 12, 2025.

1-19 CHV became Medicaid Home Visiting (MHV) with the approval of Turquoise Care in 2024. The program is referred to as CHV in this report as this was the terminology utilized during the Centennial Care 2.0 demonstration period.

1-20 Centers for Medicare & Medicaid Services. CMS Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-cms-amendment-appvl-02072020.pdf. Accessed on: Aug 12, 2025.

(ECECD) took over CHV administration in July 2020 and continued to revise and expand the program, adding initiatives to drive utilization and provider improvement.[1-21]

HCA created housing support services to assist members with SMI in finding, acquiring, and maintaining a stable living situation with the goal of promoting members' participation in their treatment. Centennial Care 2.0 also expanded the SUD continuum of care by extending Screening, Brief Intervention, and Referral to Treatment (SBIRT) to primary care, community health centers, and urgent care facilities statewide. SBIRT identified members who could benefit from SUD services and placed them in appropriate care settings. Members requiring advanced care at American Society of Addiction Medicine (ASAM) Level Three received residential treatment with expanded services. Centennial Care 2.0 allowed members with a SUD diagnosis and a community-based SUD treatment transition plan to have increased stays in IMDs, from 15 days to an average length of stay (LOS) of 30 days if the services were more cost-effective than care provided in a non-IMD setting.[1-22]

Payment Reforms

In 2015, HCA implemented reforms, such as VBP, to pay for quality of services provided rather than the quantity of services. Through VBP arrangements, MCOs enhanced reimbursement for value strategies within their provider network, where MCOs spent a specified percentage of all provider payments through VBP arrangements. VBP expanded payment reform to achieve improved quality and health outcomes. There were three levels of VBP payment arrangements:

1. Level One: Incentives/withholds at the lower end of the risk continuum.
2. Level Two: Shared savings and bundled payments.
3. Level Three: Partial- or full-risk capitation payments at the higher end of the risk continuum.

As of December 31, 2023, MCOs were required to contribute at least 39 percent of provider payments to VBP; a minimum of 13 percent designated to Level 1, 16 percent to Level 2, and 10 percent to Level 3.[1-23]

Centennial Care 2.0 increased risk-based provider payments and required MCOs to increase the percentage of provider payments contributed to VBP levels 2 and 3. Additionally, MCOs were required to improve providers' readiness to participate in the higher risk payment arrangements while focusing on increasing VBP payments to BH, LTSS, and smaller-volume providers. VBP drove other key program goals, such as care coordination, PH and BH integration, transitions of care improvements, and reducing avoidable ED utilization. Payment reforms altered safety net care pools (SNCPs) by changing the percentage of funds allocated to additional hospital funding. At the beginning of Centennial Care 2.0, more funding was designated for uncompensated care (UCC), while a smaller percentage went to hospital quality improvement incentive (HQII) initiative.

1-21 The Focus Group Consulting for New Mexico Early Childhood Education and Care Department. Workgroup Report: Medicaid and Early Childhood Home Visiting. Available at: https://www.nmececd.org/wp-content/uploads/2021/10/Medicaid-and-Early-Childhood-Home-Visiting-Report-2021.pdf. Accessed on: Aug 12, 2025.

1-22 New Mexico Health Care Authority. Application for Renewal. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-pa.pdf. Accessed on: Aug 12, 2025.

1-23 New Mexico Health Care Authority. DY 10 Annual Monitoring Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-anul-mntrng-jan-dec-2023.pdf. Accessed on: Aug 12, 2025.

Member Engagement

Centennial Care focused on increasing member engagement to encourage members to be responsible for their own health through the Centennial Rewards (CR) incentive program.[1-24] Members received reward points for completing predetermined healthy behaviors and redeemed the points for a qualifying gift. Centennial Care 2.0 continued to improve member engagement by growing the CR program.

Amendments

On June 7, 2019, HCA submitted an amendment request to Centennial Care 2.0, seeking to expand CB slots and remove restrictions on the number of counties and individuals that could participate in the CHV program.[1-25] On February 7, 2020, CMS approved the request, immediately increasing CB slots by 1,500 and expanding the CHV program.[1-26]

HCA submitted a second amendment application on March 1, 2021, requesting to waive the IMD exclusion for all Medicaid members to maintain members' access to BH services in appropriate settings. The amendment also requested establishing HFW services for children with high-intensive needs to improve health outcomes and developing 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 sought to ensure coverage of the coronavirus disease 2019 (COVID-19) vaccine for members with limited benefit plan coverage after the Coronavirus Aid, Relief, and Economic Security (CARES) Act funding ended.[1-27] On November 5, 2021, CMS granted partial approval for HCA's Section 9817 American Rescue Plan Act (ARPA) HCBS Spending Plan.[1-28] In response, HCA submitted modifications to the second amendment on December 30, 2021, to implement the HCBS Spending Plan.[1-29] The revisions included increasing the number of CB allocation slots by 1,000 beginning in demonstration year (DY) 9 for members meeting a nursing facility level of care (NFLOC) but not standard Medicaid financial eligibility.[1-30] It also proposed raising the Community Transition Services limits from $3,500 to $4,000 every five years and increasing the environmental modification service limits from $5,000 to $6,000 per person every five years through the end of Centennial Care 2.0.

1-24 CR became Member Rewards (MR) with the approval of Turquoise Care in 2024. The program is referred to as CR in this report as this was the terminology utilized during the Centennial Care 2.0 demonstration period.

1-25 Centers for Medicare & Medicaid Services. CMS Amendment Application. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-pa2.pdf. Accessed on: Aug 12, 2025.

1-26 Centers for Medicare & Medicaid Services. CMS Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-cms-amendment-appvl-02072020.pdf. Accessed on: Aug 12, 2025.

1-27 New Mexico Health Care Authority. Centennial Care 2.0 1115 Waiver Amendment #2 Request. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-pa3.pdf. Accessed on: Aug 12, 2025.

1-28 Centers for Medicare & Medicaid Services. 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: Aug 12, 2025.

1-29 After the amendment was approved, HCA elected not to increase the number of CB allocation slots.

1-30 New Mexico Health Care Authority. Pending Application – HCBS Amendment. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-pa4.pdf. Accessed on: Aug 12, 2025.

On March 4, 2022, CMS approved expenditure authority for state payments to providers for administrating the COVID-19 vaccine retroactively from December 14, 2020, to March 10, 2021.[1-31] The COVID-19 vaccine amendment was evaluated in a Final Report submitted to CMS on February 29, 2024, and approved on July 12, 2024.[1-32] On March 28, 2023, CMS approved the remaining components of the amendment request, allowing New Mexico to receive FFP for members with SMI and SED staying in an IMD, FFP for improvements to HCBS, and the implementation of the HFW intensive care coordination benefit.[1-33, 1-34]

On September 7, 2023, CMS approved an amendment to Centennial Care 2.0, permitting legally responsible individuals (LRIs), such as relatives and guardians, to administer personal care services (PCS) for a six-month period following the end of the COVID-19 public health emergency (PHE), from May 11, 2023, to November 11, 2023.[1-35] On September 18, 2023, New Mexico submitted a supplemental request to its Section 1115 Demonstration Waiver renewal application, seeking to make the authority for LRIs to provide PCS under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit permanent.[1-36] CMS approved this request on December 15, 2023, for the remainder of Centennial Care 2.0.[1-37] In addition, CMS approved several other changes, including an increase in the total number of members eligible for CB from 6,789 to 7,789, an increase in the annual enrollment limit for the supportive housing program from 180 to 450 members with SMI, the expansion of the CHV program to incorporate additional models, and the provision of continuous eligibility for children up to the age of 6 years.

On December 9, 2022, HCA requested to renew its Section 1115 Demonstration Waiver for an additional five years.[1-38] CMS granted a temporary extension of Centennial Care 2.0 on September 5, 2023, through December

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1-31 Centers for Medicare & Medicaid Services. CMS Amendment Approval. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-covid19-amndmnt-apprvl-ca.pdf. Accessed on: Aug 12, 2025.

1-32 Centers for Medicare & Medicaid Services. COVID Vaccine Amendment Final Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-covid-vaccine-amndmnt-final-rpt.pdf. Accessed on: Aug 12, 2025.

1-33 Centers for Medicare & Medicaid Services. CMS SMI/SED Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-ca1.pdf. Accessed on: Aug 12, 2025.

1-34 CMS approved the SMI/SED program on March 28, 2023; however, the implementation plan was not approved until July 10, 2025, effective August 1, 2025. As such, SMI/SED service changes were not implemented during Centennial Care 2.0.
Centers for Medicare & Medicaid Services. NM Approval Letter SMI SED IP. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-turquoise-care-appvl-07102025.pdf. Accessed on: Aug 12, 2025.

1-35 Centers for Medicare & Medicaid Services. CMS COVID-19 PHE Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-ca2.pdf. Accessed on: Aug 12, 2025.

1-36 Centers for Medicare & Medicaid Services. State Amendment Application. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-extnsn-addndum-pa6.pdf. Accessed on: Aug 12, 2025.

1-37 Centers for Medicare & Medicaid Services. Extension Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-appvl-12152023.pdf. Accessed on: Aug 12, 2025.

1-38 Centers for Medicare & Medicaid Services. State Application – Demonstration Extension. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-pa5.pdf. Accessed on: Aug 12, 2025.

31, 2024.[1-39] Centennial Care 2.0 was formally terminated on July 25, 2024, following the approval of New Mexico's renewal application and the implementation of Turquoise Care.[1-40]

Demographics

Centennial Care 2.0 targeted four Medicaid member population groups, including:

- Temporary Assistance for Needy Families (TANF) and related members
- Supplemental security income (SSI) Medicaid
- SSI dual-eligible
- Medicaid expansion

TANF and related members consisted of families with dependent children under the age of 18 years who met a set income, encompassing newborns, infants, and children; CHIP members; pregnant women; low-income parents or caretakers; and members with breast or cervical cancer.[1-41] The SSI Medicaid and dual-eligible populations consisted of members who were aged, blind, or disabled or working disabled. SSI Medicaid included members eligible for Medicaid only, while members who were also eligible for Medicare were included in the SSI dual-eligible population. The Medicaid expansion population included individual members ages 19–64 years with an income up to 138 percent of the FPL.

The COVID-19 PHE Maintenance of Effort (MOE) provided continuous eligibility for members enrolled from March 18, 2020, through April 1, 2023. Figure 1-2 illustrates Centennial Care and Centennial Care 2.0 enrollment from January 2013 to June 2024. Enrollment increased after Medicaid expansion and the implementation of Centennial Care in 2014 and the COVID-19 PHE in 2020. Enrollment peaked at 818,306 members in April 2023, before declining to an average of 1.0 percent per year following termination of the MOE.

1-39 Centers for Medicare & Medicaid Services. Demonstration Approval – Temporary Extension. Available at: nm-centennial-care-appvl-12152023.pdf. Accessed on: Aug 12, 2025.

1-40 Centers for Medicare & Medicaid Services. Demonstration Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-extn-aprvl-07252024.pdf. Accessed on: Aug 12, 2025.

1-41 New Mexico Health Care Authority. Temporary Assistance for Needy Families. Available at: https://www.hsd.state.nm.us/lookingforassistance/temporary_assistance_for_needy_families/. Accessed on: Aug 12, 2025.

Figure 1-2—Managed Care Enrollment, January 2013–June 2024

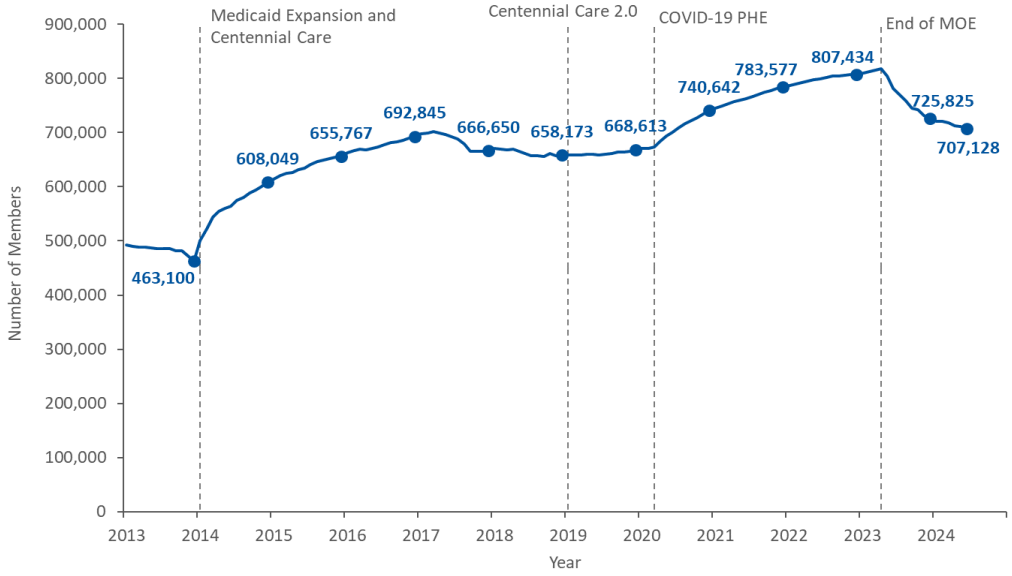
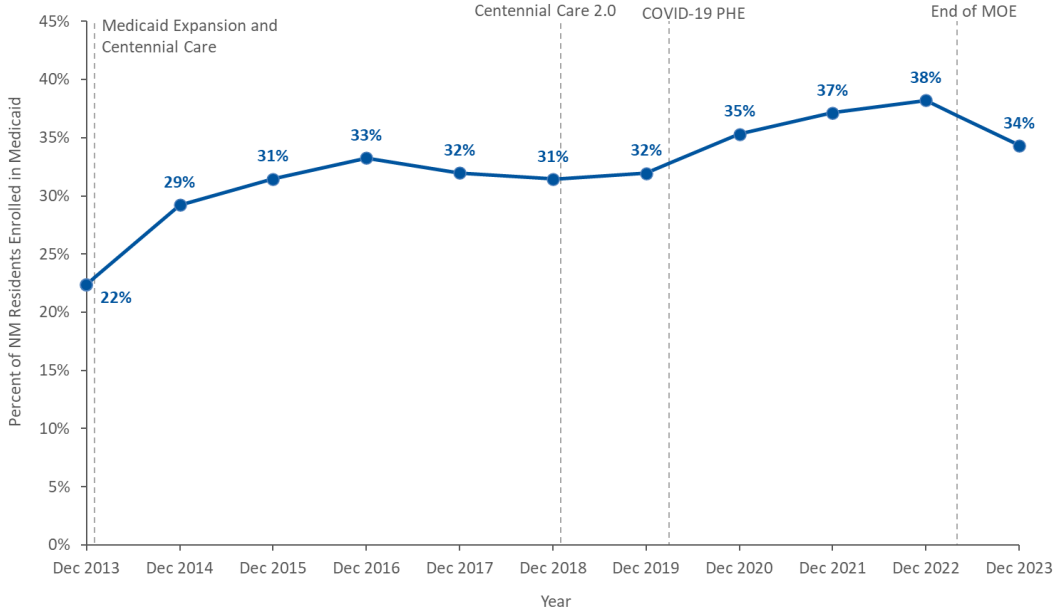


Figure 1-3 displays the percentage of New Mexico residents who were enrolled in managed care from December 2013 through December 2023. New Mexico had the highest percentage of residents enrolled in Medicaid across the United States during this period.[1-42] The percentage of enrolled members increased following Medicaid expansion and the COVID-19 PHE, and continued to rise until termination of the MOE in 2023.

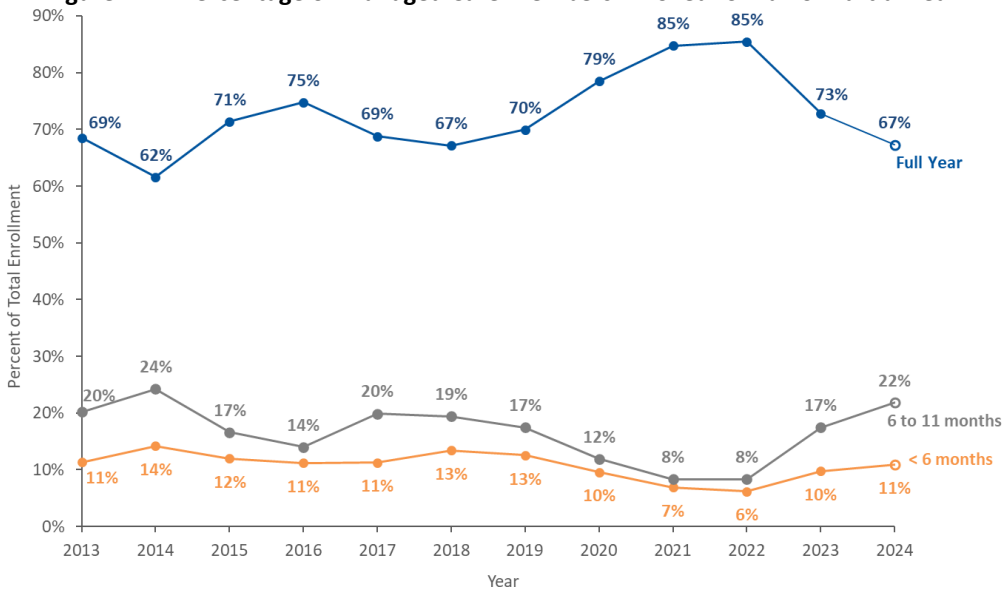
Figure 1-3—Percentage of New Mexico Residents Enrolled in Managed Care, December 2013–December 2023



1-42 KFF. Medicaid State Fact Sheets. Available at https://www.kff.org/interactive/medicaid-state-fact-sheets/. Accessed on: Aug 12, 2025.

Figure 1-4 shows that at least 62 percent of members were enrolled in managed care for a full 12 months each year, increasing to 85 percent by 2021. The percentage of members enrolled in Centennial Care 2.0 for a full 12 months decreased by 12 percent from 2022 to 2023 following termination of the MOE. Less than 20 percent of members were enrolled in Medicaid for less than six months of each year.

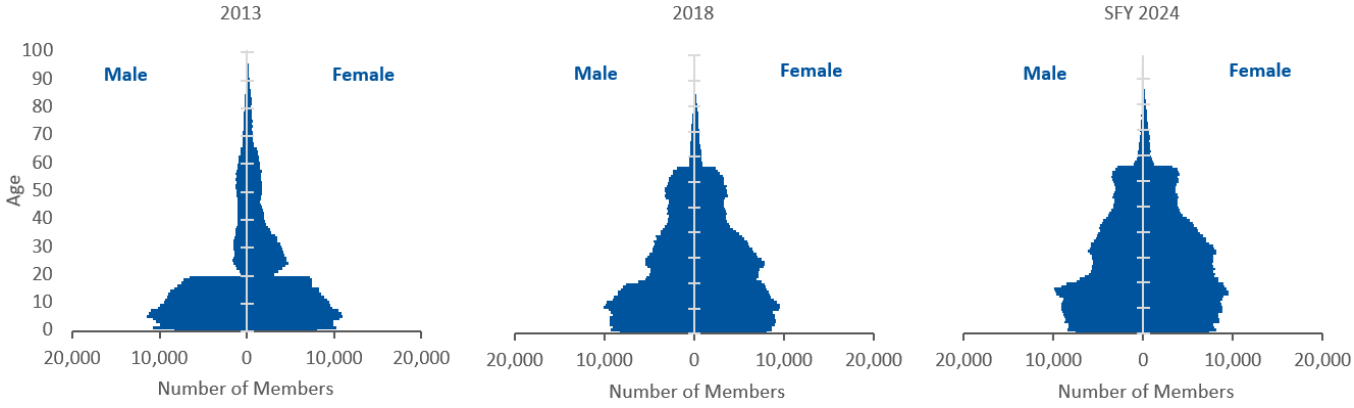
Figure 1-4—Percentage of Managed Care Members Enrolled for Full or Partial Year



Note: The 2024 data point with an open circle represents the full calendar year and does not exclusively reflect Centennial Care 2.0 performance due to the approval of Turquoise Care in July 2024.

Figure 1-5 illustrates the changes in age and gender distribution from pre-Medicaid expansion in 2013, post-Medicaid expansion in 2018, and the final year of Centennial Care 2.0 in state fiscal year (SFY) 2024.[1-43] Prior to Medicaid expansion, there were few adult males enrolled in Medicaid, and approximately two-thirds of enrolled members were children. By SFY 2024, adults comprised 59 percent of the Centennial Care 2.0 population.

Figure 1-5—Change in Member Age and Gender Distribution



1-43 Appendix A, Attachments, Supplemental Results, contains additional detail on the percent change in age and gender distribution between calendar year (CY) 2013, CY 2018, and SFY 2024.

Previous Evaluation Report Findings

The Centennial Care 2.0 Interim Evaluation Report, approved by CMS on September 29, 2023, demonstrated New Mexico's progress toward its evaluation goals.[1-44] Despite the challenges and disruptions to the healthcare system resulting from the COVID-19 PHE, several notable successes were achieved under Centennial Care 2.0:

- Members who received peer support showed improvements in their engagement with SUD treatment.
- Members who engaged with HHs maintained high rates of preventive care visits, even when care was disrupted due to the COVID-19 PHE.
- The COVID-19 PHE necessitated a shift toward telemedicine, which saw significant usage increases.

The COVID-19 PHE also negatively impacted care in several areas, including members' access to preventive and well-care visits. Additional challenges were:

- The measures utilized to assess CR were insufficient to rigorously evaluate the impact of the program, as they did not control for participant self-selection bias.
- Some programs, such as CHV, did not include a comparison group to properly identify a counterfactual and only included one measure to assess the program. The independent evaluator recommended that the State identify additional robust measures to effectively evaluate the CR and CHV programs.

[1-44] Centers for Medicare & Medicaid Services. Interim Evaluation Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-interim-evaluation-rpt.pdf. Accessed on: Aug 12, 2025.

2. Evaluation Questions and Hypotheses

The primary purpose of the summative evaluation is to determine whether Centennial Care 2.0 achieved the five aims outlined in the Background section. This chapter provides the logic models, hypotheses, and research questions used to evaluate each aim, as described in the Centers for Medicare & Medicaid Services (CMS)-approved Evaluation Design, which focus on evaluating the impact of Centennial Care 2.0 on its objectives.[2-1]

Demonstration Goals

Centennial Care 2.0 supported improvements to achieve five primary aims:

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

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

Hypotheses and Research Questions

The aims of Centennial Care 2.0 were comprehensively evaluated through 21 hypotheses and 57 research questions. As described in the Evaluation Design, the hypotheses were developed based on their ability to measure performance, identify areas for potential improvement, and form comparison groups to identify the effects of Centennial Care 2.0. This section outlines the hypotheses and research questions in relation to the logic models used for each aim.

Aim One

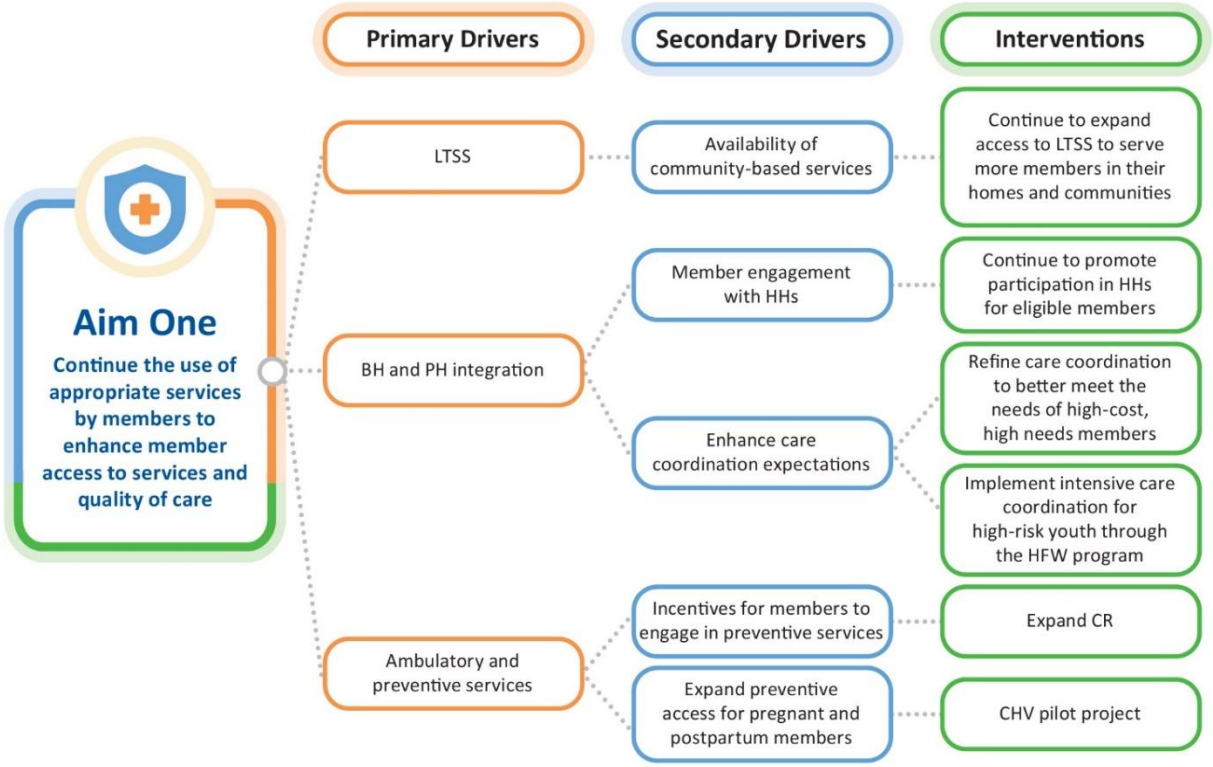
Logic Model

Centennial Care 2.0 aimed to ensure that Medicaid members received the right amount of care, delivered at the right time, and in the right setting. Additionally, Centennial Care 2.0 focused on measuring care in terms of quality rather than quantity.

2-1 Centers for Medicare & Medicaid Services. CMS Approved Evaluation Design. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-aprvl-04232024.pdf. Accessed on: Aug 12, 2025.

The Evaluation Design outlined specified logic models that connected program interventions to specific initiatives and applicable programmatic areas. Hypotheses and research questions for each aim were derived from the logic model. Figure 2-1 displays the logic model for Aim One.

Figure 2-1—Aim One Logic Model



Note: The impact of the COVID-19 PHE on the interventions described will be assessed where possible. BH: behavioral health; CHV: Centennial Home Visiting; COVID-19: coronavirus disease 2019; CR: Centennial Rewards; HFW: high-fidelity wraparound; HH: Health Home; LTSS: long-term services and supports; PH: physical health; PHE: public health emergency

Hypotheses and Research Questions

Table 2-1 presents the hypotheses and research questions corresponding with Aim One.

Table 2-1—Aim One Hypotheses and Research Questions

Hypothesis 1: Continuing to expand access to LTSS and increasing the enrollment limit of the CB Program in 2022 will maintain or increase the number of CB members throughout the demonstration period.
• **Research Question 1**: Has the number of members accessing CB services been maintained or increased year-over-year following the increase of CB slots in 2022?
Hypothesis 2: The ability for LRI to provide PCS to individuals receiving CB or EPSDT PCS will ensure member access to CB or EPSDT PCS services.
• **Research Question 1**: Is the percentage of members receiving EPSDT or CB PCS services the same or higher after the implementation of this benefit?
• **Research Question 2**: Are members able to receive the same or more EPSDT or CB PCS services after the implementation of this benefit?

Hypothesis 3: Promoting participation in a HH will result in increased member engagement with the HH and increase access to integrated PH and BH care in the community.
• **Research Question 1**: Is there an increase in the number/percentage of members enrolled in a HH?
• **Research Question 2**: Is the proportion of members engaged in a HH receiving any PH services higher than those not engaged in a HH?
Hypothesis 4: Enhanced care coordination supports integrated care interventions, which lead to higher levels of access to preventative/ambulatory health services.
• **Research Question 1:** Is there an increase in Centennial Care members who have at least one claim for preventative/ambulatory care in a year?
• **Research Question 2:** Does engagement in a HH result in beneficiaries receiving more ambulatory/preventative health services?
Hypothesis 5: Engagement in a HH and care coordination support integrative care interventions, which improve quality of care.
• **Research Question 1**: To what extent is HH engagement associated with improved disease management?
• **Research Question 2**: Does HH engagement result in increased follow-up after hospitalization for mental illness?
Hypothesis 6: The implementation of the HFW program will serve high needs beneficiaries with a SED diagnosis.
• **Research Question 1**: Is the HFW program enrolling the intended target population?
• **Research Question 2**: What are barriers or facilitators to implementing the HFW program?
Hypothesis 7: Expanding member incentives for preventive care through the CR program will encourage members to engage in preventive care services.
• **Research Question 1**: Has the percentage of Centennial Care members participating in CR increased?
• **Research Question 2:** Are participating CR members more likely to receive preventive/ambulatory services on an annual basis than those who have not participated in the CR program in the previous 12 months?
• **Research Question 3**: Are CR incentive redeeming members more likely to receive preventative/ambulatory services on an annual basis than those who have not redeemed incentives in the 12-month period following the initial preventive visit?
Hypothesis 8: Expanding member access to prenatal care through the CHV pilot program will improve infant health.
• **Research Question 1**: Is the percentage of babies born with a LBW (<2,500 grams) to mothers participating in the CHV pilot program lower than the percentage of LBW babies born to Medicaid mothers who do not participate in the CHV pilot program?

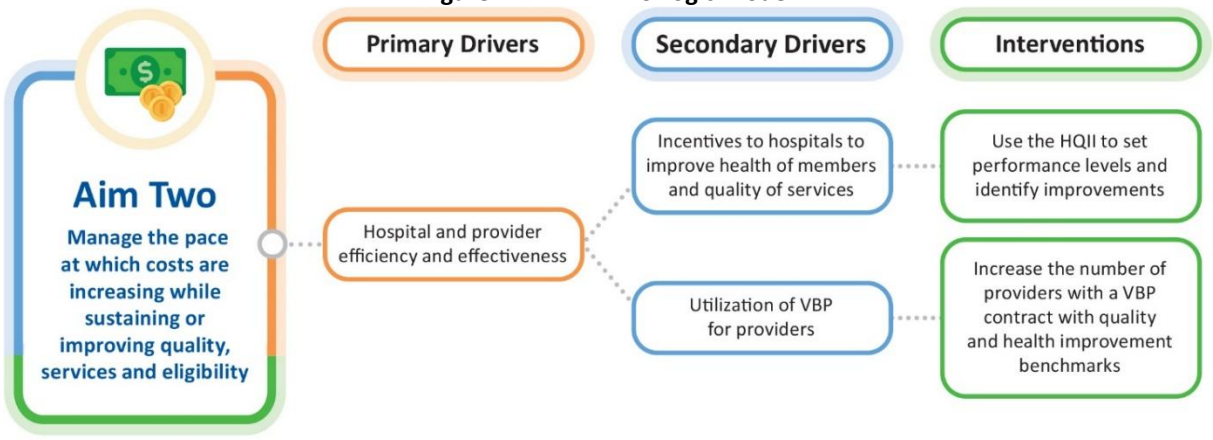
Note: BH: behavioral health; CB: community benefit; CHV: Centennial Home Visiting; CR: Centennial Rewards; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; HFW: high-fidelity wraparound; HH: Health Home; LRI: legally responsible individuals; LBW: low birth weight; LTSS: long-term services and supports; PCS: personal care services; PH: physical health; SED: serious emotional disturbance

Aim Two

Logic Model

Centennial Care 2.0 aimed to slow the growth rate of costs or "bend the cost curve" over time without inappropriate reductions in quality, benefits, eligibility, or provider rates. The CMS-approved Evaluation Design specified logic models, which related program interventions to specific initiatives and applicable programmatic areas. Evaluation hypotheses and research questions for each aim were derived from the logic model. Figure 2-2 illustrates the logic model for Aim Two.

Figure 2-2—Aim Two Logic Model



Note: The impact of the COVID-19 PHE on the interventions described will be assessed where possible. COVID-19: coronavirus disease 2019; HQII: Hospital Quality Improvement Initiative; PHE: public health emergency; VBP: value-based purchasing

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 VBP contracts will manage costs while sustaining or improving quality.
• **Research Question 1**: Has the number of providers with VBP contracts increased?
• **Research Question 2**: Has the number of providers participating in VBP arrangements, who meet quality metric targets, increased?
• **Research Question 3**: Has the amount paid in VBP arrangements increased?
• **Research Question 4**: Has reported performance of Domain 1 measures in the SNCP Hospital Quality Improvement Program been maintained or improved?
• **Research Question 5**: Do cost trends align with expected reimbursement and benefit changes?

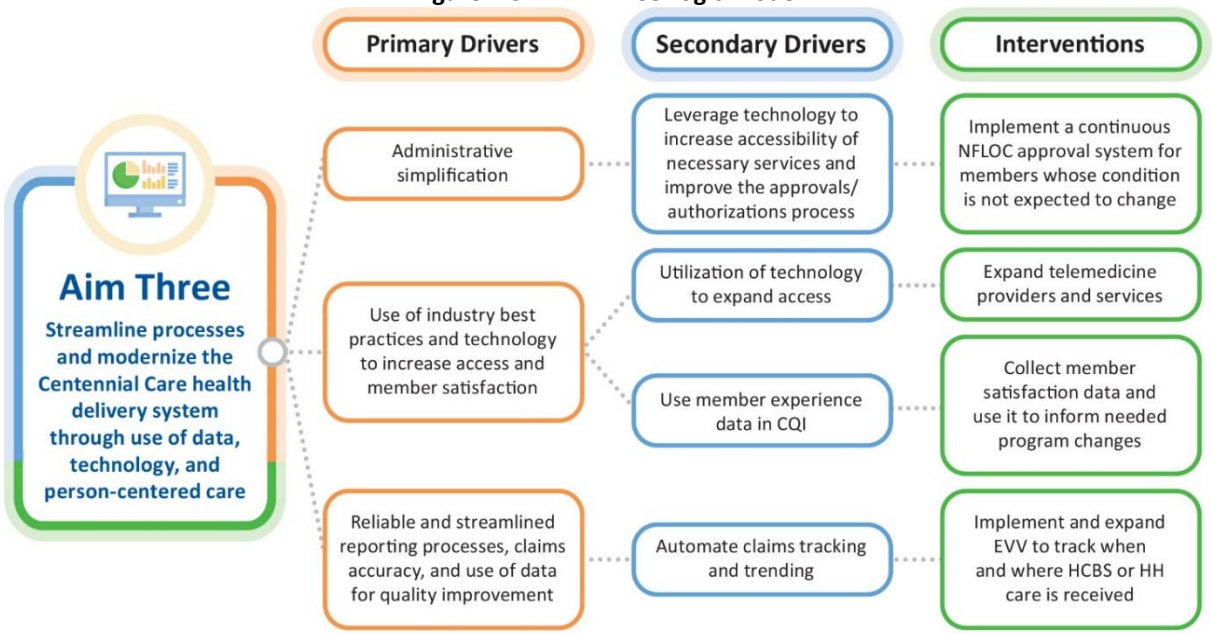
Note: SNCP: safety net care pool; VBP: value-based purchasing

Aim Three

Logic Model

Centennial Care 2.0 aimed to streamline and modernize New Mexico's Medicaid program. The CMS-approved Evaluation Design specified logic models, which related program interventions to specific initiatives and applicable programmatic areas. Evaluation hypotheses and research questions for each aim were derived from the logic model. Figure 2-3 presents the logic model for Aim Three.

Figure 2-3—Aim Three Logic Model



Note: The impact of the COVID-19 PHE on the interventions described will be assessed where possible. COVID-19: coronavirus disease 2019; CQI: continuous quality improvement; EVV: electronic visit verification; HCBS: home– and community-based services; HH: Health Home; NFLOC: nursing facility level of care; PHE: public health emergency

Hypotheses and Research Questions

Table 2-3 presents the hypotheses and research questions corresponding with Aim Three.

Table 2-3—Aim Three Hypotheses and Research Questions

Hypothesis 1: 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.
• **Research Question 1**: Has the number of continuous NFLOC approvals increased during the Demonstration?
Hypothesis 2: The use of technology and 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?
• **Research Question 2**: Has the number of unduplicated members with a telemedicine visit increased during Centennial Care 2.0?
• **Research Question 3**: Has member satisfaction increased during Centennial Care 2.0?
Hypothesis 3: Implementation of EVV is associated with increased accuracy in reporting services rendered.
• **Research Question 1**: Has the number of claims submitted through EVV increased?
• **Research Question 2**: Has the proportion of paid or unpaid hours retrieved due to false reporting decreased?

Note: CQI: continuous quality improvement; EVV: electronic visit verification; NFLOC: nursing facility level of care

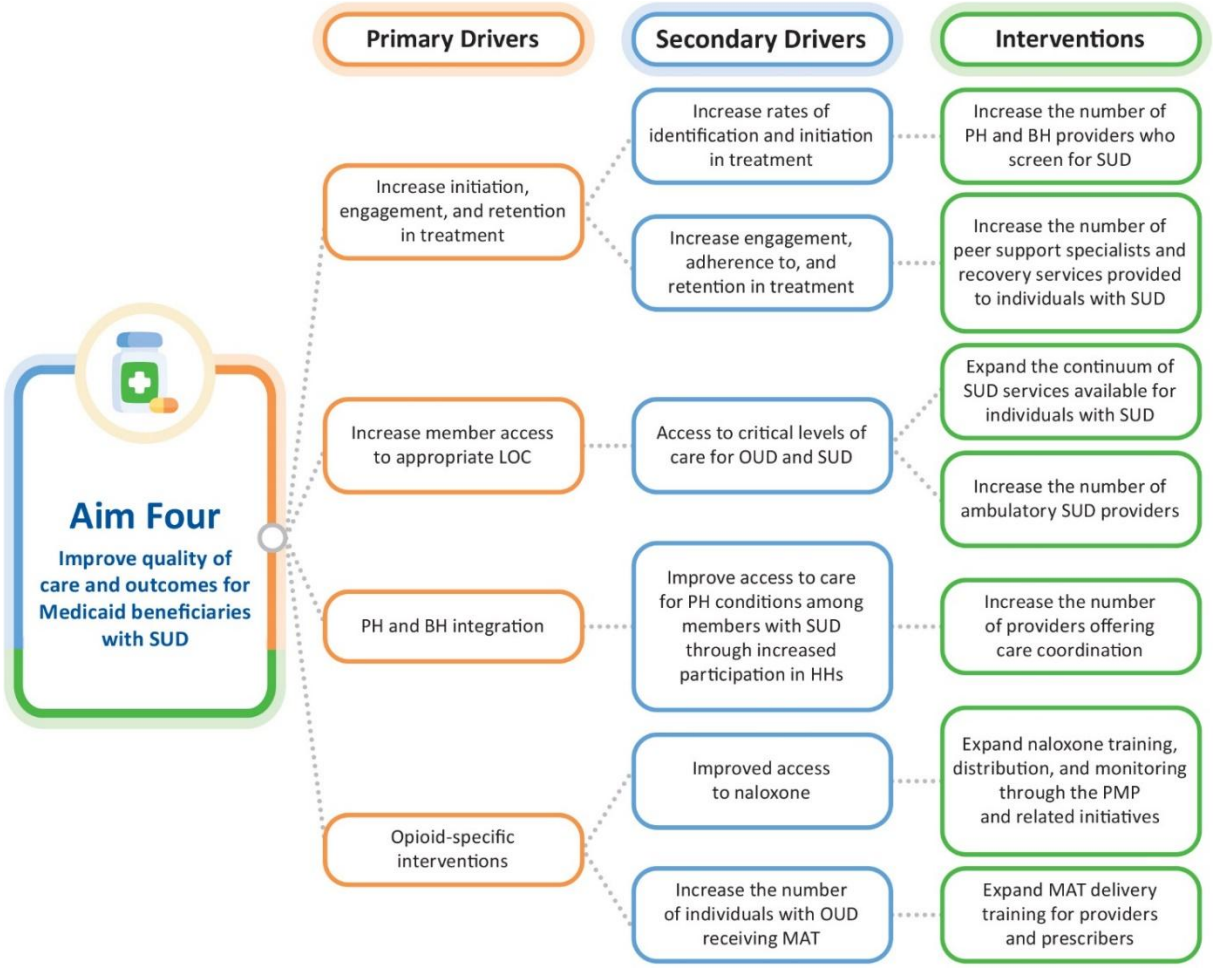
Aim Four

Logic Model

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

The CMS-approved Evaluation Design specified logic models, which related program interventions to specific initiatives and applicable programmatic areas. Evaluation hypotheses and research questions for each aim were derived from the logic model. Figure 2-4 displays Aim Four's logic model.

Figure 2-4—Aim Four Logic Model



Note: The impact of the COVID-19 PHE on the interventions described will be assessed where possible. BH: behavioral health; COVID-19: coronavirus disease 2019; HH: Health Home; LOC: level of care; MAT: medication-assisted treatment; OUD: opioid use disorder; PH: physical health; PHE: public health emergency; PMP: prescription monitoring program; SUD: substance use disorder

Hypotheses and Research Questions

Table 2-4 presents the hypotheses and research questions corresponding 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 AOD dependence treatment.
• **Research Question 1**: Did the number of BH and PH providers who screen beneficiaries for SUD increase?
• **Research Question 2**: Did the number of individuals screened for SUD increase?
• **Research Question 3**: Has the percentage of individuals with SUD who received any SUD related service increased?
• **Research Question 4**: Did the percentage of individuals who initiated AOD 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.
• **Research Question 1**: Has the percentage of individuals with a SUD diagnosis who received peer support services increased?
• **Research Question 2**: Does receiving peer support increase the percentage of individuals engaged in AOD treatment?
• **Research Question 3**: Does receiving peer support increase the treatment tenure for individuals receiving AOD treatment?
• **Research Question 4**: Does receiving peer support increase the treatment tenure for MAT for OUD?
Hypothesis 3: The Demonstration will improve access to a comprehensive continuum of SUD care which will result in decreased utilization of ED and IP hospitalization and SUD IP readmissions.
• **Research Question 1**: Has the continuum of services available for individuals with SUD expanded in terms of which services are available?
• **Research Question 2**: Has capacity for ambulatory SUD services increased?
• **Research Question 3**: Has the utilization of EDs by individuals with SUD decreased?
• **Research Question 4**: Has the utilization of IP hospital settings for SUD related treatment decreased?
• **Research Question 5**: Has the utilization of IP hospital settings for withdrawal management decreased?
• **Research Question 6**: Have IP SUD readmissions decreased for individuals with SUD diagnoses?
• **Research Question 7**: Have increasing trends in total cost of care been slowed for individuals with SUD diagnoses?
• **Research Question 8**: 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 comorbid conditions, which will result in increased utilization for PH conditions.
• **Research Question 1**: Has the percentage of individuals diagnosed with SUD receiving care coordination increased?
• **Research Question 2**: Has the number of individuals with SUD receiving preventive healthcare increased?
Hypothesis 5: The Demonstration will increase use of naloxone, MAT, and enhanced monitoring and reporting of opioid prescriptions through the PMP, which will result in fewer overdose deaths due to opioid use.
• **Research Question 1**: Has there been an expansion of naloxone distribution and training?
• **Research Question 2**: Has the number of providers using MAT services increased?
• **Research Question 3**: Has the number of individuals with opioid or alcohol use disorder receiving MAT increased?
• **Research Question 4**: Is there evidence of enhanced policies and practices related to the PMP, real-time PMP updates, member/provider lock-in programs and limits/edits at pharmacy points-of-sale?
• **Research Question 5**: Is there a decrease in the number of deaths due to overdose?

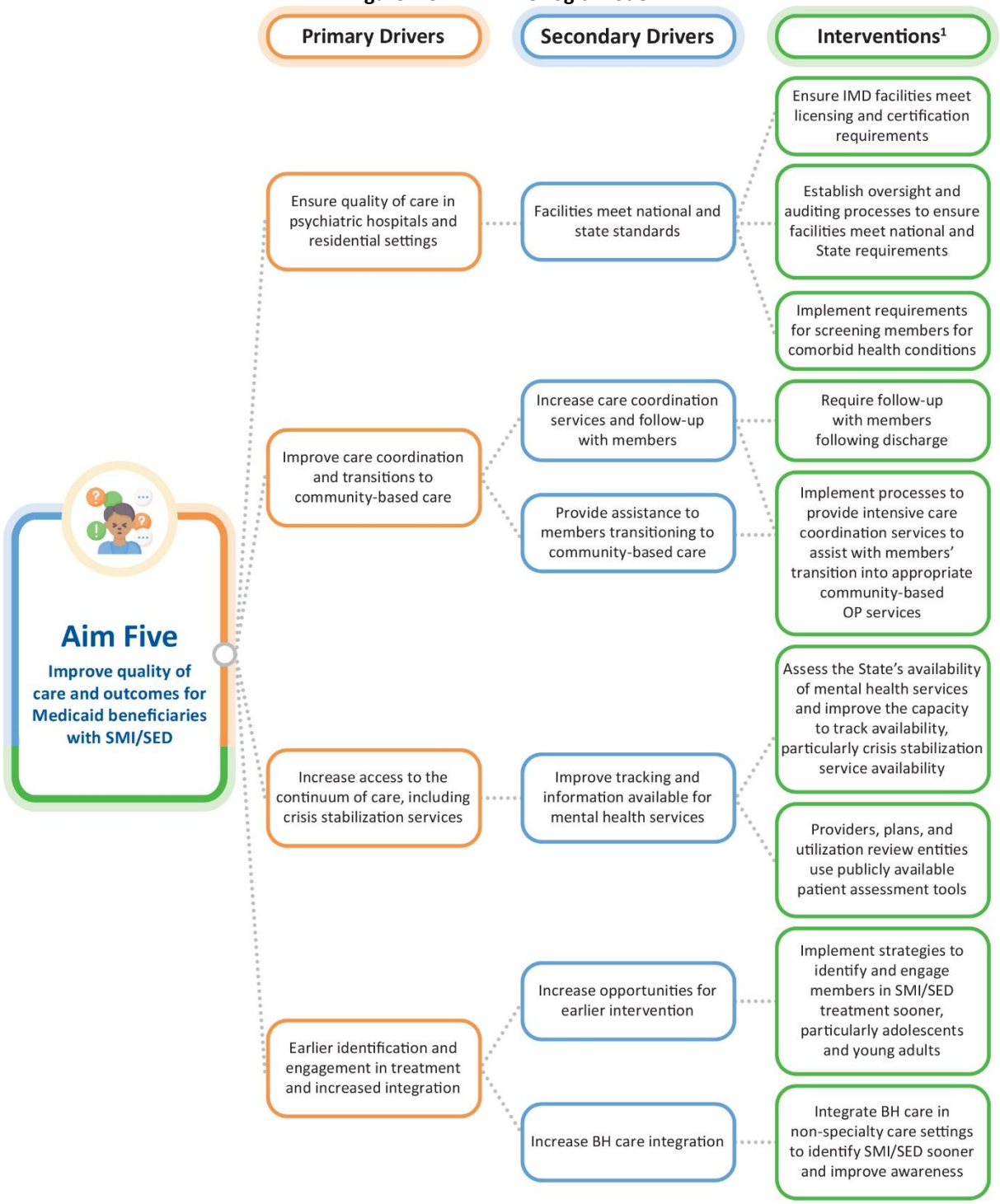
Note: AOD: alcohol or other drug; BH: behavioral health; ED: emergency department; IP: inpatient; MAT: medication-assisted treatment; PH: physical health; PMP: prescription monitoring program; SUD: substance use disorder

Aim Five

Logic Model

Centennial Care 2.0 sought to ensure access to high-quality services for members with an SMI/SED diagnosis. The CMS-approved Evaluation Design specified logic models, which related program interventions to specific initiatives and applicable programmatic areas. Evaluation hypotheses and research questions for each aim were derived from the logic model. Figure 2-5 illustrates the logic model for Aim Five.

Figure 2-5—Aim Five Logic Model



[1]The SMI/SED program implementation plan was not approved by CMS during the Centennial Care 2.0 demonstration period. The interventions in this logic model represent the activities that the State planned to enact within the unapproved implementation plan.
Note: BH: behavioral health; CMS: Centers for Medicare & Medicaid Services; IMD: Institution for Mental Diseases; OP: outpatient; SED: serious emotional disturbance; SMI: serious mental illness

Hypotheses and Research Questions

Table 2-5 presents the hypotheses and research questions corresponding with Aim Five.

Table 2-5—Aim Five Hypotheses and Research Questions

Hypothesis 1: The Demonstration will maintain an average LOS for IMDs of 30 days.
• **Research Question 1**: Has the average LOS for IMDs been maintained at 30 days?
Hypothesis 2: The Demonstration will result in increased rates of care coordination for members with SMI/SED.
• **Research Question 1**: Has the percentage of individuals with SMI/SED receiving care coordination increased?
Hypothesis 3: The Demonstration will decrease utilization and LOS in EDs among Medicaid members who met eligibility criteria of members with SMI/SED.
• **Research Question 1**: Has the utilization of EDs by individuals with SMI/SED decreased? • **Research Question 2**: Have increasing trends in total cost of care been slowed for individuals with SMI/SED diagnoses? • **Research Question 3**: Have SMI/SED costs for individuals with SMI/SED diagnoses changed proportionally as expected with increased identification and engagement in treatment?
Hypothesis 4: The Demonstration will increase the identification of individuals engaged with SMI/SED and increase treatment integration, including specialized services.
• **Research Question 1**: Has the number of individuals identified and/or engaged in SMI/SED treatment increased? • **Research Question 2**: Are members being diagnosed and identified with SMI/SED conditions sooner by receiving SMI/SED diagnoses from non-BH providers? • **Research Question 3**: Has the establishment of specialized settings and services, including crisis stabilization services, focused on the needs of individuals experiencing SMI/SED increased?

Note: BH: behavioral health; ED: emergency department; IMD: Institution for Mental Diseases; LOS: length of stay; SED: serious emotional disturbance; SMI: serious mental illness

3. Methodology

The Centennial Care 2.0 summative evaluation utilized a mixed-methods evaluation design.[3-1] Quantitative methods included descriptive statistics to show changes over time in both counts and rates for specific metrics, as well as interrupted time series (ITS) or difference-in-differences (DiD) analyses to assess whether Centennial Care 2.0 affected changes across specific outcomes. A qualitative component was completed, involving interviews with the New Mexico Health Care Authority (HCA) and Children, Youth, and Families Department (CYFD) staff to gather their perceptions and experience with the implementation of the high-fidelity wraparound (HFW) program. Additionally, beneficiary surveys administered by the managed care organizations (MCOs) as part of their Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3-2] surveys assessed members' rating of their personal doctor, health plan, and overall healthcare.

Target and Comparison Populations

The evaluation target population was Centennial Care 2.0 managed care members, subgroups of managed care members who received Centennial Care 2.0 interventions, and providers who served those members. The specific member subgroups included:

- Long-term care (LTC) members.
- Long-term services and supports (LTSS) members enrolled in the Community Benefit (CB) program.
- Members enrolled in a Health Home (HH).
- Members who received fully delegated care coordination from value-based purchasing (VBP) contracted providers.
- Members engaged in the Centennial Rewards (CR) program.
- Members enrolled in the Centennial Home Visiting (CHV) pilot program.
- Members enrolled in the HFW program.
- Members with a substance use disorder (SUD) diagnosis.
- Members with a serious mental illness/serious emotional disturbance (SMI/SED) diagnosis.

Provider subgroups assessed included Safety Net Care Pool (SNCP) Hospital Quality Improvement Incentive (HQII) hospitals, providers with VBP contracts, and providers who served members with SUD.

The evaluation did not include randomized treatment and control groups. Where possible, comparison groups demonstrated whether changes in outcomes were due to Centennial Care 2.0. As Centennial Care 2.0 was implemented for all members simultaneously, there was no valid comparison group for many initiatives because

3-1 Centers for Medicare & Medicaid Services. Approved Evaluation Design. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-aprvl-04232024.pdf. Accessed on: Aug 12, 2025.

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

data were unavailable for a comparable population not targeted by Centennial Care 2.0.[3-3] Certain programs (e.g., HHs and CHV) allowed for comparisons based on member self-selection or specific outreach criteria. Where possible, adjustments were made to account for differences between the intervention and comparison groups.

Evaluation Period

Centennial Care 2.0 was approved on December 14, 2018, through December 31, 2023.[3-4] On September 5, 2023, Centennial Care 2.0 was temporarily extended through December 31, 2024.[3-5] Centennial Care 2.0 was formally terminated on July 25, 2024, with the approval of its successor, Turquoise Care.[3-6] The baseline and evaluation periods presented in this Summative Evaluation Report are shown in Table 3-1.[3-7]

Table 3-1—Evaluation Periods

Baseline Period	January 1, 2018–December 31, 2018
Evaluation Period	January 1, 2019–June 30, 2024

Evaluation Measures

The measures assessed in this Summative Evaluation Report were selected from data sources that provided valid and reliable data. Each data source was reviewed to ensure completeness and accuracy. HCA utilized 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 Centennial Care 2.0 quarterly and for annual MCO reports. Where possible, measures were selected from nationally recognized measure stewards, including the Centers for Disease Control and Prevention (CDC), CMS, the National Committee for Quality Assurance (NCQA), and the National Quality Forum (NQF). Table 3-2 presents the measures and stewards utilized in this evaluation. A complete measure list with specifications is presented in Appendix A, Attachments, Measure Specifications.

3-3 Since Centennial Care 2.0 targeted most managed care members 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 2023 presently available), access fees, and restrictions using the data, the T-MSIS data were not feasible for this evaluation.

3-4 Centers for Medicare & Medicaid Services. CMS Extension Approval. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-appvl-ltr-12142018.pdf. Accessed on: Aug 12, 2025.

3-5 Centers for Medicare & Medicaid Services. Demonstration Approval – Temporary Extension. Available at: nm-centennial-care-appvl-12152023.pdf. Accessed on: Aug 12, 2025.

3-6 Centers for Medicare & Medicaid Services. Demonstration Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-extn-aprvl-07252024.pdf. Accessed on: Aug 12, 2025.

3-7 The period from July 1, 2024, through July 24, 2024, will be included in the Turquoise Care evaluation and is not assessed in the Centennial Care 2.0 summative evaluation.

Table 3-2—Evaluation Measure Stewards

Number	Measure Name	Steward
1	Percentage of Centennial Care members enrolled and receiving CB services	—
2	Percent of LTSS-eligible members receiving EPSDT PCS	—
3	Percent of LTSS-eligible members receiving CB PCS	—
4	Average number of EPSDT PCS per utilizing member	—
5	Average number of CB PCS per utilizing member	—
6	Number/percentage of Centennial Care members enrolled in a HH	—
7	Number of HH members with at least one claim for PH service in the CY	—
8a	Adults' access to preventive/ambulatory health services (AAP)	NCQA
8b	Adults' access to preventive/ambulatory health services (AAP)–HH population	NCQA
9a	Children and adolescents' access to PCPs (CAP)	NCQA
9b	Children and adolescents' access to PCPs (CAP)–HH population	NCQA
10	Well-child visits in the third, fourth, fifth, and sixth years of life (W34)	NCQA
11	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	NCQA
12	Anti-depressant medication management (AMM) effective acute phase treatment	NCQA
13	Anti-depressant medication management (AMM) effective continuation phase treatment	NCQA
14	7-day follow-up after hospitalization for mental illness (FUH)	NCQA
15	30-day follow-up after hospitalization for mental illness (FUH)	NCQA
16	Number of HFW beneficiaries enrolled in the program	—
17	Percentage of HFW beneficiaries with SED diagnosis in the 11 months prior to enrollment	—
18	Stakeholders' reported barriers and facilitators to implementation	—
19	Percentage of Centennial Care 2.0 members participating in CR	—
20	Percentage of CR participating members and non-participating members with an annual preventive/ambulatory service	—
21	Percentage of CR participating and redeeming, and CR participating and non-redeeming members with an annual preventive/ambulatory service	—
22	Live births weighing less than 2,500 grams (LBW)	CDC
23	Total number of providers with VBP contracts	—
24	Number/percentage of providers meeting quality threshold	—
25	Percentage of total payments that are for providers in VBP arrangements	—
26	Percentage of qualified Domain 1 SNCP Hospital Quality Incentive measures that have maintained or improved their reported performance rates over the previous year	—
27	Cost per member trend	—
28	Cost per user trend	—
29	Number of continuous NFLOC approvals	—
30	Number of telemedicine providers	—
31	Number of members receiving telemedicine services	—
32	Member rating of healthcare	NCQA
33	Member rating of health plan	NCQA

Number	Measure Name	Steward
34	Member rating of personal doctor	NCQA
35	Number of claims submitted through EVV	—
36	Percent of paid or unpaid hours retrieved due to false reporting	—
37	Number of providers who provide SUD screening	—
38	Number of individuals screened for SUD	CMS
39	Percentage of individuals with a SUD diagnosis who received any SUD service during the MY	—
40	Initiation of AOD abuse or dependence treatment (IET)	NCQA
41	Percentage of individuals with a SUD diagnosis who received peer support	—
42	Engagement of AOD abuse or dependence treatment (IET)	Modified NCQA
43	Average LOS	—
44	Continuity of pharmacotherapy for OUD	USC NQF #3175
45	Continuum of services available	—
46	Number of providers and capacity for ambulatory SUD services	—
47	Percentage of ED visits of individuals with SUD diagnoses	—
48	Percentage of IP admissions for SUD-related treatment	—
49	Percentage of IP admissions of individuals with SUD for withdrawal management	—
50	7- and 30-day IP and residential SUD readmission rates	—
51	Total and PMPM cost (medical, behavioral, and pharmacy) for members with SUD diagnosis	—
52	Total and PMPM cost (medical, behavioral, and pharmacy) for members with SUD diagnosis by SUD source of care	—
53	Total and PMPM cost for SUD services for members with SUD diagnosis	—
54	Total and PMPM cost for SUD services by type of care (IP, OP, pharmacy, etc.)	—
55	Percentage of individuals diagnosed with SUD receiving care coordination	—
56	Percentage of individuals with SUD receiving preventive/ambulatory health services (AAP)	CMS Modified NCQA
57	Number of naloxone training and kit distributions	—
58	Number practitioners prescribing MAT	—
59	Percentage of individuals with an opioid or alcohol use disorder with MAT claims	—
60	Number of providers using the PMP*	—
61	Rate of deaths due to overdose	—
62	Average LOS in an IMD	—
63	Percentage of members with SMI/SED receiving care coordination	—
64	Number of all-cause ED visits per 1,000 MM among members who met the eligibility criteria of beneficiaries with an SMI/SED	—
65	Total and PMPM cost (medical, behavioral, and pharmacy) for members with SMI/SED diagnosis**	—
66	Total and PMPM costs (medical, behavioral, and pharmacy) for members with SMI/SED diagnosis by SMI/SED source of care**	—
67	Total and PMPM cost for SMI/SED services for members with SMI/SED diagnosis**	—
68	Total and PMPM cost for SMI/SED services by type of care (IP, OP, pharmacy, etc.)**	—

Number	Measure Name	Steward
69	Number of individuals identified with SMI/SED and number of individuals engaged in SMI/SED treatment	—
70	Number of members diagnosed with SMI/SED conditions by non-BH providers	—
71	Number of specialized settings focused on the needs of individuals experiencing SMI/SED	—

Note: AAP: Adults' Access to Preventive/Ambulatory Health Services; AOD: alcohol or other drug; BH: behavioral health; CB: community benefit; CDC: Centers for Disease Control and Prevention; CMS: Centers for Medicare & Medicaid Services; CR: Centennial Rewards; CY: calendar year; ED: emergency department; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; EVV: electronic visit verification; HFW: high-fidelity wraparound; HH: Health Home; IMD: Institution for Mental Diseases; IP: inpatient; LBW: low birth weight; LOS: length of stay; LTSS: long-term services and supports; MAT: medication-assisted treatment; MCO: managed care organization; MM: member months; MY: measurement year; NCQA: National Committee for Quality Assurance; NFLOC: nursing facility level of care; NQF: National Quality Forum; OP: outpatient; OUD: opioid use disorder; PCP: primary care provider; PCS: personal care services; PH: physical health; PMP: prescription monitoring program; PMPM: per-member per-month; SED: serious emotional disturbance; SMI: serious mental illness; SNCP: safety net care pool; SUD: substance use disorder; USC: University of Southern California; VBP: value-based payment

*The Evaluation Design outlined that Measure 60 would assess the *Number of policy and procedure manual references*; however, the *Number of providers using the PMP* is reported in this Summative Evaluation Report to align with the data provided by the New Mexico Board of Pharmacy.

**Measures 65 through 68 were updated to reflect an assessment of SMI/SED rather than SUD, correcting a labeling error in the Evaluation Design.

Data Sources

Multiple data sources were utilized to evaluate Centennial Care 2.0. These included administrative claims and encounter data, MCO reports, MCO CAHPS reports, Behavioral Health Services Division (BHSD) reports, Department of Health (DOH) data, low birth weight (LBW) data, VBP reports, CMS-64 files, program participation data, and key informant interviews. Capitation rate certification files provided by HCA 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), which was used to collect, manage, and maintain Medicaid recipient files (i.e., eligibility, enrollment, and demographics) and encounter data. Qualitative data were collected through key informant interviews to capture information related to the implementation of the HFW program.

All data used in the evaluation were cleaned and validated through standardized processes. This included extracting, loading, and transforming data to a consistent format; examining data completeness; testing validity to confirm dates and known medical codes; and analyzing data distribution over time. HCA addressed any data quality concerns identified during validation. Any unresolved limitations related to data sources are outlined in Chapter 4, Methodological Limitations.

Administrative Claims

Administrative data extracted from the MMIS were utilized to calculate most measures presented in this Summative Evaluation Report. These data included administrative claims and encounter data; fee-for-service (FFS) claims; enrollee eligibility, enrollment, and demographic data; and capitation payments. Medicaid provider data were used as necessary to identify provider type and member attribution. Medicaid professional, pharmacy, and institutional claims and encounter files were limited to final status paid and denied claims and encounters. Interim transaction and voided records were excluded from the evaluation because these records introduce uncertainty from matching adjustments and third-party liabilities to the index claims that can impact reported rates and cost calculations.

Quarterly state budget and expenditure reports (CMS-64) were used to assess cost-effectiveness, and they contain statements of expenditures for which states are entitled to federal reimbursement under Title XIX.

Key Informant Interviews

Administrative data, national surveys, and beneficiary surveys provided metrics for evaluating processes and outcomes of interest; however, these data sources did not fully capture stakeholders' perspective on Centennial Care 2.0. To address this gap, key informant interviews were conducted with State administrators for the evaluation of the HFW program. A flexible interview protocol was developed using open-ended questions to maximize the diversity and richness of responses, and to ensure a holistic understanding of interviewees' experiences. Responses were aggregated, summarized, and organized according to the protocol.

To engage with key informants, the independent evaluator collaborated with HCA to identify State administrators experienced with the implementation of HFW services. In October 2024 and January 2025, HCA contacted stakeholders directly. One virtual key informant interview with two HCA administrators was conducted in December 2024. A second virtual interview with two CYFD administrators was held in January 2025. The interviews lasted approximately 30 minutes, allowing participants to voice their detailed perspectives and experiences. The interviews with State administrators centered on the State's experience with the implementation of the HFW program under Centennial Care 2.0 authority, including barriers and facilitators to success.

Additional Data Sources

The following section details the additional data sources that were used to evaluate Centennial Care 2.0.

BHSD Reports: BHSD reported annual Narcan training and distribution data with the number of naloxone kits distributed, and persons trained based on data from the Narcan master list, Project to Prevent Prescription Drug/Opioid Overdose (PDO) Distribution & Training Summary, and State Opioid Response (SOR) quarterly Substance Abuse and Mental Health Services Administration (SAMHSA) Performance Accountability and Reporting System (SPARS) reporting.

CMS-64: Data from CMS-64 contained Section 1115 Demonstration Waiver expenditures, quarterly budget monitoring spreadsheets, and member months (MM) reports.

DOH Data: DOH Health Information Technology (HIT) provided data related to the SNCP Hospital Quality Incentive, including Domain 1 performance measures and whether those measures maintained or improved throughout Centennial Care 2.0. In addition, DOH epidemiology reports contained annual data on the number of all-cause and overdose deaths among all New Mexico residents and those enrolled in Medicaid.

LBW Data: HCA provided annual data on the number of deliveries and LBW deliveries.

MCO Reports: Data from MCO reports supported the evaluation of multiple measures and included data on legally responsible individuals (LRIs), VBP contracts and payments through VBP arrangements, claims submitted through electronic visit verification (EVV), hours paid or unpaid retrieved due to false reporting, the number of SUD providers, SUD providers' capacity for ambulatory SUD services, and MCO network providers delivering medication-assisted treatment (MAT). In addition, MCOs provided data on their continuum of services. MCO CAHPS reports contained annual member ratings of their healthcare, health plan, and personal doctor.

New Mexico Board of Pharmacy: The New Mexico Board of Pharmacy provided policy and procedure manual usage data.

Open-Ended LTC Span Summary Reports: Summary reports contained quarterly data on members with an open-ended LTC span during Centennial Care 2.0.

Program Participation Data: Program participation data were provided for the CHV, CR, HFW, and HH programs. These data included metrics such as length of participation, program enrollment type, and services provided.

Analytic Methods

Multiple analytic techniques were used depending on the type and availability of data required for the measure. Analyses deviated from methods outlined in the Evaluation Design if the data were insufficient to support the method, or data were supportive of a more rigorous method.

Descriptive Statistics and Descriptive Time Series

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 activities. These techniques were also used for some short-term outcome measures in cases wherein the role of the measure was to describe changes in the population, but not to show specific effects of Centennial Care 2.0. Measures for which there were insufficient data points for robust ITS analysis and no viable comparison available for DiD testing were assessed through a descriptive analysis of trends.

DiD

A DiD analysis was performed for all measures using claims and encounter data when a suitable comparison group could be identified (i.e., HH and peer support measures). The approach compared the changes in outcome rates between the baseline period and the evaluation period across both groups. The DiD approach controlled for any factors external to Centennial Care 2.0 that were applied equally to both groups, such as the coronavirus disease 2019 (COVID-19) public health emergency (PHE). However, the DiD analysis was still susceptible to external factors that may have differentially impacted one group and not the other. Two baseline years were employed for HH measures, allowing for statistical testing of the baseline trends to determine if the parallel trends assumption held.

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.

Health Homes

While a suitable out-of-state comparison group was not available for the entire evaluation of Centennial Care 2.0, two programs, HH and peer support, allowed for an in-state comparison group. To construct the most appropriate comparison group for the HH population, a logistic regression model was used to estimate 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 an SMI or SED diagnosis at any point during the baseline year, Chronic Illness and Disability Payment System (CDPS) risk score, and indicators for disease conditions related to participation in the HH program.[3-8] Each HH-enrolled member was matched to a non-HH member based on the propensity score and county of residence (see Appendix A, Attachments, Expanded Methodology for matching details).

Peer Support

DiD analysis was used for Measures 42, 43, and 44, related to assessing the impact of peer support services on alcohol and other drug (AOD) dependence treatment. Although the CMS-approved Evaluation Design did not specify the use of a comparison group, an in-state comparison group was developed for the DiD approach.[3-9] Members' weighted CDPS risk scores were controlled to account for potential differences in health profiles between members who received peer support services and those who did not.

ITS

ITS analysis included annual, quarterly, or monthly observations of each measure over time, beginning at least one year prior to Centennial Care 2.0 implementation. The counterfactual for the ITS analysis was the trend as it would have happened without the introduction of Centennial Care 2.0. Specific outcome measures were collected for multiple time periods both before and after Centennial Care 2.0 and related interventions. The measurements collected after Centennial Care 2.0 were compared to the projected outcome to evaluate the impact that Centennial Care 2.0 had on outcomes.

The generic ITS model used was:

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

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 period post-implementation, ε_t is an error term, and *time*×*post* is a linear time trend variable for the post-implementation period.[3-10] 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 level change in the outcome at the time of program implementation; and β_3 is the change in the slope for the measurements after the program.

3-8 CMS Section 1115 Waiver SMI/SED Technical Specifications, Appendix E, was utilized to identify SMI/SED.

3-9 Contreary, 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. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/causal-inference.pdf. Accessed on: Aug 12, 2025.

3-10 To facilitate proper interpretation of policy and trend variables, this is not a true interaction term. Rather, it is a linear time trend for the post-implementation period. This follows the approach described in Linden, A Conducting interrupted time-series analysis for single- and multiple-group comparisons. *The Stata Journal.* 15(2): 480-500. Available at: https://journals.sagepub.com/doi/epdf/10.1177/1536867X1501500208. Accessed on: Aug 12, 2025.

For measures calculated quarterly, indicator variables were added to the ITS model for each quarter to adjust for seasonality. The COVID-19 PHE was adjusted for by creating an indicator variable for quarter (Q) 2 2020 to represent the initial wave of COVID-19 PHE-related shutdowns and stay-at-home orders, and a separate indicator variable for Q3 2020 through the end of Q1 2021 to reflect subsequent New Mexico-specific public health orders.[3-11] For measures calculated annually, an indicator variable for 2020 was included in the model to adjust for the COVID-19 PHE. For measures calculated monthly, the COVID-19 PHE was adjusted for by creating an indicator variable for March 2020 to represent the first COVID-19 impacted month, a separate indicator for April 2020 to May 2020 to represent the initial wave of COVID-19 PHE-related shutdowns and stay-at-home orders, and another indicator for June 2020 through March 2021 to reflect subsequent New Mexico-specific public health orders. Additional covariates were included to control seasonal trends and changing demographic characteristics.

A comparative ITS model was implemented for measures with a comparison group, such as CR and peer support. This model detected differences between groups and assessed whether Centennial Care 2.0 impacted groups differently. The generic comparative ITS model used was:

$$Y_t = \beta_0 + \beta_1 time_t + \beta_2 post_t + \beta_3 time \times post_t + \beta_4 Group + \beta_5 Group \times post_t + \beta_6 Group \times time + \beta_7 Group \times time \times post_t + \varepsilon_t$$

where Y_t, *time*, and *post* have the same meaning as the non-comparative ITS model, *Group* is a binary indicator for the intervention group, and ε_t is an error term. The coefficients β_0, β_1, β_2, and β_3 have the same interpretation as non-comparative ITS for the non-intervention group. The coefficient β_4 represents the difference in the starting level between the intervention and the non-intervention group; β_5 is the difference in slope during the pre-implementation period between the intervention and the non-intervention group; β_6 is the difference in the level change (or "jump") in the outcome at the time of program implementation between the intervention and the non-intervention group; and β_7 is the difference in change in slope between the intervention and the non-intervention group following program implementation.

To construct the most appropriate comparison group for the members participating in CR, a logistic regression model predicted the probability that each member would participate in CR, conditional on their observed baseline characteristics (i.e., the propensity score). These characteristics included sex, age category, race, months enrolled, and Clinical Classifications Software (CCS) categories. Members who participated in CR for the first time in the analysis year were compared to members who never participated in CR at any point in Centennial Care 2.0. The number of members who never participated in CR was significantly smaller than the number of participating members, which complicated the use of propensity score matching. Instead, propensity score weighting was applied to construct comparable groups of participating and non-participating members while retaining all members in the participating group.

Financial Analysis Trend and Cost Development

The financial analysis compared the costs to the State for Centennial Care 2.0 against the estimated expected costs had Centennial Care 2.0 not been implemented. Costs were evaluated at two levels—costs to the MCOs and costs to the program through capitated arrangements.

[3-11] 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: Aug 12, 2025.

Costs to the MCOs were the actual costs associated with providing care to Centennial Care 2.0 members as recorded through paid amounts on encounters. These costs were compared to the estimated expected costs had Centennial Care 2.0 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) percentage from the Bureau of Labor Statistics. Total actual expenditure costs for providing care to Centennial Care 2.0 members were compared to the estimated expected expenditures, which were calculated by applying annual demographic and inflation factors to the baseline costs. The cost analyses do not refer to nor attempt to replicate the required formal Budget Neutrality test set at the time of CMS approval, which sets a fixed target under which Centennial Care 2.0 expenditures must fall.

Costs to the program were the capitated arrangements paid to the MCOs for the delivery of care to Centennial Care 2.0 members. To assess financial performance and cost efficiency, capitation payment annualized trends were compared against both the actual cost trends and the estimated annualized trends had Centennial Care 2.0 not been implemented. Expected trends were estimated based on changes in member demographics, population health condition-based risk score, and the medical CPI.

Based on data from the United States Bureau of Labor Statistics, prices for medical care were 29.16 percent higher in 2023 than 2013 (a $29.16 difference in value per $100 of spending), indicating a medical care average inflation rate of 2.6 percent per year. The medical care inflation rate was lower than the overall annual inflation rate of 2.9 percent during this same period. The medical CPI accounted for changes to cost due to inflationary factors. CPI did not account for any New Mexico Medicaid-specific policy changes that may have had a fiscal impact.

To estimate annualized trends had Centennial Care 2.0 not been implemented, normalized and unnormalized costs and trends were developed. Unnormalized and normalized claim/encounter costs and trends were calculated and analyzed at two levels. Level one analysis reviewed the per-member per-month (PMPM) cost and trend by year and compared 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 unnormalized and normalized claims/encounters was completed on a per-utilizing-member per-month (PUMPM) basis. A utilizing MM was any month in a calendar year (CY) during which a member utilized services. For the level two analysis reviews, the PUMPM cost and trend by year were compared to the average annual trend from the baseline period, the average normalized annual trend from the baseline period, and the expected average annual trend.

Unnormalized claim trends and costs represent the cost from the reported utilization data. The information presented was aggregated for all Medicaid populations. Unnormalized data analysis did not account for known demographic differences across years; as a result, program impacts and results may be biased due to the demographic changes in the underlying population. In an unnormalized analysis, cost changes were not adjusted to account for changes in the underlying population.

Normalization is the process of adjusting cost data for the known quantifiable changes that impact utilization and cost such as demographic changes, risk, and inflation. Normalization removes all known and quantifiable variation by analysis period, leading to a more accurate comparison between time periods. The sections below outline the normalization process employed for this summative evaluation.

1. Calculate the risk-adjusted PMPM for the analysis cohort.
2. Calculate the age-band/gender factor for the analysis cohort.
3. Calculate the race category factor for the analysis cohort.

4. Calculate the area factor for the analysis cohort.
5. Apply risk, age-band/gender, race, area, and medical CPI factors to paid claims to calculate the normalized PMPMs for the analysis cohort.

Normalization Factor Development

To account for demographic differences throughout Centennial Care 2.0, claims/encounters were normalized for condition-based risk score, combined age and gender variation, race variation, and variation in cost by geographic area. CDPS model version 6.5 was used to develop person-level, condition-based risk scores.

Risk Factor Trend

CDPS is a diagnostic-based risk adjustment model widely used to adjust capitated payments for MCOs that enroll Medicaid members. CDPS uses International Classification of Diseases (ICD) codes to assign CDPS categories that indicate an 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 were assigned to a CDPS weight. CDPS weights were 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 member.

Average annual risk trend represents the average annual growth in the average member weighted CDPS risk score throughout the analysis period.

$$Average\ Annual\ Risk\ Trend_t = \left(\left(\frac{Member\ Weighted\ CDPS\ Risk\ Score_t}{Member\ Weighted\ CDPS\ Risk\ Score_0}\right)^{\left(\frac{1}{t}\right)}\right) - 1$$

Age Factor Trend

The risk-adjusted PMPM was 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 were 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 MMs 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 were 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 years had an annual risk-adjusted claims cost PMPM of $105 and the entire population had an annual risk-adjusted claims cost PMPM of $100, then the age-band/gender factor would be 1.05 for the female ages 20–24 years cohort.

Age-band/gender factors were calculated based on the annual risk-adjusted member-level claim cost PMPM. The factors were calculated for each year 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, A_x is the risk-adjusted member-level individual claim cost, and A_T represents the annual risk-adjusted claim cost PMPM for the entire population. The calculated factors were reviewed over multiple time periods, and final factors were developed to ensure the highest statistical R^2 for a given age-band/gender grouping. A single set of age-band/gender factors were developed ensuring that changes in age factors were applied consistently across all areas and years.

Consistent age factors were 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.

Average annual aging trend represents the average annual growth in the average age-band/gender factor, AB, throughout the analysis period.

$$Average\ Annual\ Aging\ Trend_t = \left(\left(\frac{AB_t}{AB_0} \right)^{\left(\frac{1}{t}\right)} \right) - 1$$

Race Factor Trend

The age-band/gender and risk-adjusted PMPM was used to develop the race category 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 age-band/gender and risk-adjusted PMPM costs were calculated at a race category grouping level as well as at the total level for the entire population:

$$J_x = \sum R_x / AB_x$$

where J represents the annual age-band/gender and risk-adjusted claim cost PMPM for a race category grouping, x; R is risk-adjusted member-level individual claim cost, and AB represents the annual age-band/gender factor for an age-band/gender. The risk-adjusted individual claim-level expenditures and corresponding eligible members for a selected age-band/gender grouping were summed across each year. The annual risk and age-band/gender factors adjusted claim PMPM output was developed to calculate race category factors between each stratification comparing the age-band/gender, risk-adjusted, and race category grouping PMPM to the total population level

annual age-band/gender and risk-adjusted member-level claim cost PMPM. The annual race category factor was calculated as:

$$JF_x = J_x / J_T$$

where *JF* represents the annual race category factor, *x* is the race category grouping, J_x is risk and age-band/gender factors adjusted claim cost, and J_T represents the annual risk and age-band/gender factors adjusted PMPM for the entire population. The calculated factors were reviewed over multiple time periods, and final factors were developed to ensure the highest statistical R^2 for a race category grouping. A single set of race category factors were developed ensuring that changes in race category stratifications were applied consistently across all areas and years.

Average annual race factor trend represents the average annual growth in the average race factor, *JF*, throughout the analysis period.

$$Average\ Annual\ Race\ Trend\ _t = \left(\left(\frac{JF_t}{JF_0} \right)^{\left(\frac{1}{t}\right)} \right) - 1$$

Area Factor Trend

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

$$G_x = \sum R_x / AB_x / JF_x$$

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

$$GF_x = G_x / G_T$$

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

Average annual area factor trend represents the average annual growth in the average area factor, *GF*, throughout the analysis period.

$$Average\ Annual\ Area\ Trend_t = \left(\left(\frac{GF_t}{GF_0}\right)^{\left(\frac{1}{t}\right)}\right) - 1$$

Service Category Distribution Trend

The service category distribution represents the total actual paid claims cost impact of members utilizing services differently throughout the evaluation period. Services include inpatient (IP), outpatient (OP), OP emergency department (ED), LTC, professional, and pharmacy. The annual risk, age-band/gender, race category, and area factors adjusted claim PMPM output was developed to calculate relativities between service categories and the overall annual risk, age-band/gender, race and area category adjusted claim cost PMPM. The annual service category distribution factor was calculated as:

$$SF_x = S_x / S_T$$

where *SF* represents the annual service category distribution factor; *x* is the service category grouping; S_x is risk, age-band/gender, race, and area category factors adjusted claim cost; and S_T represents the annual risk, age-band/gender, race and area category factors adjusted PMPM for the entire population.

Average annual service category distribution factor trend represents the average annual change in the average service category distribution factor, *SF*, throughout the analysis period.

$$Average\ Annual\ Service\ Category\ Distribution\ Trend_t = \left(\left(\frac{SF_t}{SF_0}\right)^{\left(\frac{1}{t}\right)}\right) - 1$$

Cost and Trends

Cost and trends were calculated and reviewed in six ways:

- **Actual Total Cost** represents the total expenditure for each review period:

  $$X_t = \sum MC_t$$

  where *X* represents the actual total cost for the population or time period under review, and *MC* represents the costs at a member level for the time period under review.
- **Actual PMPM** represents the PMPM 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.

- **Counterfactual PMPM** represents the expected PMPM cost over the review period. It was calculated by multiplying the ratio of the age-band/gender factor between the review period and the year prior, the ratio of the race category factor between the review period and the year prior, the ratio of the geographic factor between the review period and the year prior, and the inflation rate for the review period:

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

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

  where *E* represents the counterfactual PMPM cost, *t* represents the review period, *AB* represents the annual age-band/gender age factor for an age-band/gender, *JF* represents the annual race category factor, *GF* represents the annual geographic factor, *C* represents the annual condition-based CDPS risk score, *i* represents the inflation rate, and *Y* represents the claims PMPM cost.

- **Counterfactual Total Cost** represents the expected total expenditure for each review period. It was 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 counterfactual 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 was 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.

- **Counterfactual 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 was 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 counterfactual 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.

Qualitative Synthesis

State representatives with HCA and CYFD participated in virtual key informant interviews for the HFW program evaluation in December 2024 and January 2025. A flexible interview protocol was developed using open-ended questions to maximize the diversity and richness of responses, ensuring a holistic understanding of each subject's experience. The interviews lasted approximately 30 minutes and were recorded to ensure accuracy in notetaking and transcription.

Responses gathered through notes and transcription were imported into the qualitative data analysis software MAXQDA, where qualitative data were extracted, aggregated, summarized, and analyzed using open coding techniques to identify key themes and concepts raised by interviewees. Axial coding techniques were then used to identify relationships between concepts, such as access to care and unintended consequences, that were identified during open coding. The coding system and analysis developed were utilized to create a written synthesis of the key informant interviews, presented in Chapter 5, Results. While the results were not statistically representative, the interview responses provided context and insight into stakeholders' experiences with HFW program implementation.

4. Methodological Limitations

The following section details the methodological limitations of the Summative Evaluation Report for the New Mexico Health Care Authority (HCA) Section 1115 Demonstration Waiver, Centennial Care 2.0. This section elaborates on the strengths and weaknesses of the Evaluation Design, data sources and collection, and analyses used in the summative evaluation.

Evaluation Design

The Summative Evaluation Report presents baseline and evaluation period rates for performance measures and other metrics aligned with the primary objectives of Centennial Care 2.0. A strength of this evaluation was the use of a variety of data sources to assess access to services and quality of care; modernization of the health delivery system through data, technology, and person-centered care; and members with a substance use disorder (SUD). Evaluation measures were selected based on their relevance to the processes and outcomes impacted by Centennial Care 2.0. Many of the measures were based on standardized, validated metrics from recognized measure stewards.

The measures and methodology utilized to evaluate Centennial Care 2.0 had several key limitations. First, because Centennial Care 2.0 was implemented statewide and all eligible members received interventions, an in-state comparison group was unavailable for most programs, excluding the Health Home (HH) program, members who received peer support, and the Centennial Home Visiting (CHV) pilot program. Although Transformed Medicaid Statistical Information System (T-MSIS) data from the Centers for Medicare & Medicaid Services (CMS) could have supported the creation of a state-level comparison group, these data were not feasible for use in this summative evaluation. T-MSIS data may become available to support a counterfactual comparison group for evaluating Centennial Care 2.0's successor, Turquoise Care. At the time of this summative evaluation, it was possible to obtain data from another state with similar population characteristics and Medicaid policies and procedures. Therefore, the counterfactual comparison used was the comparison of measure rates projected out from the baseline into the evaluation period. The results indicated 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 the Summative Evaluation Report was the impact of the coronavirus disease 2019 (COVID-19) public health emergency (PHE). The COVID-19 PHE resulted in substantial changes to the processes used in the delivery of healthcare. In New Mexico, healthcare utilization was significantly reduced in 2020 and impacted the summative evaluation results to varying degrees. Where possible, analyses were adjusted to account for the impact of the COVID-19 PHE. For measures analyzed using interrupted time series (ITS) analysis, knowledge about state-specific case counts, shutdowns, and stay-at-home orders was incorporated into the model to account for the effect of the COVID-19 PHE through controlling for affected months, quarters, or years in regression analyses. For measures that employed a difference-in-differences (DiD) approach, the relative change over time in outcomes between comparison groups was the estimate of interest. As a result, stronger inferences about program impacts may be drawn as the COVID-19 PHE effect was assumed to apply equally to both groups. However, the specifications for other measures required long look-back periods or annual assessments of members that would not allow for such adjustments. Due to this limitation, the 2020 rates of certain measures confounded the impact of the COVID-19 PHE with any program impacts, and the analysis could not disentangle the two sources of change.

Furthermore, undetected differences between the target and comparison populations may have led to biased results. Unlike a true randomized controlled trial, members voluntarily chose to participate in the HH program, receive peer support services, or participate in/redeem CR rewards. These participants may have been systematically different from those who were eligible but elected not to participate in ways not captured by administrative data. The use of a matched comparison population for the comparison group mitigated bias caused by the lack of randomization; however, no method can completely remove self-selection bias.

Lastly, it is possible that remaining unobserved differences between the matched groups created a regression to the mean (RTM) effect, which occurs when the matching process selects units that are extreme relative to their respective group means to achieve matched sample balance.[4-1] Biased conclusions may occur when otherwise "healthy" members are matched during a time period of unusually high utilization and/or prevalence of comorbidities, then "regress" back to their mean from prior to the matching period. However, since the measures that evaluated the HH program were reported as rates consisting of numerator and denominator criteria, the probability of numerator events must be affected by RTM to bias conclusions. If outcome measures included costs or service utilization, it is expected that RTM would bias results because the comparison group would "regress" back to their means during the evaluation year. In these situations, it would be plausible that the baseline comparison group 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 in this study, it is expected that RTM bias was minimal.

Data Sources and Data Collection

The Summative Evaluation Report utilized a range of data sources, including, but not limited to, administrative data, Medicaid enrollment data, demographic data, claims and encounter data, managed care organization (MCO) reports, Behavioral Health Services Division (BHSD) reports, and Department of Health (DOH) reports. The variety of data sources was a major strength, as it allowed the State to uniquely answer research questions that might have otherwise been impossible to answer with administrative data alone.

While using numerous data sources was a strength, each data source had weaknesses which are important to understand within the context of the evaluation. For example, the claims and encounter data were generated as part of the Medicaid billing process and, as a result, may not have been as complete or sensitive as a thorough review of patients' medical charts. This weakness may have been mitigated if the lack of sensitivity in the claims and encounter data remained relatively stable over time and if the measures calculated from these data followed trends consistent with the underlying processes and outcomes of interest.

In addition, the MCO data reported varied year-over-year, which may have been due to changes in reporting templates. As a result, it was unclear whether the data provided reflected a true change to the measure or if they were a reporting artifact. These data were provided as reported by each MCO and were not independently validated. Further, MCO data on the continuum of services available for members with SUD did not align with the State's internal data on the number of providers practicing under specified provider types. This discrepancy will be addressed in the forthcoming Turquoise Care Interim Evaluation Report, and alternative data sources may be utilized. Lastly, data provided for CHV participation did not include unique identification fields that could be

[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.

mapped to delivery and low birth weight (LBW) data. As such, CHV member data could not be fully matched to the delivery and LBW data.

Analyses

The methodologies used in the Summative Evaluation Report included ITS, DiD, qualitative, and descriptive analyses. Excluding qualitative and descriptive analyses, the results provided an understanding of whether measures exhibited statistically significant changes following the implementation of Centennial Care 2.0.

ITS, a robust quasi-experimental approach, was used to evaluate treatment effects where data were available for multiple time points during the baseline and evaluation periods. A strength of a single group ITS is its ability to adjust for underlying trends in the baseline period and 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 and result in biased conclusions about the impact of Centennial Care 2.0.[4-2] Where possible, ITS analyses included a comparison population to help control for confounding changes.

Repeated observations of the outcome prior to and following the intervention were used to estimate a counterfactual trend during the evaluation period, based on the projection of the baseline period. The ITS power relies 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] In particular, annual measures analyzed using ITS included four data points during the baseline period and three data points during the evaluation period, which may not allow for accurate representations of trends.

A comparison group for the peer support and HH populations allowed for the use of DiD. DiD provided stronger conclusions about program impacts because the members participating in a HH or receiving peer support services were compared to similar members who did not participate in the programs. However, a key assumption of DiD is that the trends between the intervention and comparison groups were parallel prior to program implementation. The parallel trends assumption can be tested by identifying and analyzing baseline trends in the outcomes.

To be included in the DiD analysis, members had to be enrolled during both the baseline period and evaluation periods. Selecting a baseline period too far removed from the start of Centennial Care 2.0 would have resulted in a greater number of members who were not continuously enrolled due to high enrollment and disenrollment patterns among Medicaid members. These members would have been excluded from the DiD analysis.

The peer support group had limited members prior to 2018. As a result, only one year of baseline data were available for evaluation, and the parallel trends assumption could not be tested. For HH measures, the baseline

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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: Aug 12, 2025.

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.

period included 2016 and 2017. Due to small sample sizes, statistical testing on baseline trends had limited statistical power, increasing the likelihood of failing to detect meaningful differences. To accommodate this, baseline trends were also assessed visually to determine if the parallel trends assumption was met for HH measures.

Due to the phased county-by-county roll-out and ramp-up effects of the first year of HH implementation, that first year did not provide an accurate reflection of program performance and was excluded from the evaluation.

In contrast, only a descriptive comparison of measure rates during the baseline period and evaluation periods was possible for certain measures, highlighting a main limitation in the inability to draw causal inferences. Descriptive analyses do not provide a sufficiently strong comparison group to definitively conclude whether Centennial Care 2.0 caused changes in the measure rates, as the analysis does not attempt to isolate the impact of Centennial Care 2.0. External factors, such as the COVID-19 PHE, may have contributed to changes in measure rates, coding and reporting practices in the claims/encounter data, and prescribing practices.

A final limitation of the analytic methods involved the ability to demonstrate why specific measures improved, worsened, or remain unchanged. While statistical analysis characterized the direction, magnitude, and statistical significance of measure rate changes, the analysis did not identify underlying causes. As the only qualitative component conducted for the evaluation focused on the high-fidelity wraparound (HFW) program implementation, the ability to explain the reasons for changes was limited. Therefore, the causes of observed changes or the lack thereof in specific measure rates cannot be identified.

5. Results

The following section describes measure results grouped by research question and related hypotheses for the evaluation of the New Mexico Health Care Authority's Section 1115 Demonstration Waiver, Centennial Care 2.0. For details on the measure specifications and full measure results, reference Appendix A, Attachments.

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

Aim One Key Findings

Table 5-1 presents the key findings by hypothesis for Aim One.

Table 5-1—Aim One Key Findings

Hypothesis	Key Finding
1	The percentage of members who enrolled in and received CB services began increasing in 2013 and remained steady after the 2023 slot increase.
2	Measures assessing the effect of LRIs on member access to CB and EPSDT PCS increased for EPSDT PCS and showed mixed results for CB PCS. Both the percentage of members who received EPSDT PCS and the number of EPSDT PCS delivered per utilizing member increased, suggesting that member access for EPSDT PCS improved during Centennial Care 2.0. Slight decreases in the percentage of LTSS-eligible members enrolled in CB PCS were likely the result of the COVID-19 PHE. This result, along with a halted decreasing trend in the number of CB PCS per utilizing member, suggested that member access to CB PCS was partially maintained during Centennial Care 2.0.
3	Centennial Care 2.0 HH enrollment increased beginning in April 2019. The percentage declined slightly in 2022, which may be due to incomplete HH enrollment data. The percentage of HH members with a PH claim increased to nearly 100 percent while the percentage of non-HH members with a PH claim generally decreased.
4	Although adult rates for access to preventive/ambulatory health services decreased during Centennial Care 2.0, results largely aligned with the national median. Similarly, children and adolescents rates for access to PCPs decreased across all age stratifications. Adult HH members' rates for access to preventive/ambulatory health services and children and adolescent rates for access to PCPs increased compared to the baseline period, while non-HH member rates decreased.
5	The results for measures assessing improvements in quality of care were mixed year-over-year and did not demonstrate statistically significant differences in the change in rates between HH and non-HH members.
6	The HFW program primarily served members younger than age 18 years. Less than half of HFW members had a diagnosis consistent with the CMS SED definition; however, nearly all members had an alternative BH diagnosis. State administrators felt that HFW implementation under Centennial Care 2.0 authority was a smooth and effective process.
7	Approximately half of members participated in CR annually. Members who participated in CR were more likely to have a preventive/ambulatory visit than members who did not and members who redeemed points were more likely to have a follow-up preventive visit than members who did not redeem points. There were no statistically significant changes associated with Centennial Care 2.0.
8	Regression-adjusted rates of LBW deliveries among members participating in the CHV group generally declined throughout Centennial Care 2.0, while remaining stagnate for non-CHV members. In 2023, the rate of LBW deliveries for CHV members was lower than that of non-CHV members.

Note: BH: behavioral health; CB: Community Benefit; CHV: Centennial Home Visiting; CMS: Centers for Medicare & Medicaid Services; COVID-19: coronavirus disease 2019; CR: Centennial Rewards; EPSDT: Early and Periodic Screening, Diagnostic and Treatment; HFW: high-fidelity wraparound; HH: Health Home; LBW: low birth weight; LRI: legally responsible individual; LTSS: long-term support services; PCP: primary care provider; PCS: personal care services; PH: physical health; PHE: public health emergency; SED: serious emotional disturbance

Aim One Results

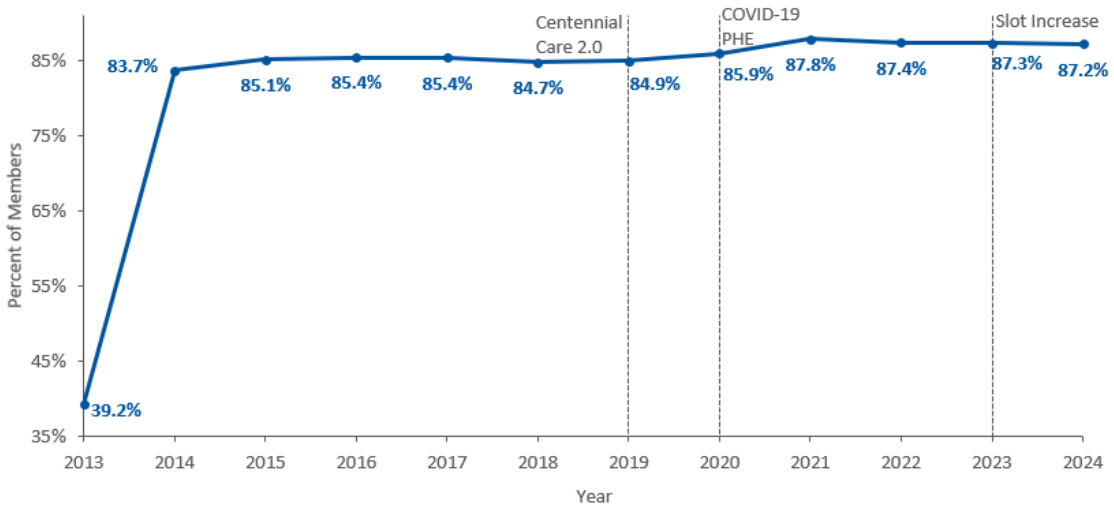
Hypothesis 1: Continuing to expand access to long-term support services (LTSS) and increasing the enrollment limit of the Community Benefit (CB) Program in 2022 will maintain or increase the number of CB members throughout the demonstration period.

Research Question (RQ) 1: Has the percentage of members accessing CB services been maintained or increased year-over-year following the increase of CB slots in 2022?

Percentage of Centennial Care members enrolled and receiving CB services (Measure 1)

Figure 5-1 shows that the percentage of LTSS-eligible members who enrolled in and received CB services increased from 39.2 percent in 2013 to 83.7 percent in 2014, where rates remained steady until 2020. The Centers for Medicare & Medicaid Services (CMS) authorized the addition of CB slots in 2020, which increased the percentage of members who accessed CB services to 87.8 percent in 2021. An amendment increased available CB slots in 2022, effective in early 2023; however, there was no associated increase in services utilization.

Figure 5-1—Percentage of Members Who Enrolled In and Received CB Services



Data Source: Medicaid Management Information System (MMIS) data were used in the analysis of Measure 1.
Annual measurement periods were used for all years except 2024, which represents data through June 2024, the last full month of Centennial Care 2.0.

Hypothesis 2: The ability for legally responsible individuals (LRI) to provide personal care services (PCS) to individuals receiving CB or Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) PCS will ensure member access to CB or EPSDT PCS services.

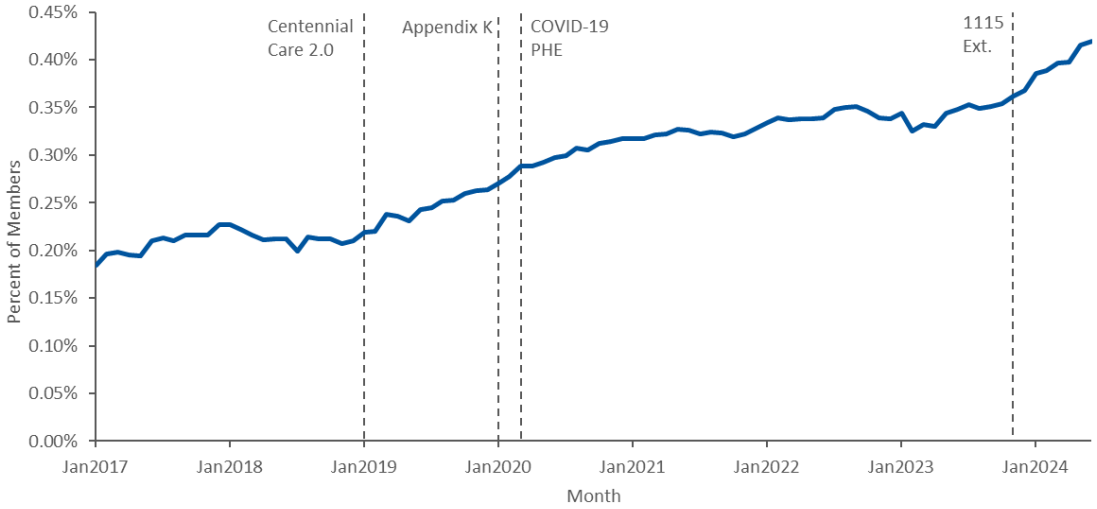
RQ 1: Is the percentage of members receiving EPSDT or CB PCS services the same or higher after the implementation of this benefit?

PCS evaluated for Measure 2 through Measure 5 were not exclusive to LRIs and included any provider who delivered PCS. To supplement the evaluation of Aim 1 Hypothesis 2, data were provided on the number of LRIs with billed/paid claims from November 2019 to December 2023. The total monthly number of LRIs with billed/paid claims increased from 90 LRIs to 404 LRIs, largely driven by Presbyterian Health Plan (PHP). Monthly counts of LRIs with billed/paid claims are presented in Appendix A, Attachments, Supplemental Results.

Percent of members receiving EPSDT PCS (Measure 2)[5-1]

Figure 5-2 shows the monthly percentage of members under age 21 years who received EPSDT PCS from January 2017 to June 2024.[5-2] The percentage of members who received EPSDT PCS increased when Centennial Care 2.0 was implemented in 2019; however, the LRI benefit was not approved until the Appendix K amendment took effect in January 2020.[5-3] The rate of members who received EPSDT PCS was relatively stable at approximately 0.20 percent per month prior to Centennial Care 2.0. The rate nearly doubled from 0.22 percent at Centennial Care 2.0 implementation to 0.42 percent in June 2024.

Figure 5-2—Percentage of Members Who Received EPSDT PCS



Data source: MMIS data were used in the analysis of Measure 2
Note: 1115 Ext: Centennial Care 2.0 temporary extension.

Percent of LTSS-eligible members receiving CB PCS (Measure 3)

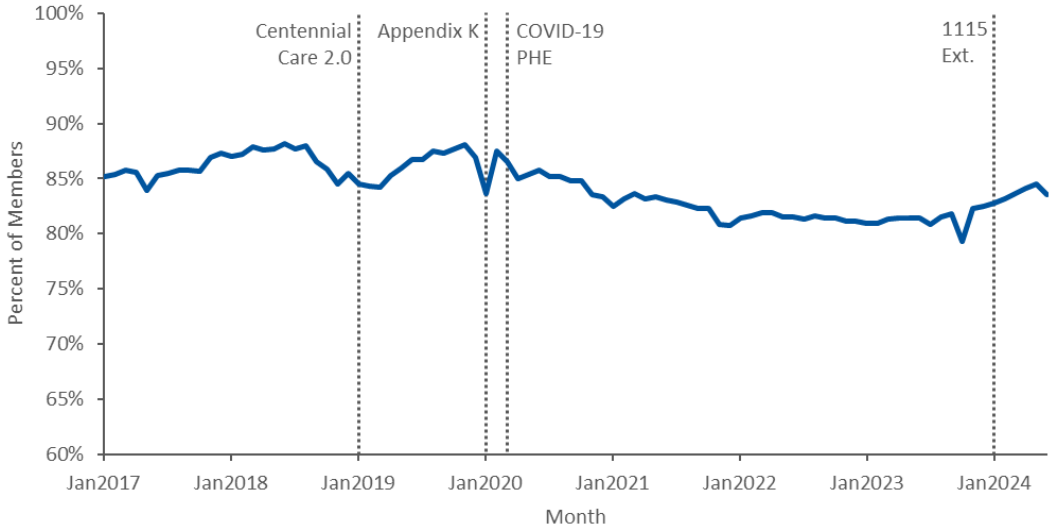
Figure 5-3 displays the monthly percentage of LTSS-eligible members ages 21 years and older enrolled in CB who received CB PCS from January 2017 to June 2024. The percentage of members who received CB PCS remained relatively stable at 85.0 percent prior to the Appendix K amendment. After a brief increase in March 2020, the rate fell to 79.2 percent in October 2023 before increasing to 83.5 percent in June 2024. The change indicated that the coronavirus disease 2019 (COVID-19) public health emergency (PHE) and other potential external factors (e.g., caregiver shortages in rural areas of the State), may have influenced CB PCS enrollment.

5-1 Measure 2 was revised from *Percent of LTSS-eligible members receiving EPSDT PCS*, specified in the Evaluation Design, to *Percent of members receiving EPSDT PCS* as LTSS-eligible members were not the intended population for EPSDT.

5-2 Members who received EPSDT PCS from personal care attendants who are both LRIs and non-LRIs were included in analyses because LRIs were categorized under the private duty nurse provider type.

5-3 Centers for Medicare & Medicaid Services. Section 11135 Waiver Flexibilities – New Mexico COVID-19. Available at: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/99961. Accessed on: Aug 12, 2025.

Figure 5-3—Percentage of LTSS-Eligible Members Enrolled in CB Who Received CB PCS



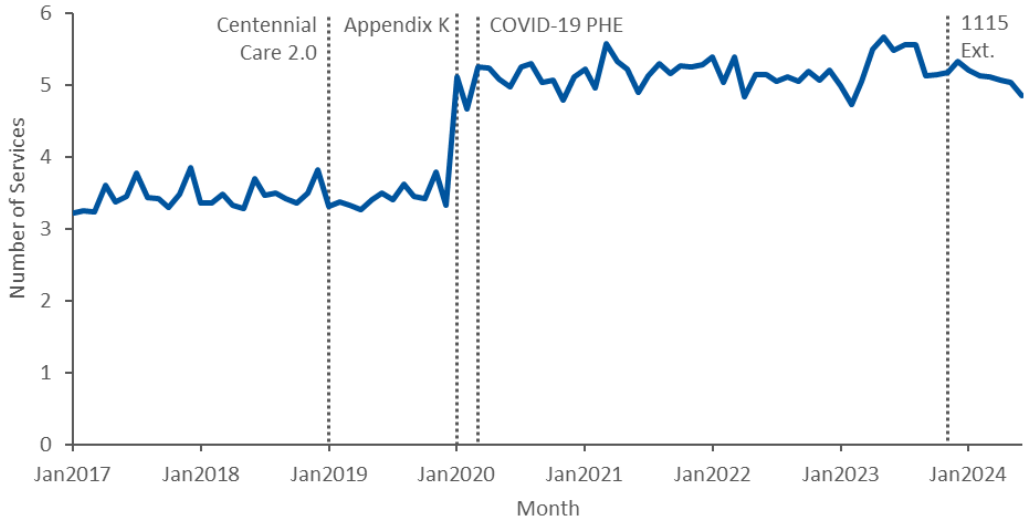
Data source: MMIS data were used in the analysis of Measure 3.
Note: 1115 Ext: Centennial Care 2.0 temporary extension.

RQ 2: Are members able to receive the same or more EPSDT or CB PCS services after the implementation of this benefit?

Average number of EPSDT PCS services per utilizing member (Measure 4)

Figure 5-4 shows that the average monthly utilization of EPSDT PCS was relatively stable at approximately 3.5 services per utilizing member prior to the Appendix K amendment. Monthly utilization increased to five services following the Appendix K amendment, indicating that the LRI benefit increased the frequency of services among members who utilized any EPSDT PCS.

Figure 5-4—Average Number of EPSDT PCS Per Utilizing Member

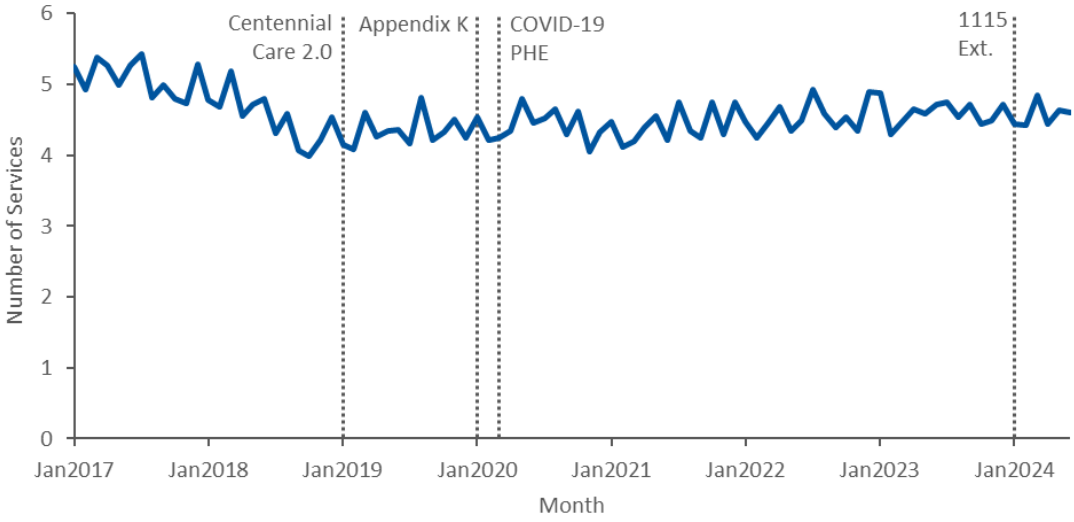


Data source: MMIS data were used in the analysis of Measure 4.
Note: 1115 Ext: Centennial Care 2.0 temporary extension.

Average number of CB PCS services per utilizing member (Measure 5)

Figure 5-5 illustrates that the average monthly utilization of CB PCS was approximately 5.0 services in January 2017 and decreased to approximately 4.5 services prior to Centennial Care 2.0 implementation. Following implementation, the utilization remained relatively stable through June 2024, indicating that Centennial Care 2.0 prevented further decline in CB PCS utilization.

Figure 5-5—Average Number of CB PCS Per Utilizing Member



Data source: MMIS data were used in the analysis of Measure 5.
Note: 1115 Ext: Centennial Care 2.0 temporary extension.

Hypothesis 3: Promoting participation in a Health Home (HH) will result in increased member engagement with a HH and increase access to integrated physical and behavioral health (BH) care in the community.

RQ 1: Is there an increase in the number/percentage of members enrolled in a HH?

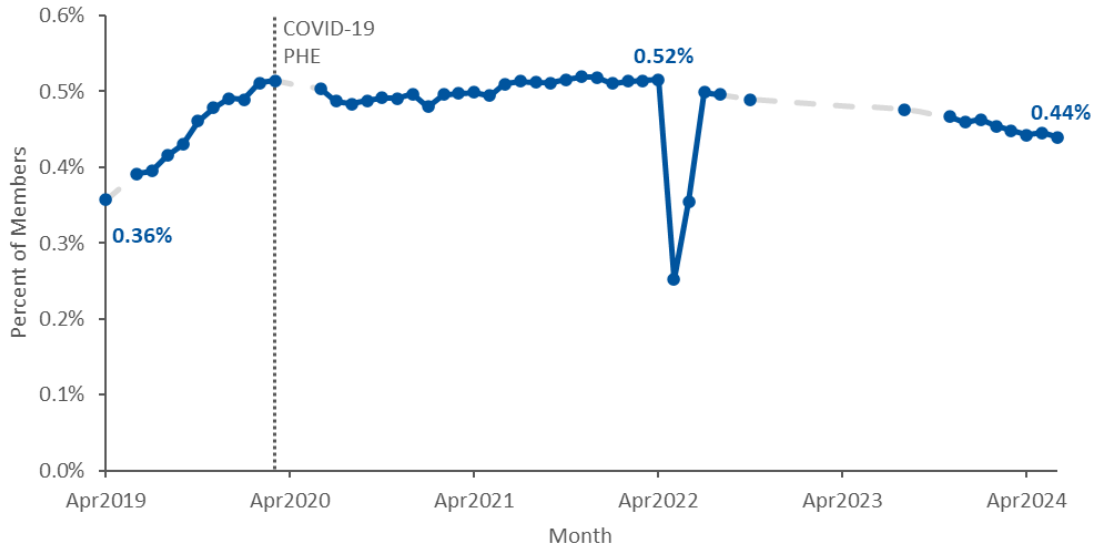
No HH enrollment data were provided for January 2019–March 2019, May 2019, April 2020–May 2020, September 2022, November 2022–July 2023, or September 2023–October 2023. Only members enrolled in an HH beginning in April 2019 were assessed due to these limitations. Additional details on the number of members enrolled in HH are available in Appendix A, Attachments, Supplemental Results.

Due to gaps in the HH enrollment data, several HH measures employed a difference-in-differences (DiD) analysis, rather than the interrupted time series (ITS) analysis with comparison group specified in the Evaluation Design. DiD analyses were limited to 2019 through 2022 as over half of the 2023 monthly HH enrollment files were unavailable. HH members were matched to non-HH members using a propensity score model including member demographics, predominant county of residence, and chronic conditions present at baseline. Baseline rates from 2016 and 2017, prior to HH expansion, were compared to evaluation period rates. The number of baseline period members varied due to changing populations throughout Centennial Care 2.0. The parallel trends assumption was examined using a visual inspection and statistical testing. Additional information on the methodology employed and the results of parallel trends statistical testing can be found in Appendix A, Attachments, Expanded Methodology.

Number/percentage of Centennial Care members enrolled in a HH (Measure 6)

Figure 5-6 presents the percentage of Centennial Care 2.0 members enrolled in an HH to determine if increased HH promotion aligns with an increase in the percentage of members enrolled in HH. The HH program initially provided fully delegated care coordination for members with serious mental illness/serious emotional disturbance (SMI/SED) and included members with SUD beginning in April 2021.[5-4] HH enrollment rose from 0.36 percent in April 2019 to its peak of 0.52 percent in April 2022 before decreasing to 0.44 percent in June 2024. May and June 2022 rates may be low due to incomplete HH enrollment data rather than an actual decrease in enrollment.

Figure 5-6—Percentage of Centennial Care 2.0 Members Enrolled in a HH



Data Source: MMIS data and HH Enrollment Roster data were used in the analysis of Measure 6.
Note: The grey dashes indicate months where data for HH enrollment was not received.

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

Number of HH members with at least one claim for PH service in the calendar year (CY) (Measure 7)

Table 5-2 shows that approximately 96 to 97 percent of HH and non-HH members had a PH claim or encounter during the baseline period. The rate among HH members increased to nearly 100 percent during Centennial Care 2.0, while the non-HH member rate decreased to between 90 and 93 percent. The difference in change between the groups increased annually, indicating that HH enrollment contributed to increased PH utilization. Statistical testing indicated no significant differences in trends between HH and non-HH members during the baseline period. A visual inspection of the data trends confirmed that the trends were approximately parallel, satisfying the parallel trends assumption for all years.

[5-4] New Mexico Health Care Authority. Approval of State Plan Amendment NM-23-0008. Available at: https://www.hca.nm.gov/wp-content/uploads/SPA-23-0008-High-Fide.pdf. Accessed on: Aug 12, 2025.

Table 5-2—Number of HH Members With At Least One PH Claim

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2019	HH	97.0% N=3,908	99.8% N=1,954	2.9pp	6.8pp (<0.001)
	Non-HH	97.0% N=3,908	93.0% N=1,954	-4.0pp	
2020	HH	96.5% N=5,092	99.8% N=2,546	3.3pp	7.9pp (<0.001)
	Non-HH	96.2% N=5,092	91.7% N=2,546	-4.6pp	
2021	HH	96.8% N=5,602	99.7% N=2,801	2.9pp	8.1pp (<0.001)
	Non-HH	96.4% N=5,602	91.2% N=2,801	-5.3pp	
2022	HH	96.7% N=5,468	99.8% N=2,734	3.1pp	9.4pp (<0.001)
	Non-HH	96.8% N=5,468	90.5% N=2,734	-6.3pp	

Data Source: MMIS data and HH enrollment roster data were used in the analysis of Measure 7.
Note: N represents the denominator count. Annual measurement periods were used. The baseline period includes 2016 and 2017. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. Full model results are presented in Appendix A, Attachments, Supplemental Results.
pp: percentage point

Hypothesis 4: Enhanced care coordination supports integrated care interventions, which lead to higher levels of access to preventative/ambulatory health services.

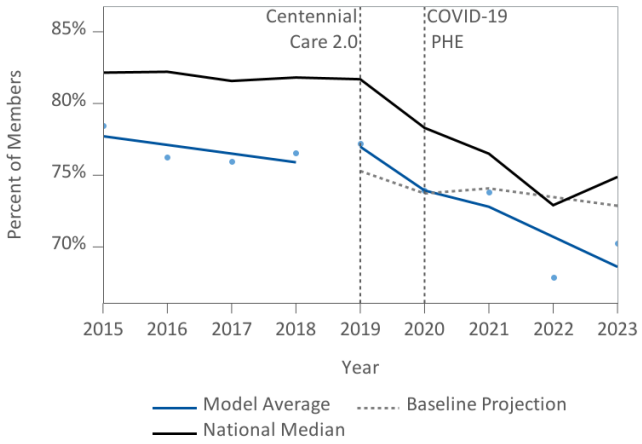
RQ 1: Is there an increase in Centennial Care members who have at least one claim for preventative/ambulatory care in a year?

An ITS analysis controlling for seasonality and the COVID-19 PHE evaluated Measures 8a, 9a, and 10 to determine the impact of Centennial Care 2.0 on the percentage of members who received preventive/ambulatory care. Full regression results are provided in Appendix A, Attachments, Supplemental Results.

Adults' access to preventive/ambulatory health services (AAP) (Measure 8a)

Figure 5-7 and Table 5-3 present the annual model-based average rate for adults with access to preventive/ambulatory health services (blue line), the projection had the baseline trend continued (grey dashed line), and the national median trend (black line). Prior to Centennial Care 2.0, access to preventive/ambulatory services declined by 0.6 percentage points per year (p=0.074). After Centennial Care 2.0, the decline accelerated by a statistically significant decrease of 1.5 percentage points per year (p=0.023); however, these results were largely aligned with the national median, which also decreased from 2019 to 2022.

Figure 5-7—Adult Access to Preventive/Ambulatory Health Services



Data Source: MMIS data were used in the analysis of Measure 8a.

Table 5-3—Measure 8a ITS Results

Variable	Percent Change	*p*-value
Intercept	77.7%***	<0.001
Pre-Centennial Care 2.0 annual trend	-0.6pp*	0.074
Level change	1.7pp*	0.094
Change in annual trend	-1.5pp**	0.023

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 8a.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

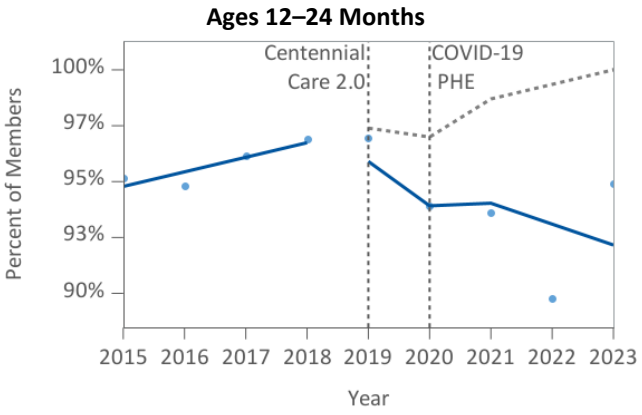
Children and adolescents' access to primary care providers (PCPs) (CAP) (Measure 9a)

Measure 9a results are reported for four age groups: 12–24 months, 25 months–6 years, 7–11 years, and 12–19 years. Decreases across all four groups may be attributed to lasting effects of the COVID-19 PHE. The national median trend was not reported due to measure retirement.

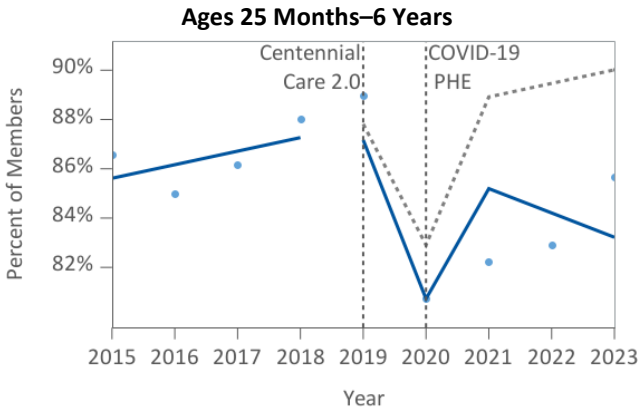
Figure 5-8 and Table 5-4 present the annual model-based average rates of children and adolescents with access to a PCP (blue line) and the projected rates had the baseline trend continued (grey dashed line). The annual trends for members ages 12 to 24 months and ages 25 months to 6 years increased slightly during the baseline period (p=0.554 and p=0.634, respectively), and the annual trends for members ages 7 to 11 years and ages 12 to 19 years remained steady throughout the baseline period (p=0.991 and p=0.875, respectively).

There were no significant level changes at Centennial Care 2.0 implementation for any age group. The change in the annual trend decreased compared to the baseline trend for all age groups; however, none of these changes were statistically significant. The increase in rates for members ages 25 months to 6 years and ages 7 to 11 years following 2020 may indicate a recovery in PCP access following the COVID-19 PHE.

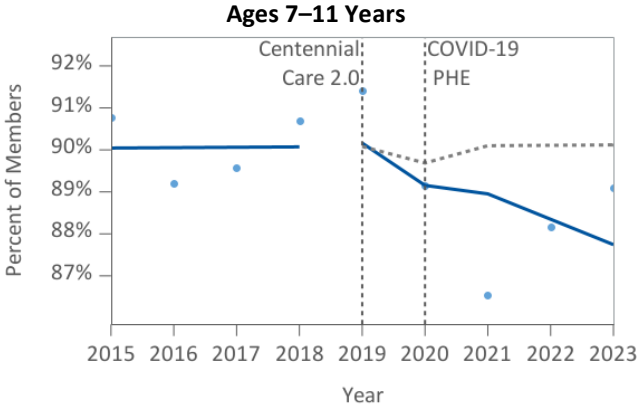
Figure 5-8—Children and Adolescents' Access to PCPs



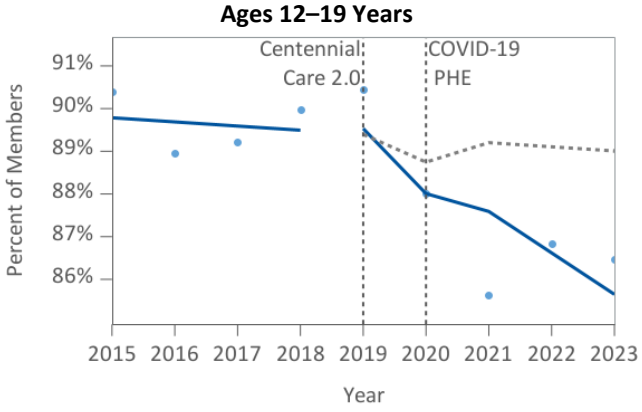
Data Source: MMIS data were used in the analysis of Measure 9a.



Data Source: MMIS data were used in the analysis of Measure 9a.



Data Source: MMIS data were used in the analysis of Measure 9a.



Data Source: MMIS data were used in the analysis of Measure 9a.

Table 5-4—Measure 9a ITS Results

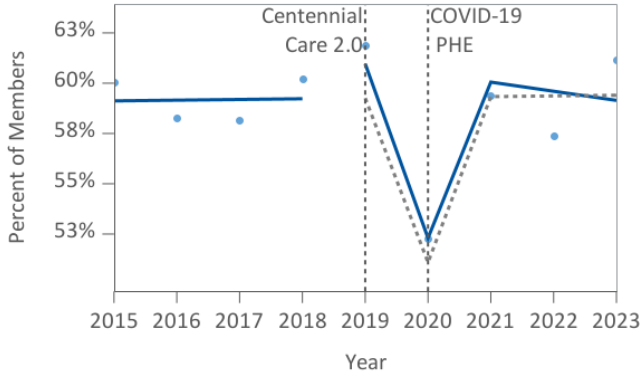
Variable	Estimate			
	12–24 Months	25 Months–6 Years	7–11 Years	12–19 Years
Intercept	94.8%*** (<0.001)	85.6%*** (<0.001)	90.0%*** (<0.001)	89.8%*** (<0.001)
Pre-Centennial Care 2.0 annual trend	0.7pp (0.554)	0.6pp (0.634)	0.01pp (0.991)	-0.1pp (0.875)
Level change	-1.5pp (0.688)	-0.6pp (0.868)	0.1pp (0.976)	0.1pp (0.949)
Change in annual trend	-1.6pp (0.279)	-1.5pp (0.315)	-0.6pp (0.547)	-0.9pp (0.295)

*p<0.1, **p<0.05, ***p<0.001. p-values are presented in parentheses.
Data source: MMIS data were used in the analysis of Measure 9a.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

Well-child visits in the third, fourth, fifth and sixth years of life (W34) (Measure 10)

Figure 5-9 and Table 5-5 illustrate the annual model-based averages of child and adolescent well-child visits in the third, fourth, fifth, and sixth years of life (blue line) and the projected rates had the baseline trend continued (grey dashed line). Well-child visits remained steady prior to Centennial Care 2.0, increasing annually by 0.04 percentage points (p=0.968). There was a level increase of 1.7 percentage points at implementation (p=0.580), followed by a decrease in the change in the annual trend by an average of 0.5 percentage points per year relative to the baseline trend (p=0.662). The decrease in visits in 2020, followed by an increase in rates, indicated that changes in well-child visits may be partially attributed to the COVID-19 PHE.

Figure 5-9—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



Data Source: MMIS data were used in the analysis of Measure 10.

Table 5-5—Measure 10 ITS Results

Variable	Percent Change	*p*-value
Intercept	59.1%***	<0.001
Pre-Centennial Care 2.0 annual trend	0.04pp	0.968
Level change	1.7pp	0.580
Change in annual trend	-0.5pp	0.662

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 10.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

RQ 2: Does engagement in a HH result in beneficiaries receiving more ambulatory/preventative health services?

Adults' access to preventive/ambulatory health services (AAP)–HH Population (Measure 8b)

Table 5-6 displays that adult HH member rate for access to preventive ambulatory health services increased significantly compared to adult non-HH members. The change in adult HH member rates ranged from 7.6 percentage points to 11.0 percentage points greater than the change in adult non-HH member rates throughout Centennial Care 2.0 (p<0.001). Statistical testing indicated no significant differences in trends between adult HH and non-HH members during the baseline period. A visual inspection of the data trends confirmed that the trends were approximately parallel, satisfying the parallel trends assumption for all years.

Table 5-6—Adults' Access to Preventive/Ambulatory Health Services

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2019	HH	91.5% N=2,483	95.5% N=1,221	4.0pp	8.2pp (<0.001)
	Non-HH	91.0% N=2,539	86.9% N=1,149	-4.2pp	
2020	HH	89.2% N=3,019	91.8% N=1,533	2.6pp	7.6pp (<0.001)
	Non-HH	90.6% N=3,043	85.6% N=1,539	-5.1pp	
2021	HH	90.3% N=3,018	93.5% N=1,626	3.3pp	11.0pp (<0.001)
	Non-HH	90.5% N=3,035	82.8% N=1,624	-7.7pp	
2022	HH	90.2% N=2,824	93.0% N=1,203	2.8pp	9.3pp (<0.001)
	Non-HH	90.8% N=2,816	84.3% N=1,077	-6.5pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 8b.
Note: Annual measurement periods were used. The baseline period includes 2016 and 2017. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. N represents the denominator count. Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

Children and adolescents' access to PCPs (CAP)–HH Population (Measure 9b)

Table 5-7 shows that the child and adolescent HH member rate for access to PCPs increased significantly compared to non-HH members between the baseline and evaluation periods. HH member rates increased by 1.5 percentage points to 3.5 percentage points between each baseline and evaluation year, with the largest HH impact in 2020 at 8.0 percentage points ($p<0.001$). Non-HH member rates increased by 0.5 percentage points in 2019 but declined by 2.8 percentage points to 5.4 percentage points between the baseline and evaluation periods. Statistical testing indicated no significant differences in trends between HH and non-HH members during the baseline period. A visual inspection of the data trends confirmed that the trends were approximately parallel, satisfying the parallel trends assumption for all years.

Table 5-7—Children and Adolescents' Access to PCPs

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2019	HH	95.1% N=1,348	96.6% N=590	1.5pp	1.0pp (0.393)
	Non-HH	94.1% N=1,298	94.5% N=494	0.5pp	
2020	HH	94.3% N=1,982	97.8% N=871	3.5pp	8.0pp (<0.001)
	Non-HH	95.4% N=1,949	90.9% N=747	-4.5pp	

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2021	HH	95.0% N=2,473	97.0% N=1,027	2.0pp	7.3pp (<0.001)
	Non-HH	93.8% N=2,444	88.4% N=939	-5.4pp	
2022	HH	94.8% N=2,538	98.0% N=785	3.2pp	6.0pp (<0.001)
	Non-HH	94.5% N=2,529	91.7% N=685	-2.8pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 9b.
Note: Annual measurement periods were used. The baseline period includes 2016 and 2017. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented since Centennial Care 2.0 ended in July 2024. N represents the denominator count. Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

Hypothesis 5: Engagement in a HH and care coordination support integrative care interventions, which improve quality of care.

RQ 1: To what extent is HH engagement associated with improved disease management?

Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD) (Measure 11)

Table 5-8 demonstrates that HH and non-HH member rates for diabetes screening decreased in 2019 and 2020 compared to the baseline period. Healthcare Effectiveness Data and Information Set (HEDIS®) [5-5] benchmarks also declined by 5 percentage points over the same period, indicating possible COVID-19 PHE impacts. Rates increased in 2021 by 1.1 percentage points and 2.3 percentage points for HH and non-HH members, respectively, and remained steady in 2022. The results indicate statistically insignificant differences in the change in rates between HH and non-HH members. Statistical testing indicated no significant differences in trends between HH and non-HH members during the baseline period. A visual inspection of the data trends confirmed that the trends were approximately parallel, satisfying the parallel trends assumption for all years.

Table 5-8—Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who Used Antipsychotic Medications

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2019	HH	79.2% N=419	77.3% N=269	-1.9pp	-0.2pp (0.971)
	Non-HH	79.1% N=273	77.4% N=93	-1.7pp	
2020	HH	79.4% N=486	74.0% N=300	-5.4pp	-4.1pp (0.448)
	Non-HH	78.0% N=328	76.7% N=133	-1.4pp	

5-5 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2021	HH	79.8% N=491	80.9% N=341	1.1pp	-1.2pp (0.833)
	Non-HH	78.1% N=356	80.4% N=107	2.3pp	
2022	HH	78.4% N=467	78.4% N=255	0.1pp	-0.4pp (0.944)
	Non-HH	77.6% N=303	78.0% N=82	0.5pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 11.
Note: Annual measurement periods were used. The baseline period includes 2016 and 2017. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented since Centennial Care 2.0 ended in July 2024. N represents the denominator count. Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

Anti-depressant medication management (AMM) Effective Acute Phase Treatment (Measure 12)

Table 5-9 shows that the rate of HH members who remained on antidepressant medication for at least 84 days declined by 3.7 percentage points in 2019, while the rate increased by 2.6 percentage points for non-HH members. From 2020 to 2022, the change in HH member rates ranged from 3.8 percentage points (p=0.623) to 12.3 percentage points (p=0.160); however, these changes were not statistically significant and less than expected based on changes among non-HH members.[5-6] Statistical testing indicated no significant differences in trends between HH and non-HH members during the baseline period; however, a visual inspection of the changes in rates from 2016 to 2017 indicated that the trends were not parallel in 2019. As a result, any observed differences may be due to underlying trends, and the 2019 results should be interpreted with caution.

Table 5-9—Anti-Depressant Medication Management—Effective Acute Phase Treatment

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2019	HH	44.3% N=230	40.6% N=160	-3.7pp	-6.3pp (0.430)
	Non-HH	46.3% N=257	48.9% N=88	2.6pp	
2020	HH	41.8% N=280	43.3% N=210	1.5pp	-6.7pp (0.362)
	Non-HH	43.6% N=275	51.9% N=104	8.3pp	
2021	HH	44.7% N=275	50.3% N=189	5.5pp	-3.8pp (0.623)
	Non-HH	43.6% N=305	52.9% N=85	9.3pp	

5-6 Small sample sizes may impact the statistical significance of Measure 12.

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2022	HH	44.3% N=255	45.3% N=161	1.0pp	-12.3pp (0.160)
	Non-HH	45.1% N=293	58.3% N=60	13.3pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 12.
Note: Annual measurement periods were used. The baseline period includes 2016 and 2017. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented since Centennial Care 2.0 ended in July 2024. N represents the denominator count. Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

Anti-depressant medication management (AMM) Effective Continuation Phase Treatment (Measure 13)

Table 5-10 displays HH and non-HH member rates for the use of antidepressant medication for at least 180 days. The changes in rates among HH members ranged from 5.0 percentage points (p=0.467) to 7.5 percentage points (p=0.327) in 2019, 2020, and 2022, which were less than expected based on the non-HH member change. In 2021, HH member rates increased by 2.3 percentage points compared to baseline, while non-HH member rates decreased by 3.5 percentage points. Directionality of the rate changes was inconsistent and not statistically significant throughout the Centennial Care 2.0 period for both groups. Statistical testing indicated no significant differences in trends between HH and non-HH members during the baseline period; however, a visual inspection of the changes in rates from 2016 to 2017 indicated that these trends were not parallel in 2022. Any observed differences may be due to underlying trends, and the 2022 results should be interpreted with caution.

Table 5-10—Anti-Depressant Medication Management—Effective Continuation Phase Treatment

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2019	HH	27.4% N=230	23.1% N=160	-4.3pp	-5.0pp (0.467)
	Non-HH	28.8% N=257	29.5% N=88	0.8pp	
2020	HH	25.0% N=280	25.2% N=210	0.2pp	-6.7pp (0.301)
	Non-HH	22.9% N=275	29.8% N=104	6.9pp	
2021	HH	28.4% N=275	30.7% N=189	2.3pp	5.9pp (0.392)
	Non-HH	25.9% N=305	22.4% N=85	-3.5pp	
2022	HH	28.2% N=255	29.8% N=161	1.6pp	-7.5pp (0.327)
	Non-HH	24.2% N=293	33.3% N=60	9.1pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 13
Note: Annual measurement periods were used. The baseline period includes 2016 and 2017. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented since Centennial Care 2.0 ended in July 2024. N represents the denominator count. Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

RQ 2: Does HH engagement result in increased follow-up after hospitalization for mental illness?

7–day follow-up after hospitalizations for mental illness (FUH) (Measure 14)

Table 5-11 shows HH and non-HH member rates for seven-day follow up after hospitalization for mental illness. The changes in rates among HH members was 12.8 percentage points (p=0.106), 7.5 percentage points (p=0.260), and 11.6 percentage points (p=0.134) higher than expected based on non-HH member changes in 2019, 2020, and 2021, respectively. Conversely, in 2022, HH member rates were 3.8 percentage points lower than expected (p=0.641). These results indicate that the change in the rate of HH members with seven-day follow-up after hospitalization for mental illness was not statistically different than the change in rate of non-HH members. Statistical testing indicated no significant differences in trends between HH and non-HH members during the baseline period; however, a visual inspection of the change in rates from 2016 to 2017 indicated that these trends were not parallel in 2019 and 2020. Therefore, any observed differences may be due to underlying trends, and the 2019 and 2020 results should be interpreted with caution.

Table 5-11—7-Day Follow-Up After Hospitalization for Mental Illness

Year	Group	Regression Adjusted Rates			DiD Estimate (p-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2019	HH	40.9% N=330	41.5% N=347	0.6pp	12.8pp (0.106)
	Non-HH	34.8% N=244	22.6% N=53	-12.2pp	
2020	HH	41.2% N=405	39.8% N=377	-1.4pp	7.5pp (0.260)
	Non-HH	36.1% N=277	27.2% N=81	-8.9pp	
2021	HH	41.5% N=390	42.5% N=438	0.9pp	11.6pp (0.134)
	Non-HH	38.8% N=281	28.1% N=57	-10.7pp	
2022	HH	39.6% N=371	44.9% N=301	5.2pp	-3.8pp (0.641)
	Non-HH	33.2% N=226	42.2% N=45	9.0pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 14.
Note: Annual measurement periods were used. The baseline period includes 2016 and 2017. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented since Centennial Care 2.0 ended in July 2024. N represents the denominator count. Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

30–day follow-up after hospitalizations for mental illness (FUH) (Measure 15)

Table 5-12 shows HH and non-HH member rates for follow up within 30 days after hospitalization for mental illness. HH member rates fluctuated throughout Centennial Care 2.0. HH member rates increased by 24.4 percentage points in 2021, while non-HH member rates decreased by 10.7 percentage points. Results across the

Centennial Care 2.0 period were not statistically significant.[5-7] Statistical testing indicated no significant difference in the trends between HH and non-HH members during the baseline period; however, a visual inspection of the changes in rates from 2016 to 2017 indicated that these trends were not parallel in 2019 and 2020. Therefore, any observed differences may be due to underlying trends, and the 2019 and 2020 results should be interpreted with caution.

Table 5-12—30-Day Follow-Up After Hospitalization for Mental Illness

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2019	HH	65.5% N=330	63.1% N=347	-2.3pp	11.0pp (0.207)
	Non-HH	58.6% N=244	45.3% N=53	-13.3pp	
2020	HH	67.7% N=405	65.5% N=377	-2.1pp	5.9pp (0.442)
	Non-HH	57.4% N=277	49.4% N=81	-8.0pp	
2021	HH	41.5% N=390	66.0% N=438	24.4pp	35.2pp (0.282)
	Non-HH	63.3% N=281	52.6% N=57	-10.7pp	
2022	HH	65.0% N=371	67.1% N=301	2.2pp	4.6pp (0.597)
	Non-HH	53.5% N=226	51.1% N=45	-2.4pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 15.
Note: Annual measurement periods were used. The baseline period includes 2016 and 2017. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented since Centennial Care 2.0 ended in July 2024. N represents the denominator count. Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

Hypothesis 6: The implementation of the high-fidelity wraparound (HFW) program will serve high needs beneficiaries with a serious emotional disturbance (SED) diagnosis.

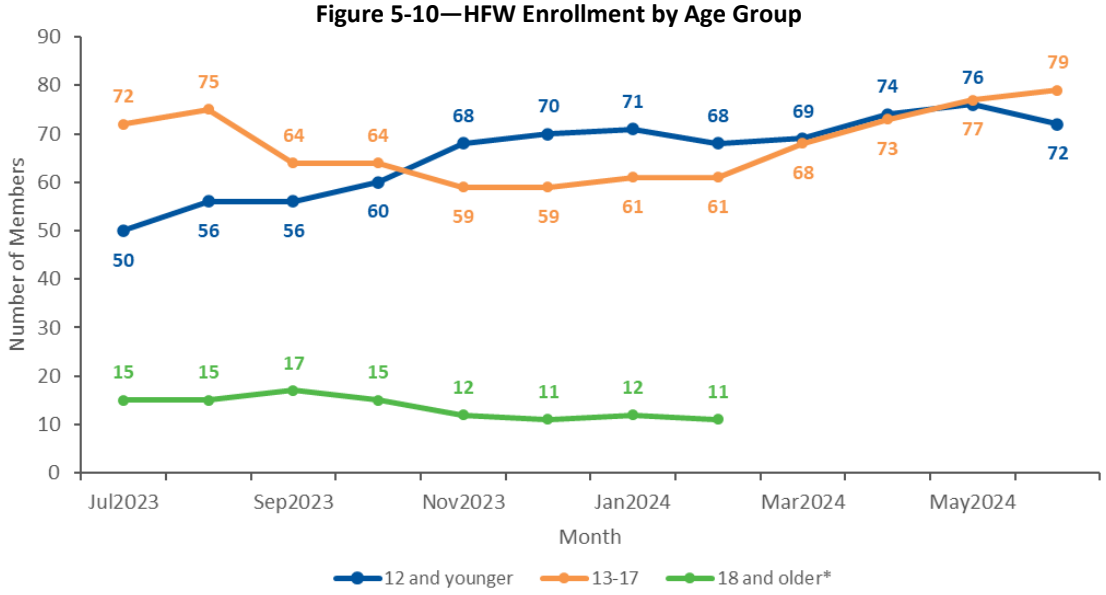
RQ 1: Is the HFW program enrolling the intended target population?

Number of HFW beneficiaries enrolled in the program, measured monthly (Measure 16)

Figure 5-10 displays monthly HFW program enrollment among members ages 12 years and younger, 13 to 17 years, and 18 years and older. HFW enrollment among members ages 12 years and younger and 13 to 17 years increased from July 2023 to June 2024 by 44.0 percent and 9.7 percent, respectively. Most HFW members were younger than 18 years, indicating that the HFW program primarily served children and adolescents as intended.

5-7 Small sample sizes may impact the statistical significance of Measure 15.

Figure 5-10—HFW Enrollment by Age Group

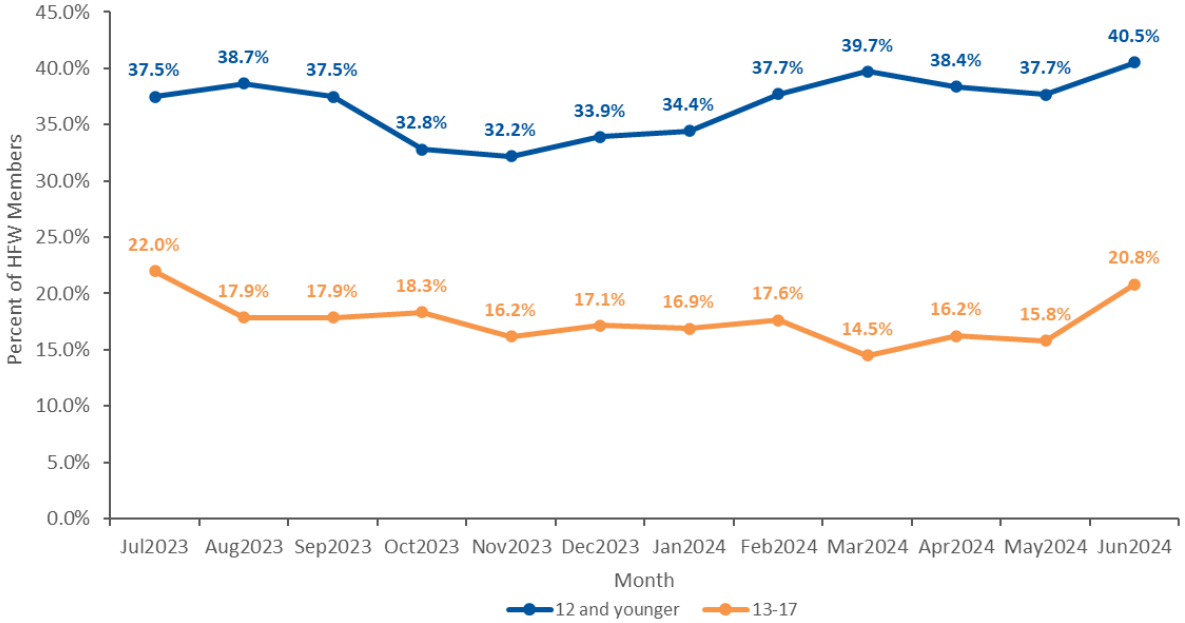


Data source: MMIS and HFW roster data were used in the analysis of Measure 16.
Note: *Months with 10 or fewer members were suppressed for anonymity.

Percentage of HFW beneficiaries with SED diagnosis in the 11 months prior to enrollment (Measure 17)

Figure 5-11 illustrates the percentage of members with an SED diagnosis in the 11 months prior to HFW program enrollment. SED diagnoses were more prevalent among members ages 12 years and younger than members ages 13 to 17 years, with an average difference of 19.1 percentage points.

Figure 5-11—Percentage of HFW Members with SED Diagnosis in the 11 Months Prior to Enrollment by Age Group



Data source: MMIS and HFW roster data were used in the analysis of Measure 17.
Note: Members ages 18 years and older were suppressed for anonymity due to numerator counts of 10 members or less.

Table 5-13 presents the results of analyses with an alternative SMI or SED definition, which shows higher rates of SMI/SED diagnoses across all ages (less than 41 percent utilizing the original CMS definition compared to over 90 percent using the alternative definition).[5-8] This indicates that while the HFW program served children and young adults in need of BH support, conditions were not limited to those typically included in the CMS definition of SED programming.[5-9]

Table 5-13—Percentage of HFW Members with Alternative SED Diagnosis in the 11 Months Prior to Enrollment

	Member Age (Years)		
Month	12 and younger	13–17	18 and older
July 2023	98.0%	98.6%	93.3%
August 2023	94.6%	97.3%	93.3%
September 2023	94.6%	96.9%	94.1%
October 2023	96.7%	98.4%	93.3%
November 2023	97.1%	100.0%	91.7%
December 2023	97.1%	100.0%	—
January 2024	97.2%	100.0%	91.7%
February 2024	98.5%	100.0%	100.0%
March 2024	100.0%	100.0%	—
April 2024	100.0%	100.0%	—
May 2024	100.0%	100.0%	—
June 2024	100.0%	100.0%	—

Data source: MMIS and HFW roster data were used in the analysis of Measure 17.
Note: — represents suppression for anonymity due to member counts less than 10.

RQ 2: What are barriers or facilitators to implementing the HFW program?

Stakeholders' reported barriers and facilitators to implementation (Measure 18)

Key stakeholders at HCA and the New Mexico Children, Youth, and Families Department (CYFD) described their experience implementing the HFW program under Centennial Care 2.0 authority. Following its approval on March 28, 2023, stakeholders found the implementation of the HFW program under Centennial Care 2.0 to be a smooth and effective process. The implementation successes and barriers cited by informants are presented in Table 5-14 and Table 5-15. An expanded summary of the key informant interviews can be found in Appendix A, Attachments, Supplemental Results.

5-8 SMI/SED was defined as members with bipolar disorder, schizophrenia, and/or major depressive disorder, as described in Appendix E of CMS' Section 1115 Demonstration Waiver SMI/SED Technical Specifications Manual; however, this definition may not adequately capture diagnoses relevant to the HFW population. To account for this, Measure 17 was also analyzed using a state-supplied alternative SMI/SED definition that included a comprehensive list of BH conditions.

5-9 Specifically, the CMS definition does not include conditions such as anxiety, autism spectrum disorder, and post-traumatic stress disorder, which are included in the alternative definition.

Table 5-14—HFW Program Implementation Successes

Success	Description
Program Continuity	HFW services were initially established under individual funding contracts prior to transitioning to Centennial Care 2.0 authority. There were no major operational changes to the established program during the transition, which contributed to the program's continued stability and success.
Program Expansion	The State expanded the number of providers enrolled in the program and the number of members receiving HFW services.
Provider Outreach	HCA and CYFD outreached to providers, offering email guidance that included enrollment instructions and HFW service billing directions. The State remained available to provide further guidance and clarification for providers.
Stakeholder Collaboration	A steering committee composed of staff from HCA, MAD, the BHSD, and NMSU met weekly during the transition of HFW services to Centennial Care 2.0 authority, providing clear program direction. The committee reviewed provider applications, evaluated areas for program improvement, and resolved challenges and stakeholder concerns.

Note: BHSD: Behavioral Health Services Division; CYFD: Children, Youth, and Families Department; HCA: Health Care Authority; HFW: high-fidelity wraparound; MAD: Medical Assistance Division; NMSU: New Mexico State University

Table 5-15—HFW Program Implementation Barriers

Barrier	Description
Education Requirements	The bachelor's degree education requirement in the STCs did not align with providers' education levels. This caused a six-month delay in enrollment as HCA, CYFD, and CMS adjusted the STCs to include an equivalent number of years' experience. [5-10]
Staff Turnover	There were two years between the State's application to cover HFW services through Centennial Care 2.0 authority and CMS approval. In this time, the State experienced staff turnover and spent unplanned time and resources ensuring that the program followed the direction intended by original staff.
Sustainability Planning	Providers struggled to estimate the number of members they needed to serve to financially sustain HFW services within their service array.
Workforce Shortages	Provider workforce shortages uniquely impacted the HFW program, as training and certification were required to deliver the services. As a result, alternative internal providers and staff could not spontaneously cover HFW provider absences.

Note: CMS: Centers for Medicare & Medicaid Services; CYFD: Children, Youth, and Families Department; HCA: Health Care Authority: HFW: high-fidelity wraparound; STCs: Special Terms and Conditions

Hypothesis 7: Expanding member incentives for preventive care through the Centennial Rewards (CR) program will encourage members to engage in preventive care services.

RQ 1: Has the percentage of Centennial Care members participating in CR increased?

All Centennial Care 2.0 members were eligible to participate in CR, a member engagement, rewards, and quality improvement program administered by Finity, Inc. Members earned points by completing targeted healthy activities, such as prenatal care visits, flu shots, or hemoglobin A1c (HbA1c) tests, aligning with HEDIS and State performance measures. Program participation was defined as members who were engaged in CR through multimedia communications and who completed at least one healthy reward activity. CR was designed to control redemption costs by using gamification and Finity's "Register-to-Redeem" methodology, similar to traditional

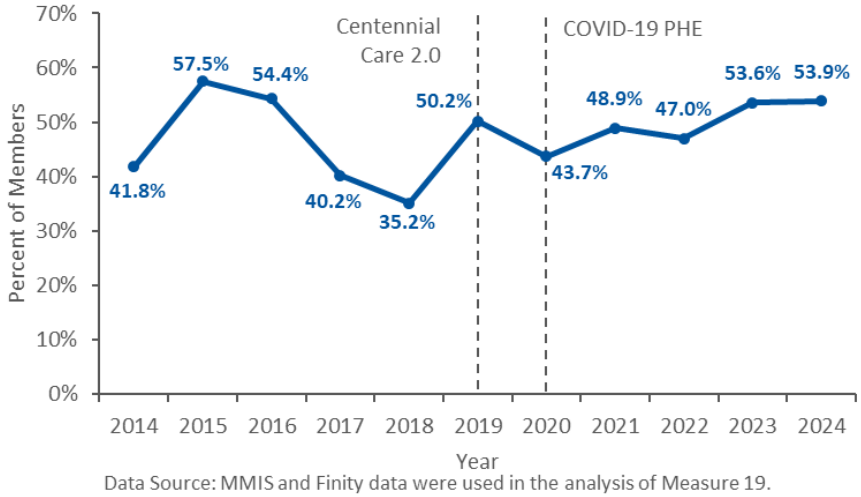
[5-10] This challenge was largely mitigated by the reallocation of general funds to support providers who did not initially meet education requirements, as this only impacted two providers and did not result in disruption of services.

loyalty programs (e.g., airline and credit card points programs). Members completed a registration process, including a health scan, to redeem rewards. Approximately 25 percent of program participants redeemed their rewards during the evaluation period.

Percentage of Centennial Care members participating in CR (Measure 19)

Figure 5-12 displays the percentage of Centennial Care 2.0 members who participated in CR from 2014 to 2024. The percentage of participating members prior to Centennial Care 2.0 varied from 57.5 percent in 2015 to 35.2 percent in 2018.[5-11] Participation increased during Centennial Care 2.0, from 43.7 percent in 2020 to 53.9 percent in 2024.

Figure 5-12—Percentage of Centennial Care 2.0 Members Who Participated in CR



Data Source: MMIS and Finity data were used in the analysis of Measure 19.

RQ 2: Are participating CR members more likely to receive preventive/ambulatory services on an annual basis than those who have not participated in the CR program in the previous 12 months?

Percentage of CR participating members and non-participating members with an annual preventive/ambulatory service (Measure 20)

A comparative ITS analysis assessed whether CR increased the percentage of members with an annual preventive/ambulatory service. To facilitate propensity score weighting, participating members were those in their first year of CR participation, while non-participating members never participated in CR.[5-12] To control for potential selection bias, members were weighted using a propensity score model that calculated each member's likelihood of participating in CR according to his or her demographics and chronic conditions at baseline.[5-13]

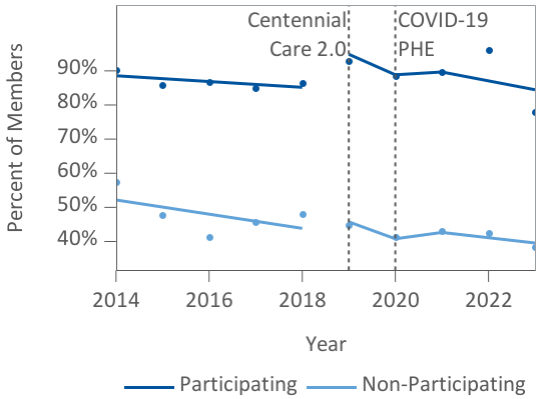
5-11 The decline in CR participation from 2015 to 2018 may have been caused by State-reported budget reductions. The subsequent increase in participation through June 2024 may be attributed to State-reported increases in engagement.

5-12 Limiting participation to first-year members ensured that covariates calculated at baseline (i.e., year prior to the study year) were not confounded by participation in the CR program.

5-13 Propensity score was calculated based on member's age category, race, gender, months enrolled, and chronic conditions.

Figure 5-13 and Table 5-16 illustrate that the model-predicted rate for non-participating members was 52.2 percent in 2014, 36.4 percentage points lower than participating members rate (p<0.001). These results indicate that participating members received preventive/ambulatory services at a higher rate than non-participating members. The rate for non-participating members increased by 4.0 percentage points, while the rate for participating members increased by an additional 6.6 percentage points at Centennial Care 2.0 implementation (p=0.363 and p=0.193, respectively). The rates for both groups decreased throughout Centennial Care 2.0; however, changes were not statistically significant.[5-14]

Figure 5-13—Percentage of CR Participating and Non-Participating Members with an Annual Preventive/Ambulatory Service



Data Source: MMIS and Finity data were used in the analysis of Measure 20.

Table 5-16—Measure 20 ITS Results

Variable	Estimate	*p*-value
Intercept for non-participating members	52.2%***	<0.001
Pre-Centennial Care 2.0 monthly trend for non-participating members	-2.1pp	0.152
Level change at implementation of Centennial Care 2.0 for non-participating members	4.0pp	0.363
Change in monthly trend post-Centennial Care 2.0 implementation for non-participating members	0.5pp	0.710
Difference in intercept for participating members	36.4pp***	<0.001
Difference in pre-Centennial Care 2.0 monthly trend for participating members	1.2pp	0.411
Difference in level change at Centennial Care 2.0 implementation for participating members	6.6pp	0.193
Difference in change in monthly trend post-Centennial Care 2.0 implementation for participating members	-2.3pp	0.322

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS and Finity data were used in the analysis of Measure 20.
Note: pp: percentage point.

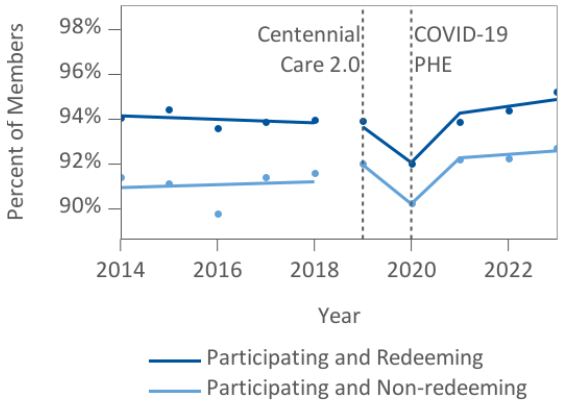
5-14 While Measure 20 provides evidence for the association between CR and preventive/ambulatory visits, it is possible that members who were already likely to receive services participated in CR to collect rewards, rather than the CR program incentivizing members to receive services.

RQ 3: Are CR incentive redeeming members more likely to receive preventative/ambulatory services on an annual basis than those who have not redeemed incentives in the 12-month period following the initial preventive visit?

Percentage of CR participating and redeeming, and CR participating and non-redeeming members with an annual preventive/ambulatory service (Measure 21)

Figure 5-14 and Table 5-17 illustrate the percentage of members who had a second preventive/ambulatory visit within 12 months of an initial visit among CR redeeming members and members who participated in CR but did not redeem points. CR participating/redeeming members had a higher rate of preventive/ambulatory visits than participating/non-redeeming members throughout Centennial Care 2.0. Rates remained flat and parallel throughout Centennial Care 2.0. These results indicate that CR participating/redeeming members had higher rates of a second preventive/ambulatory visits within a 12-month period than participating/non-redeeming members; however, there were no significant changes associated with Centennial Care 2.0.

Figure 5-14—Percentage of Participating/Redeeming and Participating/Non-Redeeming Members with an Annual Preventive/Ambulatory Service



Data Source: MMIS and Finity data were used in the analysis of Measure 21.

Table 5-17—Measure 21 ITS Results

Variable	Estimate	*p*-value
Intercept for non-participating members	91.0%***	<0.001
Pre-Centennial Care 2.0 monthly trend for non-participating members	0.1pp	0.618
Level change at implementation of Centennial Care 2.0 for non-participating members	0.7pp	0.172
Change in monthly trend post-Centennial Care 2.0 implementation for non-participating members	0.1pp	0.501
Difference in intercept for participating members	3.2pp***	<0.001
Difference in pre-Centennial Care 2.0 monthly trend for participating members	-0.1pp	0.311

Variable	Estimate	*p*-value
Difference in level change at Centennial Care 2.0 implementation for participating members	-0.8pp	0.159
Difference in change in monthly trend post-Centennial Care 2.0 implementation for participating members	0.3pp	0.104

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS and Finity data were used in the analysis of Measure 21.
Note: pp: percentage point.

Hypothesis 8: Expanding member access to prenatal care through the Centennial Home Visitation (CHV) pilot program will improve infant health.

RQ 1: Is the percentage of babies born with low birth weight (LBW) (< 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?

Live births weighing less than 2,500 grams (Measure 22)

The CHV program was implemented in 2019 to improve maternal and infant health outcomes in four New Mexico counties and was expanded statewide in 2020. Although mothers generally could only enroll up to date of delivery, one of the two CHV program models, Parents as Teachers, allowed for postpartum enrollment. The Early Childhood Education and Care Department continued to revise and expand the CHV program throughout Centennial Care 2.0.

Table 5-18 shows the rate of LBW deliveries among members who participated in CHV (CHV members) and those who did not (non-CHV members) since 2019.[5-15, 5-16] Due to small CHV population sizes, particularly in the initial years evaluated, effect sizes are provided as a supplemental metric to assess the differences between the CHV members and non-CHV members, which are not dependent on sample or population sizes.[5-17, 5-18] As such, results from statistical testing should be interpreted with caution.[5-19] The 2018 regression adjusted rate of LBW deliveries among non-CHV members was 4.6 percent, increasing to over 6 percent by 2020 and for the remainder of Centennial Care 2.0. There were few CHV members prior to 2022; however, the regression-adjusted rate of LBW deliveries among CHV members was nearly triple that of non-CHV members in 2019 (p=0.011). The

5-15 Data provided by HCA regarding deliveries among CHV and non-CHV program participants were assessed. CHV participant data were provided separately from the delivery data without matching key fields. Approximately 85 percent of CHV participants were matched to deliveries utilizing matching algorithms. The 15 percent that were not matched were excluded from analyses.

5-16 Logistic regression controlled for differences in age and risk profile between CHV and non-CHV members utilizing members' Chronic Illness and Disability Payment System (CDPS) risk scores. Reported rates were derived from the model and therefore adjusted for the mother's weighted risk score.

5-17 Cohen's *h* is used to calculate the effect size of two proportions. While an effect size of 0.20 has commonly represented a "small" effect as originally suggested by Cohen, Cohen writes, "the terms 'small,' 'medium,' and 'large' are relative, not only to each other, but to the area of behavioral science or even more particularly to the specific content and research method being employed in any given investigation" (p. 25). Because of the clinical importance of birthweight on neonatal health and outcomes, at may be appropriate to consider a smaller effect size, such as 0.10, as representing clinically meaningful differences.

5-18 Cohen, J. Statistical Power Analysis for the Behavioral Sciences, 2nd Ed. Hillsdale, N.J.: L. Erlbaum Associates; 1988:25.

5-19 For example, a supplemental power analysis to identify the minimum detectible difference between the LBW rate among CHV members and non-CHV members in 2020 found the rate for non-CHV members would need to be approximately 22.5 percent, given the observed sample sizes at a power of 0.8 and alpha of 0.05. This suggests the number of members is insufficient to identify statistically significant differences for clinically meaningful results.

regression-adjusted rates among CHV members declined considerably throughout Centennial Care 2.0, from 15.5 percent in 2019 to 4.7 percent in 2023, 2.1 percentage points lower than non-CHV members (p=0.024).

Non-CHV members had fewer LBW deliveries than CHV members in 2019. Members continued to join CHV throughout Centennial Care 2.0, during which LBW delivery rates among CHV members stabilized at rates similar to non-CHV members. Although CHV members had lower rates of LBW deliveries than non-CHV members in 2023, the 2024 rates returned to being approximately equal between the groups.

Table 5-18—Comparison of LBW Deliveries Between CHV and Non-CHV Members

	CHV Members		Non-CHV Members			
Year	N	Adjusted Rate	N	Adjusted Rate	*p*-value	Effect Size++
2018	–	–	13,971	4.6%	–	–
2019	37	15.1%	14,017	5.7%	0.011**	0.358
2020	69	9.7%	13,563	6.4%	0.225	0.176
2021	85	5.0%	13,298	6.4%	0.576	0.020
2022	586	6.9%	13,007	6.9%	0.954	0.014
2023	560	4.7%	12,439	6.8%	0.024**	0.087
2024+	279	7.1%	5,998	7.1%	0.996	0.007

Data Source: MMIS, HCA-supplied deliveries list, LBW deliveries, and CHV participant data were used in the analysis of Measure 22.
Note: N represents the denominator count. *p<0.1, **p<0.05, ***p<0.001
+Annual measurement periods were used for all years except 2024, which represents data through June 2024, the last full month of the Centennial Care 2.0 demonstration.
++Cohen's *h* was calculated as a measure of effect size.

Aim Two: Manage the pace at which costs are increasing while sustaining or improving quality, services, and eligibility

Aim Two Key Findings

Table 5-19 presents the key findings by hypothesis for Aim Two.

Table 5-19—Aim Two Key Findings

Hypothesis	Key Finding
1	The number of providers with VBP contracts and the percentage of payments through VBP increased during Centennial Care 2.0. Quality metric data were limited; however, results indicated that quality was maintained. Throughout Centennial Care 2.0, there were cost savings on a PMPM and PUMPM basis, including PMPM cost savings of 0.5 percent and PUMPM cost savings of 0.8 percent when comparing the counterfactual annualized paid claims trend to the annualized paid claims trend. Additionally, the capitation payments made to the MCOs were sufficient to cover members' cost of care from 2013–2023.

Note: MCO: managed care organization; PMPM: per-member per-month; PUMPM; per-utilizing-member per-month; SNCP: safety net care pool; VBP: value-based purchasing

Aim Two Results

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.

RQ 1: Has the number of providers with VBP contracts increased?

Total number of providers with VBP contracts (Measure 23)

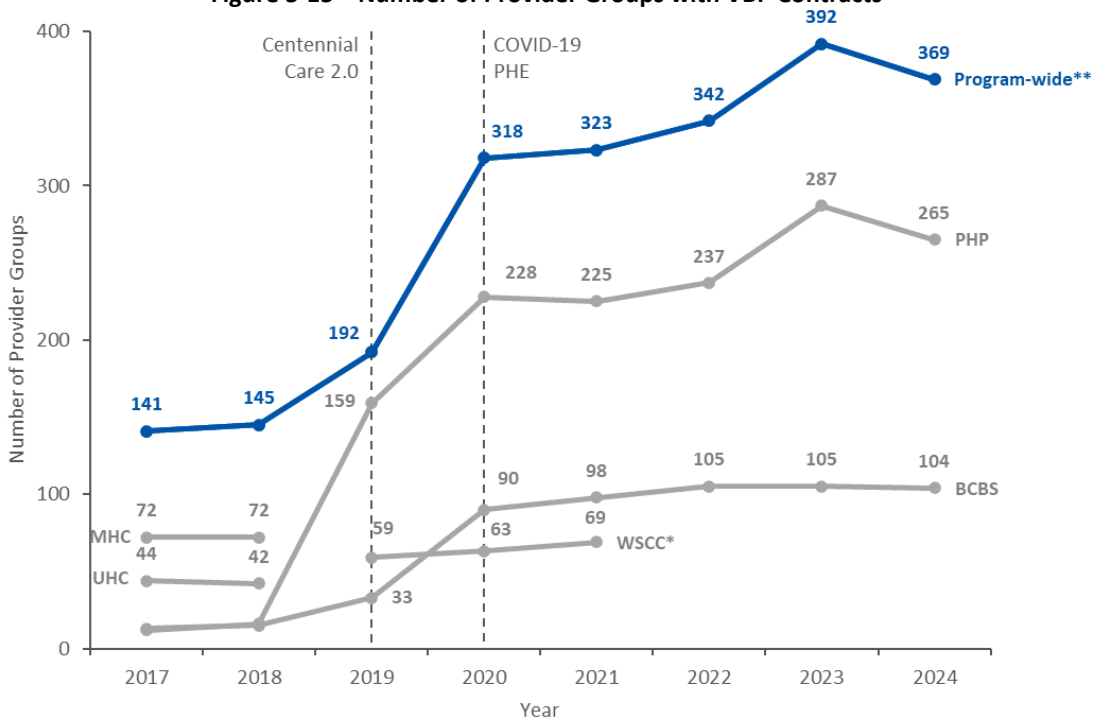
Table 5-20 and Figure 5-15 display the total number of Centennial Care 2.0 provider groups with VBP contracts by managed care organization (MCO) (Blue Cross Blue Shield [BCBS], Molina Healthcare of New Mexico [MHC], PHP, United Healthcare of New Mexico [UHC], and Western Sky Community Care [WSCC]) and Centennial Care 2.0 program-wide. The number of provider groups with VBP contracts increased from 141 groups in 2017 to 369 groups in 2024. The largest annual program-wide increase of 126 provider groups occurred between 2019 and 2020.

Table 5-20—Number of Provider Groups with VBP Contracts

MCO	2017	2018	2019	2020	2021	2022	2023	2024
BCBS	13	15	33	90	98	105	105	104
MHC	72	72	—	—	—	—	—	—
PHP	12	16	159	228	225	237	287	265
UHC	44	42	—	—	—	—	—	—
WSCC*	—	—	59	63	69	*	*	*
Program-wide**	**141**	**145**	**192**	**318**	**323**	**342**	**392**	**369**

Data source: MCO Annual Supplemental VBP reports were used in the analysis of Measure 23.
Note: — represents years in which an MCO was not contracted with Centennial Care 2.0.
*WSCC data were incorrectly reported from 2022–2024. Only years with correctly reported data are displayed.
**WSCC was excluded from the program-wide total.

Figure 5-15—Number of Provider Groups with VBP Contracts



Data source: MCO Annual Supplemental VBP reports were used for the analysis of Measure 23.
*WSCC data were incorrectly reported from 2022–2024. Only years with correctly reported data are displayed.
**WSCC was excluded from the program-wide total.

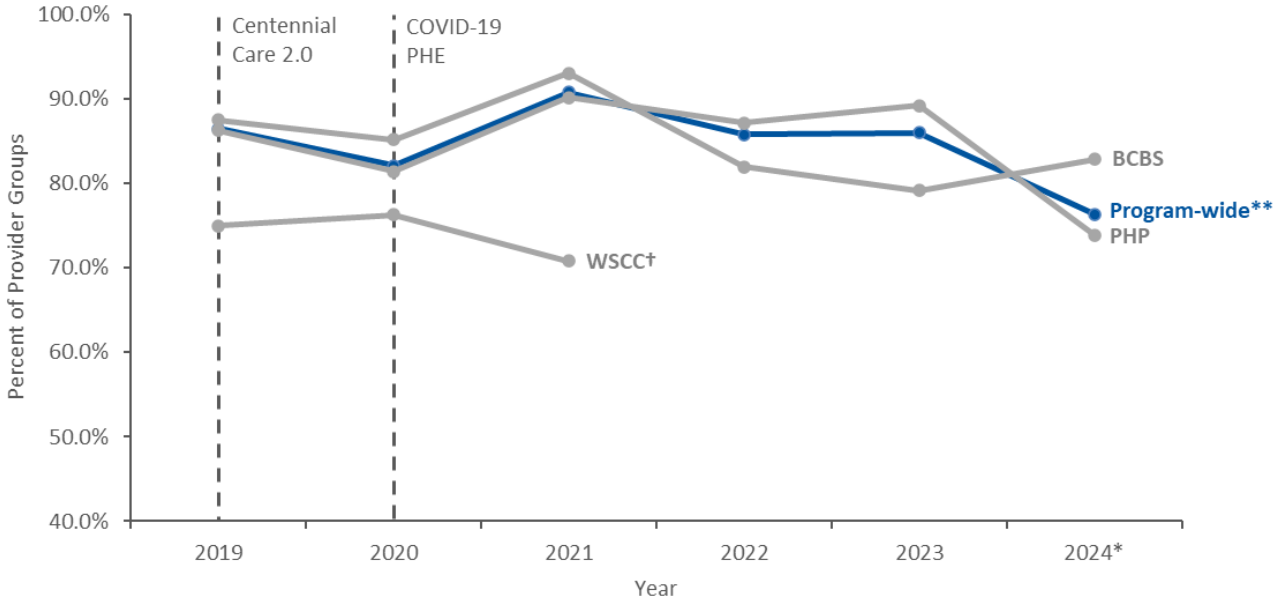
RQ 2: Has the number of providers participating in VBP arrangements, who meet quality metric targets increased?

Number/percentage of providers meeting quality threshold (Measure 24)

Figure 5-16 displays the percentage of providers with VBP contracts who reported quality metrics and met at least one quality metric target (QMT) between 2019 and 2024, while Figure 5-17 presents the average percentage of QMTs met by provider groups.[5-20] The percentage of program-wide provider groups who met at least one QMT decreased by 0.5 percent from 2019 to 2023, while the average percentage of QMTs met by provider groups program-wide decreased by 6.4 percentage points. Results presented are descriptive and causal conclusions cannot be drawn as no QMT data were available prior to Centennial Care 2.0.

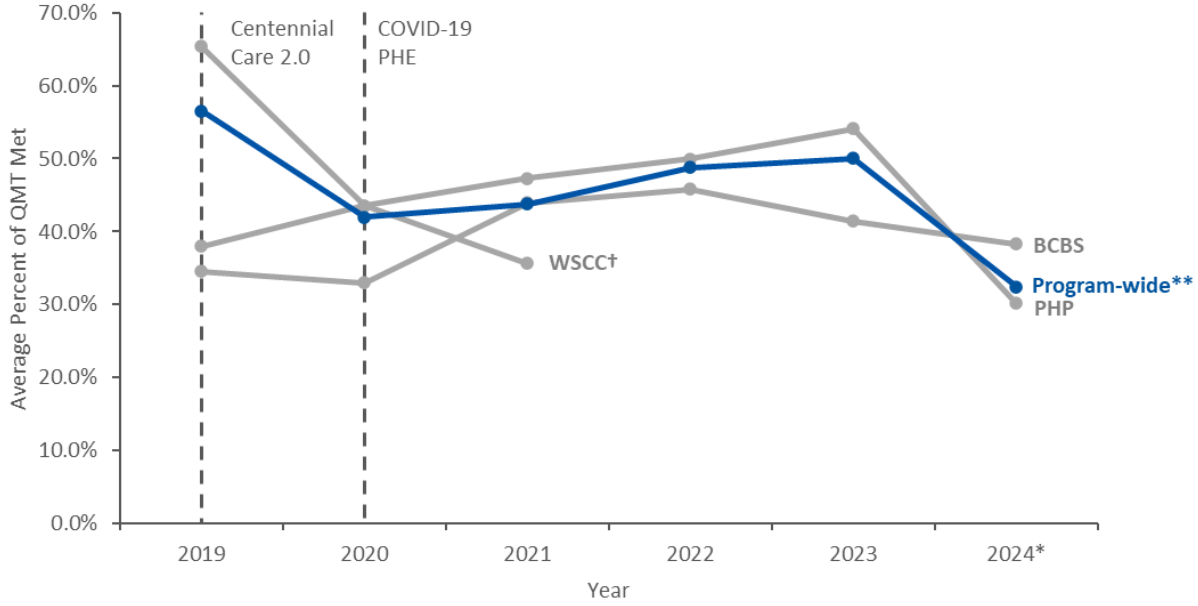
5-20 Quality metric data through June 30, 2024, were provided at the provider group level, primarily consisting of multiple providers. Annual metrics reported in 2024 cover the period of performance from July 1, 2023, to June 30, 2024; therefore, 2024 results contain partial performance of 2023 and 2024.

Figure 5-16—Percentage of Provider Groups with VBP Contracts Who Met the Quality Threshold



Data source: MCO Annual Supplemental VBP reports were used for analysis of Measure 24.
†WSCC data were incorrectly reported from 2022–2024. Only years with correctly reported data are displayed.
*2024 data are incomplete.
**WSCC was excluded from the program-wide total.

Figure 5-17—Average Percentage of QMTs Met by Provider Groups



Data source: MCO Annual Supplemental VBP reports were used for analysis of Measure 24.
†WSCC data were incorrectly reported from 2022-2024. Only years with correctly reported data are displayed.
*2024 data are incomplete.
**WSCC was excluded from the program-wide total.

RQ 3: Has the amount paid in VBP arrangements increased?

Percentage of total payments that are for providers in VBP arrangements (Measure 25)

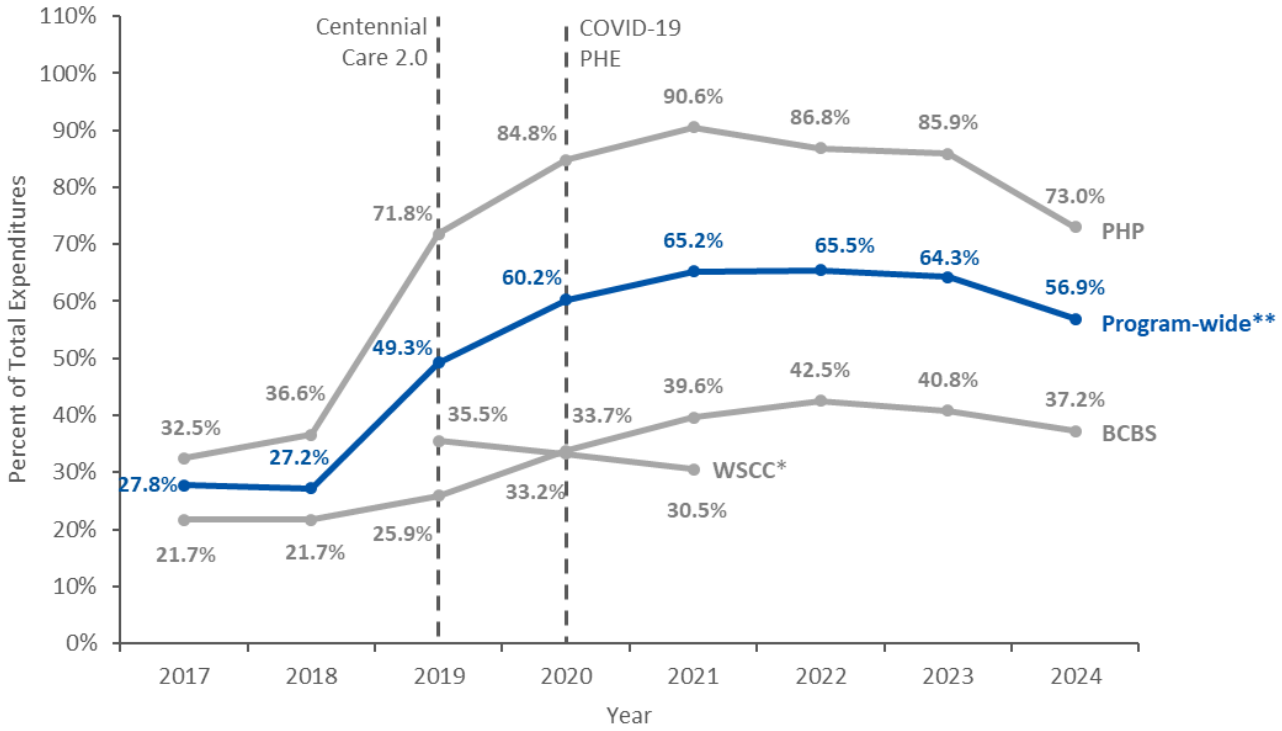
Table 5-21 shows the amount paid in VBP arrangements between 2017 and 2024 as a total dollar amount and as a percentage of total healthcare expenditures. Figure 5-18 shows the percentage paid in VBP arrangements as a percentage of total healthcare expenditures. The program-wide percentage of expenditures attributed to VBP arrangements increased by 29.1 percentage points from 2017 (27.8 percent) to 2024 (56.9 percent). The largest increase in VBP payments (22.1 percentage points) occurred between 2018 and 2019 following Centennial Care 2.0 implementation.

Table 5-21—Amount Paid in VBP Arrangements and Percentage of Total Healthcare Expenditures (Millions)

Year	BCBS	MHC	PHP	UHC	WSCC	Program-wide**
2017	$142.9 (21.7%)	$154.8 (15.1%)	$247.5 (32.5%)	$243.6 (61.5%)	—	$788.8 (27.8%)
2018	$155.1 (21.7%)	$155.4 (15.8%)	$288.3 (36.6%)	$150.4 (57.1%)	—	$749.2 (27.2%)
2019	$359.4 (25.9%)	—	$1,033.5 (71.8%)	—	$91.5 (35.5%)	$1,392.9 (49.3%)
2020	$498.4 (33.7%)	—	$1,347.6 (84.8%)	—	$107.3 (33.2%)	$1,845.0 (60.2%)
2021	$555.1 (39.6%)	—	$1,287.3 (90.6%)	—	$102.2 (30.5%)	$1,842.5 (65.2%)
2022	$691.6 (42.5%)	—	$1,521.6 (86.8%)	—	*	$2,213.3 (65.5%)
2023	$699.1 (40.8%)	—	$1,594.1 (85.9%)	—	*	$2,293.2 (64.3%)
2024	$291.5 (37.2%)	—	$696.3 (73.0%)	—	*	$987.8 (56.9%)

Data Source: VBP reports were used in the analysis of Measure 25.
Note: Data are displayed in millions. — represents years when the MCO was not contracted with Centennial Care 2.0. Annual measurement periods were used for all years except 2024, which represents data through June 2024, the last full month of Centennial Care 2.0.
*WSCC data were incorrectly reported from 2022–2024. Only years with correctly reported data are displayed.
**WSCC was excluded from the program-wide total.

Figure 5-18—Percentage of Total Healthcare Expenditures Paid in VBP Arrangements



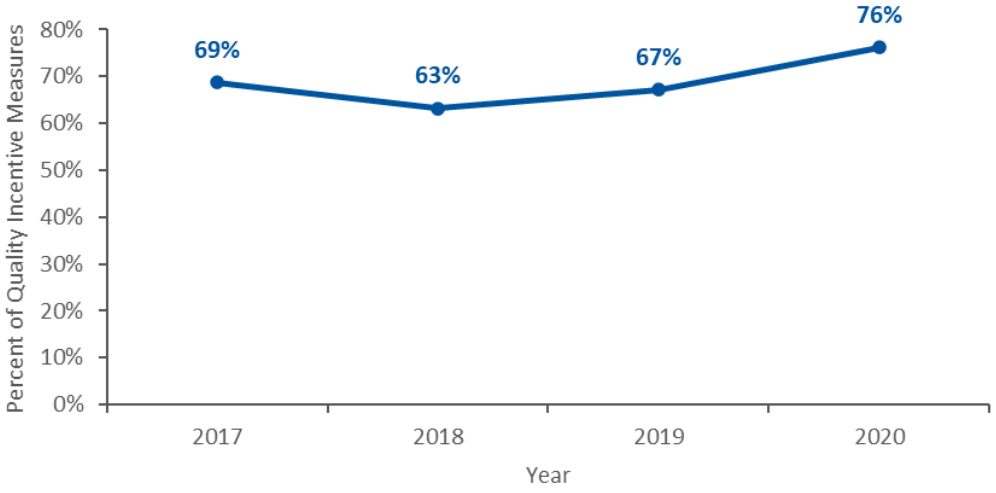
Data source: MCO Annual Supplemental VBP reports were used in the analysis of Measure 25.
*WSCC data were incorrectly reported from 2022-2024. Only years with correctly reported data are displayed.
**WSCC was excluded from the program-wide total.

RQ 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 26)

The hospital quality improvement incentive (HQII) initiative transitioned to the hospital access program on January 1, 2022, after which HQII no longer operated under Centennial Care 2.0 authority. The data provided covered the period from 2017 through 2020. Figure 5-19 demonstrates that the percentage of improved quality incentive measures decreased from 69 percent in 2017 to 63 percent in 2018 before increasing to 76 percent in 2020.

Figure 5-19—Percentage of Improved Quality Incentive Measures



Data source: Department of Health Health Information Technology and New Mexico Hospital Association data were used in the analysis of Measure 26.

RQ 5: Do cost trends align with expected reimbursement and benefit changes?

Financial analyses compared Centennial Care 2.0 costs to expected (counterfactual) costs in the absence of the program. Expected expenditures were estimated based on changes in member demographics, population health condition-based risk score, and the medical cost price index (CPI).[5-21, 5-22] Total actual expenditure costs for Centennial Care 2.0 members were then compared to the estimated expected expenditures, which were calculated by applying annual demographic and inflation factors to 2013 baseline costs. Additional information on adjustment factor development can be found in the "Financial Analysis Trend and Cost Development" section of the *Methodology* chapter of this report. Capitation rate data, developed by the State's actuarial partners, were based on historical claims, with adjustments based on the expected financial impacts due to policy, provider reimbursement, and benefit changes. These financial analyses do not refer to nor attempt to replicate the formal CMS-required budget neutrality test, which sets a fixed target under which expenditures must fall. Additional cost results can be found in Appendix A, Attachments, Supplemental Results.

Cost per member trend (Measure 27)

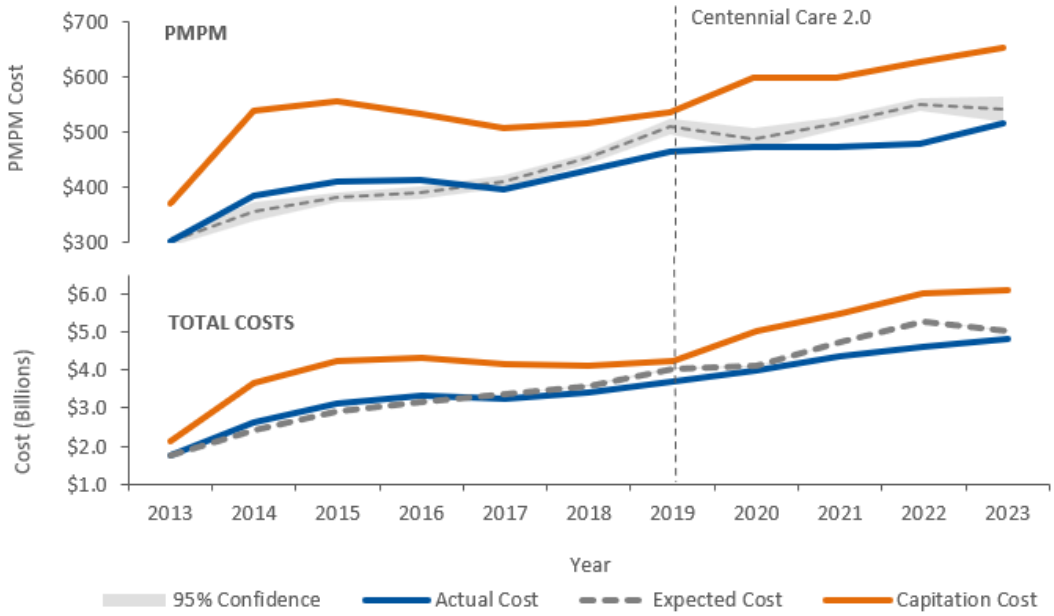
Figure 5-20 displays the per-member per-month (PMPM) claim/encounter costs and total expenditures from 2013 through 2023 for the capitated cost, actual incurred cost, and the expected (counterfactual) cost. Both the actual and counterfactual costs increased from 2013 through 2023. Capitation costs were higher than the actual incurred and expected (counterfactual) costs, indicating that the MCOs received sufficient compensation to cover

5-21 U.S. Bureau of Labor Statistics. CDP) 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: Aug 12, 2025.

5-22 UC San Diego. CDPS. Available at: https://hwsph.ucsd.edu/research/programs-groups/cdps.html#Using-CDPS-Risk-Scores. Accessed on: Aug 12, 2025.

members' cost of care. The actual PMPM costs incurred were less than the expected (counterfactual) PMPM costs with 95 percent confidence throughout Centennial Care 2.0.

Figure 5-20—PMPM and Total Cost

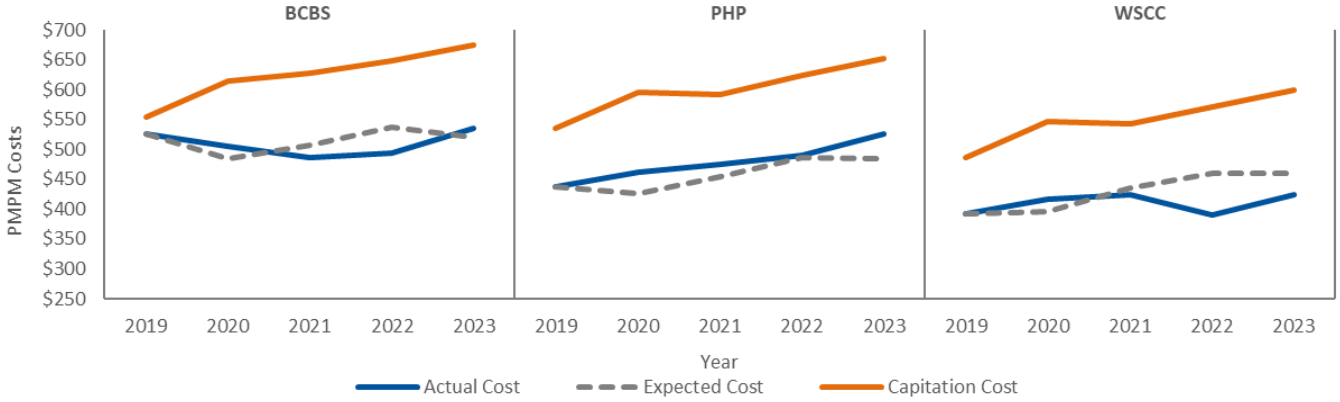


Note: Confidence bands are based on the monthly PMPM cost and represent variation in costs throughout the year.
Data source: MMIS and capitation data were used in the analysis of Measure 27.

Figure 5-21 displays BCBS, PHP, and WSCC PMPM claim/encounter costs, including the actual incurred cost, the expected (counterfactual) cost, and capitation cost, from 2019 through 2023. MCOs' PMPM capitated costs were consistently higher than the actual incurred and counterfactual costs, indicating that capitated payments were sufficient to cover members' cost of care.

On average, PHP accounted for 53 percent of the total member month (MM) enrollment distribution and had actual incurred PMPM costs consistently higher than the counterfactual PMPM costs during Centennial Care 2.0. BCBS, despite representing only 36 percent of the total MMs enrollment, had the largest PMPM costs for all years. BCBS also exhibited annual fluctuations when comparing actual incurred and counterfactual PMPM costs. In 2020 and 2023, BCBS reported higher actual incurred PMPM costs compared to the counterfactual PMPM costs; however, 2021 and 2022 actual incurred costs were less than the counterfactual costs. WSCC, with only 11 percent of the total MM enrollment, regularly outperformed expectations, with actual incurred PMPM costs falling below the counterfactual PMPM costs every year except 2020.

Figure 5-21—Actual, Expected, and Capitated PMPM Costs



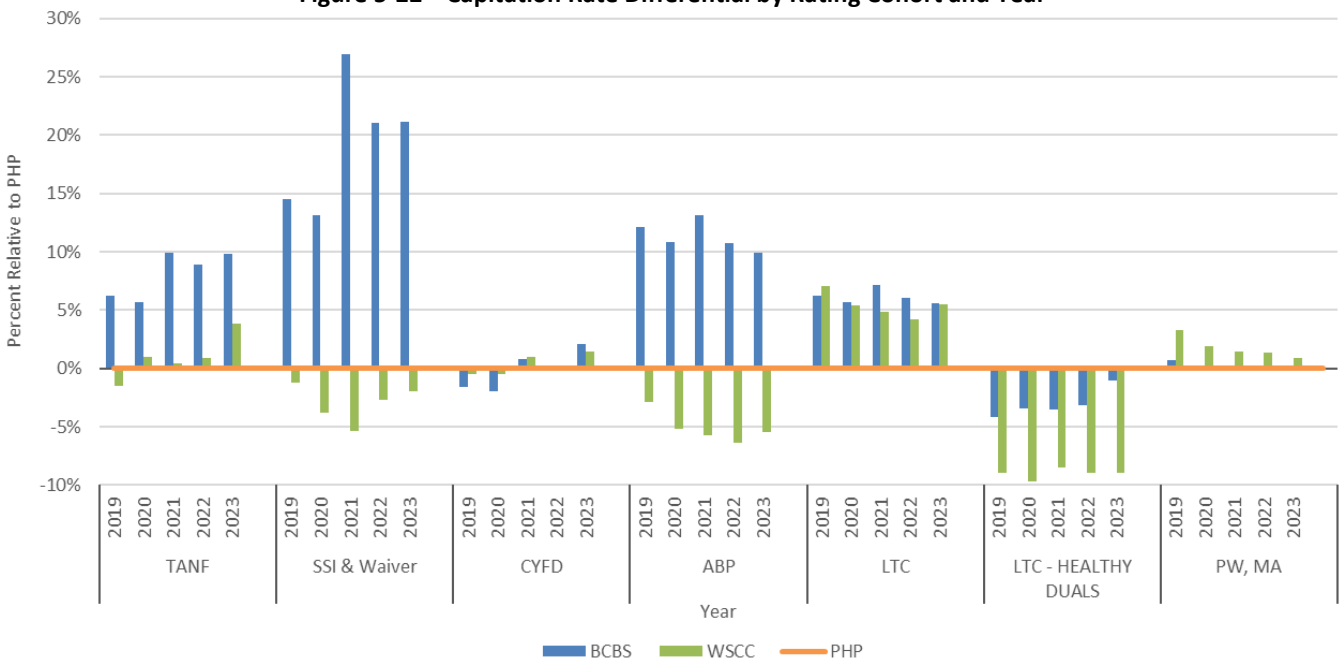
Data source: MMIS and capitation data were used in the analysis of Measure 27.

Figure 5-22 displays the percentage difference in MCOs' capitation rates stratified by capitation rating cohort and year.[5-23, 5-24] CYFD and pregnant women (PW) medical assistance (MA) cohort capitation rates were similar, within 5 percent of PHP. The largest difference in capitation rates was identified in the Social Security Income (SSI) and Waiver BCBS cohort across all years, with a 27 percent higher capitation rate than PHP in 2021. BCBS and WSCC exhibited lower long-term care (LTC)–Healthy Duals capitation rates than PHP for all years.

5-23 Cohorts were based on New Mexico Medicaid rate development capitation rating cohorts. The cohorts included in analyses were Temporary Assistance for Needy Families (TANF), SSI and Waiver, CYFD, alternative benefit plan (ABP), LTC, LTC Healthy Duals, and PW and MA.

5-24 Capitation rate data developed by the State's actuarial partners were compared for Centennial Care 2.0 cohorts from 2019 to 2023. PHP capitation rates were used as the comparison baseline because PHP accounted for over 50 percent of the MM enrollment distribution, displayed in Figure 5-25 as the orange horizontal line at 0 percent.

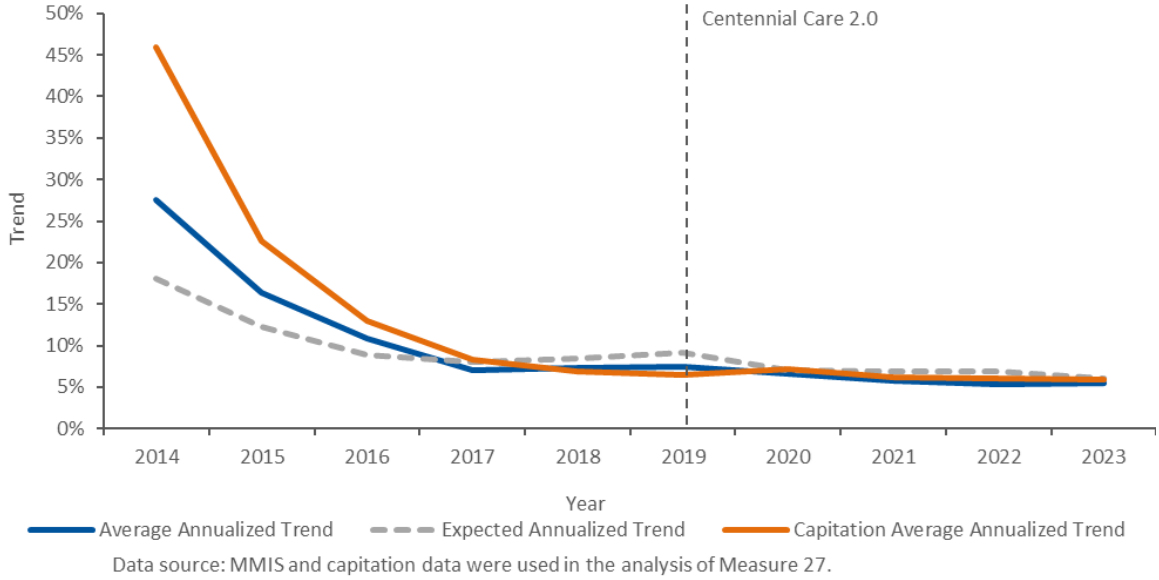
Figure 5-22—Capitation Rate Differential by Rating Cohort and Year



Data source: MMIS and capitation data were used in the analysis of Measure 27.
Note: Positive values represent the percent greater than the PHP capitation rate for that cohort and year. Negative values represent the percent less than the PHP capitation rate for that cohort and year.

Figure 5-23 shows trend calculations based on 2013 risk and demographic changes. The average annualized trend decreased from the 27.5 percent baseline rate to 7.3 percent in 2018 and 5.5 percent in 2023. Throughout Centennial Care 2.0, the average annualized trend and capitation average annualized trend were at or below the expected (counterfactual) annualized trends.

Figure 5-23—Cost Per Member Trend



Data source: MMIS and capitation data were used in the analysis of Measure 27.

Table 5-22 shows the impacts of known cost and demographic variable changes for paid claims from 2013 to 2023. The annual impact of each known driver was applied to the PMPM claims cost from the 2013 baseline to calculate the counterfactual claims PMPM. Both the average annualized trend and the expected (counterfactual) average annualized trend decreased from 2013 to 2023, and the average annualized trend was below the expected (counterfactual) trend during Centennial Care 2.0. The calculated counterfactual claims trend incorporating all known external impacts was 6.0 percent compared to the annualized paid claims trend of 5.5 percent during Centennial Care 2.0. These results indicate that Centennial Care 2.0 achieved an estimated claims cost savings of 0.5 percent.

Table 5-22—Counterfactual Paid Claims Trend Development

Cost Impact Components	2013 Factors	2023 Factors	Cumulative Factor Change [2]	Years	Average Annualized Factor Trend [3]
	[A]	[B]	[C]=[B]/[A]	[D]	[E]=[C]^(1/[D])-1
Aging	1.0099	1.0202	1.0102	10	0.1%
Race	1.0300	1.0124	0.9829	10	-0.2%
Area	1.0169	0.9991	0.9825	10	-0.2%
Risk	0.9814	1.2923	1.3168	10	2.8%
CPI	1.0000	1.3560	1.3560	10	3.1%
Service Category Distribution	1.0000	1.0297	1.0297	10	0.3%
Counterfactual Paid Claims[1]	**1.0381**	**1.8620**	**1.7936**	**10**	**6.0%**

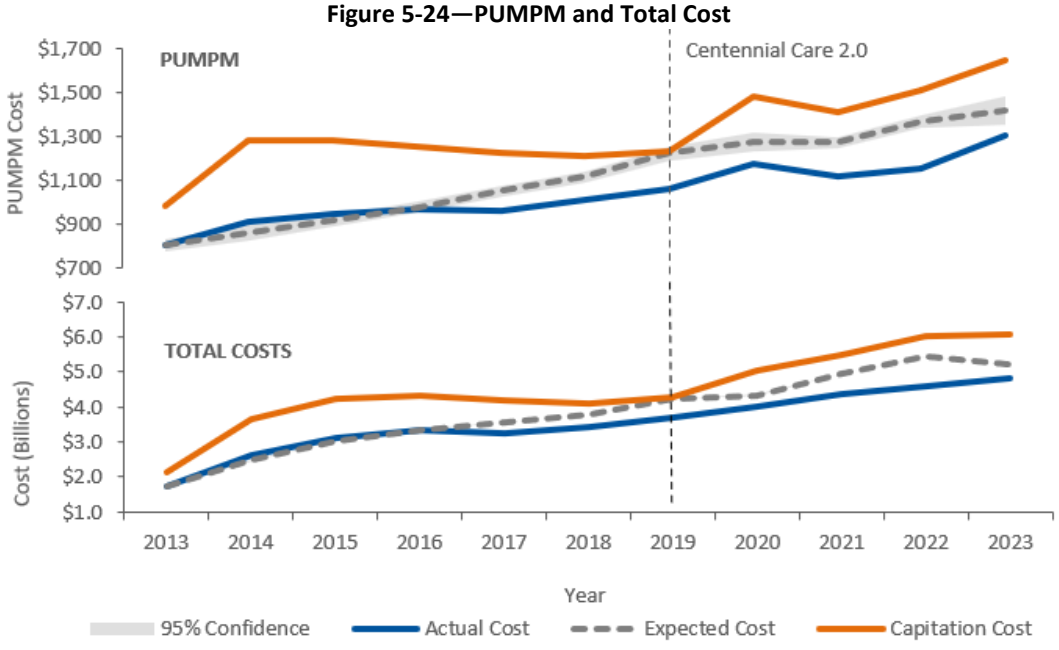
	Average Annualized Trend	2013 to 2023
[E]	Counterfactual Annualized Paid Claims Trend	6.0%
[F]	Annualized Paid Claims Trend [4]	5.5%
[G]=(1+[E])/(1+[F])-1	**Savings Below Counterfactual Annualized Paid Claims Trend**	**0.5%**

Note: Average annual MM for the evaluation period used was 8,090,986.
[1] The counterfactual paid claims factor for calendar year (CY) 2013 and CY 2023 is the product of each factor listed in the respective year.
[2] As described in the methodology, cost factors were developed for each demographic stratification and risk. The change in those cost factors over the evaluation period is represented by the cumulative factor change. Trends are developed as the average of the cumulative factor change across the evaluation period.
[3] The average annualized trends presented in the table above represent the average change throughout the evaluation period and cannot be summed to generate the average annual counterfactual paid claims trend.
[4] The annualized paid claims trend represents the average annual change in the actual cost of care of the population throughout the evaluation period.

Cost per user trend (Measure 28)

Figure 5-24 displays the per-utilizing-member per-month (PUMPM) claims costs and total expenditures from 2013 to 2023 for the capitated cost, actual incurred cost, and the expected (counterfactual) cost. A utilizing MM was any month in a CY during which a member incurred a claim or encounter. The capitation costs were higher than the actual incurred and expected (counterfactual) costs, indicating that the MCOs received sufficient compensation for members' cost of care. The actual incurred PUMPM costs were less than the expected (counterfactual) PUMPM costs with 95 percent confidence throughout Centennial Care 2.0.

Figure 5-24—PUMPM and Total Cost

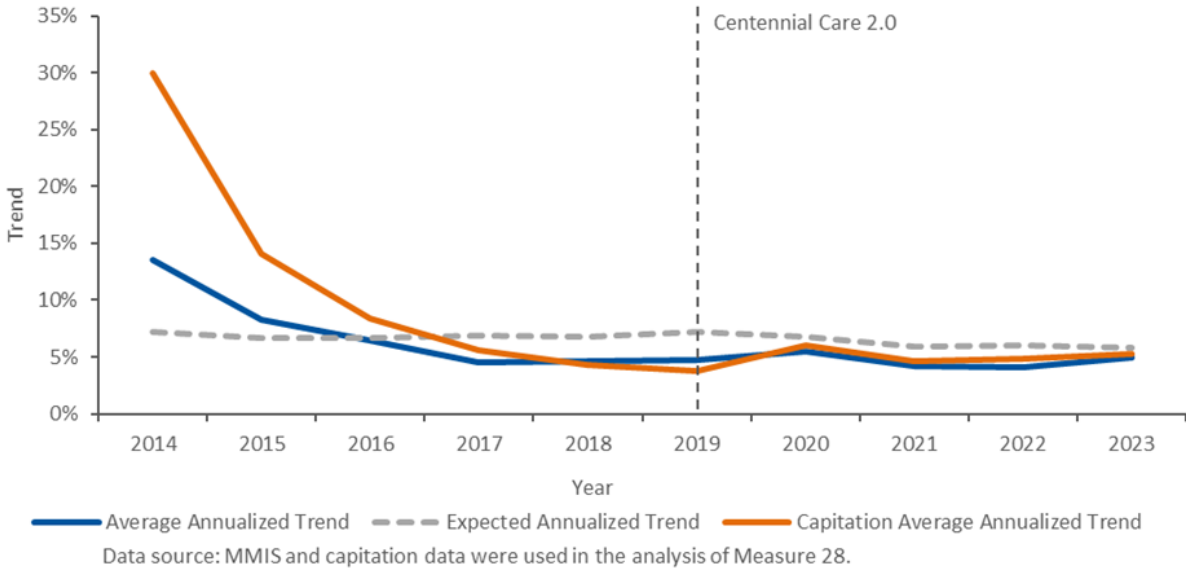


Note: Confidence bands are based on the monthly PMPM cost and represent variation in costs throughout the year.
Data source: MMIS and capitation data were used in the analysis of Measure 28.

Figure 5-25 shows several trend calculations based on 2013 risk and demographic changes. Overall, the average annualized trend decreased from the baseline of 13.6 percent to 4.9 percent. The average annualized trend increased slightly during Centennial Care 2.0, from 4.6 percent in 2018 to 4.9 percent in 2023. The average

annualized trend and capitation average annualized trend were at or below the expected (counterfactual) annualized trends throughout Centennial Care 2.0.

Figure 5-25—Cost Per Utilizing Member Trends



Data source: MMIS and capitation data were used in the analysis of Measure 28.

Population demographics changes also impacted the per utilizing member trends. The Chronic Illness and Disability Payment System (CDPS) Version 6.5 condition-based risk score for the utilizing population was substantially higher than for the enrolled population from 2014 to 2016, causing the average annualized trend to be higher than the expected (counterfactual) average annualized trend for those years. Continued Centennial Care 2.0 population growth led to a substantial shift in the distribution by risk and age. The average age of the 2013 utilizing population was 27.0 years, increasing to 31.9 years in 2023. The member distribution by geographic region and race did not change substantially from 2013 to 2023.

Table 5-23 shows the impacts of the known cost and demographic variable changes for paid claims from 2013 to 2023. The annual impact of each known driver was applied to the PUMPM claims cost from the 2013 baseline to calculate the counterfactual claims PUMPM. Both the average annualized trend and the expected (counterfactual) average annualized trend decreased from 2013 to 2023, and the average annualized trend was below the expected (counterfactual) average annualized trend during Centennial Care 2.0. The calculated counterfactual claims trend incorporating all known external impacts was 5.8 percent; comparing this to the annualized paid claims trend of 4.9 percent during Centennial Care 2.0 shows that the program achieved an estimated claims cost savings of 0.8 percent for the utilizing population.

Table 5-23—Counterfactual Utilizing Paid Claims Trend Development

Cost Impact Components	2013 Factors	2023 Factors	Cumulative Factor Change [2]	Years	Average Annualized Factor Trend [3]
	[A]	[B]	[C]=[B]/[A]	[D]	[E]=[C]^(1/[D])-1
Aging	1.3059	1.1852	0.9076	10	-1.0%
Race	0.9959	1.0120	1.0162	10	0.2%
Area	1.0136	1.0013	0.9878	10	-0.1%
Risk	1.7340	2.2556	1.3008	10	2.7%
Cost Price Index (CPI)	1.0000	1.3560	1.3560	10	3.1%
Service Category Distribution	1.0000	1.0958	1.0958	10	0.9%
Counterfactual Paid Claims[1]	**2.2857**	**4.0251**	**1.7610**	**10**	**5.8%**
		Average Annualized Trend			**2013 to 2023**
[E]	Counterfactual Annualized Paid Claims Trend				5.8%
[F]	Annualized Paid Claims Trend [4]				4.9%
[G]=(1+[E])/(1+[F])-1	**Savings Below Counterfactual Annualized Paid Claims Trend**				**0.8%**

Note: Average annual MM for the evaluation period used was 3,369,355.
[1] The counterfactual paid claims factor for CY 2013 and CY 2023 is the product of each factor listed in the respective year.
[2] As described in the methodology, cost factors were developed for each demographic stratification and risk. The change in those cost factors over the evaluation period is represented by the cumulative factor change. Trends are developed as the average of the cumulative factor change across the evaluation period.
[3] The average annualized trends presented in the table above represent the average change throughout the evaluation period and cannot be summed to generate the average annual counterfactual paid claims trend.
[4] The annualized paid claims trend represents the average annual change in the actual cost of care of the population throughout the evaluation period.

Aim Three: Streamline processes and modernize the Centennial Care health delivery system through use of data, technology, and person-centered care

Aim Three Key Findings

Table 5-24 presents the key findings by hypothesis for Aim Three.

Table 5-24—Aim Three Key Findings

Hypothesis	Key Finding
1	The number of continuous NFLOC approvals increased during Centennial Care 2.0.
2	The number of telemedicine providers and number of members who received telemedicine services increased slightly during Centennial Care 2.0, with the greatest increase following the onset of the COVID-19 PHE. There were no statistically significant changes in member satisfaction with the health plan or overall healthcare associated with Centennial Care 2.0. Member satisfaction with personal doctor increased initially following implementation among adults, and the annual trend decreased after implementation for both adults and children.
3	The number of claims submitted through EVV increased at a slower rate than in the pre-implementation period. Data were insufficient to analyze reporting accuracy.

Note: COVID-19: coronavirus disease 2019; EVV: electronic visit verification; NFLOC: nursing facility level of care; PHE: public health emergency

Aim Three Results

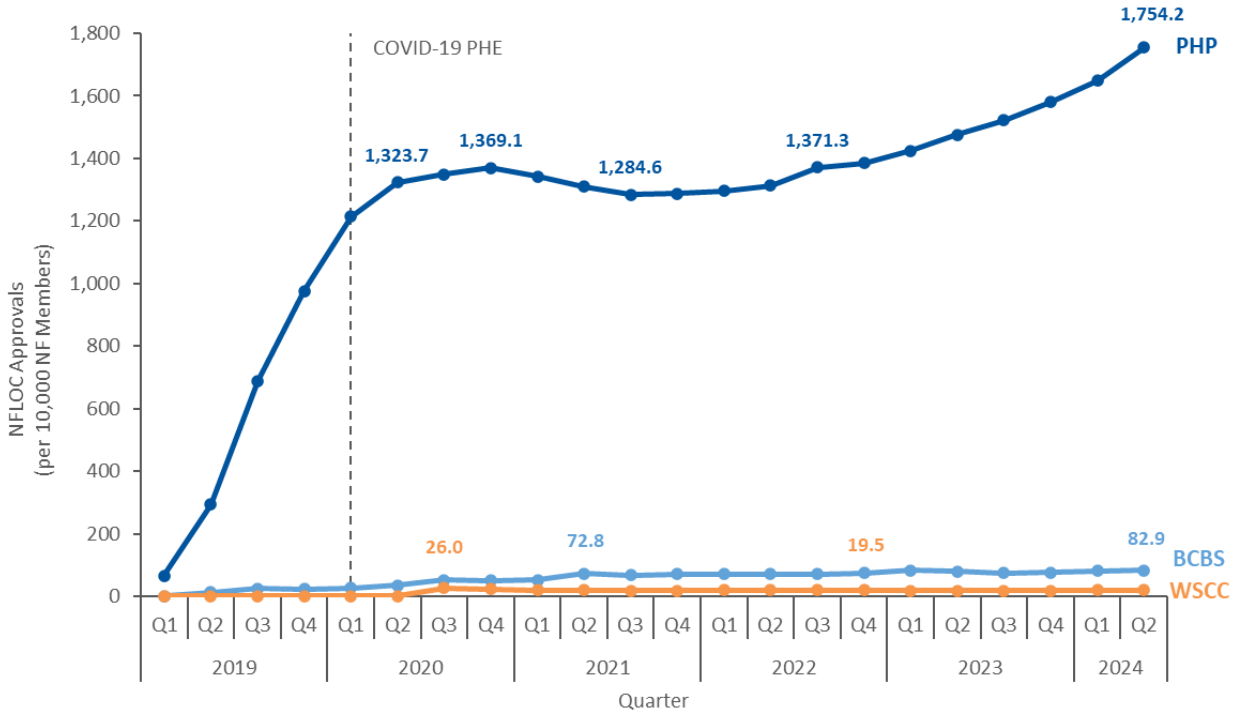
Hypothesis 1: The demonstration will relieve administrative burden by implementing a continuous Nursing Facility Level of Care (NFLOC) approval with specific criteria for members whose condition is not expected to change over time.

RQ 1: Has the number of continuous NFLOC approvals increased during the Demonstration?

Number of continuous NFLOC approvals (Measure 29)

Figure 5-26 shows the continuous NFLOC approval rates of BCBS, PHP, and WSCC. PHP consistently reported the highest NFLOC approval rates, increasing from 65.0 approvals per 10,000 nursing facility (NF) members in quarter (Q) 1 2019 to 1,754.2 approvals in Q2 2024, with the majority of the growth occurring in 2019. BCBS and WSCC NFLOC approval rates also increased from zero at the beginning of Centennial Care 2.0, but their rates remained less than PHP's rate, at 4.7 percent and 1.1 percent of the rate for PHP, respectively, in Q2 2024.

Figure 5-26—Number of Continuous NFLOC Approvals



Data source: Summary reports of open-ended LTC spans and MCO reports were used in the analysis of Measure 29.

Hypothesis 2: The use of technology and continuous quality improvement (CQI) processes align with increased access to services and member satisfaction.

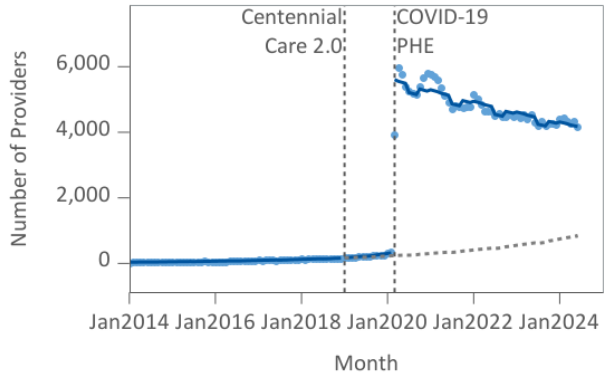
RQ 1: Has the number of telemedicine providers increased during Centennial Care 2.0?

Major service delivery changes occurred from 2014 to 2024, including a substantial telemedicine increase coinciding with the COVID-19 PHE. To account for this change, Measures 30 and 31 employed an ITS model with three time periods to separate the changes caused by the COVID-19 PHE from those due to Centennial Care 2.0.[5-25]

Number of telemedicine providers (Measure 30)

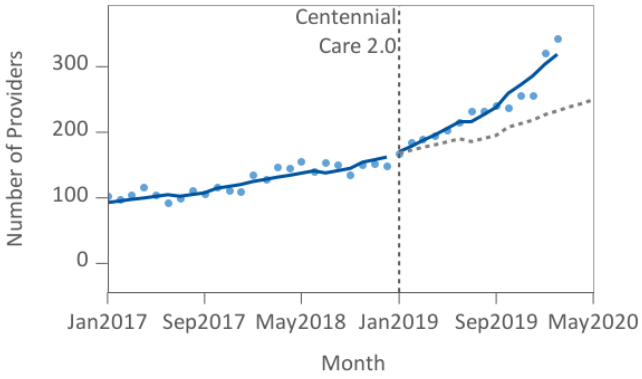
Figure 5-27, Figure 5-28, and Table 5-25 illustrate the model-based monthly average number of telemedicine providers (blue line) and the projected number of providers had the baseline trend continued (grey dashed line) from January 2014 to June 2024 and January 2017 to February 2020, respectively. The number of telemedicine providers increased by 2.5 percent per month prior to Centennial Care 2.0. Monthly growth increased by an additional 2.4 percent between Centennial Care 2.0 implementation and the start of the COVID-19 PHE, representing the most accurate Centennial Care 2.0 impact (p<0.001). Telemedicine providers increased from 343 providers in January 2020 to 5,979 providers in March 2020, then decreased through the remainder of Centennial Care 2.0.

Figure 5-27—Number of Telemedicine Providers



Data Source: MMIS data were used in the analysis of Measure 30.

Figure 5-28—Number of Telemedicine Providers at Centennial Care 2.0 Implementation



Data Source: MMIS data were used in the analysis of Measure 30.

5-25 A generalized linear model (GLM) with a log link was constructed to account for the number of providers being positive and not normally distributed. This model allowed for more accurate analysis; however, interpretation was more complex than a simple linear regression model. Measure 30 and Measure 31 results are presented as percentage changes in the number of providers.

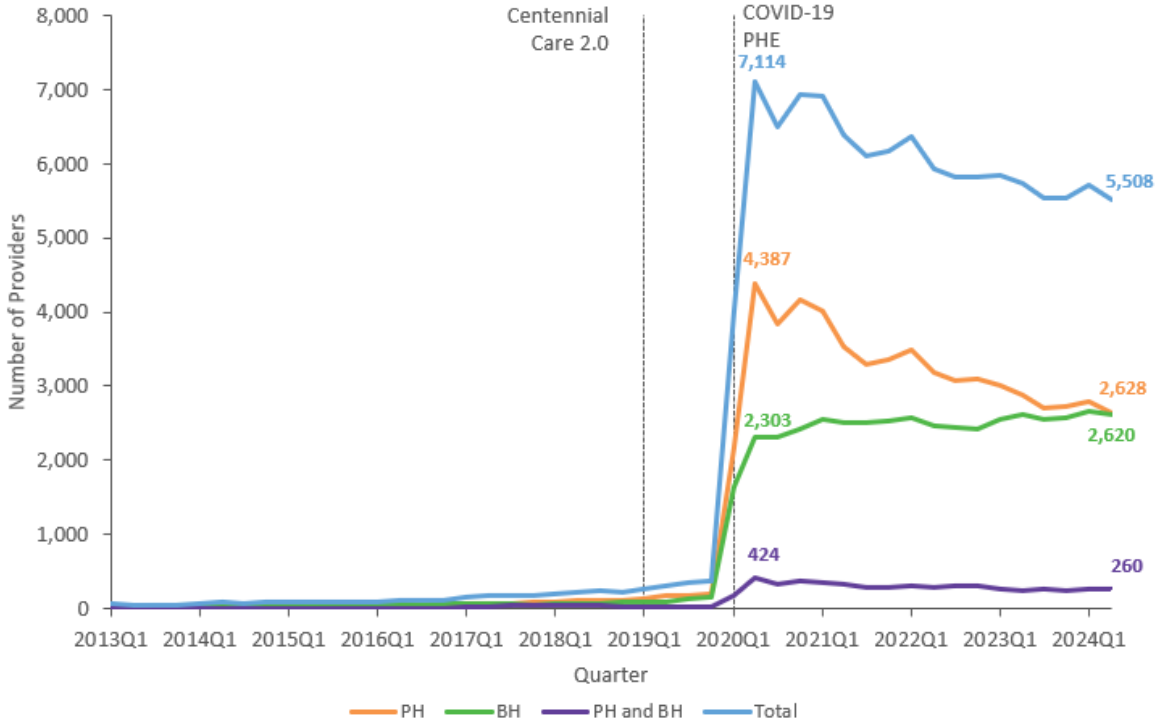
Table 5-25—Measure 30 ITS Results

Variable	Percent Change	*p*-value
Intercept	38.0***	<0.001
Pre-Centennial Care 2.0 monthly trend	2.5%***	<0.001
Level change at implementation	1.1%	0.805
Change in monthly trend	2.4%***	<0.001

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 30.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results.

Figure 5-29 shows the quarterly number of telemedicine providers by service type from Q1 2013 through Q2 2024. The number of PH providers increased to 4,387 after the COVID-19 PHE, followed by a decline to 2,628 providers in Q2 2024. Conversely, the number of BH providers rose to 2,303 in Q2 2020 and increased further to 2,620 in Q2 2024, indicating that BH providers increased telemedicine use even in the absence of the COVID-19 PHE.

Figure 5-29—Number of Telemedicine Providers by Service Type



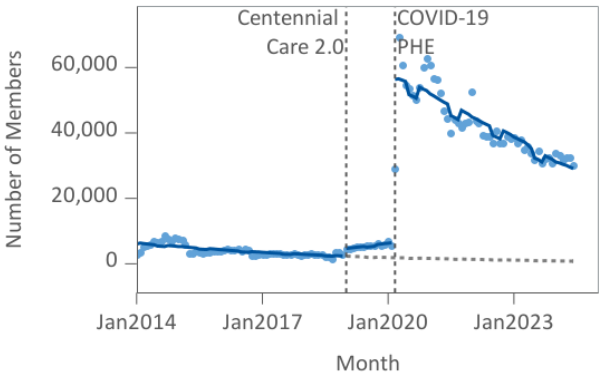
Data source: MMIS data were used in the analysis of Measure 30.

RQ 2: Has the number of unduplicated members with a telemedicine visit increased during Centennial Care 2.0?

Number of members receiving telemedicine services (Measure 31)

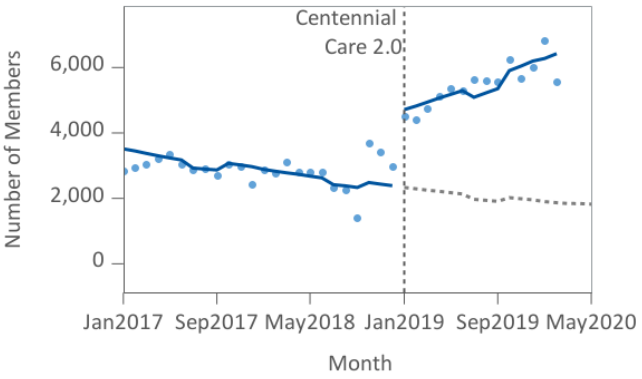
Figure 5-30, Figure 5-31, and Table 5-26 illustrate the model-based monthly average number of members who used telemedicine (blue line) and the projected number of members had the baseline trend continued (grey dashed line) from January 2014 to June 2024 and from January 2017 to March 2020, respectively. The number of telemedicine users decreased monthly by 1.7 percent prior to Centennial Care 2.0. At implementation, the number of telemedicine users more than doubled, increasing by 102.0 percent (p<0.001). The rate of monthly change increased by 4.2 percent per month, indicating that Centennial Care 2.0 increased telemedicine utilization (p<0.001). The number of members who received telemedicine services increased at the COVID-19 PHE onset, from 5,561 members in February 2020 to 69,344 members in April 2020. The number of members then declined through the remainder of Centennial Care 2.0; however, rates remained higher than prior to the COVID-19 PHE.

Figure 5-30—Number of Members Who Used Telemedicine



Data Source: MMIS data were used in the analysis of Measure 31.

Figure 5-31—Number of Members Who Used Telemedicine at Centennial Care 2.0 Implementation



Data Source: MMIS data were used in the analysis of Measure 31.

Table 5-26—Measure 31 ITS Results

Variable	Percent Change	*p*-value
Intercept	6,550.8***	<0.001
Pre-Centennial Care 2.0 monthly trend	-1.7%***	<0.001
Level change at implementation	102.0% ***	<0.001
Change in monthly trend	4.2%***	<0.001

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 31.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results.

RQ 3: Has member satisfaction increased during Centennial Care 2.0?

MCOs administered annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[5-26] surveys to assess members' experience with their healthcare. To accurately evaluate changes in member experience during Centennial Care 2.0, the results from each report were applied to the previous year, reflecting when surveys were administered (e.g., members' 2019 experience is reflected in the 2020 CAHPS report). An ITS analysis assessed member rating of healthcare, member rating of health plan, and member rating of personal doctor.[5-27] Statewide rates were calculated by weighting plan-specific rates by annual MCO enrollment shown in Table 5-27.[5-28] Analyses controlled for 2020 COVID-19 PHE impacts using a dummy variable; however, lingering PHE effects may impact rates in subsequent years. Annual measurement periods were used in CAHPS analyses, and 2024 rates are not presented for Measures 32 through 34 since Centennial Care 2.0 ended in July 2024.

Table 5-27—Annual MCO Enrollment

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
BCBS										
Adult	73,917	81,850	90,237	86,996	100,135	140,710	162,821	177,818	186,703	162,121
Child	45,126	48,282	53,119	52,019	60,729	97,599	105,325	109,708	111,273	104,370
PHP										
Adult	83,627	100,125	111,369	108,121	176,494	211,836	233,281	250,579	260,453	225,349
Child	117,281	117,587	118,721	111,091	131,608	163,919	167,314	168,672	166,888	153,594

Data Source: MMIS data were used to determine MCO enrollment.

Member rating of healthcare (Measure 32)

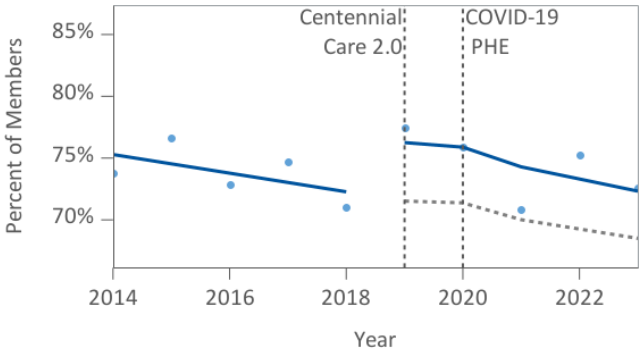
Figure 5-32, Figure 5-33, and Table 5-28 illustrate the model-based yearly average rate of positive member ratings of their healthcare (blue line) and the projection had the baseline trend continued (grey dashed line). The percentage of adult members with a positive healthcare rating decreased annually by 0.8 percentage points prior to Centennial Care 2.0 (p=0.083). There was a level change of 4.7 percentage points at implementation (p=0.068), followed by a decrease in the change in the annual trend by 0.2 percentage points per year compared to the baseline projection (p=0.634). The percentage of child members with a positive rating of healthcare increased by 1.5 percentage points at implementation (p=0.400), and the annual trend decreased by 0.1 percentage points per year (p=0.830).

5-26 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

5-27 Ratings were provided on a scale of 0 to 10, with a high rating considered a score of 8, 9, or 10. Therefore, Measures 32 to 34 represent the percentage of respondents indicating a rating of either 8, 9, or 10. Additional measure specification information can be found in Appendix A, Attachments, Measure Specifications.

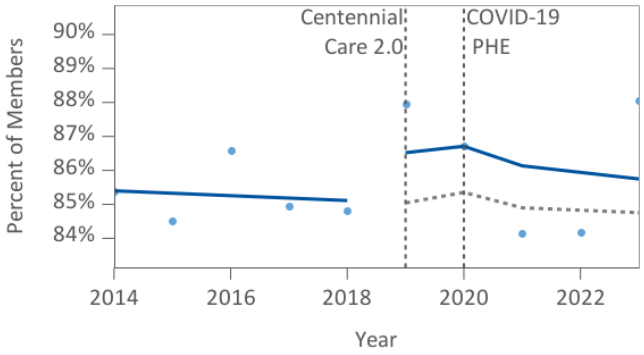
5-28 Only BCBS and PHP were included in the analysis to ensure continuity across Centennial Care and Centennial Care 2.0. BCBS and PHP rates are presented in Appendix A, Attachments, Supplemental Results.

Figure 5-32—Percentage of Adult Members with a Positive Rating of Healthcare



Data Source: MCO CAHPS reports were used in the analysis of Measure 32.

Figure 5-33—Percentage of Child Members with a Positive Rating of Healthcare



Data Source: MCO CAHPS reports were used in the analysis of Measure 32.

Table 5-28—Measure 32 ITS Results

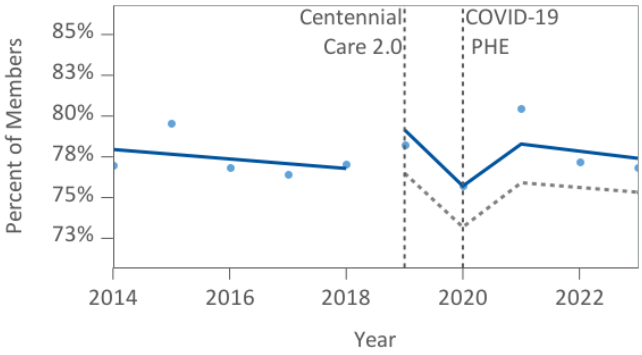
Variable	Estimate	*p*-value
Adult		
Intercept	75.3%***	<0.001
Pre-Centennial Care 2.0 annual trend	-0.8pp*	0.083
Level change at implementation	4.7pp*	0.068
Change in annual trend	-0.2pp	0.634
Child		
Intercept	85.4%***	<0.001
Pre-Centennial Care 2.0 annual trend	-0.1pp	0.542
Level change at implementation	1.5pp	0.400
Change in annual trend	-0.1pp	0.830

*p<0.1, **p<0.05, ***p<0.001
Data Source: MCO CAHPS reports were used in the analysis of Measure 32.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

Member rating of health plan (Measure 33)

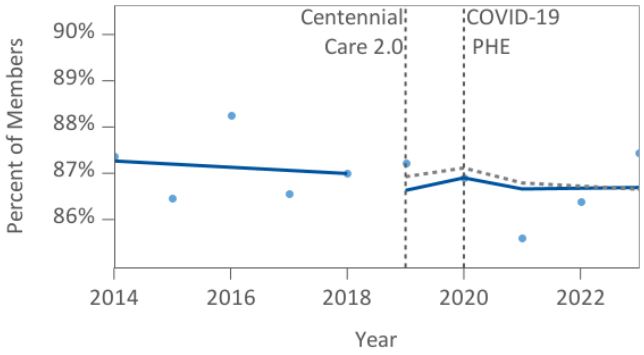
Figure 5-34, Figure 5-35, and Table 5-29 illustrate the model-based annual average rate of positive member rating of their health plan (blue line) and the projection had the baseline trend continued (grey dashed line) for adult and child members. The percentage of adult members with a positive rating of their health plan increased by 2.7 percentage points at Centennial Care 2.0 implementation (p=0.080). There were no significant changes in the annual adult trend compared to the baseline (p=0.686). Approximately 87 percent of child members reported a positive rating of their health plan throughout Centennial Care 2.0. There were no significant findings in the level change at implementation or in the change in the annual trend (p=0.685 and p=0.726, respectively).

Figure 5-34—Percentage of Adult Members with a Positive Rating of Health Plan



Data Source: MCO CAHPS reports were used in the analysis of Measure 33.

Figure 5-35—Percentage of Child Members with a Positive Rating of Health Plan



Data Source: MCO CAHPS reports were used in the analysis of Measure 33.

Table 5-29—Measure 33 ITS Results

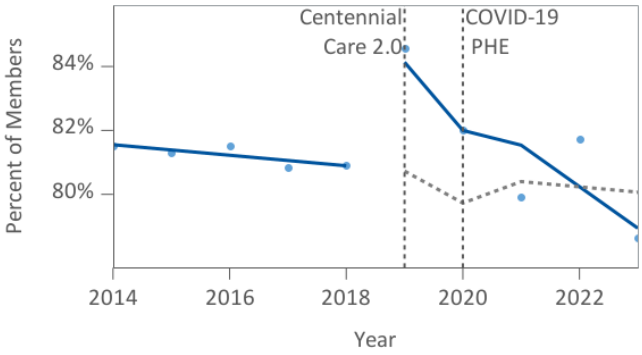
Variable	Estimate	*p*-value
Adult		
Intercept	78.0%***	<0.001
Pre-Centennial Care 2.0 annual trend	-0.3pp	0.209
Level change at implementation	2.7pp*	0.080
Change in annual trend	-0.1pp	0.686
Child		
Intercept	87.3%***	<0.001
Pre-Centennial Care 2.0 annual trend	-0.1pp	0.447
Level change at implementation	-0.3pp	0.685
Change in annual trend	0.1pp	0.726

*p<0.1, **p<0.05, ***p<0.001
Data Source: MCO CAHPS reports were used in the analysis of Measure 33.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

Member rating of personal doctor (Measure 34)

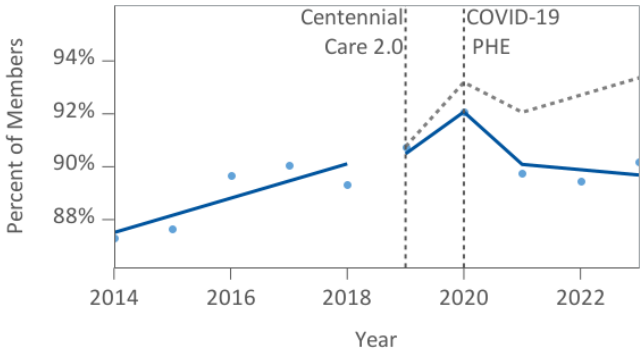
Figure 5-36, Figure 5-37, and Table 5-30 illustrate the model-based annual average rate of positive member rating of their personal doctor (blue line) and the projection had the baseline trend continued (grey dashed line). The percentage of adult members with a positive rating of their personal doctor decreased by 0.2 percentage points annually prior to Centennial Care 2.0 (p<0.001). Satisfaction rose to over 84 percent in 2019, resulting in a level change of 3.4 percentage points at implementation (p=0.002). The trend decreased by an average of 1.1 percentage points per year during Centennial Care 2.0 relative to the baseline trend (p=0.002). Child members' rating of their personal doctor increased by 0.6 percentage points annually prior to Centennial Care 2.0 (p=0.009). Following implementation, however, the change in the trend declined by an average of 0.8 percentage points per year relative to the baseline trend (p=0.003).

Figure 5-36—Percentage of Adult Members with a Positive Rating of Personal Doctor



Data Source: MCO CAHPS reports were used in the analysis of Measure 34.

Figure 5-37—Percentage of Child Members with a Positive Rating of Personal Doctor



Data Source: MCO CAHPS reports were used in the analysis of Measure 34.

Table 5-30—Measure 34 ITS Results

Variable	Estimate	*p*-value
Adult		
Intercept	81.6%***	<0.001
Pre-Centennial Care 2.0 annual trend	-0.2pp***	<0.001
Level change at implementation	3.4pp**	0.002
Change in annual trend	-1.1pp**	0.002
Child		
Intercept	87.5%***	<0.001
Pre-Centennial Care 2.0 annual trend	0.6pp**	0.009
Level change at implementation	-0.3pp	0.742
Change in annual trend	-0.8pp**	0.003

*p<0.1, **p<0.05, ***p<0.001
Data Source: MCO CAHPS reports were used in the analysis of Measure 34.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

Hypothesis 3: Implementation of electronic visit verification (EVV) is associated with increased accuracy in reporting services rendered.

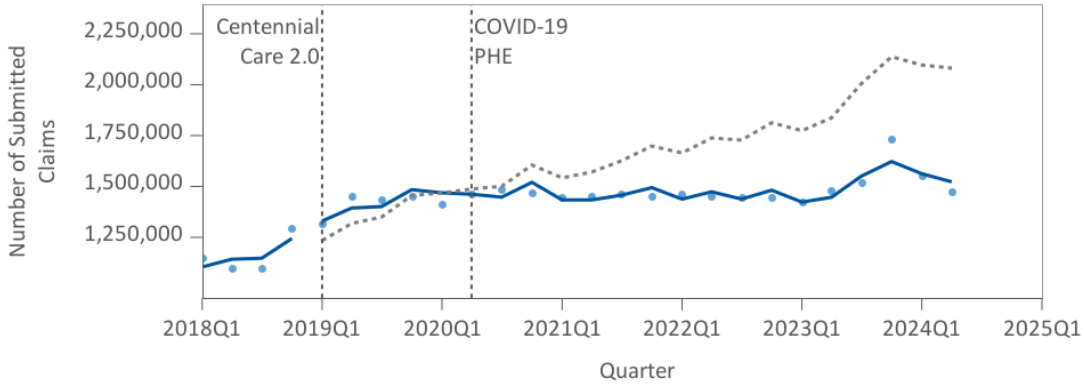
RQ 1: Has the number of claims submitted through EVV increased?

Number of claims submitted through EVV (Measure 35)

Figure 5-38 and Table 5-31 illustrate the model-based quarterly average number of claims submitted through EVV (blue line) and the projection had the baseline trend continued (grey dashed line). The number of EVV claims increased by an average of 2.0 percent per quarter prior to Centennial Care 2.0 (p<0.001). The quarterly number of EVV claims initially increased by 7.7 percent at Centennial Care 2.0 implementation, followed by a quarterly 1.8 percent decrease (p<0.001). These results indicate that, while Centennial Care 2.0 was associated with an initial increase in EVV claims, EVV claim growth stabilized. Supplemental analysis of total claims

indicated that the percentage of all claims submitted through EVV remained at or above approximately 99 percent throughout Centennial Care 2.0, which suggests the absolute number of claims submitted through EVV could not grow as projected by the baseline trend, as the baseline projection exceeded the total number of claims possible.

Figure 5-38—Claims Submitted Through EVV



Data Source: MCO Report #35 was used in the analysis of Measure 35.

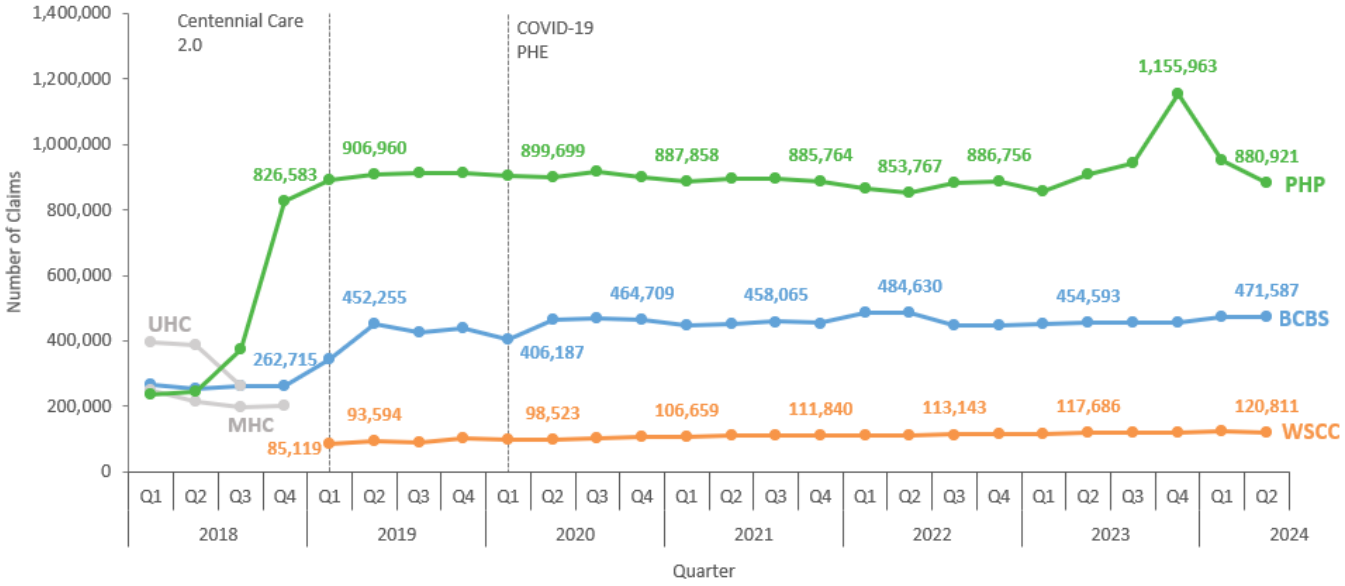
Table 5-31—Measure 35 ITS Results

Variable	Estimate	*p*-value
Intercept	1,179,751***	<0.001
Pre-Centennial Care 2.0 quarterly trend	2.0%***	<0.001
Level change at implementation	7.7%***	<0.001
Change in quarterly trend	-1.8%***	<0.001

*p<0.1, **p<0.05, ***p<0.001
Data Source: MCO Report #35 data were used in the analysis of Measure 35.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results.
pp: percentage point.

Figure 5-39 displays the number of claims submitted through EVV from Q1 2018 to Q2 2024 by MCO. Overall, MCOs' EVV claims increased during Centennial Care 2.0. PHP and BCBS EVV claims increased in 2018 before stabilizing at approximately 880,000 claims and 450,000 claims, respectively, excluding a spike in PHP EVV claims to 1,155,963 claims in Q4 2023. WSCC EVV claims increased from 85,119 claims in Q1 2019 to 120,811 claims in Q2 2024.

Figure 5-39—Number of Submitted Claims Through EVV by MCO



Data Source: MCO Report #35 data were used in the analysis of Measure 35.

RQ 2: Has the proportion of paid or unpaid hours retrieved due to false reporting decreased?

Percent of paid or unpaid hours retrieved due to false reporting (Measure 36)

Table 5-32 shows number and percentage of quarterly reported paid or unpaid hours retrieved due to false reporting by MCOs from 2020 to 2024. Due to a lack of baseline data, limited evaluation period data, and a high prevalence of zero hours reported, results presented are descriptive and cannot provide causal conclusions.

Table 5-32—Reported Paid or Unpaid Hours Retrieved Due to False Reporting

	2020			2022		2023				2024	
Plan	Q1	Q2	Q3	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
BCBS	0 (0.000%)	0 (0.000%)	0 (0.000%)	539 (0.027%)	310 (0.016%)	0 (0.000%)	76 (0.004%)	1,569 (0.078%)	230 (0.011%)	3,074 (0.141%)	88 (0.004%)
PHP	86 (0.002%)	168 (0.005%)	112 (0.003%)	115 (0.003%)	136 (0.005%)	1,881 (0.046%)	83 (0.002%)	56 (0.002%)	0 (0.000%)	0 (0.000%)	0 (0.000%)
WSCC	0 (0.000%)	0 (0.000%)	0 (0.000%)	0 (0.000%)	0 (0.000%)	0 (0.000%)	0 (0.000%)	0 (0.000%)	0 (0.000%)	0 (0.000%)	0 (0.000%)

Data source: MCO report data were used in the analysis of Measure 36.
Note: BCBS, PHP, and WSCC Q4 2020 to Q2 2022 data reported zero instances of false reporting and have been excluded from this table. The percentage (displayed in parentheses) is a rate out of the total number of hours delivered by each MCO each quarter.

Aim Four: Improved quality of care and outcomes for Medicaid beneficiaries with SUD

Aim Four Key Findings

Table 5-33 presents the key findings by hypothesis for Aim Four.

Table 5-33—Aim Four Key Findings

Hypothesis	Key Finding
1	The number of providers who offered SUD screening increased throughout Centennial Care 2.0. The number of individuals screened for SUD increased after Centennial Care 2.0 implementation; however, the change in the monthly trend declined compared to baseline. The percentage of individuals with SUD who received any SUD-related service decreased. The percentage of members who initiated AOD abuse or dependence treatment increased; however, there were no statistically significant changes associated with Centennial Care 2.0 implementation.
2	SUD members' peer support utilization increased at Centennial Care 2.0 implementation before stabilizing. Peer support members had higher rates of continuity of pharmacotherapy for OUD and higher engagement and longer retention in AOD dependence treatment than non-peer support members. DiD trends between peer support members and non-peer support members varied by measure, providing contradictory results about the effects of Centennial Care 2.0 on peer support outcomes.
3	The number of BH facilities generally increased throughout Centennial Care 2.0, although the number and variety of services could not reliably be identified. ED utilization and SUD IP admissions did not change significantly for SUD members; however, IP hospitalization increased after Centennial Care 2.0 implementation. While certain components, such as non-ED OP, LTC, and SUD-other, had declining cost trends, there was insufficient evidence that overall SUD costs slowed, as increases in pharmacy and SUD-IMD expenses suggest that cost pressure was shifted rather than eliminated.
4	The percentage of members with preventive/ambulatory service exhibited a level increase and an increase in the annual trend following Centennial Care 2.0 implementation. The rate of members with fully delegated care coordination increased until the COVID-19 PHE, after which the rate declined, which may be due to incomplete HH enrollment data.
5	The number of naloxone kits distributed, the number of individuals who received overdose prevention training, and the number of providers utilizing the PMP increased after Centennial Care 2.0 implementation. The number of PHP and WSCC providers who offered MAT increased compared to the baseline period; however, the quarterly trend in the percentage of members with an OUD or AUD utilizing MAT decreased compared to the baseline period. Medicaid member overdose deaths increased at a higher rate than the statewide increase.

Note: AOD: alcohol and other drug; AUD: alcohol use disorder; BH: behavioral health; DiD: difference-in-differences; ED: emergency department; HH: health home; IMD: Institution for Mental Diseases; IP: inpatient; LTC: long-term care; MAT: medication-assisted treatment; OP: outpatient; OUD: opioid use disorder; PHP: Presbyterian Health Plan; PMP: prescription monitoring program; SUD: substance use disorder; WSCC: Western Sky Community Care

Aim Four Results

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 or other drug (AOD) dependence treatment.

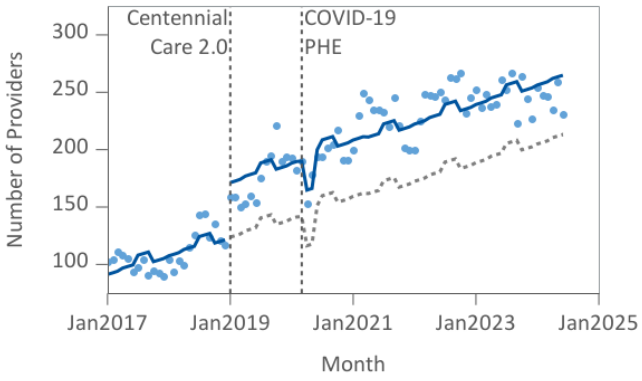
RQ 1: Did the number of BH and PH providers who screen beneficiaries for SUD increase?

Number of providers who provide SUD screening (Measure 37)

Figure 5-40 and Table 5-34 illustrate the model-based monthly average number of providers who offered SUD screening (blue line), and the projection had the baseline trend continued (grey dashed line). The number of providers increased by 1.4 providers per month prior to Centennial Care 2.0 (p=0.007). There was an increase of

47.5 providers upon Centennial Care 2.0 implementation (p<0.001), followed by an increase in the change in the trend by an average of 0.1 providers per month relative to the baseline trend (p=0.903).

Figure 5-40—Number of Providers Who Provided SUD Screening



Data Source: MMIS data were used in the analysis of Measure 37.

Table 5-34—Measure 37 ITS Results

Variable	Estimate	*p*-value
Intercept	91.3***	<0.001
Pre-Centennial Care 2.0 monthly trend	1.4**	0.007
Level change	47.5***	<0.001
Change in monthly trend	0.1	0.903

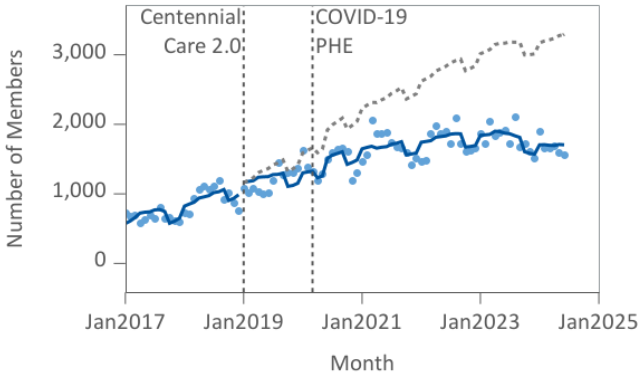
*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 37.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results.

RQ 2: Did the number of individuals screened for SUD increase?

Number of individuals screened for SUD (Measure 38)

Figure 5-41 and Table 5-35 illustrate the model-based monthly average number of members screened for SUD (blue line) and the projection had the baseline trend continued (grey dashed line). SUD screening increased by 25.6 members per month prior to Centennial Care 2.0 (p=0.024). The trend declined by an average of 24.6 members per month during Centennial Care 2.0 relative to the baseline trend (p=0.008).

Figure 5-41—Number of Individuals Screened for SUD



Data Source: MMIS data were used in the analysis of Measure 38.

Table 5-35—Measure 38 ITS Results

Variable	Estimate	*p*-value
Intercept	822.2**	0.001
Pre-Centennial Care 2.0 monthly trend	25.6**	0.024
Level change	7.3	0.953
Change in monthly trend	-24.6**	0.008

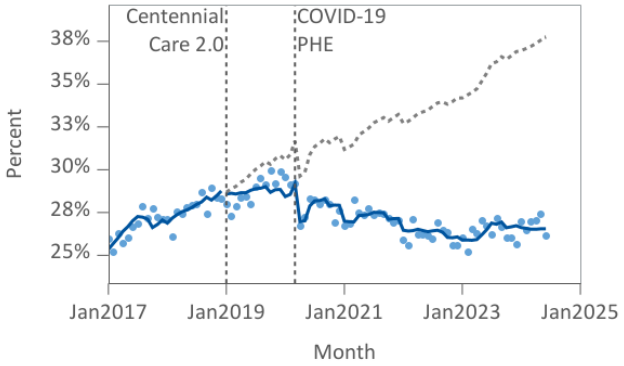
*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 38.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results.

RQ 3: Has the percentage of individuals with 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 39)

Figure 5-42 and Table 5-36 present the model-based monthly average rate of individuals with SUD who received an SUD service (blue line), and the projection had the baseline trend continued (grey dashed line). The percentage of members with SUD who received any SUD service increased by 0.3 percentage points per month prior to Centennial Care 2.0 (p<0.001). The monthly trend decreased by an average of 0.2 percentage points during Centennial Care 2.0 relative to the baseline trend (p<0.001). Although the overall trend declined during Centennial Care 2.0, rates increased slightly just before the COVID-19 PHE, from 28.0 percent in January 2019 to 29.2 percent in February 2020. This indicates that the monthly trend decrease may be partially attributed to the effects of the COVID-19 PHE.

Figure 5-42—Percentage of Individuals with an SUD Diagnosis Who Received Any SUD Service During the MY



Data Source: MMIS data were used in the analysis of Measure 39.

Table 5-36—Measure 39 ITS Results

Variable	Estimate	*p*-value
Intercept	20.3%***	<0.001
Pre-Centennial Care 2.0 monthly trend	0.3pp***	<0.001
Level change	-0.1pp	0.898
Change in monthly trend	-0.2pp***	<0.001

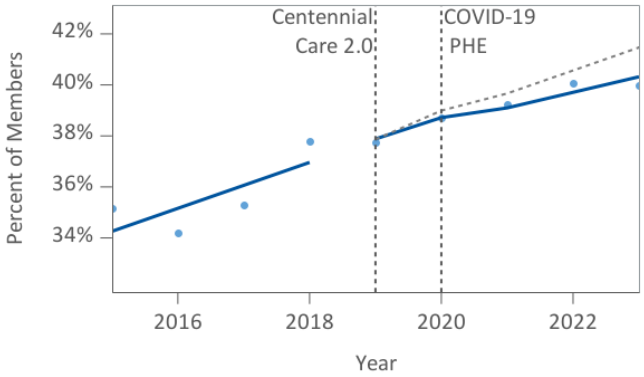
*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 39.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

RQ 4: Did the percentage of individuals who initiated AOD treatment increase?

Initiation of AOD abuse or dependence treatment (IET) (Measure 40)

Figure 5-43 and Table 5-37 present the percentage of members over age 13 years with a new AOD abuse or dependance episode who initiated treatment within 14 days, with the model-based average rate each year (blue line) and the projected rates had the baseline trend continued (grey dashed line). The percentage of members who initiated treatment increased by 0.9 percentage points per year prior to Centennial Care 2.0, followed by a non-significant decrease in the trend by 0.3 percentage points per year during Centennial Care 2.0 (p=0.390). While the percentage of individuals who initiated AOD treatment increased during the baseline and evaluation periods, the rate of increase was slightly and not statistically significantly lower during Centennial Care 2.0.

Figure 5-43—Percentage of Members with New AOD Episode Who Initiated Treatment



Data Source: MMIS data were used in the analysis of Measure 40.

Table 5-37—Measure 40 ITS Results

Variable	Estimate	*p*-value
Intercept	34.3%***	<0.001
Pre-Centennial Care 2.0 annual trend	0.9 pp**	0.044
Level change at implementation	0.0 pp	0.986
Change in annual trend	-0.3 pp	0.390

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 40.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

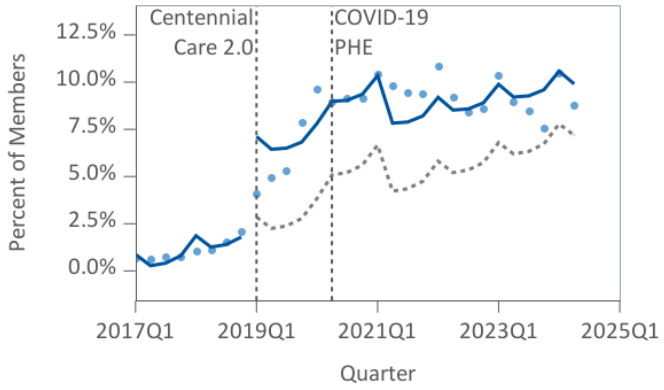
Hypothesis 2: The demonstration will increase peer support services which will result in more individuals engaging in and retained in AOD dependence treatment.

RQ 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 41)

An ITS analysis assessed changes in SUD peer support utilization rates during baseline and evaluation periods. Figure 5-44 and Table 5-38 present the model-based average quarterly rate (blue line) and the projection had the baseline trend continued (grey dashed line). SUD peer support increased by 0.2 percentage points per quarter prior to Centennial Care 2.0 (p=0.249). The average rate increased by 4.3 percentage points following implementation (p=0.002), then declined by an average of 0.1 percentage points per quarter relative to the baseline (p=0.733). These results demonstrate that Centennial Care 2.0 was associated with increased peer support; however, it did not significantly change trends of peer support utilization.

Figure 5-44—Percentage of Individuals with SUD Who Received Peer Support



Data Source: MMIS data were used in the analysis of Measure 41.

Table 5-38—Measure 41 ITS Results

Variable	Estimate	*p*-value
Intercept	0.9%	0.337
Pre-Centennial Care 2.0 quarterly trend	0.2pp	0.249
Level change at implementation	4.3pp**	0.002
Change in quarterly trend	-0.1pp	0.733

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 41.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

RQ 2: Does receiving peer support increase the percentage of individuals engaged in AOD treatment?

A DiD analysis examined whether peer support increased the number of members who engaged and remained in AOD treatment by comparing the change in rates among members who received peer support services (peer support members) to members who did not (non-peer support members). Baseline rates from 2018 were compared to evaluation period rates. Due to changing populations throughout Centennial Care 2.0, the number of baseline members varied. Members' baseline risk score was controlled for systematic differences between peer support and non-peer support members.

Engagement of AOD abuse or dependence treatment (IET) (Measure 42)

Table 5-39 displays the percentage of members who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit. Peer support members' engagement increased annually compared to the baseline, while non-peer support members' rates decreased. Peer support members engaged in treatment at higher rates than non-peer support members during Centennial Care 2.0; between 26.8 and 37.2 percent of peer support members engaged in AOD treatment, which was up to three times greater than non-peer support members' engagement. The DiD between peer and non-peer support members ranged from 7.1 percentage points in 2020 (p=0.024) to 18.6 percentage points in 2023 (p<0.001). Results indicate that Centennial Care 2.0 was associated with an increase in the number of individuals who engaged in AOD treatment.

Table 5-39—Percentage of Members Who Initiated Treatment and Who Had Two or More Additional AOD Services or MAT Within 34 Days of the Initiation Visit

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2019	Peer Support	23.5% N=231	32.9% N=692	9.3pp	11.2pp (0.002)
	Non-Peer Support	17.5% N=26,475	15.6% N=25,690	-1.8pp	
2020	Peer Support	23.0% N=231	27.4% N=861	4.3pp	7.1pp (0.024)
	Non-Peer Support	17.2% N=26,475	14.4% N=22,598	-2.8pp	
2021	Peer Support	23.4% N=231	26.8% N=1,384	3.4pp	7.3pp (0.010)
	Non-Peer Support	17.4% N=26,475	13.5% N=23,588	-3.9pp	
2022	Peer Support	23.2% N=231	35.7% N=1,309	12.5pp	17.2pp (<0.001)
	Non-Peer Support	17.3% N=26,475	12.6% N=22,764	-4.6pp	
2023	Peer Support	23.1% N=231	37.2% N=1,233	14.1pp	18.6pp (<0.001)
	Non-Peer Support	17.2% N=26,475	12.7% N=21,703	-4.5pp	

Data Source: MMIS data were used in the analysis of Measure 42.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. N represents the denominator count. pp: percentage point.

RQ 3: Does receiving peer support increase the treatment tenure for individuals receiving AOD treatment?

Average length of stay (LOS) (Measure 43)

Table 5-40 displays the average treatment tenure for peer support and non-peer support members. Peer support members participated in AOD abuse and dependence treatment longer than non-peer support members. Peer support members' baseline treatment averaged approximately 230 days, more than twice the length of non-peer support members' average treatment tenure. However, treatment tenure for peer support members decreased substantially throughout the demonstration period. Peer support member treatment tenure was approximately equal to the baseline in 2021 and by 2022, treatment tenure was 25 days shorter than the baseline. This change coincides with an increase in the number of peer support members from 135 baseline members to 1,545 members in 2023, indicating that the decrease in tenure may reflect more participating members with a shorter tenure. The average treatment tenure for peer support members increased by 109 days and decreased by 10 days for non-peer support members at Centennial Care 2.0 implementation, a 119-day difference (p<0.001). By 2023, treatment tenure for peer support members and non-peer support members decreased from the baseline by 24 and 23 days, respectively: a one-day difference (p=0.900). This indicates that while peer support members' treatment tenure was consistently longer than non-peer support members treatment tenure, the positive effect associated with Centennial Care 2.0 diminished over time.

Table 5-40—Average AOD Treatment Tenure (Days)

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
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=908	19	38 (<0.001)
	Non-Peer Support	93 N=12,285	75 N=10,988	-18	
2021	Peer Support	230 N=135	232 N=932	2	19 (0.100)
	Non-Peer Support	93 N=12,285	76 N=9,800	-17	
2022	Peer Support	230 N=135	204 N=1,376	-25	-5 (0.659)
	Non-Peer Support	93 N=12,285	72 N=8,433	-20	
2023	Peer Support	229 N=135	205 N=1,545	-24	-1 (0.900)
	Non-Peer Support	92 N=12,285	69 N=9,194	-23	

Data Source: MMIS data were used in the analysis of Measure 43.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. N represents the denominator count.

RQ 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 44)

Table 5-41 compares the percentage of peer support and non-peer support members with pharmacotherapy for OUD who had at least 180 days of continuous treatment. Non-peer support members' rates remained similar to the baseline during Centennial Care 2.0, with the largest difference being a 2.4 percentage point increase from the baseline in 2023. Peer support members' rates were relatively low during the baseline period and increased between 12.7 and 19.4 percentage points in the evaluation period. Peer support members' rates relative to non-peer support members increased between 10.3 and 22.9 percentage points between the baseline and evaluation period (p=0.116 and p=0.002, respectively). These results indicate that Centennial Care 2.0 was associated with an increase in the percentage of members with continuous pharmacotherapy for OUD in all but one year.

Table 5-41—Continuity of Pharmacotherapy for OUD

Year	Group	Regression Adjusted Rates			DiD Estimate (*p*-value)
		Time Period			
		Baseline	Evaluation Year	Change	
2019	Peer Support	20.9% N=50	38.6% N=330	17.7 pp	17.4pp (0.022)
	Non-Peer Support	27.3% N=10,967	27.6% N=11,703	0.3 pp	
2020	Peer Support	19.1% N=50	41.6% N=1,947	22.5 pp	22.9pp (0.002)
	Non-Peer Support	25.9% N=10,967	25.5% N=10,526	-0.5 pp	
2021	Peer Support	18.8% N=50	38.2% N=3,635	19.4 pp	19.8pp (0.005)
	Non-Peer Support	25.6% N=10,967	25.2% N=9,016	-0.4 pp	
2022	Peer Support	19.1% N=50	34.6% N=4,014	15.5 pp	15.4pp (0.024)
	Non-Peer Support	25.9% N=10,967	26.0% N=8,799	0.1 pp	
2023	Peer Support	19.1% N=50	31.9% N=4,195	12.7 pp	10.3pp (0.116)
	Non-Peer Support	25.9% N=10,967	28.3% N=8,694	2.4 pp	

Data Source: MMIS data were used in the analysis of Measure 44.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. N represents the denominator count. pp: percentage point.

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 (IP) hospitalization and SUD IP readmissions.

RQ 1: Has the continuum of services available for individuals with SUD expanded in terms of which services are available?

Continuum of services available (Measure 45)

Measure 45 examines the continuum of services available to SUD members. MCO data were limited to the Centennial Care 2.0 period, restricting the ability to compare pre- and post-implementation trends.[5-29] The data provided demonstrated trends in the continuum of care for members with a SUD from Q4 2021 to Q2 2024. Table 5-42 presents the continuum by facility type, and Figure 5-45 through Figure 5-51 provide MCO-specific visualizations.

[5-29] MCO data provided to support Measure 45 did not align with the State's records on the number of reported providers per facility type. This discrepancy will be addressed in the forthcoming Interim Evaluation Report for Turquoise Care.

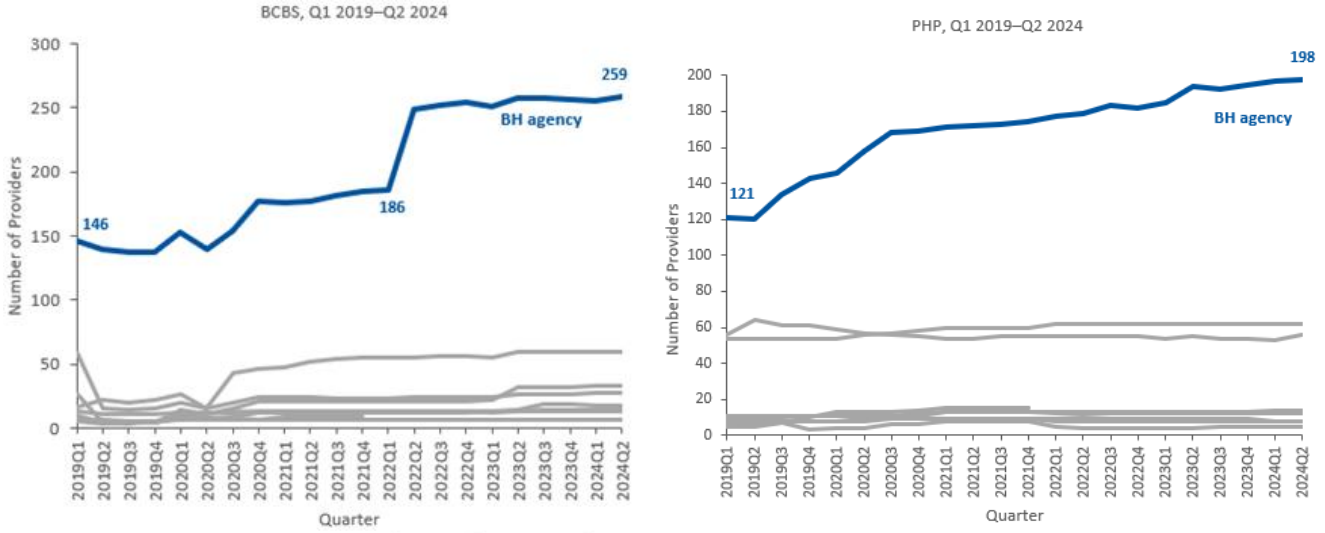
Table 5-42—Number of Providers Reported Across All MCOS, Q4 2021 and Q2 2024

Facility Type	Number of Providers Q4 2021	Number of Providers Q2 2024
ARTC–Adult, SUD	15	32
ARTC–Juvenile, BH	24	23
BH Agency	553	757
Community Mental Health Center	36	45
CSA	97	99
FQHC/RHC Providing BH Services	250	259
Hospital, Psychiatric	28	35
Hospital, Psychiatric Unit in General Hospital	31	34
IHS or 638 Tribal Facility Providing BH Services	116	123
OTC/Methadone Clinic	40	42
Psychiatric Emergency Services	0	—
Residential Non-Joint Commission Group Home	0	—
Residential Treatment Center, Joint Commission Certified	17	26
Residential Treatment Center, Non-Joint Commission Certified	9	9
RHC	0	—
School Based Health Services	0	—
Treatment Foster Care I	26	24
Treatment Foster Care II	9	—

Data Source: MCO Reports—Continuum of Services data were used in the analysis of Measure 45.
Note: — represents that no data were received. ARTC: accredited residential center; BH: behavioral health; CSA: core service agency; FQHC: federally qualified health center; IHS: Indian Health Service; OTC: over the counter; RHC: rural health clinic; SUD: substance use disorder

Figure 5-45 illustrates the number of BCBS and PHP BH agency providers. BCBS reported a 77.4 percent increase from 146 providers in Q1 2019 to 259 in Q2 2024. PHP providers increased by 63.6 percent, from 121 providers in Q1 2019 to 198 in Q2 2024.

Figure 5-45—Number of BH Agency Providers, BCBS and PHP

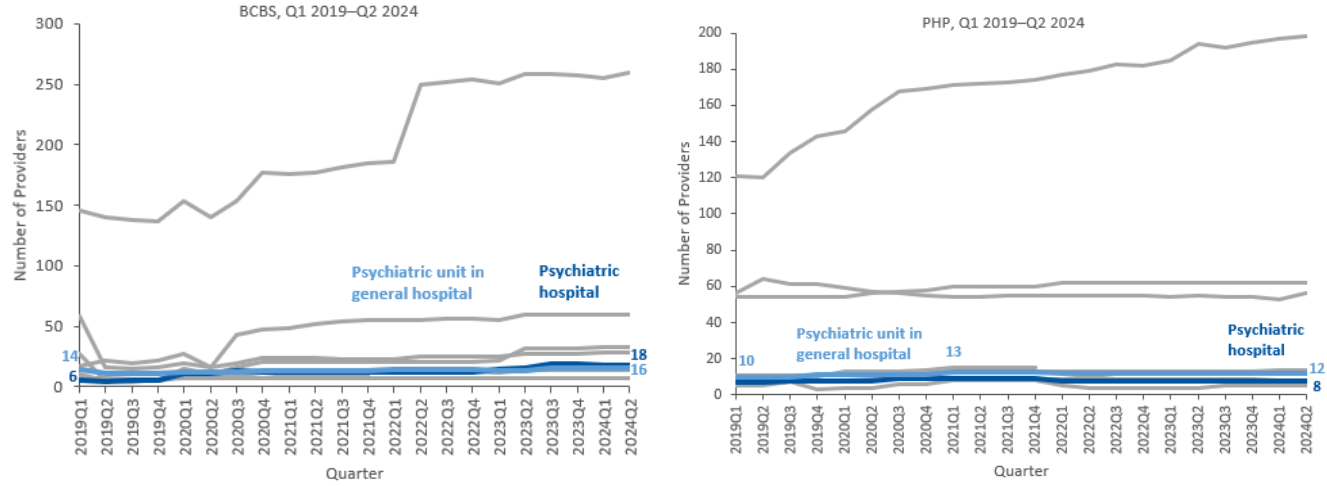


Data Source: MCO Reports - Continuum of Services data were used in the analysis of Measure 45.

Data Source: MCO Reports - Continuum of Services data were used in the analysis of Measure 45.

Figure 5-46 illustrates that BCBS reported 14 providers in psychiatric units in a general hospital setting in Q1 2019, which increased slightly to 16 providers in Q2 2024. BCBS reported six psychiatric unit providers in Q1 2019 and 18 providers in Q2 2024. PHP had 10 providers in psychiatric units in a general hospital setting in Q1 2019 and 12 in Q2 2024. PHP had seven psychiatric hospital providers in Q1 2019 and eight in Q2 2024.

Figure 5-46—Number of Psychiatric Unit Providers, BCBS and PHP

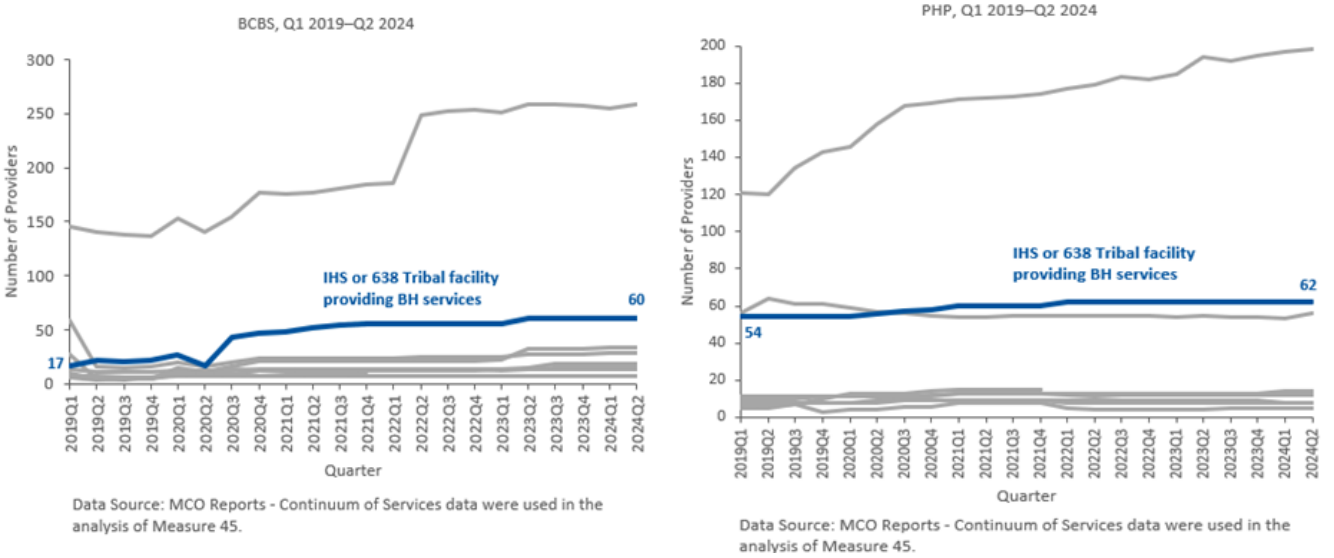


Data Source: MCO Reports - Continuum of Services data were used in the analysis of Measure 45.

Data Source: MCO Reports - Continuum of Services data were used in the analysis of Measure 45.

Figure 5-47 illustrates providers identified in Indian Health Service (IHS) or 638 Tribal facilities who provided BH services. In Q1 2019, BCBS reported 17 providers, which increased to 60 providers in Q2 2024. PHP identified 54 providers in Q1 2019 and 62 providers in Q2 2024.

Figure 5-47—Number of Tribal Facility Providers, BCBS and PHP

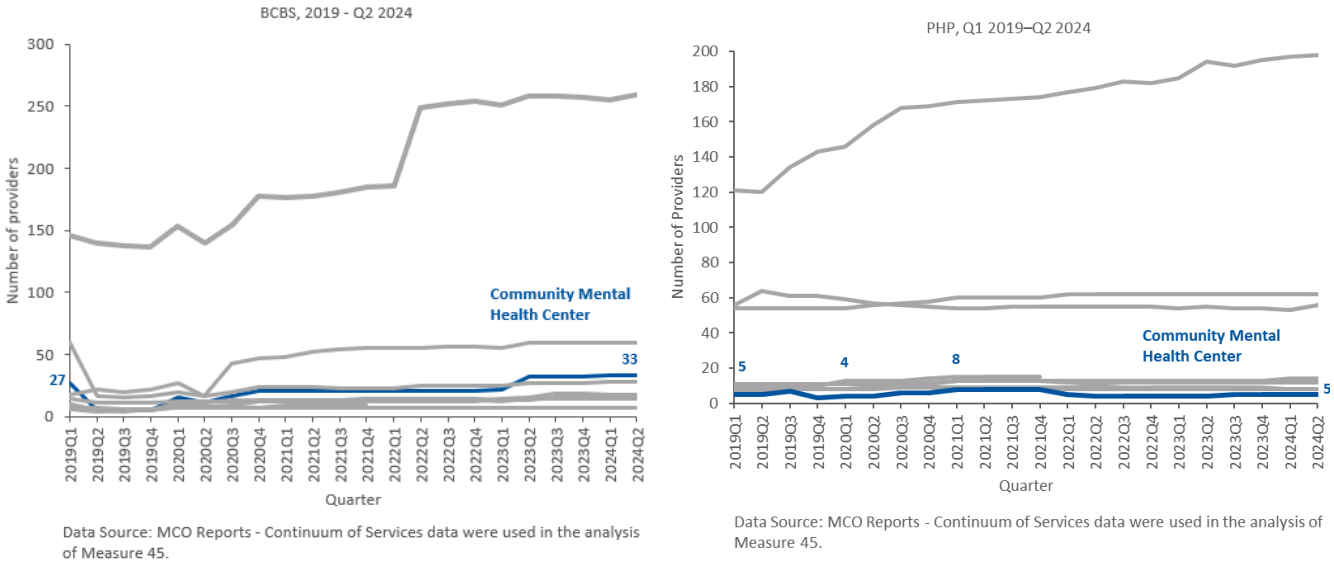


Data Source: MCO Reports - Continuum of Services data were used in the analysis of Measure 45.

Data Source: MCO Reports - Continuum of Services data were used in the analysis of Measure 45.

Figure 5-48 presents BCBS and PHP providers identified as community mental health center providers. BCBS reported an increase from 27 providers in Q1 2019 to 33 providers in Q2 2024. PHP reported five providers in Q1 2019 and Q2 2024.

Figure 5-48—Number of Community Mental Health Center Providers, BCBS and PHP

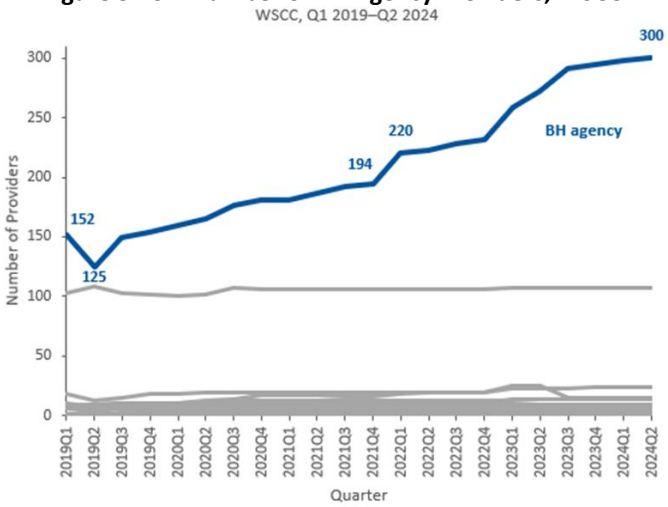


Data Source: MCO Reports - Continuum of Services data were used in the analysis of Measure 45.

Data Source: MCO Reports - Continuum of Services data were used in the analysis of Measure 45.

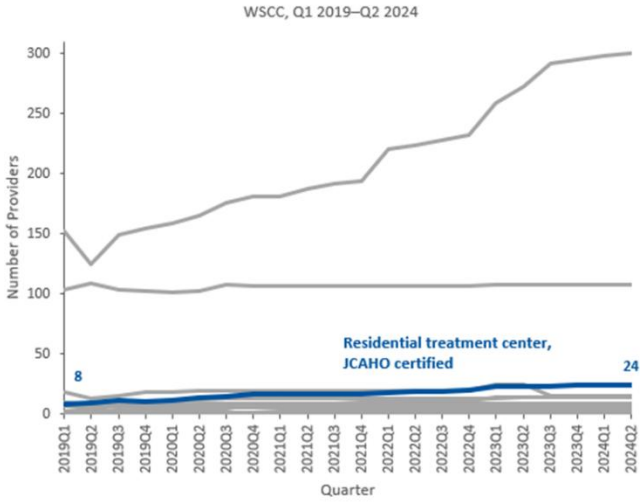
Figure 5-49 and Figure 5-50 present WSCC's BH and residential treatment center providers. In Q1 2019, WSCC had 152 BH providers, nearly doubling to 300 providers in Q2 2024. In Q1 2019, WSCC identified eight providers in a residential treatment center, which tripled to 24 providers in Q2 2024.

Figure 5-49—Number of BH Agency Providers, WSCC



Data Source: MCO Reports - Continuum of Services data were used in the analysis of Measure 45.

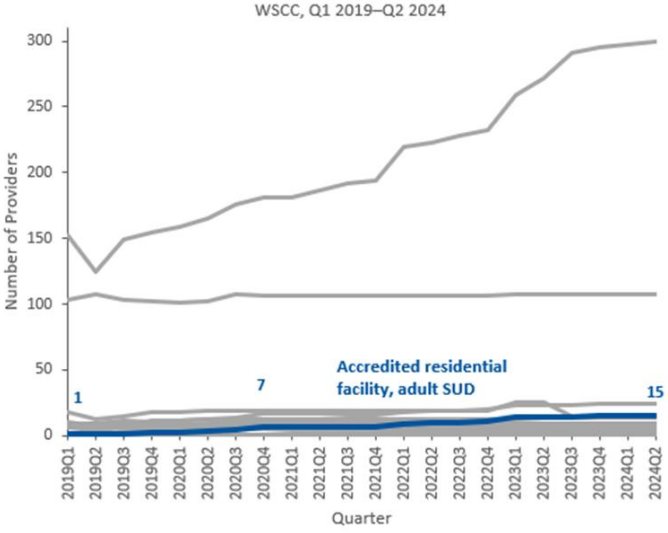
Figure 5-50—Number of Residential Treatment Center, Joint Commission (JCAHO) Certified Providers, WSCC



Data Source: MCO Reports - Continuum of Services data were used in the analysis of Measure 45.

Figure 5-51 shows the number of WSCC providers associated with accredited residential facilities for adults with SUD. A single provider in Q1 2019 increased to 15 providers in Q2 2024.

Figure 5-51—Number of ARTCs, Adult SUD Providers, WSCC



Data Source: MCO Reports - Continuum of Services data were used in the analysis of Measure 45.

RQ 2: Has capacity for ambulatory SUD services increased?

Number of providers and capacity for ambulatory SUD services (Measure 46)

Measure 46 estimated the projected capacity of SUD providers during Centennial Care 2.0. BCBS and PHP supplied SUD provider lists between 2018 and Q2 2024. WSCC supplied data beginning in 2019. An ITS analysis, as outlined in the Evaluation Design, was not feasible due to one year of available baseline data. The average provider Medicaid panel size in 2018 was calculated and used to estimate maximum Medicaid panel size for new SUD providers. The actual panel sizes each year were analyzed and compared them to the projection. Existing providers (i.e., those who provided SUD services in 2018) and new providers (i.e., those who did not provide SUD services in 2018) were compared seperately.[5-30]

Table 5-43 shows that existing SUD providers served an average of 191 members in 2018, increasing to 214 members in 2019. These results suggest that providers accepted more SUD members than the year prior; however, the 2019 average new provider panel size was only 72 members. Although the cause of the discrepancy is unclear, it suggests that added capacity of new SUD providers did not correspond to a proportional increase in the number of members served.[5-31] The average existing provider panel size remained relatively steady (around 200 members) until a sharp decline in 2022 to an average panel size of 97 members. This decline was most likely due to a reporting problem rather than an actual decline in SUD providers or capacity. BCBS had the largest proportion of operating SUD providers, reporting 1,249 and 1,365 SUD providers in 2022 and 2023, respectively. However, BCBS reported 7,997 SUD providers in 2021, and in Q1 and Q2 2024 BCBS reported over 9,000 SUD providers.

5-30 There may be differences between actual and projected panel sizes for several reasons. Lower-than-projected new provider panel sizes may be a result of provider reluctance to take on members, saturation of the Medicaid market, or providers operating in geographic areas with few 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 members.

5-31 This discrepancy may be a result of new providers coming from MCOs that did not operate in 2019, switching accepted MCOs.

BCBS providers also had higher average panel sizes than PHP or WSCC providers, suggesting that missing BCBS provider data would lead to lower average panel sizes.

Table 5-43—Number of Providers and Capacity for Ambulatory SUD Services, Existing and New Providers

Year	Existing Providers			New Providers		
	Number of Providers	Average Panel Size	Percent of Projected Capacity	Number of Providers	Average Panel Size	Percent of Projected Capacity
2018	5,381	191	N/A	N/A	N/A	N/A
2019	5,035	214	112%	3,965	72	38%
2020	5,311	184	97%	4,350	84	44%
2021	4,957	200	105%	5,826	95	50%
2022*	2,145	97	51%	6,126	70	37%
2023*	2,072	88	46%	7,447	64	34%
2024	3,575	71	37%	11,416	56	29%

Data Source: MCO SUD provider reports and MMIS data were used in the analysis of Measure 46.
*Data from 2022 and 2023 are likely incomplete due to reporting inconsistencies.
Note: Annual measurement periods were used for all years except 2024, which represents data through June 2024, the last full month of Centennial Care 2.0.

BCBS and PHP providers who delivered SUD services to members in 2018 maintained through 2021; however, SUD providers not contracted with BCBS or PHP in 2018 had a much smaller panel size beginning in 2019. Due to incomplete data prior to Centennial Care 2.0, it is unclear if the smaller panel size among providers not contracted with BCBS or PHP in 2018 would be expected if these providers had similarly small panel sizes in 2018 under a plan that had left Centennial Care 2.0 in 2019. Table 5-44 demonstrates that, following the sharp declines in 2022 and 2023, there were 14,991 providers in 2024, 11,416 of which were new providers with an average panel size of 60 members. This reflects an increase in total SUD providers. The low average panel size is likely a result of partial 2024 data.

Table 5-44—Number of Providers and Capacity for Ambulatory SUD Services, All Providers

Year	All Providers		
	Number of Providers	Average Panel Size	Percent of Projected Capacity
2019	9,000	152	79%
2020	9,661	139	73%
2021	10,783	144	75%
2022*	8,271	77	40%
2023*	9,519	69	36%
2024	14,991	60	31%

Data Source: MCO SUD provider reports and MMIS data were used in the analysis of Measure 46.
*Data from 2022 and 2023 are likely incomplete due to reporting inconsistencies.
Note: Annual measurement periods were used for all years except 2024, which represents data through June 2024, the last full month of Centennial Care 2.0.

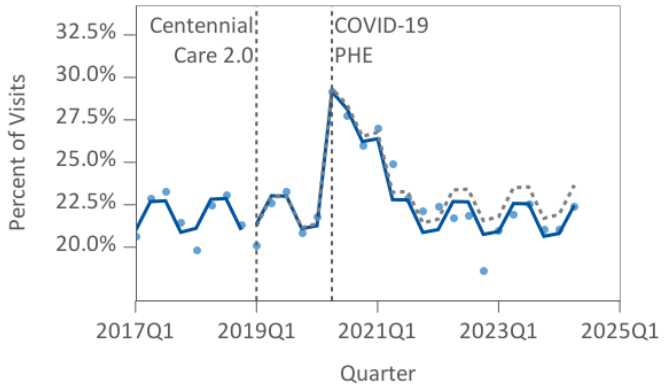
RQ 3: Has the utilization of EDs by individuals with SUD decreased?

An ITS analysis controlling for seasonality and the COVID-19 PHE assessed Measure 47 through Measure 50 to determine if Centennial Care 2.0 improved access to a comprehensive continuum of SUD care. These measures assessed changes in ED utilization, IP hospitalization, and IP readmission rates for SUD members between the baseline and evaluation periods. Full regression results are provided in Appendix A, Attachments, Supplemental Results.

Percentage of ED visits of individuals with SUD diagnoses (Measure 47)

Figure 5-52 and Table 5-45 present the quarterly model-based average rates of ED visits by SUD members (blue line) and the projected rates had the baseline trend continued (grey dashed line). ED visits by SUD members remained stable at approximately 21 percent prior to Centennial Care 2.0, with a slight increase in the trend of 0.03 percentage points per quarter (p=0.829). Upon Centennial Care 2.0 implementation, there was a small level change of 0.1 percentage points (p=0.890), followed by a slight decline in the trend by an average of 0.1 percentage points per quarter compared to the baseline trend (p=0.701). Neither of these changes were statistically significant. The percentage of ED visits increased in Q1 2020, coinciding with the COVID-19 PHE. Results indicate that ED visits by SUD members changed minimally as a result of Centennial Care 2.0.

Figure 5-52—Percentage of ED Visits by Individuals with SUD



Data Source: MMIS data were used in the analysis of Measure 47.

Table 5-45—Measure 47 ITS Results

Variable	Estimate	*p*-value
Intercept	21.0%***	<0.001
Pre-Centennial Care 2.0 quarterly trend	0.03pp	0.829
Level change at implementation	0.1pp	0.890
Change in quarterly trend	-0.1pp	0.701

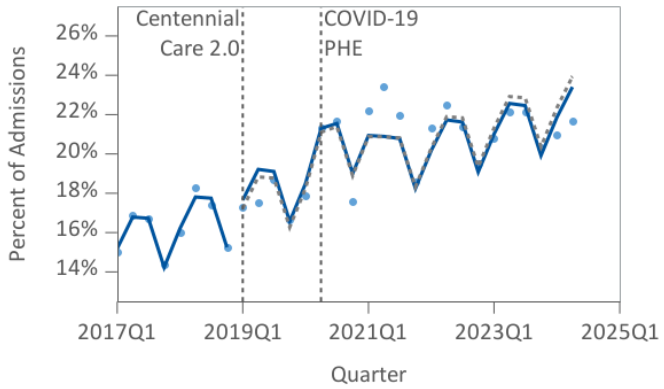
*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 47.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

RQ 4: Has the utilization of IP hospital settings for SUD related treatment decreased?

Percentage of IP admissions for SUD related treatment (Measure 48)

Figure 5-53 and Table 5-46 present the quarterly model-based average rates of IP admissions for SUD-related treatment (blue line) and the projected rates had the baseline trend continued (grey dashed line). SUD-related IP admissions increased by an average of 0.26 percentage points per quarter prior to Centennial Care 2.0 (p=0.133). Upon Centennial Care 2.0 implementation, there was a level change of 0.4 percentage points (p=0.658), followed by a slight decrease in the quarterly trend by an average of 0.05 percentage points per quarter compared to the baseline trend (p=0.786). Centennial Care 2.0 trends aligned with the baseline projection, indicating that Centennial Care 2.0 did not decrease the percentage of IP admissions for SUD-related treatment.

Figure 5-53—Percentage of IP Admissions for SUD-Related Treatment



Data Source: MMIS data were used in the analysis of Measure 48.

Table 5-46—Measure 48 ITS Results

Variable	Estimate	*p*-value
Intercept	15.2%***	<0.001
Pre-Centennial Care 2.0 quarterly trend	0.26pp	0.133
Level change at implementation	0.4pp	0.658
Change in quarterly trend	-0.05pp	0.786

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 48.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

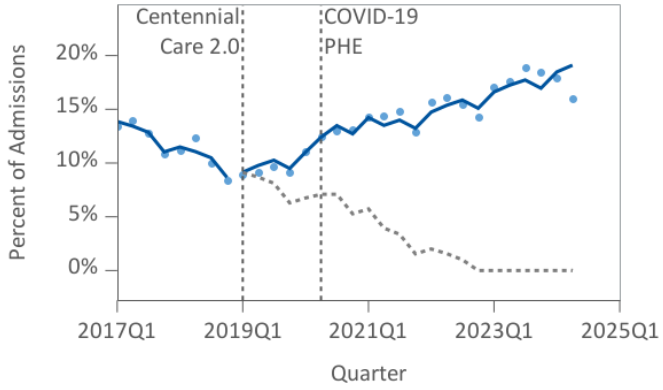
RQ 5: Has the utilization of IP hospital settings for withdrawal management decreased?

Percentage of IP admissions of individuals with SUD for withdrawal management (Measure 49)

Figure 5-54 and Table 5-47 present the quarterly model-based average rates of IP admissions of SUD members admitted for withdrawal management (blue line) and the projected rates had the baseline trend continued (grey dashed line). SUD IP admissions for withdrawal management decreased by 0.6 percentage points per quarter prior to Centennial Care 2.0 (p=0.002). Upon Centennial Care 2.0 implementation, there was a change of 0.02 percentage points (p=0.980), followed by a statistically significant increase in the trend by an average of 1.1

percentage points per quarter relative to the baseline trend (p<0.001). The results indicate that Centennial Care 2.0 did not decrease IP withdrawal management admissions for SUD members.

Figure 5-54—Percentage of IP Admissions for Individuals with an SUD for Withdrawal Management



Data Source: MMIS data were used in the analysis of Measure 49.

Table 5-47—Measure 49 ITS Results

Variable	Estimate	*p*-value
Intercept	13.9%***	<0.001
Pre-Centennial Care 2.0 quarterly trend	-0.6pp**	0.002
Level change at implementation	0.02pp	0.980
Change in quarterly trend	1.1pp***	<0.001

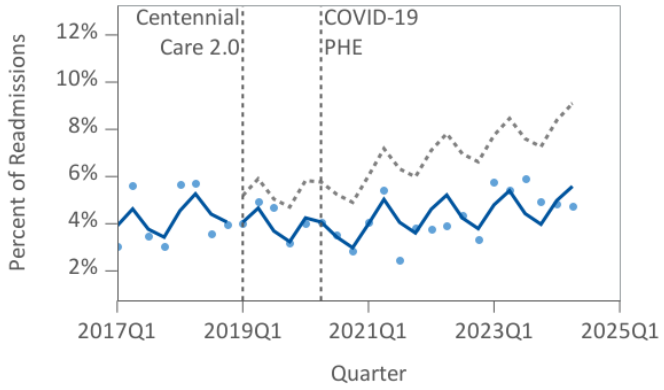
*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 49.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

RQ 6: Have IP SUD readmissions decreased for individuals with SUD diagnoses?

7- and 30-day IP and residential SUD readmission rates (Measure 50)

Figure 5-55, Table 5-48, Figure 5-56, and Table 5-49 present the quarterly model-based average rates of IP and residential readmissions for discharged SUD members (blue line) and the projected rates had the baseline trend continued (grey dashed line). There was a slight increase in the rate of 7- and 30-day readmissions prior to Centennial Care 2.0. Upon Centennial Care 2.0 implementation, the rate of readmissions declined by approximately 1 to 2 percentage points, and the trend declined slightly relative to the baseline trend; however, these changes were not statistically significant.

Figure 5-55—7-Day IP and Residential SUD Readmission Rates



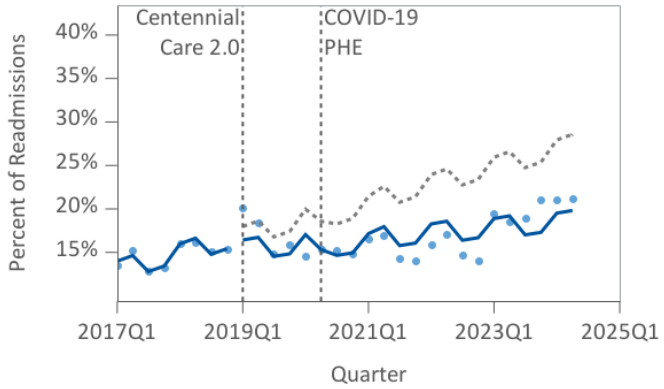
Data Source: MMIS data were used in the analysis of Measure 50.

Table 5-48—Measure 50 7-Day ITS Results

Variable	Estimate	*p*-value
Intercept	3.9%***	<0.001
Pre-Centennial Care 2.0 quarterly trend	0.2pp	0.258
Level change at implementation	-1.1pp	0.175
Change in quarterly trend	-0.1pp	0.427

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 50.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

Figure 5-56—30-Day IP and Residential SUD Readmission Rates



Data Source: MMIS data were used in the analysis of Measure 50.

Table 5-49—Measure 50: 30-Day ITS Results

Variable	Estimate	*p*-value
Intercept	14.0%***	<0.001
Pre-Centennial Care 2.0 quarterly trend	0.5pp	0.112
Level change at implementation	-1.5pp	0.388
Change in quarterly trend	-0.3pp	0.276

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 50.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

RQ 7: Have increasing trends in total cost of care been slowed for individuals with SUD diagnoses?

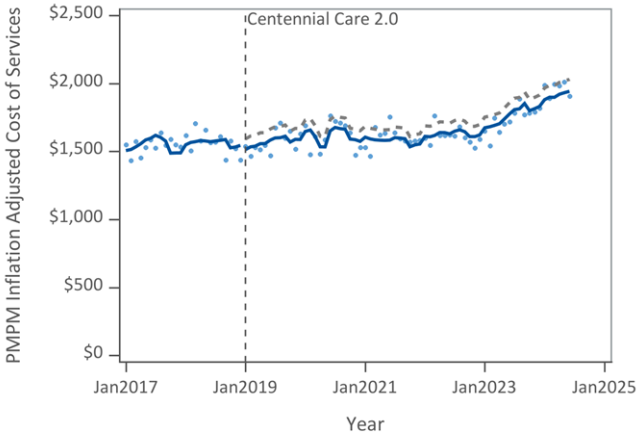
The independent evaluator adhered to the guidelines outlined in the CMS SMI/SED Evaluation Guidance, Appendix C, to evaluate the total cost of SUD, identifying SUD members and calculating associated costs.[5-32] An ITS analysis assessed the difference in PMPM cost and controlled for age, gender, disability status, seasonality indicator, and COVID-19 PHE indicator variables. A GLM with Gamma family and log link was constructed to fit the expenditure amount. SUD cost results are presented as percentage changes in costs.

Total and PMPM cost (medical, behavioral and pharmacy) for members with SUD diagnosis (Measure 51)

Figure 5-57 and Table 5-50 illustrate the model-based average cost per month (blue line) and the projected cost had the baseline trend continued (grey dashed line). Costs grew by 1.01 percent per month prior to Centennial Care 2.0 (p<0.001). Total costs decreased by 4.94 percent upon Centennial Care 2.0 implementation; however, this decrease was not statistically significant (p=0.127). Overall, there was insufficient evidence to support that increasing trends of total SUD costs for SUD members were slowed.

5-32 Centers for Medicare & Medicaid Services. Appendix C: Approaches to Analyzing Costs Associated with Section 1115 Demonstrations for Beneficiaries with SMI/SED or SUD. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf. Accessed on: Aug 12, 2025.

Figure 5-57—PMPM Cost for Members with SUD Diagnosis



Data Source: MMIS data were used in the analysis of Measure 51.

Table 5-50—Measure 51 ITS Results

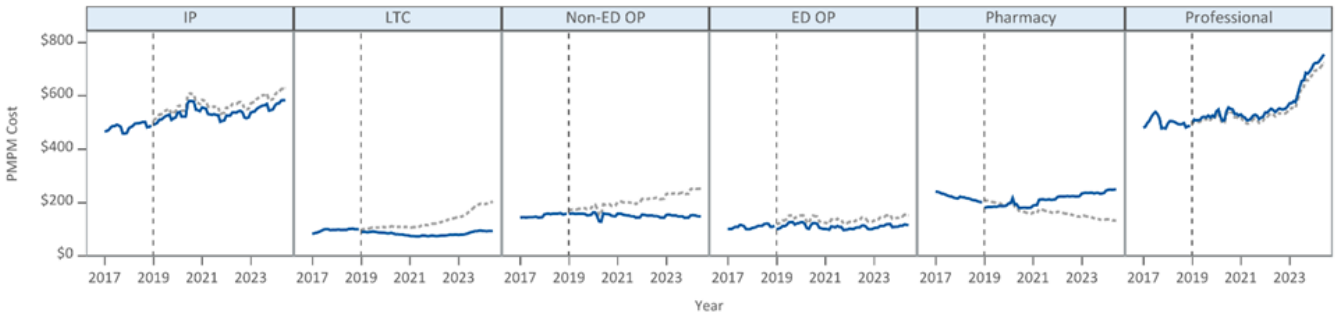
Variable	Percent Change	*p*-value
Baseline monthly trend	1.01%***	<0.001
Level change at implementation	-4.94%	0.127
Change in monthly trend	0.01%	0.954

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 51.
Note: PMPM costs were inflation adjusted and indexed to June 2024. Full model results are presented in Appendix A, Attachments, Supplemental Results.

Total and PMPM costs (medical, behavioral and pharmacy) for members with SUD diagnosis by SUD source of care (Measure 52)

Figure 5-58 and Table 5-51 present the model-based monthly average PMPM cost (blue line) and the projected cost had the baseline trend continued (grey dashed line). The analyses identified that cost trends declined relative to baseline projects for certain sources of care, including LTC and non-ED OP; however, the rising pharmacy and professional costs resulted in shifting cost pressures.

Figure 5-58—PMPM Costs Among SUD Members by Source of Care



Data source: MMIS data were used in the analysis of Measure 52.

Table 5-51—Measure 52 ITS Results

Variable	Estimate					
	IP	LTC	Non-ED OP	ED OP	Pharmacy	Professional
Baseline monthly trend	0.85%** (0.043)	1.43%*** (<0.001)	0.86%** (0.008)	1.95%*** (<0.001)	-0.59% (0.130)	1.44%*** (<0.001)
Level change at implementation	-3.50% (0.525)	-9.52%** (0.005)	-7.16%* (0.088)	-15.68%*** (<0.001)	-13.25%** (0.007)	1.33% (0.704)
Change in monthly trend	-0.06% (0.848)	-1.06%*** (<0.001)	-0.71%** (0.002)	-0.16% (0.513)	1.22%*** (<0.001)	0.04% (0.810)

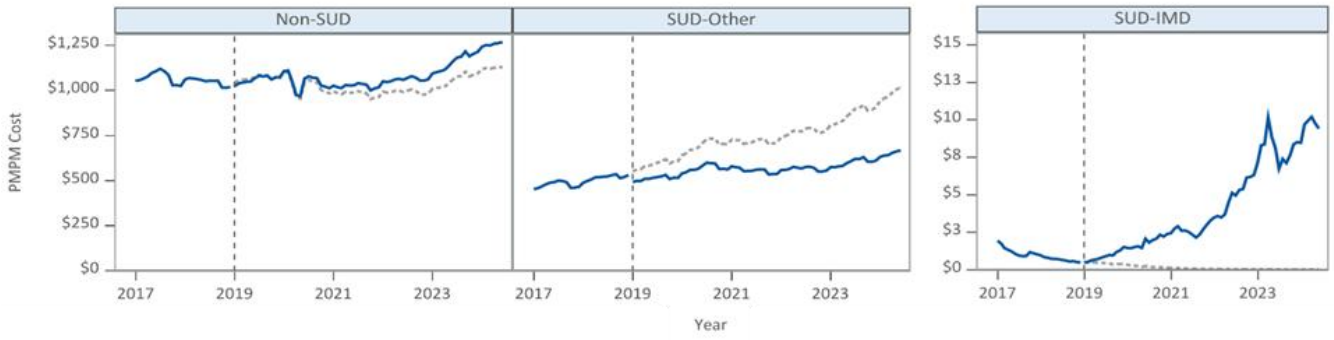
*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 52.
Note: PMPM costs were inflation adjusted and indexed to June 2024. Full model results are presented in Appendix A, Attachments, Supplemental Results.

RQ 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 SUD diagnosis (Measure 53)

Figure 5-59 and Table 5-52 present the model-based monthly average PMPM cost (blue line) and the projected cost had the baseline trend continued (grey dashed line). The analyses identified that SUD-other cost trends declined relative to the projected baseline trend; however, cost pressure remained driven by other service categories. SUD costs incurred in an Institution for Mental Diseases (IMD) increased substantially throughout the demonstration period, although these costs remained comparatively low, reaching approximately $10 PMPM in 2023.

Figure 5-59—SUD Costs Among SUD Members



Data source: MMIS data were used in the analysis of Measure 53.

Table 5-52—Measure 53 ITS Results

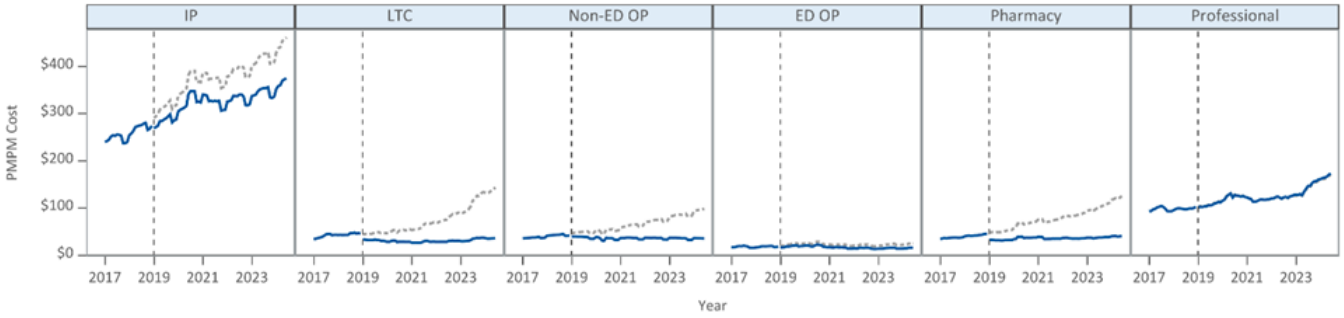
Variable	Estimate		
	Non-SUD	SUD-Other	SUD-IMD
Baseline monthly trend	0.78%**	1.54%***	-7.24%***
	(0.003)	(<0.001)	(<0.001)
Level change at implementation	-1.88%	-10.80%**	-4.59%
	(0.585)	(0.003)	(0.858)
Change in monthly trend	0.21%	-0.48%**	13.85%***
	(0.254)	(0.019)	(<0.001)

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 53.
Note: PMPM costs were inflation adjusted and indexed to June 2024. Full model results are presented in Appendix A, Attachments, Supplemental Results.

Total and PMPM cost for SUD services by type of care (IP, OP, pharmacy, etc.) (Measure 54)

Figure 5-60 and Table 5-53 present the model-based monthly average PMPM cost (blue line) and the projected cost had the baseline trend continued (grey dashed line). The analyses identified that the trend in SUD costs in the LTC, non-ED OP, and pharmacy settings declined during Centennial Care 2.0 relative to the projected baseline trend.

Figure 5-60—PMPM Costs for SUD Services Among SUD Members by Type of Care



Data source: MMIS data were used in the analysis of Measure 54.

Table 5-53—Measure 54 ITS Results

Variable	Estimate					
	IP	LTC	Non-ED OP	ED OP	Pharmacy	Professional
Baseline monthly trend	1.21%**	1.48%***	0.99%**	2.46%***	1.80%***	1.92%***
	(0.004)	(<0.001)	(0.006)	(<0.001)	(<0.001)	(<0.001)
Level change at implementation	-7.52%	-24.27%***	-15.18% ***	-15.44%**	-31.95%***	-1.38%
	(0.155)	(<0.001)	(<0.001)	(0.007)	(<0.001)	(0.786)
Change in monthly trend	-0.20%	-1.68%***	-1.30%***	-0.44%	-1.13%***	0.05%
	(0.482)	(<0.001)	(<0.001)	(0.175)	(<0.001)	(0.858)

*p<0.1, **p<0.05, ***p<0.001
Data Source: MMIS data were used in the analysis of Measure 54.
Note: PMPM costs were inflation-adjusted and indexed to June 2024. Full model results are presented in Appendix A, Attachments, Supplemental Results.

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 PH services.

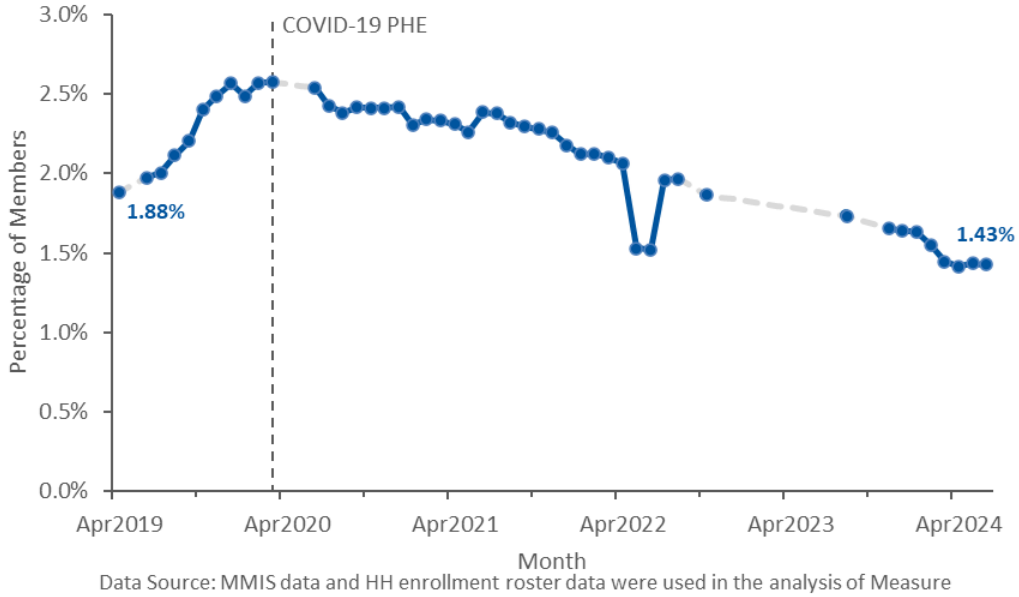
RQ 1: Has the percentage of individuals diagnosed with SUD receiving care coordination increased?

Percentage of individuals diagnosed with SUD receiving care coordination (Measure 55)

No HH enrollment data for January 2019–March 2019, May 2019, April 2020–May 2020, September 2022, November 2022–July 2023, and September 2023–October 2023 were provided. As such, only members who received care coordination beginning in April 2019 were assessed, and an ITS analysis, as outlined in the Evaluation Design, or a pre-test/post-test analysis were not conducted due to these limitations. Results presented cannot support or oppose the hypothesis that Centennial Care 2.0 will increase the number of members who received fully delegated care coordination.

Figure 5-61 illustrates the percentage of members with SUD who received care coordination. Care coordination steadily increased to 2.57 percent during the COVID-19 PHE, after which rates declined to 2.07 percent by April 2022. By June 2024, care coordination fell to 1.43 percent. The low rates in May and June 2022 may be attributable to incomplete HH enrollment data, rather than an actual enrollment decrease.

Figure 5-61—Percentage of Members with SUD Who Received Care Coordination



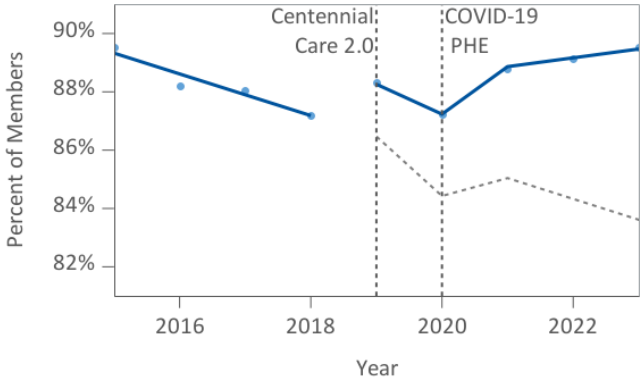
Data Source: MMIS data and HH enrollment roster data were used in the analysis of Measure 55.
Note: The grey dashes indicate months where HH enrollment data were not received.

RQ 2: Has the number of individuals with SUD receiving preventive healthcare increased?

Percentage of individuals with SUD receiving preventive/ambulatory health services (AAP) (Measure 56)

Figure 5-62 and Table 5-54 present the percentage of SUD members who received at least one ambulatory or preventive service out of all eligible SUD members, with the model-based annual average rate (blue line) and the projected rates had the baseline trend continued (grey dashed line). The rate decreased by 0.7 percentage points per year prior to Centennial Care 2.0 (p=0.003). There was a level increase of 1.8 percentage points at Centennial Care 2.0 implementation and an increase in the annual rate of 1.0 percentage points per year relative to the baseline trend (p=0.009 and p=0.002, respectively). These findings suggest that Centennial Care 2.0 mitigated a declining trend in the rate of preventive/ambulatory services among members with an SUD.

Figure 5-62—Percentage of SUD Members Who Received Preventive/Ambulatory Health Services



Data Source: MMIS data were used in the analysis of Measure 56

Table 5-54—Measure 56 ITS Results

Variable	Estimate	*p*-value
Intercept	89.3%***	<0.001
Pre-Centennial Care 2.0 annual trend	-0.7 pp**	0.003
Level change at implementation	1.8 pp**	0.009
Change in annual trend	1.0 pp**	0.002

*p<0.1, **p<0.05, ***p<0.001
Data source: MMIS data were used in the analysis of Measure 56.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

Hypothesis 5: The demonstration will increase use of naloxone, MAT, and enhanced monitoring and reporting of opioid prescriptions through the prescription monitoring program (PMP), which will result in fewer overdose deaths due to opioid use.

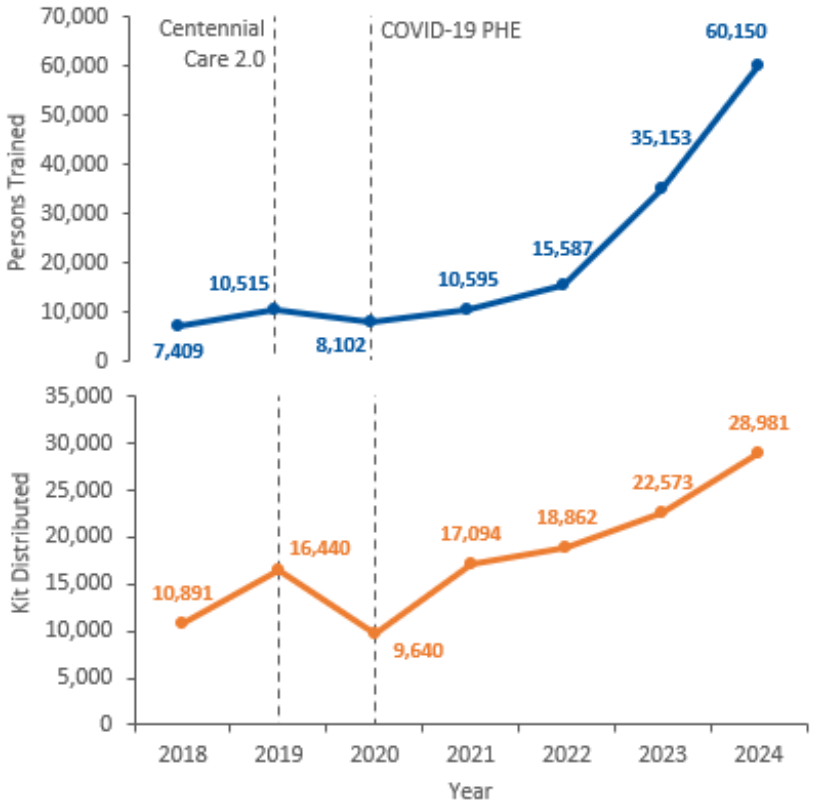
RQ 1: Has there been an expansion of naloxone distribution and training?

Number of naloxone training and kit distributions (Measure 57)

Figure 5-63 shows the number of individuals who received overdose prevention training, and the number of naloxone kits distributed from 2018 to 2024. The number of individuals who received naloxone training increased

from 7,409 in 2018 to 60,150 in 2024, while the number of naloxone kits distributed increased from 10,891 kits to 28,981 kits over the same period. These increases may be conflated with the effects of a 2019 policy requiring providers to prescribe an opioid antagonist with each opioid prescription.[5-33]

Figure 5-63—Naloxone Kits Distributed/Individuals Trained



Data Source: New Mexico Health Care Authority/Behavioral Health Services Division, Office of Substance Abuse Prevention, Narcan Master List (2018–2022), Distribution & Training Summary (2023–2024), and State Opioid Response Quarterly Performance and Accountability Reporting (2023–2024) data were used in the analysis of Measure 57.

RQ 2: Has the number of MAT providers increased?

Number of practitioners prescribing MAT (Measure 58)

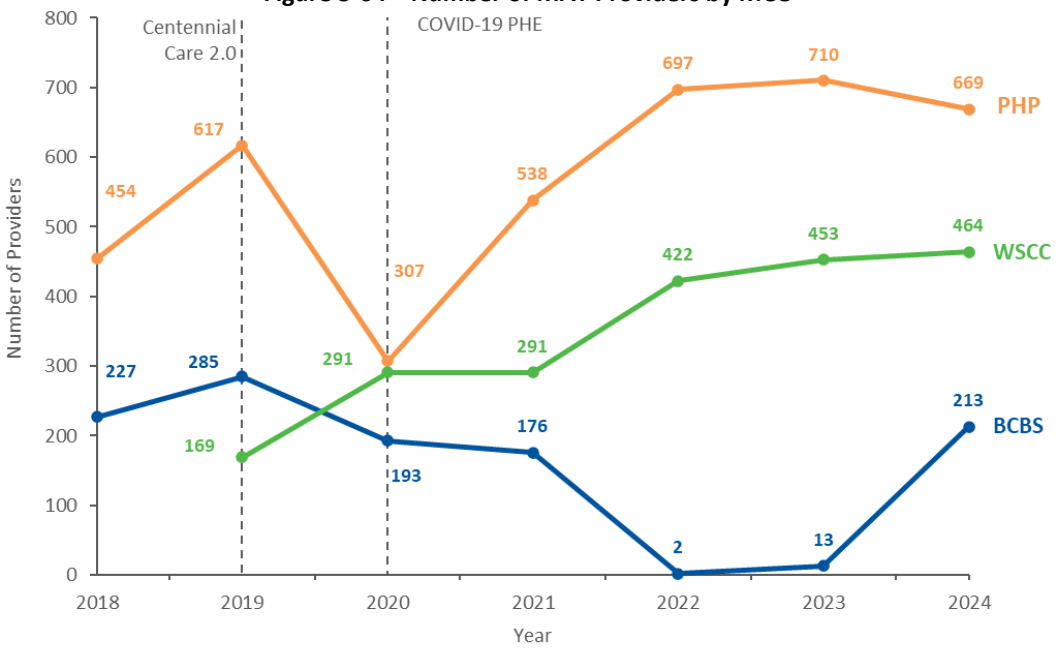
Figure 5-64 and Table 5-55 show the number of MAT providers as reported in MCO reports from 2018 to 2024. There were 227 BCBS MAT providers in 2018, which declined to nearly zero providers in 2022 before increasing to 213 providers in 2024.[5-34] There were 454 PHP MAT providers in 2018 and 669 providers in 2024, with a

[5-33] New Mexico Legislature. Senate Bill 160. Available at: https://www.nmlegis.gov/Sessions/20%20Regular/bills/senate/SB0160.pdf. Accessed on: Aug 12, 2025.

[5-34] The decrease in BCBS MAT providers in 2022 and 2023 may be indicative of incomplete data, rather than an actual decrease in providers. These results should be interpreted with caution.

temporary decrease during the COVID-19 PHE in 2020. There were 169 WSCC MAT providers in 2019, which steadily rose to 464 providers in 2024. The total number of MAT providers increased from 681 in 2018 to 1,346 in 2024.

Figure 5-64—Number of MAT Providers by MCO



Data source: MCO Report data were used in the analysis of Measure 58.
Note: Annual measurement periods were used for all years except 2024, which represents data through June 2024, the last full month of Centennial Care 2.0 .

Table 5-55—Number of MAT Providers by MCO

Plan	2018	2019	2020	2021	2022	2023	2024
BCBS	227	285	193	176	2	13	213
PHP	454	617	307	538	697	710	669
WSCC	NA	169	291	291	422	453	464
Total	**681**	**1,071**	**791**	**1,005**	**1,121**	**1,176**	**1,346**

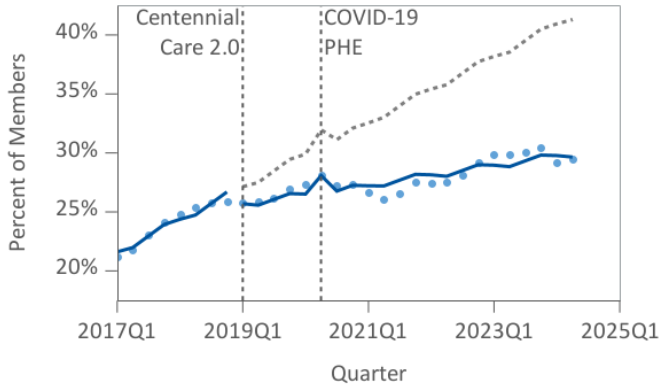
Data source: MCO and State Opioid Treatment Authority data were used in the analysis of Measure 58.

RQ 3: Has the number of individuals with opioid or alcohol use disorder receiving MAT increased?

Percentage of individuals with an opioid or alcohol use disorder with MAT claims (Measure 59)

An ITS analysis assessed changes in the rate of individuals with an OUD or alcohol use disorder (AUD) who received MAT between the baseline and evaluation periods. Figure 5-65 and Table 5-56 illustrate the model-based average rate in each quarter (blue line) and the projected rates had the baseline trend continued (grey dashed line). MAT rates increased by 0.7 percentage points per quarter prior to Centennial Care 2.0 (p<0.001). MAT rates initially decreased by 1.4 percent (p=0.038) at implementation, and the trend declined by an average of 0.5 percentage points per quarter relative to the baseline trend (p<0.001).

Figure 5-65—Percentage of Members with an OUD or AUD with MAT Claims



Data Source: MMIS data were used in the analysis of Measure 59.

Table 5-56—Measure 59 ITS Results

Variable	Estimate	*p*-value
Intercept	21.6%***	<0.001
Pre-Centennial Care 2.0 quarterly trend	0.7pp***	<0.001
Level change at implementation	-1.4pp**	0.038
Change in quarterly trend	-0.5pp***	<0.001

*p<0.1, **p<0.05, ***p<0.001
Data source: MMIS data were used in the analysis of Measure 59.
Note: Full model results are presented in Appendix A, Attachments, Supplemental Results. pp: percentage point.

RQ 4: Is there evidence of enhanced policies and practices related to the PMP, real-time PMP updates, member/provider lock-in programs and limits/edits at pharmacy points-of-sale?

Number of policy and procedure manual references (Measure 60)

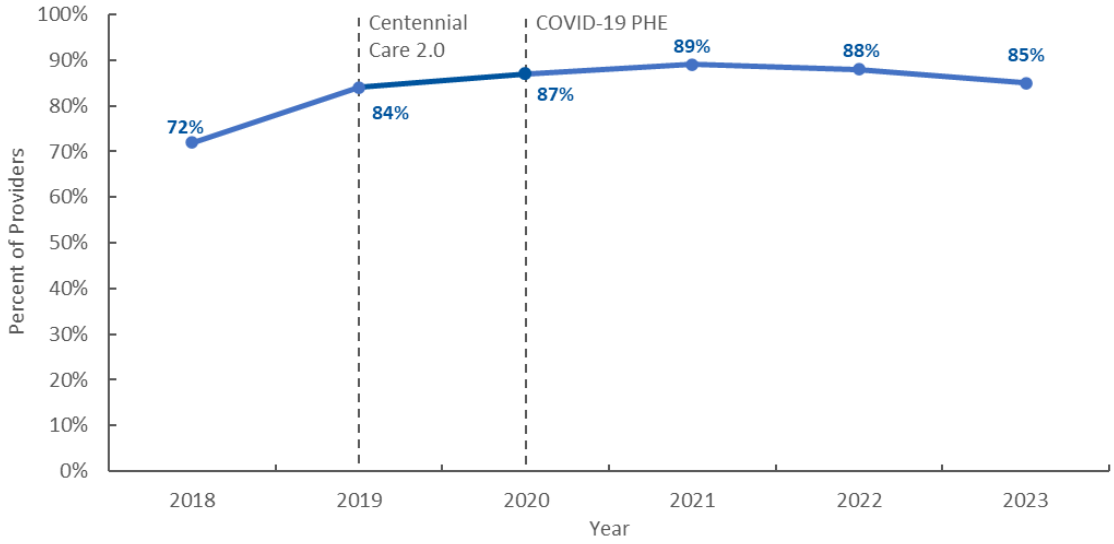
The Evaluation Design outlined an assessment of the number of policy and procedure manual references to the PMP; however, the New Mexico Board of Pharmacy supplied data for the Interim and Summative Evaluation Reports related to providers who made at least one request to the PMP to assess the State's PMPM utilization.[5-35, 5-36] Measure 60 assessed the proportion of providers who made at least one PMP request out of all providers requesting 10 or more PMP reports in a given quarter.

Figure 5-66 illustrates that the percentage of providers who made a request to the PMP increased from 72 percent in 2018 to a peak of 89 percent in 2021, before decreasing to 85 percent in 2023. The largest year-over-year increase was 12 percentage points between 2018 and 2019.

[5-35] According to the Board of Pharmacy, the PMP aimed 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."

[5-36] New Mexico Board of Pharmacy. The New Mexico PMP. Available at: https://www.nmpmp.info/. Accessed on: Aug 12, 2025.

Figure 5-66—Percentage of Providers Who Used the PMP



Data Source: Data from the New Mexico Board of Pharmacy MCO Report were used in the analysis of Measure 60.

Table 5-57 provides detailed information on the number and percentage of provider types who made a request to the PMP.

Table 5-57—Providers Types Who Used the PMP

Provider Type	2018	2019	2020	2021	2022	2023
Chiropractors	—	—	—	—	0 (0%)	0 (0%)
Dentists	7 (14%)	2 (8%)	7 (33%)	8 (28%)	7 (25%)	6 (23%)
Doctors of Oriental Medicine	—	—	—	—	—	0 (0%)
MDs	1,120 (72%)	1,122 (84%)	1,107 (87%)	1,058 (89%)	1,027 (88%)	996 (85%)
Naturopaths	—	—	—	—	—	0 (0%)
Nurse Midwives	5 (50%)	6 (67%)	4 (67%)	2 (67%)	3 (100%)	4 (80%)
Nurse Practitioners	566 (79%)	670 (89%)	708 (90%)	795 (92%)	837 (90%)	934 (86%)
Osteopaths	921 (62%)	113 (84%)	115 (87%)	101 (88%)	99 (89%)	98 (82%)
Physician Assistants	225 (75%)	229 (85%)	206 (89%)	217 (94%)	233 (90%)	238 (89%)
Pharmacist Clinicians	8 (89%)	7 (78%)	5 (63%)	9 (90%)	10 (100%)	10 (83%)

Provider Type	2018	2019	2020	2021	2022	2023
Podiatrists	22 (48%)	17 (52%)	25 (69%)	28 (78%)	28 (74%)	33 (75%)
Prescribing Psychologists	34 (89%)	33 (87%)	35 (83%)	38 (95%)	39 (98%)	41 (100%)
Unknown	2 (100%)	1 (100%)	2 (67%)	—	2 (67%)	4 (67%)
Total	**2,080 (72%)**	**2,200 (84%)**	**2,214 (87%)**	**2,256 (89%)**	**2,285 (88%)**	**2,364 (85%)**

Data source: MCO report data were used in the analysis of Measure 60.
Note: — indicates that no data were received.

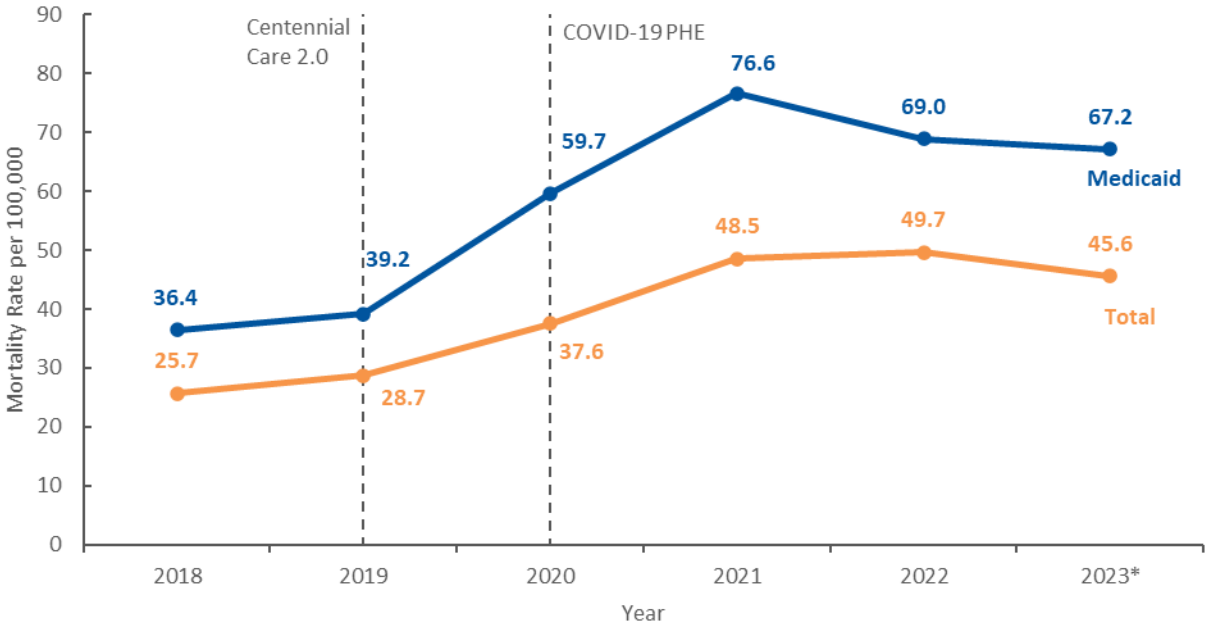
RQ 5: Is there a decrease in the number of deaths due to overdose?

Rate of deaths due to overdose (Measure 61)

Measure 61 assessed whether the number of deaths due to overdose decreased due to Centennial Care 2.0's increased use of naloxone, MAT, and enhanced monitoring and reporting of opioid prescriptions through the PMP. An ITS analysis, as outlined in the Evaluation Design, was not feasible due to one year of available baseline data. Figure 5-67 shows that the cause-specific death rate associated with overdose was substantially higher among the Medicaid population than statewide; however, the rates generally followed similar trends. New Mexico's Medicaid cause-specific death rate associated with overdose deaths increased from 36.4 deaths per 100,000 members in 2018 to 76.6 deaths per 100,000 members in 2021, before dropping to 67.2 deaths per 100,000 members in 2023, an overall increase of 84.6 percent from 2018 to 2023. The statewide cause-specific death rate associated with overdose deaths increased from 25.7 deaths per 100,000 New Mexico residents in 2018 to 49.7 per 100,000 residents in 2022, followed by a decrease to 45.6 deaths per 100,000 residents in 2023, representing an overall increase of 77.4 percent. National age-adjusted overdose death rates followed a similar trend compared to New Mexico, with rates increasing in 2020 and 2021 before stagnating in 2022 and decreasing in 2023, an overall increase of 51.2 percent from 2018.[5-37] Data for 2023 provided by the State were preliminary.

[5-37] Centers for Disease Control and Prevention. Drug Overdose Deaths in the United States 2003–2023. Available at: https://www.cdc.gov/nchs/data/databriefs/db522.pdf. Accessed on: Aug 12, 2025.

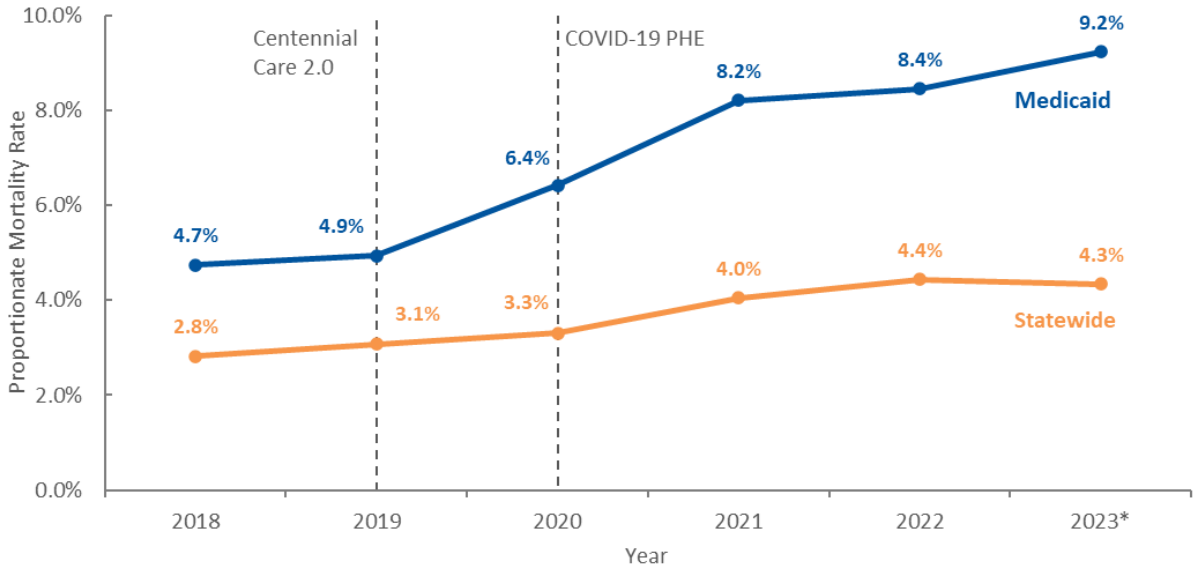
Figure 5-67—Cause-Specific Death Rate Due to Overdose



Data source: New Mexico Indicator-Based Information System, U.S. Census, and MMIS data were used in the analysis of Measure 61.
*Data from 2023 provided by the State were preliminary.

Figure 5-68 illustrates that the overdose proportionate mortality rate among members increased from 4.7 percent in 2018 to 9.2 percent in 2023, while the statewide overdose proportionate mortality rate increased from 2.8 percent in 2018 to 4.3 percent in 2023. These results demonstrate that the Medicaid population overdose proportionate mortality rate increased at a higher rate than the statewide population rate.

Figure 5-68—Proportionate Mortality Rate of Overdose Deaths



Data source: New Mexico Indicator-Based Information System, U.S. Census, and MMIS data were used in the analysis of Measure 61.
*Data from 2023 provided by the State were preliminary.

Aim Five: Improved quality of care and outcomes for Medicaid beneficiaries with SMI/SED

Aim Five Key Findings

The Centennial Care 2.0 SMI/SED authority was approved by CMS on March 28, 2023.[5-38] Following the approval, HCA collaborated with CMS to develop and receive approval for an SMI/SED implementation plan. The implementation plan was approved on July 10, 2025, effective August 1, 2025, one year following the conclusion of Centennial Care 2.0.[5-39] As a result, the State did not implement SMI/SED service changes during Centennial Care 2.0 and results presented for Aim Five are not expected to reflect changes to SMI/SED outcomes as services provided under Centennial Care 2.0 authority did not change. Consequently, the analytic methods utilized to assess Aim Five generally deviate from those specified in the Evaluation Design. It is expected that the SMI/SED services will be more rigorously assessed during the forthcoming Turquoise Care evaluation.

Table 5-58 presents the key findings by hypothesis for Aim Five.

Table 5-58—Aim Five Key Findings

Hypothesis	Key Finding
1	The average LOS for IMDs and all stays remained relatively stable throughout Centennial Care 2.0.
2	SMI/SED member care coordination increased prior to the COVID-19 PHE. Rates were maintained for two years before decreasing through the end of Centennial Care 2.0.
3	The overall increase in SMI/SED member total cost of care slowed, with some costs, such as IP, LTC, and SMI/SED-other, declining or stabilizing. However, increases in pharmacy, professional, and SMI/SED-IMD costs indicate that financial pressures shifted rather than eased entirely.
4	SMI/SED identification and treatment was stable throughout Centennial Care 2.0. SMI/SED diagnoses by non-BH providers increased until March 2021 before steadily declining through the remainder of Centennial Care 2.0. No specialized settings or services were established during the evaluation period.

Note: BH: behavioral health; IMD: Institution for Mental Diseases; IP: inpatient; LOS: length of stay; LTC: long-term care; SED: serious emotional disturbance; SMI: serious mental illness

Aim Five Results

Hypothesis 1: The Demonstration will maintain an average LOS for IMDs of 30 days.

RQ 1: Has the average LOS for IMDs been maintained at 30 days?

Average LOS in an IMD (Measure 62)

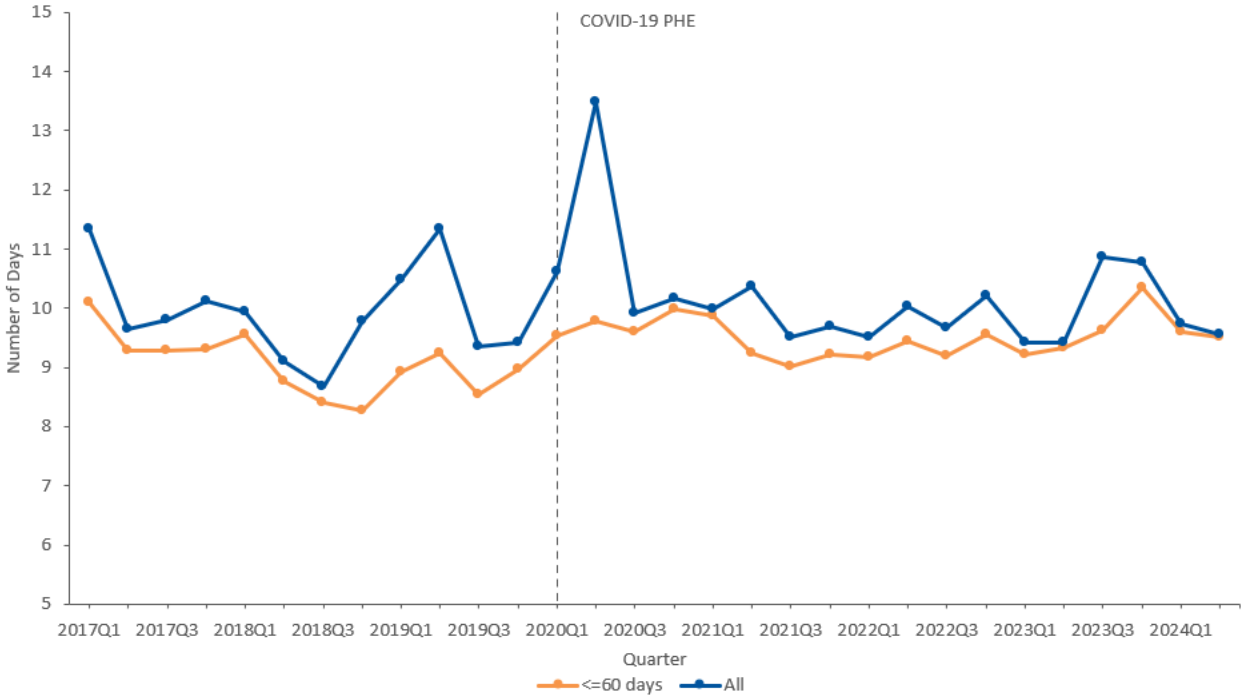
Figure 5-69 displays members' average LOS in an IMD. The average LOS under 60 days remained relatively consistent throughout the evaluation period, averaging between eight and 10 days. The average LOS of all stays, including those greater than 60 days, remained consistent between nine and 12 days, peaking at approximately

5-38 Centers for Medicare & Medicaid Services. CMS Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-ca1.pdf. Accessed on: Aug 12, 2025.

5-39 Centers for Medicare & Medicaid Services. NM Approval Letter SMI SED IP. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-turquoise-care-appvl-07102025.pdf. Accessed on: Aug 12, 2025.

13.4 days during the COVID-19 PHE in Q2 2020. The results indicate that the average LOS did not reach or maintain a length of 30 days.

Figure 5-69—Average LOS in an IMD



Data Source: MMIS data were used in the analysis of Measure 62.

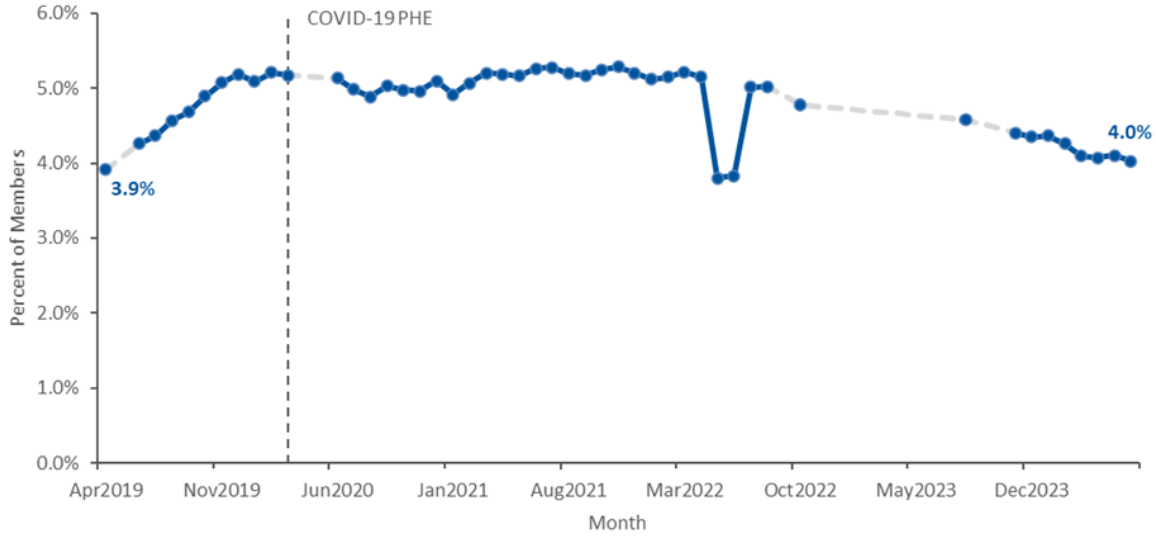
Hypothesis 2: The Demonstration will result in increased rates of care coordination for members with SMI/SED.

RQ 1: Has the percentage of members with SMI/SED receiving care coordination increased?

Percentage of members with SMI/SED receiving care coordination (Measure 63)

Figure 5-70 illustrates the percentage of members with SMI/SED who received fully delegated care coordination, measured through participation in an HH. Care coordination rates increased until the COVID-19 PHE, after which rates remained steady around 5 percent. By June 2024, rates fell to pre-COVID-19 PHE levels of approximately 4.0 percent. May and June 2022 rates may be low due to incomplete HH enrollment data, rather than a decrease in enrollment.

Figure 5-70—Percentage of Members with SMI/SED Who Received Care Coordination



Data Source: HH enrollment roster data and MMIS data were used in the analysis of Measure 63.
Note: The grey dashes indicate months where HH enrollment data were not received.

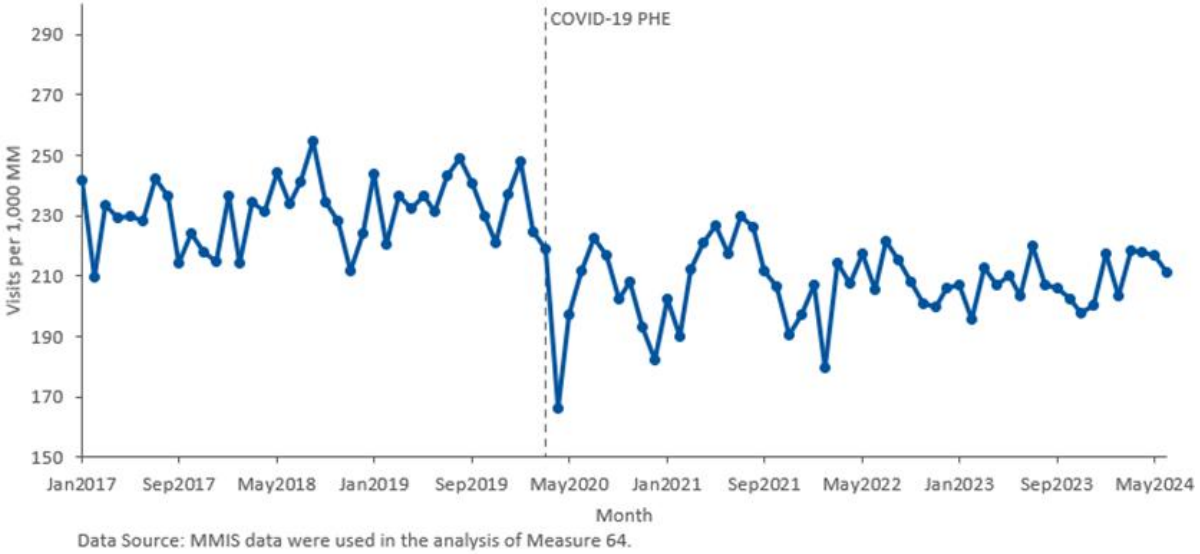
Hypothesis 3: The Demonstration will decrease utilization and LOS in EDs among Medicaid beneficiaries who met eligibility criteria of members with SMI.

RQ 1: Has the utilization of EDs by individuals with SMI/SED decreased?

Number of all-cause ED visits per 1,000 MM among members who met the eligibility criteria of beneficiaries with an SMI/SED (Measure 64)

Figure 5-71 displays the rates of all-cause ED visits among members with an SMI/SED. ED visits sharply declined at the beginning of the COVID-19 PHE, after which rates remained lower than pre-COVID-19 PHE, averaging 207 visits and 232 visits per 1,000 MM, respectively.

Figure 5-71—Number of All-Cause ED Visits per 1,000 MM for Members with SMI/SED



Data Source: MMIS data were used in the analysis of Measure 64.

RQ 2: Have increasing trends in total cost of care been slowed for individuals with SMI/SED diagnoses?

The independent evaluator adhered to the guidelines outlined in the CMS SMI/SED Evaluation Guidance, Appendix C, to evaluate the total cost of SMI/SED care.[5-40] The evaluator identified individuals diagnosed with SMI/SED and calculated the associated cost of services. Total and PMPM costs were inflation adjusted and indexed to June 2024.

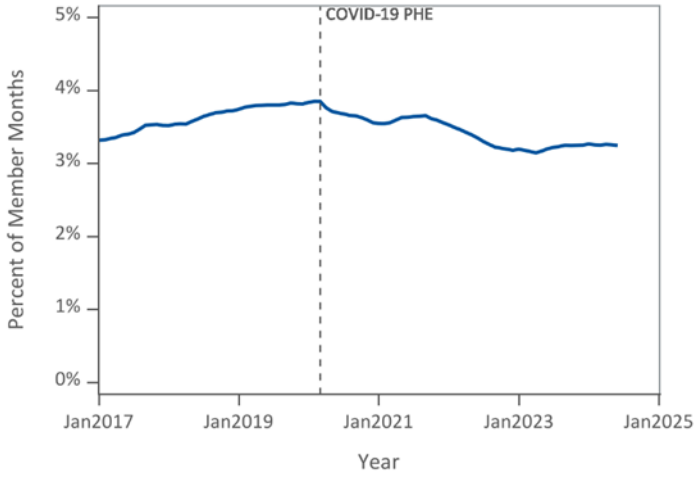
Total and PMPM cost (medical, behavioral and pharmacy) for members with SMI/SED diagnosis (Measure 65)[5-41]

Figure 5-72 illustrates that the percentage of SMI/SED members' MM among all enrolled members remained relatively stable, around 3.5 percent from 2017 to 2020. While there were approximately 25,000 members throughout the evaluation period, the percentage of SMI/SED members' MM gradually declined following the COVID-19 PHE, reaching a low point of approximately 3.1 percent in April 2023. The COVID-19 PHE increased overall enrollment, which contributed to this slight decline in the proportion of the population with SMI/SED.

5-40 Centers for Medicare & Medicaid Services. Appendix C: Approaches to Analyzing Costs Associated with Section 1115 Demonstrations for Beneficiaries with SMI/SED or SUD. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf. Accessed on: Aug 12, 2025.

5-41 Measures 65 through 68 were updated to reflect an assessment of SMI/SED rather than SUD, correcting a labeling error in the Evaluation Design.

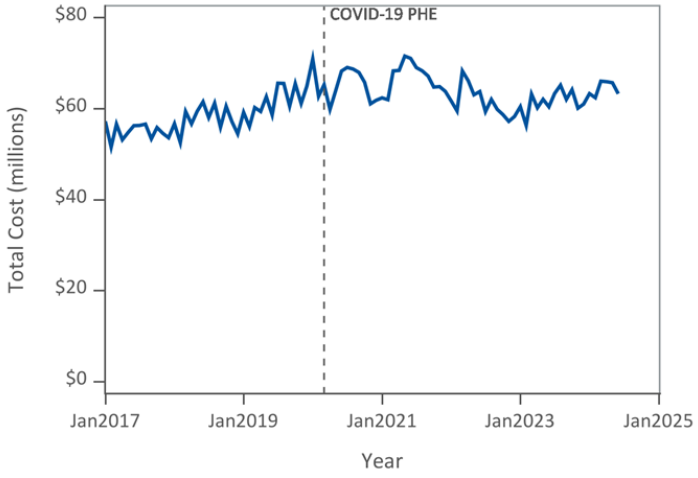
Figure 5-72—Percentage of SMI/SED MM Among All Enrolled Members



Data Source: MMIS data were used in the analysis of Measure 65.

Figure 5-73 shows the total cost for SMI/SED members from January 2017 to June 2024. Total monthly costs fluctuated between $51 million and $72 million. Total costs rose through January 2020 and stabilized near $65 million per month from January 2020 to June 2024.

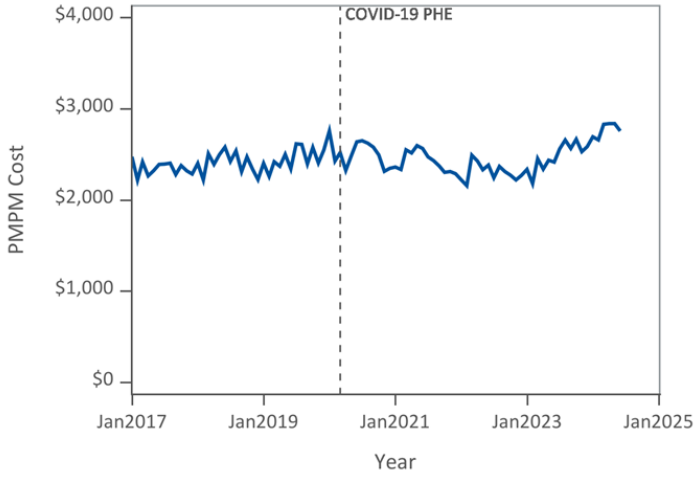
Figure 5-73—Total Cost for SMI/SED Members



Data Source: MMIS data were used in the analysis of Measure 65.

Figure 5-74 shows the PMPM cost for SMI/SED members from January 2017 to June 2024. PMPM cost fluctuated between $2,100 and $2,900 throughout Centennial Care 2.0, remaining stable with no exponential growth.

Figure 5-74—PMPM Cost for SMI/SED Members

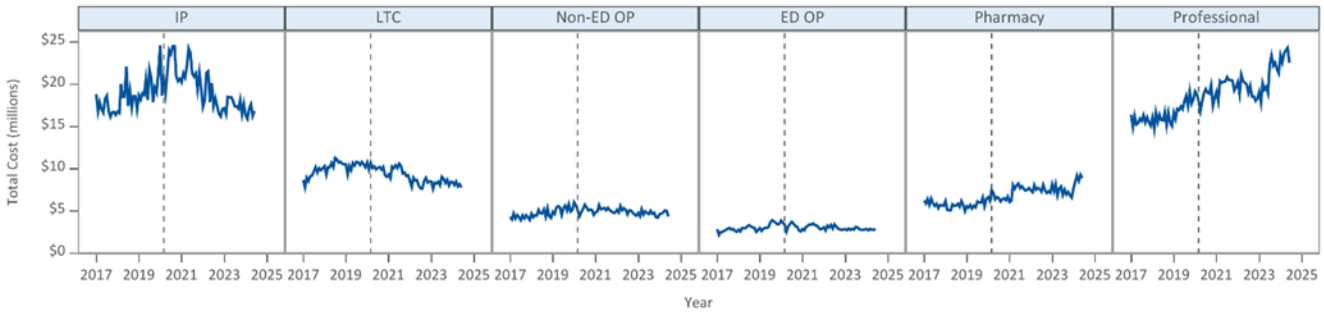


Data Source: MMIS data were used in the analysis of Measure 65.

Total and PMPM costs (medical, behavioral and pharmacy) for members with SMI/SED diagnosis by SMI/SED source of care (Measure 66)[5-42]

Figure 5-75 shows the SMI/SED members' total costs by type of care. IP costs gradually increased from approximately $19 million in January 2017 to nearly $25 million in September 2020 before returning to approximately $17 million in June 2024. LTC costs slightly increased to approximately $11 million before 2019, where they remained relatively stable before a minor decrease to approximately $8 million in June 2024. Non-ED OP costs remained stable between $3 million and $6 million, showing no significant trend over time. Similarly, the ED OP costs remained low with costs below $4 million. Pharmacy costs increased from $5 million in 2019 to $9 million by June 2024. Similarly, professional costs increased from $15 million in 2019 to nearly $25 million by June 2024.

Figure 5-75—Total Cost by Type of Care Among SMI/SED Members

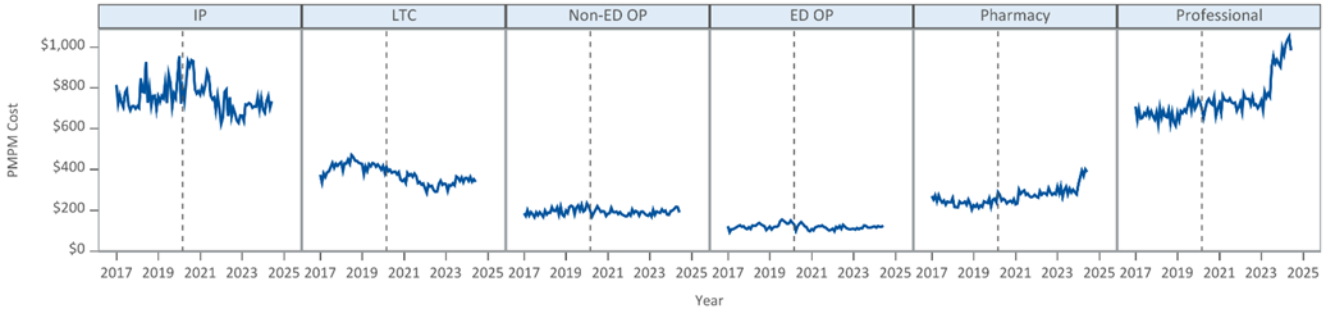


Data source: MMIS data were used in the analysis of Measure 66.
Note: Grey vertical dashed lines indicate the COVID-19 PHE.

5-42 Ibid.

Figure 5-76 shows SMI/SED members' PMPM costs by type of care. IP PMPM costs increased from approximately $720 in early 2017 to $950 in January 2020 before declining to previous levels, a decrease likely influenced by the COVID-19 PHE. LTC PMPM costs ranged between $280 and $470, slightly increasing before 2019 and declining through 2022. Non-ED OP costs were consistent between $160 and $240. Similarly, ED OP costs remained below $160 PMPM. Pharmacy PMPM costs increased from $200 to $400, increasing sharply in early 2024. Professional PMPM costs showed the most pronounced growth, increasing from approximately $650 in 2019 to $1,050 by May 2024.

Figure 5-76—PMPM Cost by Type of Care Among SMI/SED Members



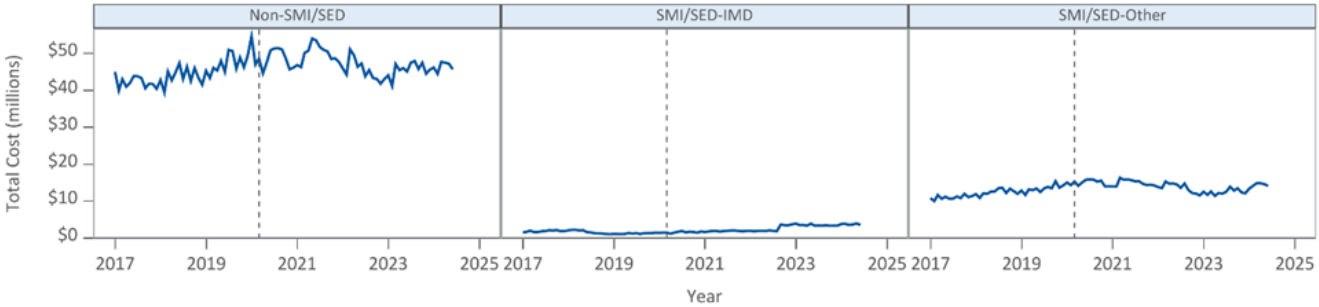
Data source: MMIS data were used in the analysis of Measure 66.
Note: Grey vertical dashed lines indicate the COVID-19 PHE.

RQ 3: Have SMI/SUD costs for individuals with SMI/SED diagnoses changed proportionally as expected with increased identification and engagement in treatment?

Total and PMPM cost for SMI/SED services for members with SMI/SED diagnosis (Measure 67)[5-43]

Figure 5-77 displays the total costs for SMI/SED services. Non-SMI/SED costs increased until January 2020, then stabilized near $50 million. SMI/SED-IMD costs initially remained relatively low; however, costs nearly doubled in September 2022, from $1.8 million to $3.6 million. SMI/SED-other costs grew gradually from approximately $10 million in January 2017 to $16 million in March 2021 before stabilizing.

Figure 5-77—Total Cost for SMI/SED Services Among SMI/SED Members

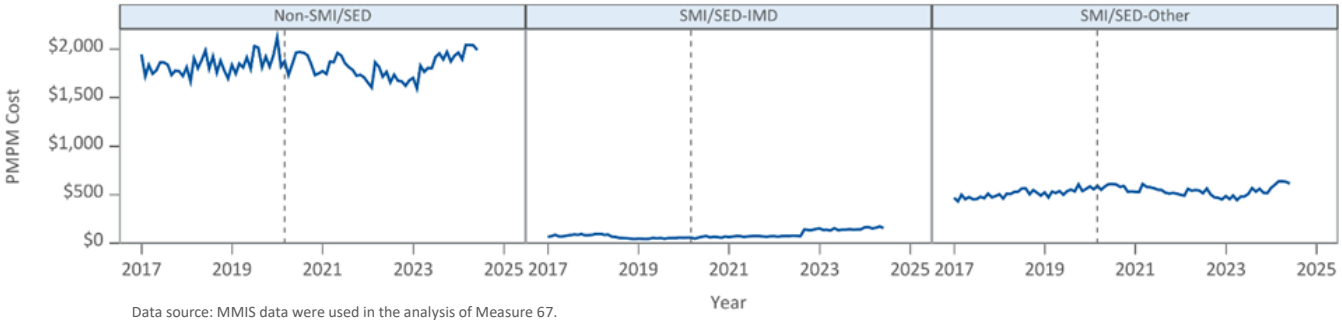


Data source: MMIS data were used in the analysis of Measure 67.
Note: Grey vertical dashed lines indicate the COVID-19 PHE.

5-43 Ibid.

Figure 5-78 displays the total costs for SMI/SED services. Non-SMI/SED PMPM costs were more stable than total cost, fluctuating between $1,500 to $2,100 PMPM. PMPM IMD costs followed a similar pattern to total cost, remaining consistently low until a notable increase in September 2022 that may be due to the elimination of BH cost-sharing that extended to IMD-related services such as IP psychiatric care and residential treatment. PMPM SMI/SED-other costs were consistently higher than SMI/SED-IMD costs between $420 to $640 PMPM.

Figure 5-78—PMPM Cost for SMI/SED Services Among SMI/SED Members

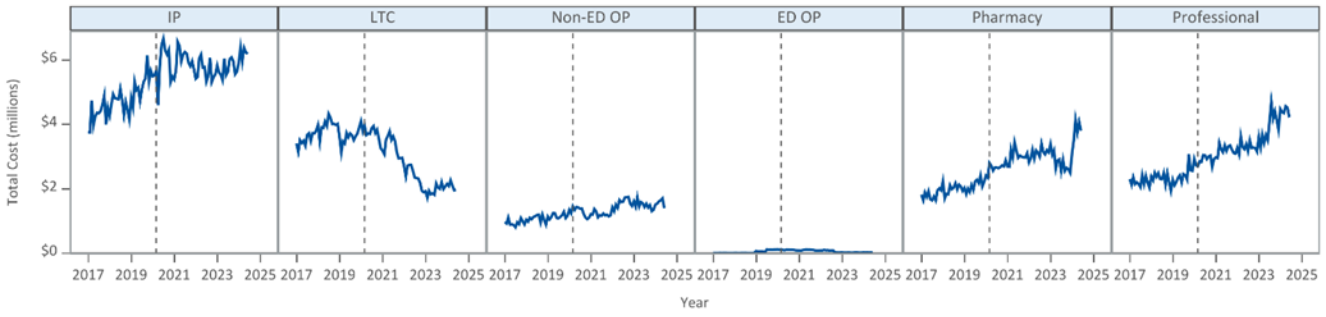


Data source: MMIS data were used in the analysis of Measure 67.
Note: Grey vertical dashed lines indicate the COVID-19 PHE.

Total and PMPM cost for SMI/SED services by type of care (IP, OP, pharmacy, etc.) (Measure 68)[5-44]

Figure 5-79 displays the total cost of SMI/SED services. IP costs increased from 2017, peaking at approximately $6.5 million in July 2020 before stabilizing. LTC costs grew to over $4 million in July 2018 before decreasing to less than $2 million by June 2024. Non-ED OP costs grew gradually from $1.0 to $1.7 million. ED OP costs remained consistently low, contributing minimally to total expenditures. Pharmacy costs increased from 2017 to 2024 with a notable increase in 2024. Professional services steadily increased, with accelerated growth after 2019.

Figure 5-79—Total Cost for SMI/SED Services by Type of Care Among SMI/SED Members



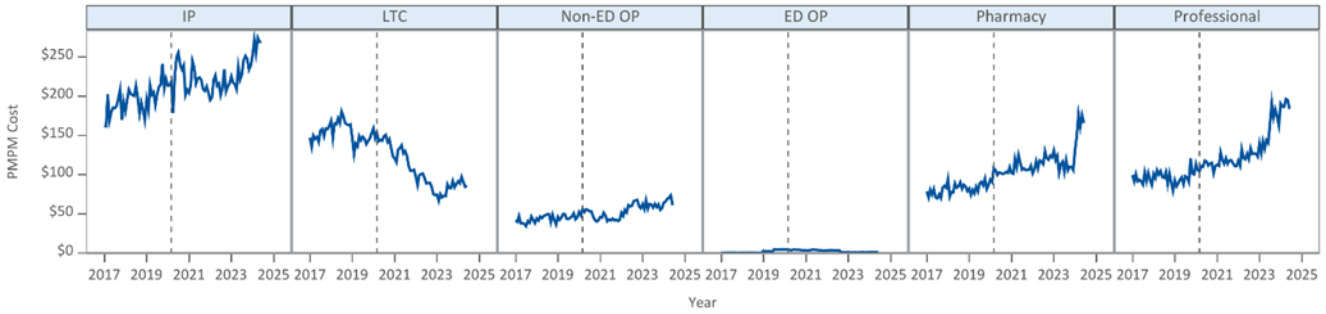
Data source: MMIS data were used in the analysis of Measure 68.
Note: Grey vertical dashed lines indicate the COVID-19 PHE.

Figure 5-80 displays the PMPM SMI/SED costs by type of care. PMPM IP trends were similar to total cost trends, peaking in April 2024 instead of July 2020, as was seen in total costs, a shift likely attributed to the reduction in MM. PMPM LTC trends closely mirrored total cost patterns, rising steadily to a peak in July 2018 before decreasing. Non-ED OP costs gradually increased, fluctuating between $30 to $75 PMPM. ED OP costs remained

5-44 Ibid.

below $5 PMPM. PMPM pharmacy trends increased beginning in 2017, spiking in early 2024, which may be attributed to pricing changes due to July 2023 Medicaid provider rate adjustments. Similarly, PMPM professional services displayed continuous growth, with accelerated spending after 2019.

Figure 5-80—PMPM Cost for SMI/SED Services by Type of Care Among SMI/SED Members



Data source: MMIS data were used in the analysis of Measure 68.
Note: Grey vertical dashed lines indicate the COVID-19 PHE.

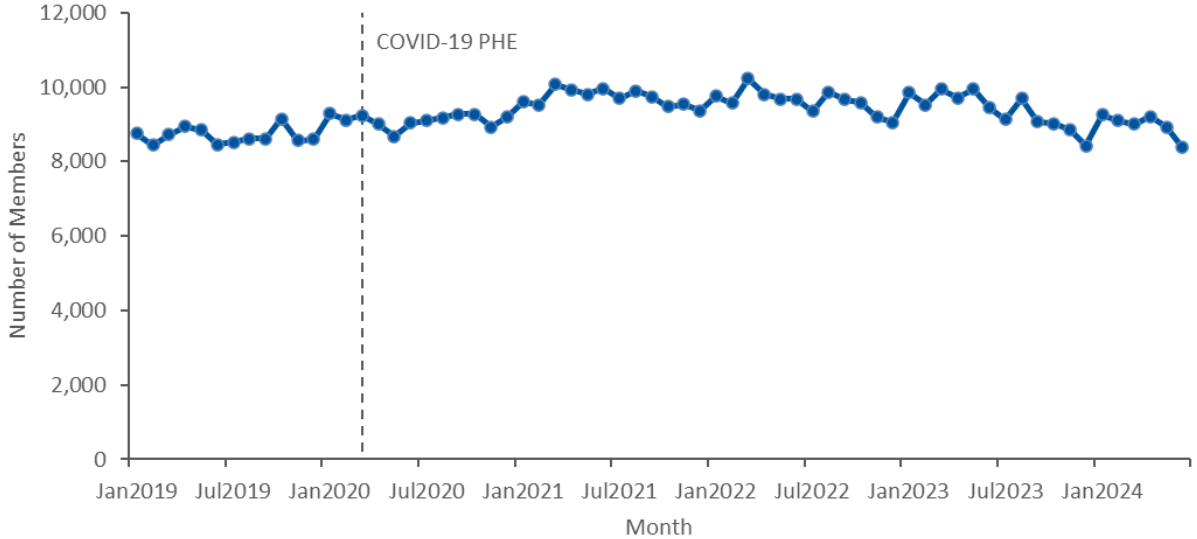
Hypothesis 4: The Demonstration will increase the identification of individuals engaged with SMI/SED and increase treatment integration, including specialized services.

RQ 1: Has the number of individuals identified and/or engaged in SMI/SED treatment increased?

Number of individuals identified with SMI/SED and number of individuals engaged in SMI/SED treatment (Measure 69)

Figure 5-81 illustrates that the number of members identified with SMI/SED who engaged in SMI/SED treatment remained relatively stable throughout Centennial Care 2.0, averaging approximately 9,274 members engaged in treatment services monthly.

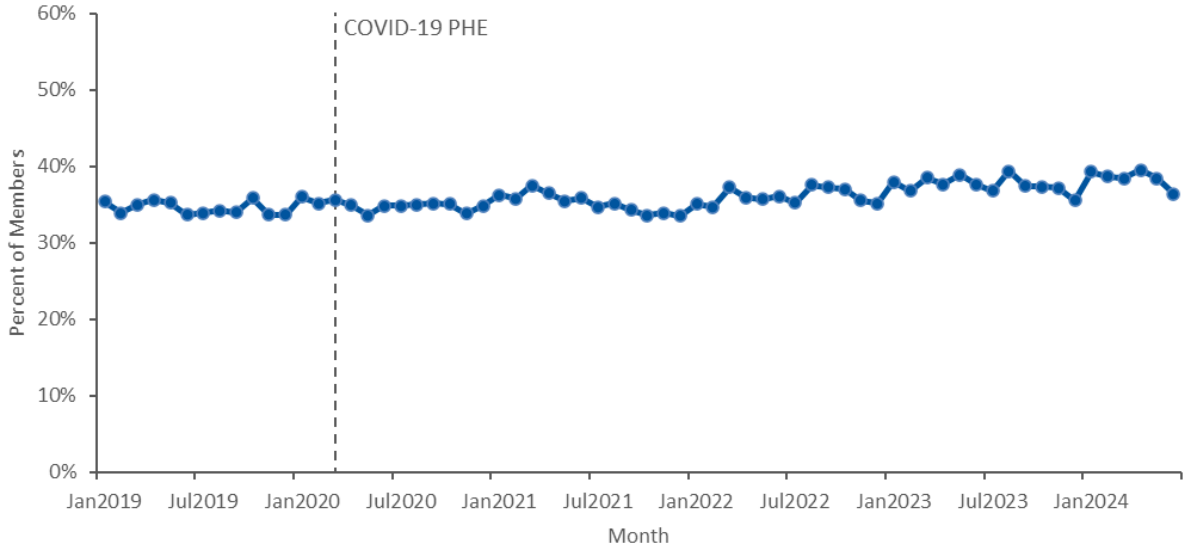
Figure 5-81—Number of Members Identified with SMI/SED and Engaged in SMI/SED Treatment



Data Source: MMIS data were used in the analysis of Measure 69.

Figure 5-82 shows that the percentage of Centennial Care 2.0 members with SMI/SED who engaged in SMI/SED treatment remained stable throughout the evaluation period, peaking at 39.5 percent in April 2024.

Figure 5-82—Percentage of Members Identified with SMI/SED and Engaged in SMI/SED Treatment



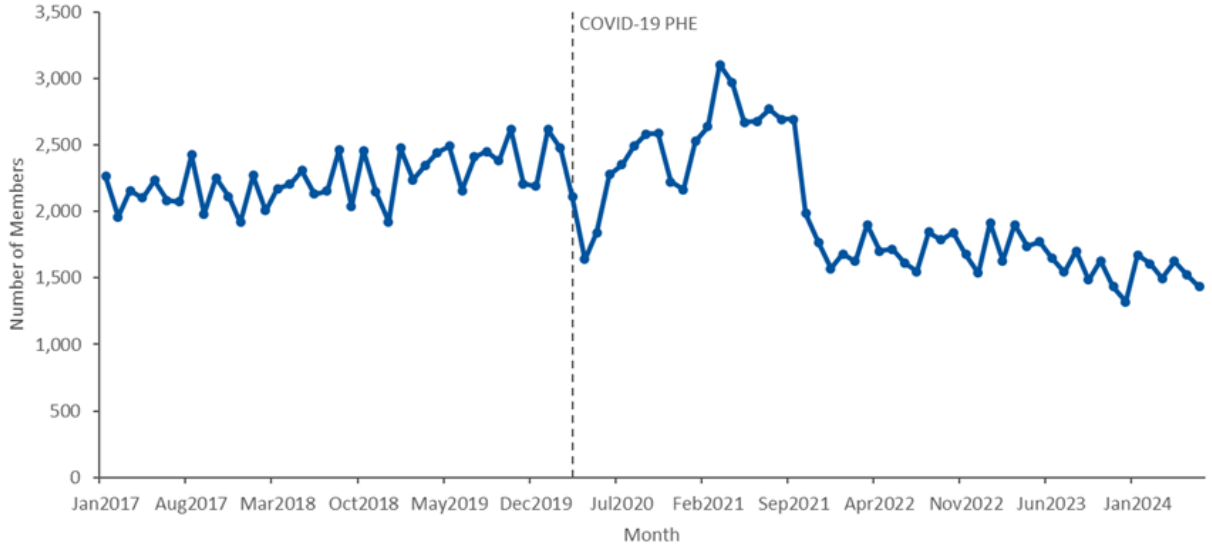
Data Source: MMIS data were used in the analysis of Measure 69.

RQ 2: Are members being diagnosed and identified with SMI/SED conditions sooner by receiving SMI/SED diagnoses from non-BH providers?

Number of members diagnosed with SMI/SED conditions by non-BH providers (Measure 70)

Figure 5-83 presents the number of members newly diagnosed with SMI/SED conditions by non-BH providers. Diagnoses remained relatively stable until the COVID-19 PHE, after which diagnoses peaked in March 2021 at 3,104 members. Diagnoses then declined through the remainder of Centennial Care 2.0, reaching the lowest point of 1,322 members diagnosed in December 2023.

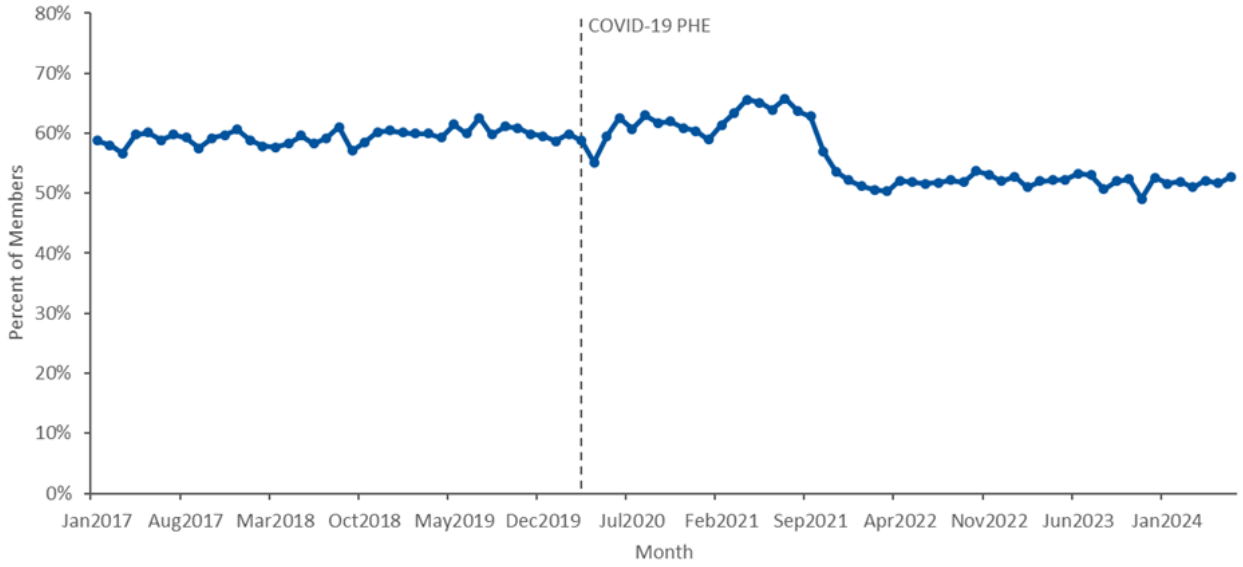
Figure 5-83—Number of Members Diagnosed with SMI/SED Conditions by Non-BH Providers



Data Source: MMIS data were used in the analysis of Measure 70.

Figure 5-84 illustrates the percentage of members diagnosed with SMI/SED by non-BH providers. Diagnoses averaged between 55 and 66 percent until September 2021. The percentage of members diagnosed decreased over 12 percentage points from September 2021 to March 2022 and averaged 50 to 54 percent for the remainder of the evaluation period.

Figure 5-84—Percentage of Members Diagnosed with SMI/SED Conditions by Non-BH Providers



Data Source: MMIS data were used in the analysis of Measure 70.

RQ 3: Has the establishment of specialized settings and services, including crisis stabilization services, focused on the needs of individuals experiencing SMI/SED increased?

Number of specialized settings focused on the needs of individuals experiencing SMI/SED (Measure 71)

The SMI/SED program implementation plan was approved by CMS on July 10, 2025, for implementation on August 1, 2025.[5-45] As a result, changes to SMI/SED services were not implemented by the end of the Centennial Care 2.0 evaluation period on June 30, 2024. No specialized settings and services, including crisis stabilization services, were established during Centennial Care 2.0, and there are no data to report for Measure 71.

[5-45] Centers for Medicare & Medicaid Services. NM Approval Letter SMI SED IP. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-turquoise-care-appvl-07102025.pdf. Accessed on: Aug 12, 2025.

6. Conclusions

The evaluation of the New Mexico Health Care Authority's (HCA's) Section 1115 Demonstration Waiver, Centennial Care 2.0, analyzed a range of programs and populations to identify successes, challenges, and opportunities for future improvement. Results generally supported the hypotheses for Aims One, Two, and Three, while results for Aim Four were mixed. Because the Centers for Medicare & Medicaid Services (CMS) did not approve the implementation plan for serious mental illness/serious emotional disturbance (SMI/SED) services until after the conclusion of Centennial Care 2.0, results for Aim Five were not indicative of demonstration performance.[6-1]

Table 6-2 outlines whether each measure supported or did not support the respective hypothesis, utilizing the criteria presented in Table 6-1.

Table 6-1—Measure Conclusion Criteria

Conclusion	Criteria
Supports the hypothesis	• Statistical testing results were significant in favorable direction. • For measures without statistical testing, changes in the results were consistent with the hypothesis.
Neither supports nor fails to support the hypothesis	• Statistical testing results were not significant. • For measures without statistical testing, there were no sustained increases or decreases in the results demonstrating consistency or inconsistency with the hypothesis.
Does not support the hypothesis	• Statistical testing results were significant in unfavorable direction. • For measures without statistical testing, changes in the results were not consistent with the hypothesis.
Insufficient data to support conclusion	• There was no pre-intervention data and there were not enough data points during the evaluation period to make a determination of increases/decreases in rates potentially attributable to Centennial Care 2.0.
N/A	• The measure did not relate to the hypothesis.

Table 6-2—Measure Results Summary

Number	Measure Name	Results Support 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 LTSS and increasing the enrollment limit of the CB Program in 2022 will maintain or increase the number of CB members throughout the demonstration period.		
1	Percentage of Centennial Care members enrolled and receiving CB services	Yes
Hypothesis 2: The ability for LRI to provide PCS to individuals receiving CB or EPSDT PCS will ensure member access to CB or EPSDT PCS services.		
2	Percent of LTSS-eligible members receiving EPSDT PCS	Yes
3	Percent of LTSS-eligible members receiving CB PCS	NS/FS

6-1 Centers for Medicare & Medicaid Services. NM Approval Letter SMI SED IP. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-turquoise-care-appvl-07102025.pdf. Accessed on: Aug 12, 2025.

Number	Measure Name	Results Support Hypothesis
4	Average number of EPSDT PCS per utilizing member	Yes
5	Average number of CB PCS per utilizing member	Yes
Hypothesis 3: Promoting participation in a HH will result in increased member engagement with a HH and increase access to integrated physical and BH care in the community.		
6	Number/percentage of Centennial Care members enrolled in a HH	Yes
7	Number of HH members with at least one claim for PH service in the CY	Yes
Hypothesis 4: Enhanced care coordination supports integrated care interventions, which lead to higher levels of access to preventative/ambulatory health services.		
8a	Adults' access to preventive/ambulatory health services (AAP)	No
8b	Adults' access to preventive/ambulatory health services (AAP)–HH population	Yes
9a	Children and adolescents' access to PCPs (CAP)	NS/FS
9b	Children and adolescents' access to PCPs (CAP)–HH population	Yes
10	Well-child visits in the third, fourth, fifth, and sixth years of life (W34)	NS/FS
Hypothesis 5: Engagement in a HH and care coordination support integrative care interventions, which improve quality of care.		
11	Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	NS/FS
12	Anti-depressant medication management (AMM) effective acute phase treatment	NS/FS
13	Anti-depressant medication management (AMM) effective continuation phase treatment	NS/FS
14	7-day follow-up after hospitalization for mental illness (FUH)	NS/FS
15	30-day follow-up after hospitalization for mental illness (FUH)	NS/FS
Hypothesis 6: The implementation of the HFW program will serve high needs beneficiaries with a SED diagnosis.		
16	Number of HFW beneficiaries enrolled in the program	Yes
17	Percentage of HFW beneficiaries with SED diagnosis in the 11 months prior to enrollment	Yes
18	Stakeholders' reported barriers and facilitators to implementation	Yes
Hypothesis 7: Expanding member incentives for preventive care through the CR program will encourage members to engage in preventive care services.		
19	Percentage of Centennial Care 2.0 members participating in CR	NS/FS
20	Percentage of CR participating members and non-participating members with an annual preventive/ambulatory service	NS/FS
21	Percentage of CR participating and redeeming, and CR participating and non-redeeming members with an annual preventive/ambulatory service	NS/FS
Hypothesis 8: Expanding member access to prenatal care through the CHV pilot program will improve infant health.		
22	Live births weighing less than 2,500 grams (LBW)	NS/FS
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.		
23	Total number of providers with VBP contracts	Yes
24	Number/percentage of providers meeting quality threshold	Insufficient[1]

Number	Measure Name	Results Support Hypothesis
25	Percentage of total payments that are for providers in VBP arrangements	Yes
26	Percentage of qualified Domain 1 SNCP Hospital Quality Incentive measures that have maintained or improved their reported performance rates over the previous year	NS/FS
27	Cost per member trend	Yes
28	Cost per user trend	Yes
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 continuous NFLOC approval with specific criteria for members whose condition is not expected to change over time		
29	Number of continuous NFLOC approvals	Yes
Hypothesis 2: The use of technology and CQI processes align with increased access to services and member satisfaction.		
30	Number of telemedicine providers	Yes
31	Number of members receiving telemedicine services	Yes
32	Member rating of healthcare	NS/FS
33	Member rating of health plan	NS/FS
34	Member rating of personal doctor	NS/FS
Hypothesis 3: Implementation of EVV is associated with increased accuracy in reporting services rendered.		
35	Number of claims submitted through EVV	Yes
36	Percent of paid or unpaid hours retrieved due to false reporting	Insufficient
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.		
37	Number of providers who provide SUD screening	Yes
38	Number of individuals screened for SUD	NS/FS
39	Percentage of individuals with a SUD diagnosis who received any SUD service during the MY	No
40	Initiation of AOD abuse or dependence treatment (IET)	NS/FS
Hypothesis 2: The demonstration will increase peer support services which will result in more individuals engaging in and retained in AOD dependence treatment.		
41	Percentage of individuals with a SUD diagnosis who received peer support	Yes
42	Engagement of AOD abuse or dependence treatment (IET)	Yes
43	Average LOS	NS/FS
44	Continuity of pharmacotherapy for OUD	Yes
Hypothesis 3: The demonstration will improve access to a comprehensive continuum of SUD care which will result in decreased utilization of ED and IP hospitalization and SUD IP readmissions.		
45	Continuum of services available	Yes[2]
46	Number of providers and capacity for ambulatory SUD services	Yes
47	Percentage of ED visits of individuals with SUD diagnoses	NS/FS
48	Percentage of IP admissions for SUD-related treatment	NS/FS

Number	Measure Name	Results Support Hypothesis
49	Percentage of IP admissions of individuals with SUD for withdrawal management	No
50	7- and 30-day IP and residential SUD readmission rates	NS/FS
51	Total and PMPM cost (medical, behavioral, and pharmacy) for members with SUD diagnosis	NS/FS
52	Total and PMPM cost (medical, behavioral, and pharmacy) for members with SUD diagnosis by SUD source of care	NS/FS
53	Total and PMPM cost for SUD services for members with SUD diagnosis	NS/FS
54	Total and PMPM cost for SUD services by type of care (IP, OP, pharmacy, etc.)	Yes
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 PH services.		
55	Percentage of individuals diagnosed with SUD receiving care coordination	No
56	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 PMP, which will result in fewer overdose deaths due to opioid use.		
57	Number of naloxone training and kit distributions	Yes
58	Number practitioners prescribing MAT	Yes
59	Percentage of individuals with an opioid or alcohol use disorder with MAT claims	No
60	Number of providers using the PMP	Yes
61	Rate of deaths due to overdose	No
Aim Five: Improved quality of care and outcomes for Medicaid beneficiaries with SMI/SED[3]		
Hypothesis 1: The Demonstration will maintain an average LOS for IMDs of 30 days.		
62	Average LOS in an IMD	N/A
Hypothesis 2: The Demonstration will result in increased rates of care coordination for members with SMI/SED.		
63	Percentage of members with SMI/SED receiving care coordination	N/A
Hypothesis 3: The Demonstration will decrease utilization and LOS in EDs among Medicaid beneficiaries who met eligibility criteria of members with SMI.		
64	Number of all-cause ED visits per 1,000 MM among members who met the eligibility criteria of beneficiaries with an SMI/SED	N/A
65	Total and PMPM cost (medical, behavioral, and pharmacy) for members with SMI/SED diagnosis	N/A
66	Total and PMPM costs (medical, behavioral, and pharmacy) for members with SMI/SED diagnosis by SMI/SED source of care	N/A
67	Total and PMPM cost for SMI/SED services for members with SMI/SED diagnosis	N/A
68	Total and PMPM cost for SMI/SED services by type of care (IP, OP, pharmacy, etc.)	N/A

Number	Measure Name	Results Support Hypothesis
Hypothesis 4: The Demonstration will increase the identification of individuals engaged with SMI/SED and increase treatment integration, including specialized services.		
69	Number of individuals identified with SMI/SED and number of individuals engaged in SMI/SED treatment	N/A
70	Number of members diagnosed with SMI/SED conditions by non-BH providers	N/A
71	Number of specialized settings focused on the needs of individuals experiencing SMI/SED	N/A

[1]Insufficient denotes insufficient data to support a conclusion.
[2]MCO data provided to support Measure 45 did not align with the State's records on the number of reported providers per facility type. This discrepancy will be addressed in the forthcoming Interim Evaluation Report for Turquoise Care and conclusions may change based on the potential utilization of alternative data sources.
[3]The conclusion for all Aim Five measures is N/A as the program was not implemented during Centennial Care 2.0 and no conclusions about the program can be drawn.
Note: AAP: Adults' Access to Preventive/Ambulatory Health Services; AOD: alcohol or other drug; BH: behavioral health; CB: community benefit; CDC: Centers for Disease Control and Prevention; CMS: Centers for Medicare & Medicaid Services; CQI: continuous quality improvement; CR: Centennial Rewards; CY: calendar year; ED: emergency department; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; EVV: electronic visit verification; HFW: high-fidelity wraparound; HH: Health Home; IMD: Institution for Mental Diseases; IP: inpatient; LBW: low birth weight; LOS: length of stay; LRI: legally responsible individual; LTC: long-term care; LTSS: long-term services and supports; MAT: medication-assisted treatment; MCO: managed care organization; MM: member months; MY: measurement year; NCQA: National Committee for Quality Assurance; NFLOC: nursing facility level of care; NQF: National Quality Forum; OP: outpatient; OUD: opioid use disorder; PCP: primary care provider; PCS: personal care services; PH: physical health; PMP: prescription monitoring program; PMPM: per-member per-month; SED: serious emotional disturbance; SMI: serious mental illness; SNCP: safety net care pool; SUD: substance use disorder; USC: University of Southern California; VBP: value-based payment

Aim One

Centennial Care 2.0 aimed to enhance member access to services and improve the quality of care through a variety of programs. Enrollment and participation in programs including Heath Homes (HHs), high-fidelity wraparound (HFW), Community Benefits (CB), Centennial Rewards (CR), and Centennial Home Visiting (CHV) were generally maintained or increased during the demonstration period. Similarly, the number of members who received personal care services (PCS), as well as the average number of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) PCS per utilizing member and average number of CB PCS per utilizing member, were maintained or increased.

Adults' access to preventive/ambulatory health services decreased throughout Centennial Care 2.0; however, consistent with national trends, adults' access to preventive/ambulatory health services among HH members and children's and adolescents' access to primary care providers (PCPs) increased. Changes in rates of anti-depressant medication management and diabetes screenings for members with schizophrenia or bipolar disorder who are using antipsychotic medications were generally lower for HH members than non-HH members, while HH members demonstrated higher changes in rates of follow-up after hospitalizations for mental illness than non-HH members. Overall, quality of care measures for HH members demonstrated mixed results and were not statistically significant.

Although the CHV program was approved to expand statewide in 2020, enrollment increased most significantly in 2022. The rate of low birth weight (LBW) deliveries among CHV members declined from nearly three times higher than that of non-CHV members in 2019 to matching non-CHV member rates in 2022 and then fell below non-CHV member rates in 2023.

Key stakeholders provided insight on both the successes and barriers of implementing the HFW program under Centennial Care 2.0. Stakeholders generally found the implementation to be effective, supported by weekly

meetings to address concerns and few operational changes during the transition to Centennial Care 2.0; however, stakeholders also noted that the delay between application submission and CMS approval resulted in the HFW program being implemented by new staff who had not been involved in the planning process. This contributed to provider education requirements that did not align with actual provider education levels. Workforce shortages further impacted the HFW program, as providers were required to complete training and certification before delivering services and could not immediately step in to cover HFW staff absences.

Aim Two

Centennial Care 2.0 aimed to manage the pace at which costs increased while sustaining or improving quality, services, and eligibility by incentivizing hospitals and increasing the number of providers with value-based purchasing (VBP) arrangements. Both the total number of providers with VBP contracts and the percentage of total payments for providers in VBP arrangements increased throughout the demonstration. Results for cost metrics, including cost per member trend and cost per user trend, indicated that Centennial Care 2.0 achieved estimated savings in claims costs. Capitation payments to managed care organizations (MCOs) were sufficient to cover the cost of members' care based on submitted claims and encounter data.

Aim Three

Centennial Care 2.0 aimed to use data, technology, and person-centered care to streamline processes and modernize the healthcare delivery system. The number of continuous nursing facility level of care (NFLOC) approvals increased during Centennial Care 2.0. Evidence suggests that, in addition to the coronavirus disease 2019 (COVID-19) public health emergency (PHE), Centennial Care 2.0 contributed to an increase in the number of telemedicine providers and utilizing members. Trends suggest that telemedicine use would likely have increased due to Centennial Care 2.0 even without the COVID-19 PHE. Members' satisfaction with their healthcare or health plan did not significantly change; however, members' satisfaction with their personal doctor decreased during Centennial Care 2.0.

Aim Four

Results related to improving the quality of care and outcomes for members with substance use disorder (SUD) were mixed. The number of providers who provide SUD screening increased; however, both the number of individuals screened for SUD and the percentage of individuals with a SUD diagnosis who received any SUD service during the measurement year (MY) decreased compared to the baseline trends. The percentage of individuals diagnosed with SUD receiving care coordination increased from Centennial Care 2.0 implementation through the COVID-19 PHE. Additionally, the percentage of individuals with SUD receiving preventive/ambulatory health services increased during the demonstration.

Peer support members had significantly higher rates of continuity of pharmacotherapy for opioid use disorder (OUD) and engagement of alcohol or other drug (AOD) abuse or dependence treatment compared to non-peer support members. The percentage of individuals with a SUD diagnosis who received peer support also increased following the implementation of Centennial Care 2.0. However, results related to average treatment tenure among peer support members were mixed.

Centennial Care 2.0 sought to improve access to a comprehensive continuum of SUD care to decrease emergency department (ED) utilization, inpatient (IP) hospitalization, and SUD IP readmissions. The number of behavioral health (BH) facilities increased during the demonstration period.

While ED utilization and SUD IP readmissions did not change significantly following the implementation of Centennial Care 2.0, IP hospitalization increased. The cost of care for SUD members remained relatively stable throughout the demonstration and did not change significantly from baseline projections; however, there was a notable increase in per-member per-month (PMPM) cost from early 2023 through June 2024, largely driven by increasing costs in professional settings. Cost trends for SUD members in non-ED, outpatient (OP), long-term care (LTC), and SUD-other settings decreased compared to baseline trends; however, there was insufficient evidence to conclude that overall cost pressures eased. Costs for SUD services provided in an Institution for Mental Diseases (IMD) increased substantially throughout Centennial Care 2.0, although the relative PMPM remained low, reaching approximately $10 PMPM in 2023.

Results support the conclusion that Centennial Care 2.0 contributed to an increase in the number of naloxone training and kit distributions and the number of individuals who received overdose prevention training. Additionally, the Number of providers using the PMP and the number of MCO network medication-assisted treatment (MAT) providers increased. Although naloxone availability increased, the percentage of people with an OUD or alcohol use disorder (AUD) with MAT claims decreased significantly compared to the baseline trend. The rate of overdose among Medicaid members also increased at a higher rate among non-Medicaid members.

Aim Five

The State's SMI/SED implementation plan was not approved by CMS during Centennial Care 2.0, and the State did not implement changes to SMI/SED services. As a result, no conclusions can be drawn regarding the effects of Centennial Care 2.0 on SMI/SED outcomes. The average length of stay (LOS) in an IMD, as well as the number/percentage of members identified with SMI/SED and engaged in SMI/SED treatment, remained stable during the demonstration. Following the COVID-19 PHE, ED utilization among SMI/SED members decreased. The percentage of SMI/SED members who received fully delegated care coordination through a HH increased until the onset of the COVID-19 PHE, then remained stable for the remainder of Centennial Care 2.0. Similar to SUD-related costs, pharmacy and professional PMPM costs for SMI/SED members increased; however, total PMPM costs remained relatively stable throughout the demonstration.

7. Interpretations, Policy Implications, and Interactions With Other State Initiatives

Centennial Care 2.0 exists within the context of New Mexico Medicaid and the State's long-range planning for outcome and quality improvement. The following sections outline the interrelations between Centennial Care 2.0 and other aspects of New Mexico Medicaid, including interpretations of results and interactions with other programs.

Interpretations

Centennial Care 2.0 introduced and maintained a variety of programs and initiatives that demonstrated varying levels of success:

- **Peer Support Services**: Members with substance use disorder (SUD) who received peer support services had higher engagement and longer retention in alcohol and other drug (AOD) dependence treatment than members who did not receive peer support. Similarly, peer support members demonstrated greater continuity of pharmacotherapy for opioid use disorder (OUD) than non-peer support members. Positive outcomes for peer support members continued throughout the coronavirus disease 2019 (COVID-19) public health emergency (PHE), while non-peer support member outcomes did not improve.
- **HH**: Members enrolled in a Health Home (HH) were more likely to access primary care providers (PCPs) and preventive care than non-members, which remained consistent during the COVID-19 PHE. Rates of access to ambulatory/preventive care among HH members generally declined. However, despite higher rates of preventive visits, quality of care results for HH members were mixed and not statistically significant.[7-1]
- **Centennial Rewards (CR)**: Approximately half of Centennial Care 2.0 members participated in the CR program. Members who participated had higher rates of engagement in preventive care services compared to members who did not participate, suggesting that the program encouraged members to engage in preventive care services.[7-2]
- **High-Fidelity Wraparound (HFW)**: The HFW program served its intended population, with nearly all participating members diagnosed with a serious emotional disturbance (SED). Key stakeholders found the transition of HFW services to Centennial Care 2.0 authority to be effective; however, the delay between the application and the Centers for Medicare & Medicaid Services (CMS) approval resulted in misaligned provider education requirements, which did not reflect actual provider education levels and contributed to delayed provider enrollment.
- **Centennial Home Visiting (CHV)**: The CHV program demonstrated decreasing rates of low birth weight (LBW) deliveries as participation increased, which may be attributed to rate stabilization or to expanded member access to prenatal care.

7-1 The lack of statistical significance was likely due to small sample sizes and limited statistical power.

7-2 As CR participation is voluntary, this finding may be influenced by self-selection bias, as those who chose to participate may have been more motivated to manage their health regardless of CR participation.

Member access to PCPs and preventive care improved in 2019 but declined in 2020, likely due to the COVID-19 PHE. Following the PHE, well-child visits in the third, fourth, fifth, and sixth years of life increased to pre-PHE levels; however, access to PCPs and preventive care did not. While statistical methods controlled for the effects of the COVID-19 PHE, it is likely that standard methods were insufficient due to the COVID-19 PHE scale. Telemedicine use expanded during the PHE, but the number of telemedicine providers and the number of members who received telemedicine services had already been increasing prior to the COVID-19 PHE. Statistically significant changes observed before the COVID-19 PHE suggest that Centennial Care 2.0 contributed to increased telemedicine delivery and utilization.

Outcomes for members with an SUD were mixed. Although the number of behavioral health (BH) facilities, providers offering SUD screening, providers using the prescription monitoring program (PMP), and providers delivering medication-assisted treatment (MAT) increased, these changes did not result in higher rates of SUD screenings; increased MAT utilization; reduction in overdose deaths; or decreased emergency department (ED) utilization, inpatient (IP) hospitalization, or SUD IP readmissions. The percentage of SUD members who received treatment and fully delegated care coordination increased in the first year of Centennial Care 2.0 but steadily declined following the COVID-19 PHE. However, SUD members had an increase in the rates of preventive services compared to the general population.

SUD cost trends for non-ED outpatient (OP), long-term care (LTC), and SUD-other services decreased during Centennial Care 2.0 compared to baseline trends; however, overall SUD cost trends did not decrease. Increased expenditures in professional, pharmacy, and SUD-Institution for Mental Diseases (IMD) settings indicate that cost pressures shifted rather than being eliminated. Notably, pharmacy per-member per-month (PMPM) costs for SUD members increased during Centennial Care 2.0, while pharmacy costs specifically for SUD treatment declined relative to the baseline and remained stable throughout the demonstration.

The financial analyses identified general PMPM and per-utilizing-member per-month (PUMPM) cost savings. The number of providers with value-based purchasing (VBP) contracts and the percentage of payments through VBP increased. Quality metrics were maintained during this period, indicating that Centennial Care 2.0 managed the pace at which costs increased while sustaining quality. In addition, capitation payments to the managed care organizations (MCOs) from 2013 through 2023 were sufficient to cover the cost of care for members.

Although a formal serious mental illness (SMI)/SED implementation plan was not approved during Centennial Care 2.0, PMPM costs for members with SMI/SED increased in pharmacy and professional settings but remained stable overall. Approximately 35 to 40 percent of SMI/SED members were engaged in treatment during the demonstration.

Policy Implications

The continuation of successful programs, such as HH and peer support, is recommended. Members enrolled in HHs experienced improved access to PCPs and preventive care services. Members who received peer support services experienced higher rates of engagement and retention of AOD dependence treatment, along with greater continuity of pharmacotherapy for OUD. Throughout Centennial Care 2.0, approximately 4 to 5 percent of SMI/SED members and 1 to 3 percent of SUD members enrolled in an HH. Additionally, about 7 to 10 percent of SUD members received peer support services. Increasing HH enrollment and participation among SMI/SED and SUD members may support improved health outcomes. Further research should be encouraged and shared to explore additional ways that HH and peer support services can enhance health and promote appropriate service utilization within the Medicaid population.

The HFW program should continue current member outreach strategies as they appear to reach the intended population. Key stakeholders at the New Mexico Health Care Authority (HCA) and the New Mexico Children, Youth, and Families Department (CYFD) described success with provider outreach, offering guidance for new providers and remaining available for ongoing support and clarification. However, stakeholders also noted challenges, such as struggling to estimate the number of members needed to financially sustain HFW services and workforce shortages that limited the ability to cover provider absences. The State and relevant stakeholders should collaborate on how to address these barriers.

Centennial Care 2.0 contributed to increased distribution of naloxone, as well as the number of providers who offered MAT and providers who utilized the PMP, with the intention to lower the rate of overdose deaths due to opioids; however, rates of overdose deaths among New Mexico Medicaid members increased, aligning with national trends. The State should continue implementing and developing mitigation strategies and initiatives aimed at reducing overdose fatalities.

Financial analyses revealed that capitation payments from 2013 to 2023 were sufficient to cover the average cost of care incurred by MCOs. On average, capitation payments were 27 percent higher than the actual claims/encounter costs, with a range of 16 and 40 percent above those costs. This variation may suggest that the underlying data and assumptions used to derive capitation payment amounts should be reviewed to ensure they are representative of the expected costs of the Centennial Care 2.0 population.

Interactions With Other State Initiatives

New Mexico implemented multiple strategies to reduce opioid misuse and dependence, including expanding the SUD continuum of care by extending Screening, Brief Intervention, and Referral to Treatment (SBIRT) to primary care, community health centers, and urgent care facilities and allowing increased stays in IMDs for members with an SUD diagnosis and plans to transition to community-based SUD treatment. In addition, HCA managed the New Mexico Opioid Crisis State Targeted Response Grant and a PMP.[7-3] The combination of these activities throughout the State represented a concerted effort to reduce the impact of opioid misuse and addiction. It is likely the concerted efforts of all of these approaches produced the observed results.

Background on Other State Initiatives

State Initiatives

HCA operated numerous programs, initiatives, and grants outside of Centennial Care 2.0 to provide care for its members. Throughout the evaluation period, the Substance Abuse and Mental Health Services Administration (SAMHSA) granted organizations in New Mexico over $185 million in mental health and substance use funds. Key grants provided to HCA included the Substance Use Prevention, Treatment, and Recovery Services Block Grant, which supported planning, implementation, and evaluation activities for SUD prevention and treatment, and the Community Mental Health Services Block Grant, which facilitated comprehensive community mental health services throughout the State.[7-4] HCA also managed the New Mexico Opioid Crisis State Targeted

[7-3] Details of these programs can be found in the "Background on Other State Initiatives" section.
[7-4] Substance Abuse and Mental Health Services Administration. Grants Dashboard. Available at: https://www.samhsa.gov/grants/awards/2018/SM-17-008. Accessed on: Aug 12, 2025.

Response Grant (Opioid STR), which funded the training and distribution of naloxone to first responders and pharmacy staff, as well as provider training for delivering MAT to patients with OUD.[7-5]

HCA promoted provider participation in Project Extension for Community Healthcare Outcomes (ECHO), particularly in rural, tribal, and underserved communities. Project ECHO held educational sessions on healthcare topics including pain management, perinatal OUD, alcohol use, and mental health to facilitate provider collaboration and knowledge on best practices. In 2023, 3,100 providers participated in Project ECHO trainings.[7-6]

HCA developed many SUD health information technology (HIT) initiatives, including a PMP. By December 2023, 89.5 percent of providers consulted the PMP before prescribing medications, a 6 percent increase in utilization since the implementation of Centennial Care 2.0 in 2019.[7-7,7-8] HCA and MCOs collaborated through the Drug Utilization Review (DUR) Board to develop a controlled substances monitoring program. The DUR met quarterly to discuss accomplishments regarding monitoring parameters and gather input from the MCOs on improving clinician reviews of members' history of controlled substance prescriptions in the PMP.[7-9]

Additionally, HCA implemented the ED information exchange (EDIE) to support hospitals, HHs, and MCOs in coordinating care and providing transitional services and assistance. The EDIE tracked registered high-risk and high ED utilizers, providing real-time notifications and insights when patients entered the ED.[7-10] HCA collaborated with the MCOs to reduce non-emergent ED visits through the Low Acuity Non-Emergent (LANE) Care initiative. Centennial Care 2.0 MCO contracts required monitoring of members' ED use and identification of high utilizers. Each MCO employed different strategies:

- Blue Cross Blue Shield of New Mexico (BCBS) implemented a text campaign targeting high-ED utilizers in the preceding 60 days with information on how to locate a PCP or urgent care before visiting an ED.[7-11]
- Presbyterian Health Plan (PHP) encouraged member engagement in preventive services through letters, phone calls, face-to-face meetings, and its 24/7 nurse advice phone line, providing triage and guidance on the appropriate setting of care.[7-12]
- Western Sky Community Care (WSCC) partnered with a community behavioral health (BH) provider to follow-up with members after BH-related ED visits, providing monetary incentives to receive follow-up care.

7-5 Yes New Mexico. Naloxone Distribution and Training. Available at: https://yes.nm.gov/nmhr/s/naloxone-distribution-and-training?language=en_US#:~:text=The%20STR%20grant%20funds%2C%20in%20part%2C%20the%20training,purchase%20of%20naloxone%20each%20year%20of%20the%20initiative. Accessed on: Aug 15, 2025.

7-6 New Mexico Health Care Authority. DY 10 Annual Monitoring Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-anul-mntrng-jan-dec-2023.pdf. Accessed on: Aug 15, 2025.

7-7 Ibid.

7-8 New Mexico Health Care Authority. DY 7 Annual Monitoring Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/annual-monitoring-reports-jan-dec-2020.pdf. Accessed on: Aug 15, 2025.

7-9 New Mexico Health Care Authority. DY 8 Q3 Monitoring Report. Available at: https://www.hsd.state.nm.us/wp-content/uploads/NM_1115-DY8Q3_CMS-Quarterly-Monitoring-Report_20211228.pdf. Accessed on: Aug 15, 2025.

7-10 New Mexico Health Care Authority. DY 10 Annual Monitoring Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-anul-mntrng-jan-dec-2023.pdf. Accessed on: Aug 15, 2025.

7-11 New Mexico Health Care Authority. DY 10 Annual Monitoring Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-anul-mntrng-jan-dec-2023.pdf. Accessed on: Aug 15, 2025.

7-12 New Mexico Health Care Authority. DY 8 Annual Monitoring Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/annl-monitor-rpt-jan-dec-2021.pdf. Accessed on: Aug 15, 2025.

Additionally, LANE was supported by the Community Paramedicine Program, where paramedics provided basic primary care in members' homes, particularly for rural members or those with unreliable transportation.[7-13] During visits, paramedics encouraged communication between members and PCPs.

MCO Initiatives

In addition to the statewide initiatives led by HCA, MCOs also developed initiatives to support members. Table 7-1 through Table 7-3 provide a high-level summary of key MCO initiatives throughout Centennial Care 2.0.

Table 7-1—BCBS Initiatives

Initiative	Description	Citation
BH Care Coordination Community Outreach	Performed outreach to members to assist with medication compliance.	New Mexico Health Care Authority. Quarterly Report, DY 8, Quarter 2. 2021. Available at: https://www.hsd.state.nm.us/wp-content/uploads/NM_1115-DY8Q2_CMS-Quarterly-Monitoring-Report_20210827.pdf. Accessed on: Aug 15, 2025.
Lightbeam	Implemented a new reporting tool, Lightbeam, for providers with a shared savings/VBP plan to view actionable cost and utilization data.	New Mexico Health Care Authority. DY 9 Annual Monitoring Report. 2022. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/m-centennial-care-annl-monitor-rpt-jan-dec-2022.pdf. Accessed on: Aug 15, 2025.
RSA Outreach	RSAs and transition of care staff utilized the EDIE to identify members with SUD at risk of future ED visits and provide support and services to discourage further ED usage.	New Mexico Health Care Authority. Annual Report, DY 7. 2020. Available at: https://www.hsd.state.nm.us/wp-content/uploads/DY7_CMS-Annual-Monitoring_To-CMS.pdf. Accessed on: Aug 15, 2025.
Telehealth Grant Program Update	Awarded funds to providers to develop or expand telehealth services.	New Mexico Health Care Authority. Quarterly Report, DY 6, Quarter 3. 2019. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-qtrly-rpt-jul-sep-2019.pdf. Accessed on: Aug 15, 2025.
Well-Child Visit Rate Increase	Increased rates for well-child visits provided after hours on evenings or weekends to expand access to care.	New Mexico Health Care Authority. DY 10 Annual Monitoring Report. 2023. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-anul-mntrng-jan-dec-2023.pdf. Accessed on: Aug 15, 2025.

Note: BH: behavioral health; DY: demonstration year; ED: emergency department; EDIE: emergency department information exchange; RSA: recovery support assistant; SUD: substance use disorder; VBP: value-based purchasing

7-13 New Mexico Health Care Authority. DY 10 Annual Monitoring Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-anul-mntrng-jan-dec-2023.pdf. Accessed on: Aug 15, 2025.

Table 7-2—PHP Initiatives

Initiative	Description	Citation
Diabetes Prevention Program	Developed the Path for Wellness Diabetes Prevention Program to help members prevent diabetes and manage a healthy weight.	New Mexico Health Care Authority. DY 10 Annual Monitoring Report. 2023. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-anul-mntrng-jan-dec-2023.pdf. Accessed on: Aug 15, 2025.
PHS Baby Bonuses	Developed an enrollment portal to support members in attending well-baby visits through 30 months of age.	New Mexico Health Care Authority. DY 9 Annual Monitoring Report. 2022. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/m-centennial-care-annl-monitor-rpt-jan-dec-2022.pdf. Accessed on: Aug 15, 2025.

Note: DY: demonstration year; PHS: Presbyterian Healthcare Services

Table 7-3—WSCC Initiatives

Initiative	Description	Citation
NeuroFlow	Developed a HIPAA-compliant interactive platform providing members with preventive resources to support the management of PH and mental health.	New Mexico Health Care Authority. DY 10 Annual Monitoring Report. 2023. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-anul-mntrng-jan-dec-2023.pdf. Accessed on: Aug 15, 2025.
Provider Outreach and Education	Provided outreach and education on LTC, BH, foster care, and other integrated care topics.	New Mexico Health Care Authority. DY 9 Annual Monitoring Report. 2022. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/m-centennial-care-annl-monitor-rpt-jan-dec-2022.pdf. Accessed on: Aug 15, 2025.
Pyx Health Program	Developed a free program to address loneliness, social isolation, and SDOH by providing access to health plan resources, community services, mental health support, SUD support, and pregnancy support, among other services.	New Mexico Health Care Authority. DY 9 Annual Monitoring Report. 2022. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/m-centennial-care-annl-monitor-rpt-jan-dec-2022.pdf. Accessed on: Aug 15, 2025.
Telehealth for BH Follow-Up After Acute IP Psychiatric Discharges	Contracted with Teambuilders, a BH agency, to provide telehealth assessments within seven days post-discharge from an IP mental health stay.	New Mexico Health Care Authority. Quarterly Report, Demonstration Year: 8, Quarter 1. 2021. Available at: https://www.hsd.state.nm.us/wp-content/uploads/DY8_Q1_CMS-Monitoring-Report_To-CMS.pdf. Accessed on: Aug 15, 2025.
SSD Outreach	Identified providers serving members who were prescribed antipsychotics but had not completed a glucose or lipid test in the past year. Providers with noncompliant members received educational outreach.	New Mexico Health Care Authority. Quarterly Report, Demonstration Year: 8, Quarter 3. 2021. Available at: https://www.hsd.state.nm.us/wp-content/uploads/NM_1115-DY8Q3_CMS-Quarterly-Monitoring-Report_20211228.pdf. Accessed on: Aug 15, 2025.

Note: BH: behavioral health; HIPAA: Health Insurance Portability and Accountability Act; IP: inpatient; LTC: long-term care; PH: physical health; SDOH: social determinants of health; SSD: *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*; SUD: substance use disorder

COVID-19 Initiatives

Effective March 15, 2020, two days after the President of the United States declared the COVID-19 a national PHE, states could request the use of Section 1135 Waivers. These waivers, authorized under Section 1135 of the Social Security Act, allow the United States Health and Human Services (HHS) 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.[7-14] On March 19, 2022, New Mexico submitted a Section 1135 Waiver application requesting permission to suspend prior authorizations to ensure that all medically necessary emergency care was covered.[7-15] The State also requested payments for services provided in alternative settings, permitting providers to deliver care in settings such as unlicensed facilities and temporary shelters. CMS approved New Mexico's request on March 23, 2020.[7-16]

In addition, CMS granted HCA an Appendix K contract and the temporary ability to: [7-17]

- Provide services in alternative settings including those licensed for other purposes.
- Expand services, including telehealth options.
- Allow provider enrollment and reenrollment with modified risk screening elements, such as suspending fingerprint checks and modifying training requirements to all home- and community-based (HCBS) service providers.
- Permit payment for services rendered by legally responsible individuals (LRIs).
- Modify incident reporting requirements, medication management, or other participant safeguards to ensure individual health and welfare and account for emergency circumstances.
- Continue all care coordination activities using telephonic or virtual visits.
- Include retainer payments for approved personal care services (PCS).
- Allow PCS in an acute care hospital or short-term institutional stay when the necessary supports were not available in that setting during the PHE.
- Suspend the nursing facility level of care (NFLOC) redetermination for the duration of the COVID-19 PHE.

HCA also issued flexibilities and expansions in coverage and benefits. On May 6, 2020, HCA issued the 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.[7-18] LOD #6 allowed the MCOs to waive the requirement for in-person care coordination, shifting care coordination services to operate through telephonic or virtual visits. Telehealth was further expanded in special

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7-14 Centers for Medicare & Medicaid Services. 1135 Waivers. Available at: https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness/1135-waivers. Accessed on: Aug 15, 2025.

7-15 New Mexico Health Care Authority. 1135 Waiver Request. Available at: https://nmmedicaid.portal.conduent.com/static/PDFs/NM%201135%20Waiver.pdf. Accessed on: Aug 15, 2025.

7-16 Centers for Medicare & Medicaid Services. Section 1135 Waiver Flexibilities. Available at: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/entry/54032. Accessed on: Aug 15, 2025.

7-17 New Mexico Health Care Authority. Application for Renewal. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-pa.pdf. Accessed on: Aug 15, 2025.

7-18 New Mexico Health Care Authority. Special COVID-19 LOD #6. Available at: https://nmmedicaid.portal.conduent.com/static/PDFs/Special%20COVID19%20LOD6%20Coordination%20and%20Other%20In-Home%20Services%20Community%20Benefits.pdf. Accessed on: Aug 15, 2025.

COVID-19 LOD #13—Telehealth Services, later repealed and replaced by special COVID-19 LOD #13-1, wherein HCA directed MCOs to notify providers that all possible services should be rendered via telehealth and activated new billing codes to encourage the use of telephone or virtual visits for certain providers.[7-19] The LOD included instructions on how physical health (PH), BH, applied behavior analysis, skilled nursing, and dental providers should bill for services rendered virtually or via telephone. 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 HCA waived prior authorizations for members seeking treatment or COVID-19 testing and extended existing prior authorizations for all other non-COVID-19 related services.[7-20] All modifications allowed through LODs were retroactively effective on March 11, 2020, and remained valid for the duration of the PHE.

New Mexico applied for and received several disaster relief State plan amendments (SPAs) throughout the COVID-19 PHE. Highlights of the approved SPAs included rate increases for nursing facilities, inpatient (IP) hospital services, nonemergency medical transportation (NEMT) providers, and providers of PCS to treat members with COVID-19.[7-21] In addition, SPAs provided coverage and reimbursement for COVID-19 vaccine administration. In addition to making modifications to the Medicaid system, HCA implemented numerous smaller initiatives to improve the wellbeing of members. For example, New Mexico unveiled a phone application (app) called NMConnect, allowing users to access BH professionals 24/7.[7-22] The app 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.[7-23]

On February 9, 2023, the HHS Secretary announced in a letter to state governors the termination of the COVID-19 PHE on May 11, 2023.[7-24]

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 7-4 provides a high-level summary of key MCO initiatives.

7-19 New Mexico Health Care Authority. Special COVID-19 LOD #13. Available at:https://www.hsd.state.nm.us/wp-content/uploads/Special-COVID-19-LOD-13-1-Telehealth-Services-during-the-COVID-19-emergency.pdf. Accessed on: Aug 15, 2025.

7-20 New Mexico Health Care Authority. Special COVID-19 LOD #9. Available at: https://nmmedicaid.portal.conduent.com/static/PDFs/Special%20COVID19%20LOD9%20Prior%20Authorizations%20and%20Cost%20Sharing.pdf. Accessed on: Aug 15, 2025.

7-21 New Mexico Health Care Authority. DY 10 Annual Monitoring Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-anul-mntrng-jan-dec-2023.pdf. Accessed on: Aug 15, 2025.

7-22 New Mexico Crisis and Access Line. NMConnect. Available at: https://nmmedicaid.portal.conduent.com/static/PDFs/Announcing%20the%20NMConnect%20mobile%20app.pdf. Accessed on: Aug 15, 2025.

7-23 New Mexico Children, Youth & Families Department. New Mexico Unveils App for Behavioral Health Support. Available at: https://www.cyfd.nm.gov/2020/04/14/new-mexico-unveils-app-for-behavioral-health-support/. Accessed on: Aug 15, 2025.

7-24 Centers for Medicare & Medicaid Services. CMS Snapshot February 9–16 2023. Available at: https://www.cms.gov/files/document/snapshotupdate02162023.pdf. Accessed on: Aug 15, 2025.

Table 7-4—MCO COVID-19 Initiatives

MCO	Initiative	Description
BCBS	Vaccine Promotion	Held regular COVID-19 vaccine events in communities to promote vaccination.[7-25]
PHP	Meals on Wheels	Provided 14 days of meals to members with food insecurity who tested positive for COVID-19.[7-26]
WSCC	Shots for Shoes	Partnered with organizations throughout the State to provide children older than 12 years a new pair of shoes for receiving the COVID-19 vaccine.[7-27]

Note: BCBS: Blue Cross Blue Shield of New Mexico; COVID-19: coronavirus disease 2019; PHP; Presbyterian Health Plan; WSCC: Western Sky Community Care

7-25 New Mexico Health Care Authority. DY 8 Annual Monitoring Report. 2021. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/annl-monitor-rpt-jan-dec-2021.pdf. Accessed on: Aug 15, 2025.

7-26 Ibid.

7-27 Ibid.

8. Lessons Learned and Recommendations

This Summative Evaluation Report identified several successes attributed to the New Mexico Health Care Authority (HCA) Section 1115 Demonstration Waiver, Centennial Care 2.0, as detailed in previous chapters. The evaluation also highlighted lessons learned and provided recommendations for the future, some related to Centennial Care 2.0 and others pertinent to the operation or evaluation of future State programs.

Health Homes (HHs): The HH program improved preventive visits; however, there were limited improvements in anti-depressant medication management. Additionally, incomplete reporting of HH participation lists introduced challenges to evaluating the program.

Recommendations

- HH providers should ensure communication among care coordination teams, particularly between care coordinators and pharmacists, if applicable, to support monitoring of members' use of anti-depressant medications.
- HCA and HHs should establish and maintain consistent, automated processes to accurately track HH participant enrollment and engagement.

High-Fidelity Wraparound (HFW): Stakeholders noted that the HFW provider education requirements in the Special Terms and Conditions (STCs) differed from the education levels of established providers, which led to delays in provider enrollment.[8-1]

Recommendations

- HCA should collaborate with providers and CMS to review the concordance of provider education requirements with actual providers' education level before finalizing program and policy language.

SMI/SED Amendment: The Centers for Medicare & Medicaid Services (CMS) approved the serious mental illness/serious emotional disturbance (SMI/SED) Institution for Mental Diseases (IMD) authority in March 2023; however, CMS did not approve the related implementation plan by the conclusion of Centennial Care 2.0.[8-2] As a result, the State did not implement SMI/SED service changes during the demonstration, which may have led to delayed or foregone care and the inability to evaluate the amendment in this Summative Evaluation Report.[8-3]

Recommendations

- States and CMS should ensure timely development and approval of Section 1115 Demonstration Waiver implementation plans, including those for SMI/SED programs.

8-1 Centers for Medicare & Medicaid Services. Demonstration Approval – Temporary Extension. Available at: nm-centennial-care-appvl-12152023.pdf. Accessed on: Aug 15, 2025.

8-2 Centers for Medicare & Medicaid Services. CMS Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-ca1.pdf. Accessed on: Aug 15, 2025.

8-3 The State implemented the SMI/SED program in July 2025 under Turquoise Care authority.

State of New Mexico Health Care Authority

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

Summative Evaluation Report, Appendix

December 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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Appendix A. Attachments

Evaluation Design

The current Evaluation Design for the New Mexico Health Care Authority's (HCA's) Section 1115 Demonstration Waiver, Centennial Care 2.0, was approved by the Centers for Medicare & Medicaid Services (CMS) on April 23, 2024. The current CMS-approved Evaluation Design can be found at the following link: *https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-aprvl-04232024.pdf*.

Expanded Methodology

This section contains additional methodologies utilized in the evaluation of Centennial Care 2.0.

Health Home Propensity Score Matching Methodology

Members who did not participate in a Health Home (HH) with characteristics similar to HH members were identified to determine expected HH rates. Propensity score (PS) matching (PSM) was used to select a comparison group that was statistically similar to HH members. The following section describes the methodology used to generate PSs to match members in the treatment group (i.e., HH members) with members in the comparison group (i.e., non-HH members).

Covariate Identification

Member demographic and health condition covariates were identified. The covariates identified during the baseline period were expected to be related to the likelihood of enrollment in an HH. Table A-1 provides the demographic covariates and the methods used to identify each covariate.

Table A-1—Demographic Covariates

Covariates	Identification Method
Age	Date of birth was used to identify member age at the end of the baseline period.
Male/Female	Member gender in the demographic file.
County	County the member resided for the majority of the baseline period. If there was a tie between two or more counties, the county that the member resided in most recently was assigned.
Race	Race codes in the demographic file (Caucasian, American Indian, Asian/Pacific Islander, Black, Other, Unknown).
Ethnicity	Ethnicity code in the demographic file (Hispanic).

An indicator variable for at least one serious mental illness (SMI) or severe emotional disturbance (SED) diagnosis during the baseline period and the Chronic Illness and Disability Payment System (CDPS) risk scores

were included in the models.[A-1, A-2, A-3] Two sets of health condition covariates were investigated to identify the final methodology. Encounter and fee-for-service (FFS) data were used to identify members who had a primary diagnosis of any of the health conditions presented in Table A-2.[A-4]

Table A-2—Health Condition Covariates

Covariates Set 1[A-5]	
• Acute bronchitis	• Hepatitis
• ADHD	• HIV
• Adjustment disorders	• Hypertension
• Alcohol disorder	• Intracranial injury
• Anxiety disorder	• Mood disorders
• Blindness and vision defects	• Osteoarthritis
• Cancer	• Osteoporosis
• Chronic kidney disease	• Other cardiac conditions
• Congestive heart failure	• Other nervous system disorder
• Coronary artery disease	• Other nutritional, endocrine, and metabolic disorders
• Cystic fibrosis	• Personality disorder
• Delirium dementia and amnestic and other cognitive disorders	• Pregnancy
• Developmental disorder	• Rheumatoid arthritis and related diseases
• Diabetes	• Schizophrenia and other psychotic disorders
• Disorders usually diagnosed in infancy childhood or adolescence	• Spondylosis and other back problems
• Epilepsy	• Substance-related disorders
• Esophageal disorders	• Suicide and self-injury
	• Thyroid disorders
Covariate Set 2[A-6]	
• Cancer	• SMI
• Diabetes	• Substance-related disorders
• HIV	

Note: ADHD: Attention deficit hyperactivity disorder; HIV: human immunodeficiency virus; SMI: serious mental illness

A-1 CMS Section 1115 Waiver SMI/SED Technical Specifications, Appendix E, was utilized to identify SMI/SED.

A-2 CDPS is a diagnostic classification system used by Medicaid programs to make health-based capitated payments for Temporary Assistance for Needy Families (TANF) and disabled Medicaid members.

A-3 Kronick, R., Dreyfus, T., Gilmer, T., Lee, Lora. (2000). "Improving Health-Based Payment for Medicaid Beneficiaries: CDPS" Health Care Financing Review. 21(3): 29-64.

A-4 Each health condition was represented separately as an indicator variable. For example, a member diagnosed with both asthma and hypertension would have two health condition flags, one for asthma and another for hypertension.

A-5 Covariate Set 1 was created by identifying health conditions using the Agency for Health Research and Quality (AHRQ) Clinical Classification Software (CCS) categories. Certain CCS categories were grouped together in the final covariate selection based on characteristics of the HH population and clinical relevance (e.g., the CCS category for "diabetes mellitus without complications" and "diabetes mellitus with complications" were grouped together into the Diabetes health condition covariate).

A-6 Mayer V, Mijanovich T, Egorova N, et al. Impact of New York State's Health Home program on access to care among patients with diabetes. BMJ Open Diab Res Care 2021;9:e002204. doi:10.1136/ bmjdrc-2021-002204.

PS Model and Matching Algorithm

PSs matched HH and non-HH members and allowed for the construction of a comparison group without randomized selection. The PSs reduced results bias and controlled for confounding.

The covariates were used to determine each members' PS through logistic regression. The equation for the logistic regression was:

$$\Pr(Y_i = 1) = \frac{1}{1 + \exp\left[-(\beta_0 + \beta_1 X_{i1} + \beta_2 X_{i2} + \cdots + \beta_k X_{ik})\right]}$$

where $\Pr(Y_i = 1)$ is the PS, β is a parameter to be estimated, and X is the covariate.[A-7]

The *PROC PSMATCH* procedure was used for the final matching algorithm, greedy nearest neighbor matching, on the logit of the PS using calipers of width equal to 0.2 of the standard deviation of the logit of the PS. Greedy nearest neighbor matching selected a control individual whose PS was closest to that of the treated individual, sequentially and without replacement.[A-8] If multiple control individuals were equally close to the treatment individual, one of the untreated individuals was randomly selected.

Evaluating Matched Populations

PSM created a "covariate balance" such that the matched comparison population was similar to the HH population across all baseline covariates.[A-9] Baseline characteristic imbalances between the treatment and comparison group may have remained if the statistical model used to calculate the PS was mis-specified. The covariate balance was assessed by calculating standardized differences between matched HH and non-HH members.[A-10] The standardized difference represented the difference in means of a covariate between HH and non-HH members in terms of the pooled standard deviation.[A-11] An absolute value less than 0.1 generally indicated a minimal difference between the two groups (i.e., the covariate was balanced). Additionally, an omnibus test assessed the hypothesis that the mean difference between HH and non-HH members across all measured covariates was zero.[A-12]

Matching algorithms determined the best match under alternative PS models. The matching algorithms included a greedy 5→1 digit matching, greedy matching with different calipers and caliper types (e.g., PS calipers and PS

A-7 Linden, A., Adams, J.L., and Roberts, N. (2005). "Using propensity scores to construct comparable comparison groups for disease management program evaluation." Disease Management Health Outcomes. 13(2): 107-115.

A-8 Austin P. C. (2014). A comparison of 12 algorithms for matching on the propensity score. Statistics in medicine, 33(6), 1057–1069. https://doi.org/10.1002/sim.6004.

A-9 Parsons, L.S. (2001). "Reducing Bias in Propensity Score Matched-Pair Sample Using Greedy Matching Techniques." Paper 214-26. Proceedings of the Twenty-Sixth Annual SAS Users Group International Conference. Cary (NC): SAS Institute Inc.

A-10 Austin, P.C. (2011). "An Introduction to Propensity Score Methods for Reducing the Effects of Confounding in Observational Studies," Multivariate Behav Res. 46(3): 399–424.

A-11 Stuart, E. A., Lee, B. K., & Leacy, F. P. (2013). Prognostic score-based balance measures can be a useful diagnostic for propensity score methods in comparative effectiveness research. Journal of clinical epidemiology, 66(8 Suppl), S84–S90.e1. https://doi.org/10.1016/j.jclinepi.2013.01.013.

A-12 See, Hansen, B.B. and Bowers, J. (2008). "Covariate Balance in Simple, Stratified, and Clustered Comparative Studies," Statistical Science. 23(2): 219-236.

logits at calipers of 0.1 and 0.2), replacement matching with different calipers, and greedy matching with exact matching on county of residence.[A-13]

Table A-3 presents a comparison of the PSM algorithms tested for calendar year (CY) 2019. Overall, the matching algorithms yielded a high matching rate. All model specifications of the greedy 5→1 matching algorithm resulted in matched groups that had between zero and 22 unbalanced covariates. Excluding disease covariates from replacement and greedy matching resulted in a high number of unbalanced covariates (20 matching with replacement and 21 for greedy matching). Including health condition covariate set one in replacement and greedy matching resulted in zero covariates showing statistical imbalance and matching approximately 100 percent of eligible HH members. Greedy matching algorithms were investigated based on exact matching on county of residence, with various specifications of health condition covariate sets and CDPS risk scores. The greedy nearest neighbor matching algorithm with exact matching on county, covariate set one, and the weighted CDPS risk score was selected because it provided the best covariate balance while maintaining a high matching rate of 99.5 percent (represented in boldface in Table A-3).

Table A-3—Summary of PSM Results

Matching Type	Disease Condition Covariates	CDPS Risk Score		Caliper Distance	Distance Type	Covariates Exceeding Standardized Difference Threshold	Omnibus Test *p*-value	HH Matching Rate
		Unweighted	Weighted					
Greedy 5 > 1	None	✓	✓	0.0001 to 0.1	PS	22	<.0001	100.0%
Greedy 5 > 1	Covariate set 1	✓	✓	0.0001 to 0.1	PS	0	0.9681	100.0%
Greedy 5 > 1	Covariate set 2	✓	✓	0.0001 to 0.1	PS	13	<.0001	100.0%
Greedy	None	✓	✓	0.2	LPS	21	<.0001	100.0%
Greedy	Covariate set 1	✓	✓	0.1	LPS	0	0.9288	100.0%
Greedy	Covariate set 1	✓	✓	0.2	LPS	0	0.9288	100.0%
Greedy	Covariate set 1	✓	✓	0.2	PS	0	0.9413	99.7%
Greedy	Covariate set 2	✓	✓	0.1	LPS	8	0.6347	100.0%
Greedy	Covariate set 2	✓	✓	0.2	LPS	8	0.6347	100.0%
Greedy	Covariate set 2	✓	✓	0.2	PS	8	0.6321	99.9%
Greedy–exact match on county	None	✓		0.1	LPS	14	0.6746	100.0%
Greedy–exact match on county	None		✓	0.1	LPS	15	0.0051	99.9%
Greedy–exact match on county	Covariate set 1	✓	✓	0.1	LPS	1	0.7144	99.5%
Greedy–exact match on county	Covariate set 1	✓		0.1	LPS	1	0.7510	99.6%

[A-13] Parsons, L.S. (2001). "Reducing Bias in Propensity Score Matched-Pair Sample Using Greedy Matching Techniques." Paper 214-26. Proceedings of the Twenty-Sixth Annual SAS Users Group International Conference. Cary (NC): SAS Institute Inc.

Matching Type	Disease Condition Covariates	CDPS Risk Score		Caliper Distance	Distance Type	Covariates Exceeding Standardized Difference Threshold	Omnibus Test *p*-value	HH Matching Rate
		Unweighted	Weighted					
Greedy–exact match on county	**Covariate set 1**		✓	**0.1**	**LPS**	**0**	**0.9930**	**99.5%**
Greedy–exact match on county	Covariate set 1			0.1	LPS	1	0.7605	99.6%
Greedy–exact match on county	Covariate set 2	✓	✓	0.1	LPS	8	0.9134	99.9%
Greedy–exact match on county	Covariate set 2	✓		0.1	LPS	7	1.0000	100.0%
Greedy–exact match on county	Covariate set 2		✓	0.1	LPS	7	0.9073	99.9%
Greedy–exact match on county	Covariate set 2			0.1	LPS	9	0.9862	100.0%
Replacement	None	✓	✓	0.2	LPS	20	<.0001	100.0%
Replacement	Covariate set 1	✓	✓	0.1	LPS	0	0.9986	100.0%
Replacement	Covariate set 1	✓	✓	0.2	LPS	0	0.9986	100.0%
Replacement	Covariate set 2	✓	✓	0.1	LPS	6	0.4512	100.0%
Replacement	Covariate set 2	✓	✓	0.2	LPS	6	0.4512	100.0%

Note: Covariate set one was created by grouping health conditions from the Agency for Health Research and Quality (AHRQ) Clinical Classification Software (CCS) categories. Covariate set two was based on CCS groupings from the Mayer et al. (2021) article.[A-14] The row in boldface represents the selected matching algorithm. Blank cells indicate that CPDS risk scores were not included. CDPS: Chronic Illness and Disability Payment System; HH: Health Home; LPS: logit of the propensity score; PS: propensity score

Table A-4 presents a summary of the covariate balance for the chosen matching algorithm in CY 2019. The covariate averages before and after matching non-HH and HH members, computed standardized differences, and an indicator of denoting covariates were balanced according to the absolute standardized difference threshold of 0.1. All covariates were balanced after matching with an absolute standardized difference below 0.1. The prevalence of substance-related disorders, a condition disproportionately less prevalent among non-HH members compared to HH members prior to matching, was similar to that of the matched HH group, indicating improved balance. The omnibus test *p*-value was 0.993, indicating insufficient evidence to reject the joint hypothesis that the mean differences across all covariates between the HH and non-HH groups were equal to zero. These results provide evidence that the PSM process worked as intended and non-HH members were similar in composition to HH members. Further, 99.6 percent of the full HH group was matched, indicating that results represented the majority of the HH-eligible population.

A-14 Mayer V, Mijanovich T, Egorova N, et al. Impact of New York State's Health Home program on access to care among patients with diabetes. BMJ Open Diab Res Care 2021;9:e002204. doi:10.1136/ bmjdrc-2021-002204.

Table A-4—Summary of Covariate Balance (CY 2019)

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Age	27.028	33.750	35.201	33.704	-0.077	*	43.777778
Male	0.450	0.430	0.426	0.430	0.009	*	0.3333333
Baseline SMI/SED diagnosis	0.052	0.343	0.331	0.340	0.020	*	0.8888889
Race							
American Indian	0.061	0.060	0.060	0.059	-0.002	*	0.1111111
Asian Pacific Islander	0.012	0.012	0.012	0.012	0.005	*	0
Black	0.026	0.069	0.067	0.069	0.010	*	0
Other	0.028	0.036	0.033	0.036	0.020	*	0
Unknown	0.010	0.008	0.009	0.008	-0.017	*	0
Ethnicity							
Hispanic	0.000	0.001	0.001	0.001	0.000	*	0
County							
Bernalillo	0.291	0.310	0.311	0.311	0.000	*	0.1111111
Curry	0.025	0.165	0.165	0.165	0.000	*	0
De Baca	0.001	0.004	0.004	0.004	0.000	*	0
Grant	0.014	0.033	0.033	0.033	0.000	*	0
Hidalgo	0.002	0.034	0.033	0.033	0.000	*	0.1111111
Lea	0.033	0.191	0.189	0.189	0.000	*	0.4444444
Quay	0.005	0.027	0.027	0.027	0.000	*	0
Roosevelt	0.007	0.051	0.050	0.050	0.000	*	0.3333333
Sandoval	0.053	0.067	0.067	0.067	0.000	*	0
San Juan	0.043	0.030	0.030	0.030	0.000	*	0
CDPS							
CDPS risk score	1.151	2.068	2.112	2.054	-0.032	*	5.1373465
CDPS weighted risk score	2.460	5.687	5.683	5.578	-0.017	*	29.271584
Covariate set 1							
Acute bronchitis	0.093	0.129	0.134	0.128	-0.015	*	0.3333333
ADHD	0.066	0.227	0.218	0.225	0.018	*	0.6666667
Adjustment disorders	0.093	0.180	0.177	0.180	0.007	*	0.3333333
Alcohol disorder	0.049	0.154	0.153	0.153	0.000	*	0.5555556
Anxiety disorder	0.198	0.563	0.582	0.561	-0.041	*	1
Blindness and vision defects	0.288	0.355	0.340	0.353	0.027	*	0.7777778
Coronary artery disease	0.024	0.070	0.074	0.069	-0.020	*	0.2222222
Cancer	0.045	0.078	0.086	0.077	-0.034	*	0.3333333
Cystic fibrosis	0.000	0.001	0.002	0.001	-0.014	*	0
Congestive heart failure	0.014	0.033	0.035	0.033	-0.011	*	0

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Chronic kidney disease	0.018	0.031	0.038	0.031	-0.039	*	0
Delirium dementia and amnestic and other cognitive disorders	0.016	0.045	0.050	0.044	-0.029	*	0.3333333
Developmental disorder	0.084	0.153	0.141	0.152	0.030	*	0.3333333
Diabetes	0.114	0.213	0.218	0.212	-0.014	*	0.4444444
Epilepsy	0.030	0.082	0.076	0.080	0.017	*	0.3333333
Esophageal disorders	0.099	0.238	0.250	0.236	-0.032	*	0.6666667
Hepatitis	0.026	0.074	0.070	0.073	0.012	*	0.3333333
HIV	0.002	0.007	0.008	0.007	-0.012	*	0.1111111
Hypertension	0.140	0.276	0.281	0.274	-0.015	*	0.5555556
Disorders usually diagnosed in infancy childhood or adolescence	0.030	0.099	0.093	0.098	0.019	*	0.3333333
Intracranial injury	0.023	0.052	0.045	0.051	0.029	*	0.4444444
Mood disorders	0.169	0.575	0.605	0.573	-0.065	*	1
Osteoarthritis	0.074	0.161	0.176	0.160	-0.044	*	0.4444444
Osteoporosis	0.013	0.019	0.024	0.019	-0.028	*	0
Other cardiac conditions	0.102	0.224	0.230	0.223	-0.017	*	0.3333333
Other nervous system disorder	0.179	0.387	0.400	0.385	-0.030	*	0.6666667
Other nutritional, endocrine, and metabolic disorders	0.246	0.368	0.366	0.367	0.001	*	0.6666667
Personality disorder	0.008	0.064	0.052	0.061	0.040	*	0.5555556
Pregnancy	0.050	0.054	0.050	0.054	0.021	*	0
Rheumatoid arthritis and related diseases	0.014	0.041	0.047	0.041	-0.030	*	0.1111111
Schizophrenia and other psychotic disorders	0.022	0.196	0.164	0.193	0.075	*	0.7777778
Spondylosis and other back problems	0.198	0.376	0.380	0.375	-0.012	*	0.6666667
Substance-related disorders	0.155	0.414	0.438	0.412	-0.052	*	0.7777778
Suicide and self-injury	0.024	0.152	0.128	0.149	0.061	*	0.7777778
Thyroid disorders	0.068	0.137	0.146	0.135	-0.032	*	0.5555556

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Covariate set 2							
Cancer	0.031	0.053	0.063	0.053	-0.044	*	0.1111111
Diabetes	0.110	0.212	0.211	0.211	0.000	*	0.4444444
HIV	0.016	0.034	0.029	0.034	0.029	*	0.1111111
SMI	0.179	0.625	0.634	0.623	-0.023	*	1
Substance-related disorders	0.170	0.442	0.460	0.439	-0.041	*	1
N=	413,612	1,963	1,954	1,954	.		9

Note: ADHD: attention deficit hyperactivity disorder; CDPS: Chronic Illness and Disability Payment System; HH: Health Home; HIV: human immunodeficiency virus; SED: serious emotional disturbance; SMI: serious mental illness. N is the population sample size.

Table A-5 and Table A-6 show that CY 2020, CY 2021, and CY 2022 covariate balances were similar. Results provided evidence that the PSM process worked as intended and that non-HH members were similar in composition to HH members. No covariates were unbalanced with an absolute standardized difference below 0.1. The omnibus test *p*-value was 0.7224, 0.4871, and 0.9999 for CY 2020, CY 2021, and CY 2022 respectively, indicating that there was insufficient evidence to reject the joint hypothesis that the mean differences across all covariates between HH and non-HH members were equal to zero. Of the HH group, 99.3 percent, 99.7 percent, and 99.2 percent were matched for CY 2020, CY 2021, and CY 2022, respectively, indicating that results were representative of the majority of the HH population.

Table A-5—Summary of Covariate Balance (CY 2020)

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Age	27.593	32.634	33.182	32.588	-0.031	*	39.588235
Male	0.447	0.442	0.443	0.443	0.001	*	0.2941176
Baseline SMI/SED diagnosis	0.051	0.297	0.281	0.294	0.028	*	0.8235294
Race							
American Indian	0.060	0.050	0.054	0.050	-0.018	*	0.0588235
Asian Pacific Islander	0.012	0.012	0.011	0.013	0.015	*	0
Black	0.026	0.073	0.077	0.073	-0.013	*	0.1176471
Other	0.028	0.034	0.036	0.033	-0.013	*	0.0588235
Unknown	0.009	0.008	0.009	0.008	-0.009	*	0
Ethnicity							
Hispanic	0.000	0.000	0.000	0.000	0.000	*	0
County							
Bernalillo	0.289	0.391	0.394	0.394	0.000	*	0.0588235
Curry	0.026	0.123	0.123	0.123	0.000	*	0
De Baca	0.001	0.002	0.001	0.001	0.000	*	0.1764706
Grant	0.014	0.032	0.031	0.031	0.000	*	0.1764706
Hidalgo	0.002	0.028	0.027	0.027	0.000	*	0.1764706

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Lea	0.033	0.188	0.187	0.187	0.000	*	0.2941176
Quay	0.005	0.023	0.023	0.023	0.000	*	0.0588235
Roosevelt	0.006	0.038	0.038	0.038	0.000	*	0.0588235
Sandoval	0.052	0.056	0.057	0.057	0.000	*	0
San Juan	0.042	0.024	0.024	0.024	0.000	*	0
CDPS							
CDPS risk score	1.141	1.986	1.984	1.966	-0.009	*	4.8938469
CDPS weighted risk score	2.406	5.235	5.185	5.124	-0.010	*	21.94643
Covariate set 1							
Acute bronchitis	0.094	0.128	0.120	0.126	0.019	*	0.3529412
ADHD	0.067	0.236	0.238	0.233	-0.010	*	0.5882353
Adjustment disorders	0.093	0.177	0.182	0.176	-0.016	*	0.2941176
Alcohol disorder	0.048	0.138	0.139	0.136	-0.008	*	0.3529412
Anxiety disorder	0.196	0.542	0.564	0.539	-0.051	*	1
Blindness and vision defects	0.289	0.347	0.361	0.345	-0.033	*	0.6470588
Coronary artery disease	0.023	0.060	0.061	0.059	-0.008	*	0.2352941
Cancer	0.044	0.069	0.069	0.067	-0.006	*	0.2941176
Cystic fibrosis	0.000	0.000	0.000	0.000	0.000	*	0
Congestive heart failure	0.013	0.028	0.026	0.026	0.002	*	0.2352941
Chronic kidney disease	0.017	0.026	0.019	0.026	0.042	*	0.0588235
Delirium dementia and amnestic and other cognitive disorders	0.015	0.038	0.040	0.038	-0.012	*	0.1176471
Developmental disorder	0.085	0.163	0.157	0.163	0.016	*	0.1764706
Diabetes	0.111	0.182	0.185	0.180	-0.014	*	0.4705882
Epilepsy	0.029	0.079	0.073	0.077	0.018	*	0.2941176
Esophageal disorders	0.097	0.220	0.214	0.218	0.008	*	0.6470588
Hepatitis	0.025	0.073	0.070	0.073	0.012	*	0.1176471
HIV	0.002	0.009	0.008	0.009	0.008	*	0
Hypertension	0.136	0.242	0.240	0.240	-0.002	*	0.5882353
Disorders usually diagnosed in infancy childhood or adolescence	0.030	0.105	0.104	0.103	-0.004	*	0.3529412
Intracranial injury	0.023	0.050	0.053	0.049	-0.020	*	0.2352941
Mood disorders	0.167	0.518	0.543	0.515	-0.056	*	0.8823529
Osteoarthritis	0.071	0.143	0.136	0.141	0.015	*	0.4705882

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Osteoporosis	0.012	0.013	0.014	0.013	-0.003	*	0
Other cardiac conditions	0.099	0.224	0.219	0.222	0.008	*	0.5294118
Other nervous system disorder	0.176	0.358	0.367	0.356	-0.022	*	0.6470588
Other nutritional, endocrine, and metabolic disorders	0.245	0.353	0.356	0.351	-0.011	*	0.7058824
Personality disorder	0.008	0.062	0.049	0.060	0.048	*	0.2941176
Pregnancy	0.051	0.056	0.049	0.056	0.028	*	0.0588235
Rheumatoid arthritis and related diseases	0.013	0.036	0.037	0.035	-0.015	*	0.1764706
Schizophrenia and other psychotic disorders	0.021	0.183	0.142	0.178	0.098	*	0.8823529
Spondylosis and other back problems	0.197	0.345	0.350	0.342	-0.017	*	0.7058824
Substance-related disorders	0.154	0.397	0.401	0.395	-0.013	*	0.7647059
Suicide and self-injury	0.024	0.141	0.114	0.138	0.072	*	0.5294118
Thyroid disorders	0.066	0.123	0.120	0.121	0.005	*	0.3529412
Covariate set 2							
Cancer	0.030	0.046	0.045	0.046	0.004	*	0.1176471
Diabetes	0.108	0.179	0.179	0.178	-0.005	*	0.4705882
HIV	0.016	0.037	0.039	0.038	-0.006	*	0
SMI	0.176	0.567	0.568	0.564	-0.006	*	1
Substance-related disorders	0.169	0.421	0.418	0.419	0.002	*	0.8235294
N=	387,702	2,563	2,546	2,546	.		17

Note: ADHD: attention deficit hyperactivity disorder; CDPS: Chronic Illness and Disability Payment System; HH: Health Home; HIV: human immunodeficiency virus; SED: serious emotional disturbance; SMI: serious mental illness. N is the population sample size.

Table A-6—Summary of Covariate Balance (CY 2021)

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Age	28.103	31.772	31.688	31.748	0.003	*	39.111111
Male	0.446	0.435	0.424	0.436	0.023	*	0.1111111
Baseline SMI/SED diagnosis	0.049	0.269	0.260	0.267	0.016	*	0.8888889
Race							
American Indian	0.059	0.048	0.052	0.048	-0.018	*	0
Asian Pacific Islander	0.012	0.012	0.007	0.012	0.044	*	0
Black	0.026	0.077	0.082	0.076	-0.020	*	0.1111111

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Other	0.028	0.035	0.034	0.035	0.004	*	0
Unknown	0.009	0.006	0.002	0.006	0.059	*	0
Ethnicity							
Hispanic	0.000	0.000	0.000	0.000	0.027	*	0
County							
Bernalillo	0.289	0.434	0.435	0.435	0.000	*	0.1111111
Curry	0.028	0.113	0.113	0.113	0.000	*	0
De Baca	0.001	0.002	0.002	0.002	0.000	*	0
Grant	0.014	0.017	0.017	0.017	0.000	*	0
Hidalgo	0.002	0.023	0.022	0.022	0.000	*	0.2222222
Lea	0.033	0.201	0.201	0.201	0.000	*	0.3333333
Quay	0.005	0.019	0.019	0.019	0.000	*	0.1111111
Roosevelt	0.005	0.030	0.030	0.030	0.000	*	0.1111111
Sandoval	0.052	0.056	0.055	0.055	0.000	*	0.1111111
San Juan	0.042	0.018	0.018	0.018	0.000	*	0
CDPS							
CDPS risk score	1.122	1.928	1.945	1.916	-0.016	*	5.5205514
CDPS weighted risk score	2.307	4.907	4.803	4.833	0.005	*	28.007711
Covariate set 1							
Acute bronchitis	0.094	0.125	0.127	0.125	-0.006	*	0.1111111
ADHD	0.066	0.239	0.250	0.237	-0.029	*	0.6666667
Adjustment disorders	0.093	0.193	0.203	0.192	-0.026	*	0.3333333
Alcohol disorder	0.047	0.129	0.112	0.127	0.047	*	0.6666667
Anxiety disorder	0.194	0.512	0.541	0.511	-0.061	*	0.8888889
Blindness and vision defects	0.289	0.349	0.358	0.348	-0.022	*	0.8888889
Coronary artery disease	0.021	0.054	0.055	0.054	-0.006	*	0.3333333
Cancer	0.043	0.062	0.062	0.062	0.000	*	0.1111111
Cystic fibrosis	0.000	0.000	0.000	0.000	0.027	*	0
Congestive heart failure	0.011	0.028	0.029	0.027	-0.006	*	0.1111111
Chronic kidney disease	0.015	0.027	0.025	0.027	0.013	*	0
Delirium dementia and amnestic and other cognitive disorders	0.013	0.036	0.035	0.035	0.002	*	0.2222222
Developmental disorder	0.085	0.168	0.165	0.167	0.006	*	0.4444444
Diabetes	0.107	0.165	0.169	0.165	-0.011	*	0.2222222
Epilepsy	0.028	0.072	0.062	0.071	0.036	*	0.4444444

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Esophageal disorders	0.094	0.197	0.201	0.196	-0.013	*	0.6666667
Hepatitis	0.024	0.065	0.061	0.064	0.013	*	0.2222222
HIV	0.002	0.006	0.005	0.006	0.020	*	0.1111111
Hypertension	0.129	0.221	0.211	0.220	0.023	*	0.3333333
Disorders usually diagnosed in infancy childhood or adolescence	0.030	0.105	0.100	0.104	0.014	*	0.3333333
Intracranial injury	0.022	0.046	0.050	0.045	-0.022	*	0.3333333
Mood disorders	0.163	0.475	0.483	0.473	-0.019	*	0.8888889
Osteoarthritis	0.067	0.124	0.120	0.124	0.012	*	0.1111111
Osteoporosis	0.011	0.011	0.009	0.011	0.014	*	0
Other cardiac conditions	0.096	0.196	0.195	0.196	0.001	*	0.3333333
Other nervous system disorder	0.170	0.342	0.338	0.341	0.006	*	0.7777778
Other nutritional, endocrine, and metabolic disorders	0.242	0.347	0.364	0.346	-0.037	*	0.6666667
Personality disorder	0.007	0.056	0.048	0.055	0.032	*	0.4444444
Pregnancy	0.051	0.059	0.062	0.059	-0.016	*	0.1111111
Rheumatoid arthritis and related diseases	0.013	0.031	0.037	0.031	-0.033	*	0
Schizophrenia and other psychotic disorders	0.020	0.164	0.128	0.161	0.094	*	0.8888889
Spondylosis and other back problems	0.193	0.323	0.328	0.322	-0.013	*	0.6666667
Substance-related disorders	0.151	0.357	0.356	0.356	0.001	*	0.6666667
Suicide and self-injury	0.023	0.129	0.108	0.127	0.058	*	0.7777778
Thyroid disorders	0.064	0.115	0.110	0.114	0.012	*	0.3333333
Covariate set 2							
Cancer	0.029	0.044	0.044	0.045	0.005	*	0
Diabetes	0.103	0.163	0.164	0.162	-0.005	*	0.2222222
HIV	0.016	0.032	0.029	0.032	0.017	*	0.1111111
SMI	0.172	0.518	0.506	0.516	0.021	*	1
Substance-related disorders	0.166	0.379	0.372	0.377	0.010	*	0.8888889
N=	383,544	2,810	2,801	2,801	.		9

Note: ADHD: attention deficit hyperactivity disorder; CDPS: Chronic Illness and Disability Payment System; HH: Health Home; HIV: human immunodeficiency virus; SED: serious emotional disturbance; SMI: serious mental illness. N is the population sample size.

Table A-7—Summary of Covariate Balance (CY 2022)

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Age	28.714	31.969	31.856	31.871	0.001	*	43.608696
Male	0.445	0.430	0.420	0.431	0.021	*	0.3478261
Baseline SMI/SED diagnosis	0.048	0.254	0.242	0.251	0.021	*	0.6086957
Race							
American Indian	0.059	0.046	0.049	0.045	-0.019	*	0.1304348
Asian Pacific Islander	0.012	0.012	0.014	0.012	-0.016	*	0
Black	0.026	0.073	0.077	0.074	-0.012	*	0.0434783
Other	0.029	0.036	0.040	0.036	-0.019	*	0.0869565
Unknown	0.008	0.007	0.006	0.007	0.014	*	0
Ethnicity							
Hispanic	0.000	0.000	0.000	0.000	0.027	*	0
County							
Bernalillo	0.291	0.470	0.472	0.472	0.000	*	0.173913
Curry	0.028	0.090	0.091	0.091	0.000	*	0.0434783
De Baca	0.001	0.003	0.002	0.002	0.000	*	0.0869565
Grant	0.014	0.012	0.012	0.012	0.000	*	0
Hidalgo	0.002	0.023	0.023	0.023	0.000	*	0.0434783
Lea	0.033	0.212	0.211	0.211	0.000	*	0.2608696
Quay	0.005	0.017	0.017	0.017	0.000	*	0
Roosevelt	0.004	0.024	0.023	0.023	0.000	*	0.0869565
Sandoval	0.052	0.052	0.052	0.052	0.000	*	0.1304348
San Juan	0.042	0.014	0.014	0.014	0.000	*	0.0434783
CDPS							
CDPS risk score	1.108	1.904	1.905	1.893	-0.006	*	5.3762414
CDPS weighted risk score	2.237	4.770	4.626	4.685	0.010	*	30.63276
Covariate set 1							
Acute bronchitis	0.094	0.116	0.124	0.116	-0.025	*	0.0869565
ADHD	0.065	0.222	0.225	0.222	-0.007	*	0.2173913
Adjustment disorders	0.093	0.182	0.190	0.183	-0.018	*	0.1304348
Alcohol disorder	0.045	0.120	0.115	0.120	0.014	*	0.173913
Anxiety disorder	0.192	0.491	0.510	0.492	-0.035	*	0.3478261
Blindness and vision defects	0.288	0.362	0.381	0.363	-0.037	*	0.2608696
Coronary artery disease	0.019	0.050	0.046	0.049	0.014	*	0.1304348
Cancer	0.042	0.055	0.051	0.056	0.021	*	0.0434783
Cystic fibrosis	0.000	0.000	0.000	0.000	.	*	0

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Congestive heart failure	0.010	0.025	0.025	0.024	-0.002	*	0.0869565
Chronic kidney disease	0.014	0.026	0.023	0.026	0.021	*	0
Delirium dementia and amnestic and other cognitive disorders	0.011	0.035	0.035	0.034	-0.002	*	0.0869565
Developmental disorder	0.085	0.169	0.177	0.170	-0.019	*	0.0434783
Diabetes	0.103	0.163	0.163	0.162	-0.003	*	0.2173913
Epilepsy	0.027	0.068	0.068	0.067	-0.004	*	0.173913
Esophageal disorders	0.092	0.196	0.188	0.195	0.019	*	0.3043478
Hepatitis	0.023	0.063	0.059	0.063	0.020	*	0.0869565
HIV	0.002	0.007	0.007	0.007	-0.004	*	0.0434783
Hypertension	0.123	0.213	0.215	0.213	-0.004	*	0.2173913
Disorders usually diagnosed in infancy childhood or adolescence	0.030	0.099	0.102	0.099	-0.009	*	0.0434783
Intracranial injury	0.022	0.044	0.044	0.043	-0.005	*	0.1304348
Mood disorders	0.160	0.456	0.465	0.456	-0.018	*	0.3913043
Osteoarthritis	0.065	0.118	0.117	0.117	0.001	*	0.173913
Osteoporosis	0.010	0.010	0.011	0.010	-0.011	*	0
Other cardiac conditions	0.093	0.193	0.188	0.193	0.012	*	0.173913
Other nervous system disorder	0.167	0.337	0.346	0.337	-0.019	*	0.3913043
Other nutritional, endocrine, and metabolic disorders	0.240	0.342	0.360	0.343	-0.035	*	0.2608696
Personality disorder	0.007	0.052	0.046	0.051	0.026	*	0.173913
Pregnancy	0.052	0.050	0.050	0.051	0.003	*	0
Rheumatoid arthritis and related diseases	0.013	0.029	0.028	0.029	0.004	*	0.0869565
Schizophrenia and other psychotic disorders	0.020	0.159	0.136	0.158	0.062	*	0.3478261
Spondylosis and other back problems	0.191	0.312	0.320	0.313	-0.015	*	0.2608696
Substance-related disorders	0.149	0.334	0.327	0.335	0.017	*	0.3043478
Suicide and self-injury	0.023	0.115	0.100	0.114	0.046	*	0.2173913
Thyroid disorders	0.062	0.112	0.113	0.112	-0.005	*	0.173913
Covariate set 2							
Cancer	0.028	0.041	0.031	0.041	0.053	*	0

Covariate	Full Group		Matched Samples		Standardized Difference	Balanced	Unmatched HH
	Comparison	HH	Comparison	HH			
Diabetes	0.099	0.160	0.162	0.159	-0.006	*	0.2173913
HIV	0.016	0.032	0.029	0.032	0.019	*	0.0434783
SMI	0.169	0.495	0.493	0.496	0.007	*	0.3913043
Substance-related disorders	0.163	0.354	0.344	0.354	0.021	*	0.3478261
N=	375,558	2,757	2,734	2,734	.		23

Note: ADHD: attention deficit hyperactivity disorder; CDPS: Chronic Illness and Disability Payment System; HH: Health Home; HIV: human immunodeficiency virus; SED: serious emotional disturbance; SMI: serious mental illness. N is the population sample size.

PS Model and Weighting Algorithm

PS weighting mitigated potential selection bias when evaluating the relationship between Centennial Rewards (CR) program participation and preventive/ambulatory visits (Measure 20). Eligible members were members who participated in CR for the first time or never participated in CR during Centennial Care 2.0. PS weighting retained all participating members, as the number of CR members exceeded the number of non-participating members. The PS, or probability of a member participating in CR, was calculated with a logistic regression. The equation for the logistic regression was:

$$\Pr(Y_i = 1) = \frac{1}{1 + \exp\left[-(\beta_0 + \beta_1 X_{i1} + \beta_2 X_{i2} + \cdots + \beta_k X_{ik})\right]}$$

where $\Pr(Y_i = 1)$ is the PS, the βs are parameters to be estimated and the Xs are the covariates.[A-15]

The *PROC PSMATCH* procedure was used to conduct the final weighting algorithm. Each member's PS was used to assign an average treatment effect weight.

Covariates included age category, race, gender, months enrolled in Centennial Care 2.0, and Clinical Classification Software (CCS) categories.[A-16] Table A-8 and Table A-9 display the covariate balance between CR members and members who never participated in CR before and after applying PS weights for 2014 and 2024, respectively. After PS weights were applied, near perfect covariate balance was achieved, indicating that the PS weights effectively balanced the groups by the model covariates.

[A-15] Linden, A., Adams, J.L., and Roberts, N. (2005). "Using propensity scores to construct comparable comparison groups for disease management program evaluation." Disease Management Health Outcomes. 13(2): 107-115.

[A-16] Selected CCS categories were prevalent or disproportionally represented among CR members. Final CCS categories included acute and chronic tonsillitis, blindness and vision defects, diabetes mellitus with complications, diabetes mellitus without complication, disorders usually diagnosed in infancy childhood or adolescence, other connective tissue disease, other eye disorders, other lower respiratory disease, other upper respiratory disease, other upper respiratory infections, and otitis media and related conditions.

Table A-8—Summary of Covariate Balance (CY 2014)

Covariate	Raw Unweighted		Weighted	
	CR	Never CR	CR	Never CR
Male	45.521	45.490	45.510	45.512
Months enrolled in Centennial Care 2.0	9.992	10.018	10.000	10.000
Aid Category				
Non-disabled adult	43.996	43.955	43.984	43.980
Non-disabled child	44.802	44.742	44.783	44.784
Disabled adult	9.926	9.936	9.930	9.934
Disabled child	1.275	1.367	1.303	1.303
Age Category				
5 and Under	16.103	15.941	16.054	16.055
6–13	21.179	21.213	21.190	21.188
14–20	14.203	14.277	14.227	14.229
21–54	37.503	37.560	37.521	37.519
55–64	7.031	7.058	7.040	7.039
65 and Over	3.977	3.947	3.968	3.970
CCS Category				
Blindness	14.424	14.509	14.451	14.452
Connective tissue disorders	13.521	13.898	13.636	13.636
Diabetes with complications	3.418	3.493	3.441	3.442
Diabetes without complications	7.196	7.136	7.178	7.178
Eye disorders	13.285	13.358	13.307	13.308
Issues diagnosed in childhood	1.047	1.123	1.070	1.070
Lower respiratory disease	15.664	15.524	15.622	15.623
Otitis	8.821	8.630	8.763	8.764
Tonsilitis	2.081	2.117	2.092	2.092
Upper respiratory disease	14.353	14.379	14.361	14.360
Upper respiratory infections	26.179	26.000	26.126	26.129
Race				
American Indian	5.492	5.723	5.563	5.564
Asian/Pacific Islander	1.381	1.390	1.384	1.383
Black	2.747	2.775	2.756	2.756
Hispanic	0.041	0.057	0.046	0.046
Other	2.492	2.474	2.486	2.486
Unknown	1.200	1.195	1.195	1.195
White	86.647	86.386	86.571	86.570

Note: CCS: Clinical Classification Software; CR: Centennial Rewards

Table A-9—Summary of Covariate Balance (CY 2024)

	Raw Unweighted		Weighted	
Covariate	CR	Never CR	CR	Never CR
Male	46.833	46.866	46.850	46.848
Months enrolled in Centennial Care 2.0	10.583	10.578	10.580	10.580
Aid Category				
Non-disabled adult	56.639	56.819	56.768	56.770
Non-disabled child	35.382	35.091	35.178	35.175
Disabled adult	7.203	7.330	7.289	7.291
Disabled child	0.776	0.760	0.765	0.765
Age Category				
5 and Under	11.297	11.178	11.216	11.217
6–13	16.160	16.065	16.102	16.098
14–20	14.631	14.742	14.712	14.710
21–54	45.823	45.904	45.879	45.884
55–64	8.335	8.221	8.258	8.258
65 and Over	3.743	3.874	3.832	3.833
CCS Category				
Blindness	12.070	12.058	12.058	12.062
Connective tissue disorders	13.547	13.510	13.524	13.524
Diabetes with complications	4.221	4.153	4.175	4.175
Diabetes without complications	7.502	7.436	7.459	7.458
Eye disorders	5.420	5.649	5.576	5.577
Issues diagnosed in childhood	1.967	1.993	1.986	1.985
Lower respiratory disease	9.745	9.759	9.751	9.754
Otitis	6.984	6.829	6.877	6.878
Tonsilitis	2.176	2.156	2.161	2.162
Upper respiratory disease	14.877	14.564	14.667	14.664
Upper respiratory infections	22.519	22.716	22.655	22.657
Race				
American Indian	10.018	9.829	9.889	9.890
Asian/Pacific Islander	1.189	1.179	1.181	1.182
Black	2.895	2.994	2.964	2.963
Hispanic	0.019	0.023	0.022	0.022
Other	3.798	3.998	3.935	3.936
Unknown	1.351	1.323	1.319	1.318
White	80.730	80.654	80.689	80.689

Note: CCS: Clinical Classification Software; CR: Centennial Rewards

Supplemental Results

This section contains additional results from the evaluation of Centennial Care 2.0.

Aim One

Quantitative Supplemental Results

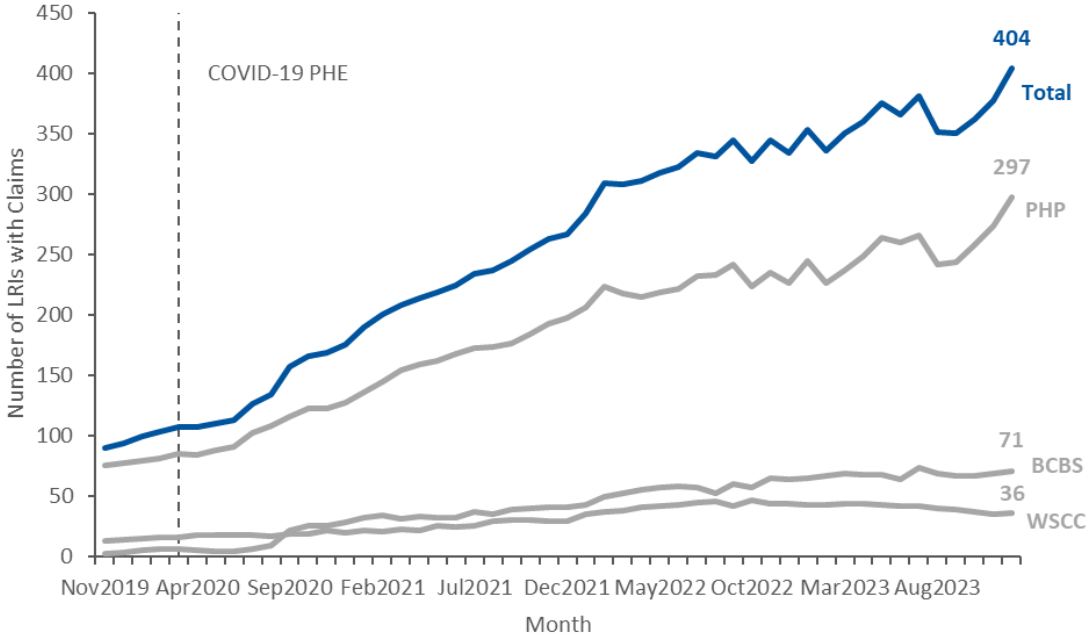
The following figure and tables provide supplemental results for the quantitative analysis of Aim One.

Table A-10—Percent Change in Managed Care Member Age and Gender

	2013		2013–2018 Percent Change		2018–SFY 2024 Percent Change	
Age	Male	Female	Male	Female	Male	Female
0–12	132,127	127,503	-8%	-8%	-7%	-7%
13–18	48,718	47,319	5%	6%	11%	10%
19–34	27,156	66,736	214%	72%	17%	12%
35–49	16,675	29,753	217%	121%	31%	28%
50–64	16,140	23,087	173%	117%	13%	14%
65+	8,976	16,404	25%	12%	22%	12%

Note: SFY: state fiscal year

Figure A-1—Measures 2–5 Supplemental Results: Number of Legally Responsible Individuals (LRIs) with Claims



Data Source: Managed care organization (MCO) report data were used in the analysis LRIs.
Note: BCBS: Blue Cross Blue Shield; COVID-19: coronavirus disease 2019; PHE: public health emergency; PHP: Presbyterian Health Plan; WSCC: Western Sky Community Care.

Table A-11—Measure 6 Supplemental Results

Month	Number of Members Enrolled in an HH	Number of Members Enrolled in Centennial Care 2.0	Percentage of Centennial Care 2.0 Members Enrolled in an HH
2019			
January	—	658,642	—
February	—	658,500	—
March	—	658,401	—
April	2,359	660,553	0.36%
May	—	660,028	—
June	2,579	658,997	0.39%
July	2,608	660,183	0.40%
August	2,746	661,278	0.42%
September	2,854	663,505	0.43%
October	3,063	664,497	0.46%
November	3,183	665,645	0.48%
December	3,281	668,613	0.49%
2020			
January	3,284	670,868	0.49%
February	3,431	671,163	0.51%
March	3,458	673,023	0.51%
April	—	684,184	—
May	—	693,852	—
June	3,524	700,771	0.50%
July	3,453	708,544	0.49%
August	3,463	716,020	0.48%
September	3,523	721,661	0.49%
October	3,574	726,865	0.49%
November	3,601	733,560	0.49%
December	3,678	740,642	0.50%
2021			
January	3,573	744,984	0.48%
February	3,711	748,838	0.50%
March	3,742	752,818	0.50%
April	3,776	756,511	0.50%
May	3,756	759,318	0.49%
June	3,886	762,500	0.51%
July	3,935	766,522	0.51%
August	3,947	770,980	0.51%

Month	Number of Members Enrolled in an HH	Number of Members Enrolled in Centennial Care 2.0	Percentage of Centennial Care 2.0 Members Enrolled in an HH
September	3,956	774,377	0.51%
October	4,012	777,821	0.52%
November	4,054	780,827	0.52%
December	4,063	783,577	0.52%
2022			
January	4,016	787,194	0.51%
February	4,057	789,991	0.51%
March	4,072	791,666	0.51%
April	4,100	795,214	0.52%
May	2,007	797,602	0.25%
June	2,836	799,290	0.35%
July	4,002	801,876	0.50%
August	3,983	803,816	0.50%
September	—	803,814	—
October	3,938	805,088	0.49%
November	—	806,747	—
December	—	807,434	—
2023			
January	—	810,358	—
February	—	812,335	—
March	—	814,787	—
April	—	818,306	—
May	—	803,926	—
June	—	781,476	—
July	—	768,662	—
August	3,613	758,607	0.48%
September	—	744,500	—
October	—	741,704	—
November	3,412	731,350	0.47%
December	3,336	725,825	0.46%
2024			
January	3,336	720,058	0.46%
February	3,273	721,068	0.45%
March	3,217	717,808	0.45%

Month	Number of Members Enrolled in an HH	Number of Members Enrolled in Centennial Care 2.0	Percentage of Centennial Care 2.0 Members Enrolled in an HH
April	3,155	712,574	0.44%
May	3,170	711,181	0.45%
June	3,111	707,128	0.44%

Data Source: Medicaid Management Information System (MMIS) and HH enrollment roster data were used in the analysis of Measure 6.
Note: — indicates no data were received. HH: Health Home.

Table A-12—Measure 7 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2019				
Intercept	3.478	0.094	1373.084	<0.001
Post-implementation indicator	-0.885	0.129	46.901	<0.001
HH indicator	-0.009	0.132	0.004	0.947
HH x post-implementation	3.893	0.599	42.190	<0.001
2020				
Intercept	3.245	0.074	1935.700	<0.001
Post-implementation indicator	-0.846	0.103	67.643	<0.001
HH indicator	0.073	0.106	0.475	0.491
HH x post-implementation	3.759	0.466	65.175	<0.001
2021				
Intercept	3.301	0.072	2091.908	<0.001
Post-implementation indicator	-0.965	0.098	96.572	<0.001
HH indicator	0.115	0.105	1.209	0.271
HH x post-implementation	3.286	0.356	85.073	<0.001
2022				
Intercept	3.398	0.076	1977.108	<0.001
Post-implementation indicator	-1.149	0.100	131.031	<0.001
HH indicator	-0.034	0.107	0.103	0.748
HH x post-implementation	3.905	0.428	83.453	<0.001

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 7.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home.

Table A-13—Measure 7 Parallel Trends Supplemental Results

Year	Group	Change	*p*-value
2019	HH	-1.0pp	(0.745)
	Non-HH	-0.8pp	
2020	HH	-0.7pp	(0.214)
	Non-HH	0.2pp	
2021	HH	-0.8pp	(0.940)
	Non-HH	-0.8pp	
2022	HH	-1.0pp	(0.248)
	Non-HH	-0.2pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 7.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home; pp: percentage point.

Table A-14—Measure 8a Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.777	0.005	152.729	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	-0.006	0.003	-2.407	0.074
Level change	0.017	0.008	2.184	0.094
Change in annual trend	-0.015	0.004	-3.600	0.023
PHE Indicator				
Peak COVID-19 (2020)	-0.010	0.004	-2.517	0.066

Data Source: MMIS data were used in the analysis of Measure 8a.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency.

Table A-15—Measure 8b Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2019				
Intercept	2.316	0.069	1113.225	<0.001
Post-implementation indicator	-0.428	0.112	14.696	<0.001
HH indicator	0.055	0.100	0.307	0.580
HH x post-implementation	1.110	0.191	33.638	<0.001
2020				
Intercept	2.270	0.062	1330.766	<0.001
Post-implementation indicator	-0.489	0.096	26.212	<0.001
HH indicator	-0.158	0.085	3.426	0.064
HH x post-implementation	0.791	0.146	29.466	<0.001

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2021				
Intercept	2.255	0.062	1325.875	<0.001
Post-implementation indicator	-0.682	0.090	57.037	<0.001
HH indicator	-0.029	0.087	0.111	0.739
HH x post-implementation	1.129	0.149	57.667	<0.001
2022				
Intercept	2.290	0.065	1233.044	<0.001
Post-implementation indicator	-0.608	0.106	32.845	<0.001
HH indicator	-0.067	0.091	0.545	0.461
HH x post-implementation	0.975	0.168	33.858	<0.001

Data Source: MMIS data and HH Enrollment Roster data were used in the analysis of Measure 8b.
Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home.

Table A-16—Measure 8b Parallel Trends Supplemental Results

Year	Group	Change	*p*-value
2019	HH	-1.0pp	(0.487)
	Non-HH	-2.2pp	
2020	HH	-1.5pp	(0.456)
	Non-HH	-0.2pp	
2021	HH	-0.3pp	(0.602)
	Non-HH	-1.1pp	
2022	HH	-0.5pp	(0.323)
	Non-HH	-1.9pp	

Data Source: MMIS data and HH enrollment roster data were used in the analysis of Measure 8b.
Note: Annual measurement periods were used. 2024 rates are not presented since Centennial Care 2.0 ended in July 2024. 2023 rates are not presented due to frequency of missing HH data. HH: Health Home; pp: percentage point.

Table A-17—Measure 9a 12–24 Months Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.948	0.019	50.107	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	0.007	0.010	0.645	0.554
Level change	-0.015	0.035	-0.432	0.688
Change in annual trend	-0.016	0.013	-1.252	0.279
PHE Indicator				
Peak COVID-19 (2020)	-0.011	0.027	-0.389	0.717

Data Source: MMIS data were used in the analysis of Measure 9a.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency.

Table A-18—Measure 9a 25 Months–6 Years Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.856	0.020	42.809	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	0.006	0.011	0.515	0.634
Level change	-0.006	0.036	-0.178	0.868
Change in annual trend	-0.015	0.013	-1.147	0.315
PHE Indicator				
Peak COVID-19 (2020)	-0.055	0.029	-1.910	0.129

Data Source: MMIS data were used in the analysis of Measure 9a.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency.

Table A-19—Measure 9a 7–11 Years Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.900	0.014	64.520	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	0.0001	0.007	0.013	0.991
Level change	0.001	0.025	0.032	0.976
Change in annual trend	-0.006	0.009	-0.657	0.547
PHE Indicator				
Peak COVID-19 (2020)	-0.004	0.020	-0.202	0.850

Data Source: MMIS data were used in the analysis of Measure 9a.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency.

Table A-20—Measure 9a 12–19 Years Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.898	0.011	82.853	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	-0.001	0.006	-0.168	0.875
Level change	0.001	0.020	0.069	0.949
Change in annual trend	-0.009	0.007	-1.203	0.295
PHE Indicator				
Peak COVID-19 (2020)	-0.006	0.015	-0.357	0.739

Data Source: MMIS data were used in the analysis of Measure 9a.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency.

Table A-21—Measure 9b Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2019				
Intercept	2.764	0.117	553.208	<0.001
Post-implementation indicator	0.087	0.230	0.142	0.706
HH indicator	0.203	0.172	1.384	0.239
HH x post-implementation	0.297	0.347	0.729	0.393
2020				
Intercept	3.028	0.108	787.077	<0.001
Post-implementation indicator	-0.727	0.167	18.991	<0.001
HH indicator	-0.213	0.145	2.145	0.143
HH x post-implementation	1.714	0.302	32.272	<0.001
2021				
Intercept	2.713	0.084	1049.428	<0.001
Post-implementation indicator	-0.683	0.132	26.857	<0.001
HH indicator	0.237	0.125	3.598	0.058
HH x post-implementation	1.203	0.243	24.448	<0.001
2022				
Intercept	2.837	0.087	1064.413	<0.001
Post-implementation indicator	-0.437	0.163	7.169	0.007
HH indicator	0.058	0.124	0.217	0.641
HH x post-implementation	1.415	0.314	20.342	<0.001

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 9b.
Note: Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home.

Table A-22—Measure 9b Parallel Trends Supplemental Results

Year	Group	Change	*p*-value
2019	HH	0.6pp	(0.953)
	Non-HH	0.6pp	
2020	HH	1.1pp	(0.787)
	Non-HH	0.6pp	
2021	HH	0.8pp	(0.653)
	Non-HH	0.3pp	
2022	HH	0.8pp	(0.109)
	Non-HH	-1.3pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 9b.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home; pp: percentage point.

Table A-23—Measure 10 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.591	0.016	38.134	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	0.0004	0.008	0.042	0.968
Level change	0.017	0.028	0.602	0.580
Change in annual trend	-0.005	0.010	-0.471	0.662
PHE Indicator				
Peak COVID-19 (2020)	-0.082	0.022	-3.705	0.021

Data Source: MMIS data were used in the analysis of Measure 9a.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency.

Table A-24—Measure 11 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2019				
Intercept	1.332	0.149	80.043	<0.001
Post-implementation indicator	-0.100	0.289	0.120	0.729
HH indicator	0.007	0.192	0.001	0.971
HH x post-implementation	-0.012	0.346	0.001	0.971
2020				
Intercept	1.269	0.133	90.425	<0.001
Post-implementation indicator	-0.078	0.245	0.100	0.751
HH indicator	0.082	0.174	0.222	0.637
HH x post-implementation	-0.227	0.300	0.575	0.448
2021				
Intercept	1.271	0.128	98.383	<0.001
Post-implementation indicator	0.139	0.275	0.255	0.614
HH indicator	0.105	0.170	0.381	0.537
HH x post-implementation	-0.069	0.328	0.044	0.833
2022				
Intercept	1.240	0.138	81.102	<0.001
Post-implementation indicator	0.028	0.300	0.009	0.925
HH indicator	0.047	0.178	0.071	0.790
HH x post-implementation	-0.025	0.355	0.005	0.944

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 11.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home.

Table A-25—Measure 11 Parallel Trends Supplemental Results

Year	Group	Change	*p*-value
2019	HH	3.7pp	(0.976)
	Non-HH	3.9pp	
2020	HH	6.6pp	(0.427)
	Non-HH	2.2pp	
2021	HH	3.4pp	(0.897)
	Non-HH	2.9pp	
2022	HH	5.6pp	(0.353)
	Non-HH	0.0pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 11.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home; pp: percentage point.

Table A-26—Measure 12 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2019				
Intercept	-0.148	0.125	1.402	0.236
Post-implementation indicator	0.103	0.247	0.172	0.678
HH indicator	-0.079	0.182	0.187	0.665
HH x post-implementation	-0.255	0.324	0.622	0.430
2020				
Intercept	-0.256	0.122	4.430	0.035
Post-implementation indicator	0.333	0.231	2.079	0.149
HH indicator	-0.076	0.172	0.194	0.659
HH x post-implementation	-0.270	0.296	0.832	0.362
2021				
Intercept	-0.257	0.115	4.959	0.026
Post-implementation indicator	0.375	0.246	2.321	0.128
HH indicator	0.045	0.167	0.074	0.786
HH x post-implementation	-0.153	0.311	0.242	0.623
2022				
Intercept	-0.199	0.117	2.859	0.091
Post-implementation indicator	0.535	0.287	3.474	0.062
HH indicator	-0.030	0.172	0.030	0.863
HH x post-implementation	-0.493	0.351	1.975	0.160

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 12.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home.

Table A-27—Measure 12 Parallel Trends Supplemental Results

Year	Group	Change	*p*-value
2019	HH	-10.2pp	(0.234)
	Non-HH	0.5pp	
2020	HH	-11.2pp	(0.458)
	Non-HH	-17.6pp	
2021	HH	-13.7pp	(0.922)
	Non-HH	-14.5pp	
2022	HH	-12.6pp	(0.308)
	Non-HH	-4.0pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 12.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home; pp: percentage point.

Table A-28—Measure 13 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2019				
Intercept	-0.905	0.138	43.197	<0.001
Post-implementation indicator	0.036	0.271	0.018	0.893
HH indicator	-0.069	0.202	0.118	0.731
HH x post-implementation	-0.263	0.361	0.529	0.467
2020				
Intercept	-1.213	0.143	71.513	<0.001
Post-implementation indicator	0.357	0.258	1.915	0.166
HH indicator	0.115	0.199	0.333	0.564
HH x post-implementation	-0.344	0.333	1.070	0.301
2021				
Intercept	-1.051	0.131	64.671	<0.001
Post-implementation indicator	-0.194	0.291	0.444	0.505
HH indicator	0.125	0.187	0.444	0.505
HH x post-implementation	0.306	0.357	0.733	0.392
2022				
Intercept	-1.140	0.136	69.911	<0.001
Post-implementation indicator	0.447	0.306	2.134	0.144
HH indicator	0.207	0.195	1.131	0.288
HH x post-implementation	-0.370	0.378	0.961	0.327

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 13.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home.

Table A-29—Measure 13 Parallel Trends Supplemental Results

Year	Group	Change	*p*-value
2019	HH	-8.8pp	(0.416)
	Non-HH	-2.3pp	
2020	HH	-10.0pp	(0.578)
	Non-HH	-13.4pp	
2021	HH	-5.6pp	(0.815)
	Non-HH	-3.6pp	
2022	HH	-6.3pp	(0.177)
	Non-HH	4.0pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 13.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home; pp: percentage point.

Table A-30—Measure 14 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2019				
Intercept	-0.626	0.134	21.723	<0.001
Post-implementation indicator	-0.602	0.355	2.885	0.089
HH indicator	0.259	0.175	2.185	0.139
HH x post-implementation	0.627	0.388	2.616	0.106
2020				
Intercept	-0.571	0.125	20.832	<0.001
Post-implementation indicator	-0.415	0.279	2.209	0.137
HH indicator	0.217	0.161	1.817	0.178
HH x post-implementation	0.355	0.315	1.270	0.260
2021				
Intercept	-0.456	0.122	13.882	<0.001
Post-implementation indicator	-0.484	0.319	2.304	0.129
HH indicator	0.114	0.160	0.512	0.474
HH x post-implementation	0.523	0.349	2.242	0.134
2022				
Intercept	-0.700	0.141	24.539	<0.001
Post-implementation indicator	0.386	0.333	1.343	0.247
HH indicator	0.279	0.177	2.485	0.115
HH x post-implementation	-0.172	0.368	0.217	0.641

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 12.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home.

Table A-31—Measure 14 Parallel Trends Supplemental Results

Year	Group	Change	*p*-value
2019	HH	2.4pp	(0.234)
	Non-HH	-7.3pp	
2020	HH	6.8pp	(0.245)
	Non-HH	-2.2pp	
2021	HH	2.3pp	(0.282)
	Non-HH	10.4pp	
2022	HH	1.3pp	(0.912)
	Non-HH	2.1pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 14.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home; pp: percentage point.

Table A-32—Measure 15 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2019				
Intercept	0.348	0.130	7.157	0.007
Post-implementation indicator	-0.537	0.305	3.098	0.078
HH indicator	0.291	0.174	2.802	0.094
HH x post-implementation	0.435	0.345	1.592	0.207
2020				
Intercept	0.298	0.122	6.024	0.014
Post-implementation indicator	-0.323	0.253	1.625	0.202
HH indicator	0.440	0.161	7.423	0.006
HH x post-implementation	0.227	0.295	0.590	0.442
2021				
Intercept	0.547	0.124	19.526	<0.001
Post-implementation indicator	-0.442	0.293	2.277	0.131
HH indicator	0.204	0.165	1.541	0.214
HH x post-implementation	0.353	0.328	1.156	0.282
2022				
Intercept	0.142	0.133	1.131	0.288
Post-implementation indicator	-0.097	0.327	0.089	0.766
HH indicator	0.475	0.172	7.629	0.006
HH x post-implementation	0.193	0.366	0.280	0.597

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 12.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home.

Table A-33—Measure 15 Parallel Trends Supplemental Results

Year	Group	Change	*p*-value
2019	HH	3.1pp	(0.190)
	Non-HH	-7.8pp	
2020	HH	6.1pp	(0.221)
	Non-HH	-3.0pp	
2021	HH	5.0pp	(0.957)
	Non-HH	5.0pp	
2022	HH	5.5pp	(0.802)
	Non-HH	3.8pp	

Data Source: MMIS and HH enrollment roster data were used in the analysis of Measure 15.
Note: Annual measurement periods were used. Rates for 2023 are not presented due to frequency of missing HH data. Rates for 2024 are not presented because Centennial Care 2.0 ended in July 2024. HH: Health Home; pp: percentage point.

Table A-34—Measure 20 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.522	0.036	14.305	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	-0.021	0.014	-1.538	0.152
Level change	0.040	0.042	0.950	0.363
Change in annual trend	0.005	0.014	0.382	0.71
CR Participating				
Participating	0.364	0.039	9.374	<0.001
Pre-Centennial Care 2.0 annual trend x participating	0.012	0.014	0.855	0.411
Level change x participating	0.066	0.047	1.387	0.193
Change in annual trend x participating	-0.023	0.022	-1.038	0.322
PHE Indicator				
COVID-19 PHE	-0.034	0.009	-3.724	0.003

Data Source: MMIS and Finity data were used in the analysis of Measure 20.
Note: COVID-19: coronavirus disease 2019; CR: Centennial Rewards; PHE: public health emergency.

Table A-35—Measure 21 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.910	0.004	231.214	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	0.001	0.001	0.512	0.618
Level change	0.007	0.005	1.460	0.172
Change in annual trend	0.001	0.001	0.696	0.501

Variable	Estimate	Standard Error	Test Statistic	*p*-value
CR Participating				
Participating	0.032	0.004	7.448	<0.001
Pre-Centennial Care 2.0 annual trend x participating	-0.001	0.001	-1.062	0.311
Level change x participating	-0.008	0.005	-1.512	0.159
Change in annual trend x participating	0.003	0.002	1.774	0.104
PHE Indicator				
COVID-19 PHE	-0.019	0.001	-18.755	<0.001

Data Source: MMIS and Finity data were used in the analysis of Measure 21.
Note: COVID-19: coronavirus disease 2019; CR: Centennial Rewards; PHE: public health emergency.

Qualitative Supplemental Results

Key stakeholders at HCA and the New Mexico Children, Youth, and Families Department (CYFD) described their experience implementing the high-fidelity wraparound (HFW) program under Centennial Care 2.0 authority in December 2024 and January 2025.

Barriers to Implementation

According to HCA informants, the Special Terms and Conditions (STCs) initially required providers to have a bachelor's degree to enroll in HFW.[A-17] Many providers were unable to meet this requirement and could not deliver HFW services. HCA and CYFD identified the number of providers who did not meet the requirement and worked with CMS to adjust the STCs to include an equivalent number of years' experience. Overall, provider enrollment in HFW was delayed by approximately six months due to the education requirement and was no longer a concern as of December 2024, due to the years of experience equivalent.

HCA staff felt that the length of time between the application and CMS approval of HFW under Centennial Care 2.0 potentially contributed to the misalignment between STC requirements and providers' education levels. The amendment application was submitted to CMS on March 1, 2021, two years before the State received CMS approval in March 2023.[A-18] In the interim, the State experienced internal turnover of staff who were instrumental in the application process, requiring the State to spend additional time and resources to determine and enact the program as intended. HCA informants intended to improve future decision documentation to ensure that internal program transitions are smooth.

The primary challenge encountered by CYFD was providers' sustainability planning. According to CYFD, providers invested significant resources to provide HFW services, including completing the provider training process. Providers struggled to estimate the number of members that they needed to serve to financially maintain the service. Providers received new members who needed HFW through referrals, which complicated their ability to plan for and ensure sustainability. To mitigate this challenge, CYFD hired a sustainability consultant to assist individual providers. The consultant reviewed providers' organizational structures and offered tailored technical assistance to determine the number of members each provider required to sustain their HFW program. CYFD

A-17 Ibid.
A-18 Centers for Medicare & Medicaid Services. Application – SMI Amendment. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-pa3.pdf. Accessed on: Dec 4, 2025.

anticipated that sustainability planning would remain an ongoing challenge as new providers continued to enroll in the service.

Additional challenges noted by CYFD included:

- Provider workforce shortages uniquely impacted HFW as training and certification were required to deliver the service. As a result, alternative internal providers and staff were unable to spontaneously cover HFW provider absences.
  - To mitigate the workforce shortage, CYFD advertised the service to other internal State divisions, providers, and communities, to increase provider enrollment and participation.
- An August 2023 State Plan Amendment (SPA) mandated that members could not receive HFW services and be a member of a HH simultaneously, which caused widespread provider and member concern as members often required both services.
  - As of the January 2025 key informant interview, CYFD and HCA were working to revise the SPA; in the meantime, members were allowed to continue to receive both services.

Implementation Successes

Stakeholders largely found the implementation of HFW under Centennial Care 2.0 authority to be a smooth and successful process. Despite the initial delays, the State successfully expanded the number of providers enrolled in the program and the number of members receiving HFW services.

"I think that it's the program that sells itself…You know, when people really see and hear about the impact that it has with families, they want to be part of it…It's an approach that I think pools together a lot of best practices." – CYFD

Prior to approval through Centennial Care 2.0, HFW was operated by CYFD through individual funding contracts (i.e., grants). The State dedicated over six years to developing and implementing the program under these alternative funding sources prior to transitioning to Centennial Care 2.0. There were no major operational changes to the established program when it moved under Centennial Care 2.0 authority, contributing to the program's stability and success through the transition.

Informants felt that HFW implementation was due to a successful collaborative effort across internal organizations. A steering committee comprised of staff from HCA, the New Mexico Medical Assistance Division (MAD), the Behavioral Health Services Division (BHSD), and New Mexico State University (NMSU) met weekly during the transition of HFW services to Centennial Care 2.0 authority, providing clear program direction. Initially, the committee reviewed provider applications to ensure certification requirements were met. This responsibility later transitioned to CYFD, after which the committee focused on program improvement, evaluation, and resolving challenges and stakeholder concerns.

HCA noted that its outreach to providers drove the success of the HFW program. HCA delivered email guidance to providers containing detailed enrollment instructions and HFW service billing directions. Providers contacted HCA and CYFD directly with questions or concerns as they enrolled in the program; CYFD most frequently received questions regarding available startup funding. The State remained available throughout implementation to provide guidance and clarification for providers.

Aim Two

This section provides the supplemental results for Aim Two.

Table A-36—Measure 24 Supplemental Results

MCO	Year	Number of Provider Groups Meeting at Least One QMT	Total Number of Provider Groups Reporting Quality Metrics	Percent
BCBS	2019	21	24	87.5%
	2020	23	27	85.2%
	2021	27	29	93.1%
	2022	41	50	82.0%
	2023	38	48	79.2%
	2024*	29	35	82.9%
PHP	2019	101	117	86.3%
	2020	101	124	81.5%
	2021	101	112	90.2%
	2022	116	133	87.2%
	2023	91	102	89.2%
	2024*	68	92	73.9%
WSCC	2019	21	28	75.0%
	2020	29	38	76.3%
	2021	34	48	70.8%
	2022	202	266	75.9%
	2023	164	281	58.4%
	2024*	3	3	100.0%
Program-Wide	2019	143	169	84.6%
	2020	153	189	81.0%
	2021	162	189	85.7%
	2022	359	449	80.0%
	2023	293	431	68.0%
	2024*	100	130	76.9%

Data source: MCO Annual Supplemental Value-Based Purchasing (VBP) reports were used in the analysis of Measure 24.
Note: Only metrics with 10 or more attributed members are included. BCBS: Blue Cross Blue Shield; MCO: managed care organization; PHP: Presbyterian Health Plan; QMT: quality metric target; WSCC: Western Sky Community Care.
*Data for 2024 were incomplete.

Table A-37—Measure 24 Supplemental Results

MCO	Year	Average Percent of QMTs Met	Interquartile Range
BCBS	2019	34.5%	38.8%
	2020	33.0%	33.3%
	2021	43.9%	16.7%
	2022	45.8%	46.7%
	2023	41.5%	46.7%
	2024*	38.3%	42.7%
PHP	2019	65.4%	50.0%
	2020	43.5%	36.8%
	2021	47.3%	38.1%
	2022	50.0%	38.1%
	2023	54.1%	46.9%
	2024*	30.2%	40.0%
WSCC	2019	38.0%	58.9%
	2020	43.5%	70.0%
	2021	35.6%	60.0%
	2022	47.4%	85.7%
	2023	34.6%	60.0%
	2024*	60.0%	40.0%
Program-Wide	2019	56.5%	75.0%
	2020	42.0%	40.0%
	2021	43.8%	38.6%
	2022	48.0%	64.6%
	2023	40.0%	71.4%
	2024*	33.1%	36.2%

Data source: MCO Annual Supplemental VBP reports were used in the analysis of Measure 24.
Note: Only metrics with 10 or more attributed members are included. BCBS: Blue Cross Blue Shield; MCO: managed care organization; PHP: Presbyterian Health Plan; QMT: quality metric target; WSCC: Western Sky Community Care.
*Data for 2024 were incomplete.

Table A-38—Total and Average Costs per Member by Year

Year	Actual PMPM Cost	Expected PMPM Cost	Capitation PMPM Cost	Actual Cost	Expected Cost	Capitation Cost
2013	$301.87	$301.87	$369.39	$1,752,158,572	$1,752,158,572	$2,144,109,959
2014	$385.03	$356.37	$539.12	$2,614,510,882	$2,419,945,416	$3,660,911,963
2015	$408.89	$380.87	$555.21	$3,129,232,395	$2,914,779,137	$4,249,010,245
2016	$411.38	$390.05	$531.78	$3,342,079,836	$3,168,775,979	$4,320,190,554
2017	$396.81	$410.74	$507.63	$3,260,227,701	$3,374,654,874	$4,170,665,979
2018	$429.46	$452.24	$516.81	$3,415,177,410	$3,596,376,695	$4,109,814,987
2019	$464.03	$509.96	$536.54	$3,683,850,264	$4,048,492,069	$4,259,504,413
2020	$473.18	$486.51	$597.69	$3,994,166,495	$4,106,688,642	$5,045,159,482
2021	$474.10	$515.03	$599.10	$4,351,843,316	$4,727,504,655	$5,499,173,815
2022	$479.69	$549.67	$627.36	$4,600,144,178	$5,271,144,842	$6,016,193,892
2023	$516.80	$541.54	$653.87	$4,812,310,919	$5,042,761,200	$6,088,713,351

Data source: MMIS data were used in the analysis of Measure 27 and 28.
Note: PMPM: per-member per-month.

Table A-39—Costs Per Member Trends by Year

Year	Average Annual Trend	Expected Annual Trend	Capitation Average Annual Trend
2014	27.5%	18.1%	45.9%
2015	16.4%	12.3%	22.6%
2016	10.9%	8.9%	12.9%
2017	7.1%	8.0%	8.3%
2018	7.3%	8.4%	6.9%
2019	7.4%	9.1%	6.4%
2020	6.6%	7.1%	7.1%
2021	5.8%	6.9%	6.2%
2022	5.3%	6.9%	6.1%
2023	5.5%	6.0%	5.9%

Data source: MMIS data were used in the analysis of Measure 27 and 28.

Table A-40—Blue Cross Blue Shield (BCBS) Costs

Year	Actual PMPM Cost	Expected PMPM Cost	Capitation PMPM Cost	Actual Cost	Expected Cost	Capitation Cost
2019	$525.04	$525.04	$553.22	$1,452,314,436	$1,452,314,436	$1,530,269,877
2020	$504.43	$483.89	$615.12	$1,520,161,752	$1,458,261,759	$1,853,709,062
2021	$487.17	$506.56	$627.99	$1,613,736,994	$1,677,986,206	$2,080,226,527
2022	$492.95	$537.80	$648.77	$1,724,942,244	$1,881,864,589	$2,270,181,253
2023	$534.92	$520.51	$674.03	$1,809,312,846	$1,760,551,206	$2,279,827,301

Data source: MMIS data were used in the analysis of Measure 27 and 28.
Note: per-member per-month.

Table A-41—Presbyterian Health Plan (PHP) Costs

Year	Actual PMPM Cost	Expected PMPM Cost	Capitation PMPM Cost	Actual Cost	Expected Cost	Capitation Cost
2019	$437.62	$437.62	$534.40	$1,947,924,351	$1,947,924,351	$2,378,702,666
2020	$462.75	$425.78	$595.15	$2,135,393,641	$1,964,779,472	$2,746,371,261
2021	$475.17	$453.39	$590.92	$2,320,433,291	$2,214,054,708	$2,885,656,041
2022	$489.19	$486.88	$624.24	$2,463,999,549	$2,452,378,923	$3,144,267,247
2023	$525.48	$485.30	$652.41	$2,532,128,115	$2,338,526,242	$3,143,730,196

Data source: MMIS data were used in the analysis of Measure 27 and 28.
Note: PMPM: per-member per-month.

Table A-42—Western Sky Community Care (WSCC) Costs

Year	Actual PMPM Cost	Expected PMPM Cost	Capitation PMPM Cost	Actual Cost	Expected Cost	Capitation Cost
2019	$393.03	$393.03	$485.77	$283,611,477	$283,611,477	$350,531,870
2020	$416.51	$395.19	$547.47	$338,611,102	$321,278,459	$445,079,159
2021	$424.79	$436.06	$542.38	$417,673,030	$428,756,107	$533,291,248
2022	$390.28	$459.66	$571.13	$411,202,384	$484,298,732	$601,745,392
2023	$423.91	$460.39	$598.82	$470,869,958	$511,388,579	$665,155,854

Data source: MMIS data were used in the analysis of Measure 27 and 28.
Note: PMPM: per-member per-month.

Table A-43—Capitation Per-Member Per-Month (PMPM) by Cohort, Plan, and Year

Year	Plan	TANF/ AFDC	SSI & Waiver	CYFD	ABP	LTC	LTC Healthy Duals	PW, MA	Grand Total
2019	BCBS	$316.67	$1,361.45	$976.71	$546.36	$3,365.88	$254.61	$1,037.30	$553.30
2019	PHP	$297.99	$1,188.80	$992.85	$487.16	$3,168.18	$265.62	$1,029.82	$534.45
2019	WSCC	$293.40	$1,174.19	$987.54	$473.02	$3,390.92	$241.92	$1,063.70	$485.91
2019	**Statewide**	**$303.84**	**$1,242.99**	**$987.83**	**$508.38**	**$3,240.94**	**$260.61**	**$1,035.51**	**$536.61**
2020	BCBS	$349.62	$1,503.86	$1,062.10	$623.78	$3,705.23	$299.08	$1,172.62	$615.45
2020	PHP	$330.93	$1,328.95	$1,082.99	$562.85	$3,505.84	$309.80	$1,173.62	$595.40
2020	WSCC	$334.06	$1,278.26	$1,077.53	$533.41	$3,695.34	$279.66	$1,196.08	$547.82
2020	**Statewide**	**$337.72**	**$1,382.06**	**$1,076.47**	**$583.26**	**$3,580.66**	**$303.96**	**$1,175.50**	**$597.98**
2021	BCBS	$361.65	$1,632.40	$1,062.95	$643.67	$3,936.87	$280.02	$1,176.99	$628.18
2021	PHP	$329.03	$1,285.84	$1,054.84	$569.18	$3,673.33	$290.30	$1,177.82	$591.09
2021	WSCC	$330.34	$1,216.60	$1,065.14	$536.34	$3,851.45	$265.62	$1,195.07	$542.58
2021	**Statewide**	**$340.67**	**$1,395.95**	**$1,058.26**	**$593.88**	**$3,768.65**	**$284.64**	**$1,179.39**	**$599.28**
2022	BCBS	$376.68	$1,696.29	$1,104.99	$664.42	$4,312.57	$303.56	$1,271.37	$649.35
2022	PHP	$346.04	$1,401.30	$1,106.39	$600.12	$4,066.91	$313.35	$1,272.30	$624.57
2022	WSCC	$348.97	$1,363.46	$1,105.72	$562.01	$4,238.87	$285.34	$1,289.58	$571.61
2022	**Statewide**	**$357.29**	**$1,498.97**	**$1,105.91**	**$620.29**	**$4,156.56**	**$307.11**	**$1,273.97**	**$627.79**

Year	Plan	TANF/ AFDC	SSI & Waiver	CYFD	ABP	LTC	LTC Healthy Duals	PW, MA	Grand Total
2023	BCBS	$383.78	$1,755.40	$1,251.99	$683.85	$4,530.52	$305.55	$1,323.31	$674.32
2023	PHP	$349.51	$1,449.01	$1,226.37	$622.34	$4,292.30	$308.76	$1,325.34	$652.66
2023	WSCC	$362.86	$1,420.39	$1,243.68	$588.52	$4,528.26	$281.12	$1,337.52	$599.43
2023	**Statewide**	**$363.22**	**$1,551.93**	**$1,235.91**	**$641.20**	**$4,384.81**	**$303.95**	**$1,326.35**	**$654.18**

Data source: MMIS data were used in the analysis of Measure 27 and 28.
Note: ABP: alternative benefit plan; AFDC: Aid to Families with Dependent Children; BCBS: Blue Cross Blue Shield; CYFD: Children, Youth, and Families Department; LTC: long-term care; MA: medical assistance; PHP: Presbyterian Health Plan; PW: pregnant women; SSI: supplemental security income; TANF: Temporary Assistance for Needy Families; WSCC: Western Sky Community Care.

Table A-44—Total and Average Costs per User

Year	Actual PUMPM Cost	Expected PUMPM Cost	Capitation PUMPM Cost	Actual Cost	Expected Cost	Capitation Cost
2013	$803.94	$803.94	$983.78	$1,752,158,572	$1,752,158,572	$2,144,109,959
2014	$913.07	$861.56	$1,278.50	$2,614,510,882	$2,467,032,231	$3,660,911,963
2015	$943.45	$914.62	$1,281.06	$3,129,232,395	$3,033,611,206	$4,249,010,245
2016	$970.01	$975.12	$1,253.89	$3,342,079,836	$3,359,691,165	$4,320,190,554
2017	$957.74	$1,050.64	$1,225.20	$3,260,227,701	$3,576,471,235	$4,170,665,979
2018	$1,007.33	$1,115.91	$1,212.22	$3,415,177,410	$3,783,320,679	$4,109,814,987
2019	$1,061.52	$1,220.85	$1,227.39	$3,683,850,264	$4,236,790,630	$4,259,504,413
2020	$1,171.57	$1,275.05	$1,479.84	$3,994,166,495	$4,346,966,689	$5,045,159,482
2021	$1,114.23	$1,270.57	$1,407.98	$4,351,843,316	$4,962,464,432	$5,499,173,815
2022	$1,154.75	$1,365.06	$1,510.22	$4,600,144,178	$5,437,956,912	$6,016,193,892
2023	$1,302.60	$1,416.01	$1,648.10	$4,812,310,919	$5,231,292,865	$6,088,713,351

Data source: MMIS data were used in the analysis of Measure 27 and 28.
Note: PUMPM: per-utilizing-member per-month.

Table A-45—Cost Per User Trends by Year Supplemental Results

Year	Average Annual Trend	Expected Annual Trend	Capitation Average Annual Trend
2014	13.6%	7.2%	30.0%
2015	8.3%	6.7%	14.1%
2016	6.5%	6.6%	8.4%
2017	4.5%	6.9%	5.6%
2018	4.6%	6.8%	4.3%
2019	4.7%	7.2%	3.8%
2020	5.5%	6.8%	6.0%
2021	4.2%	5.9%	4.6%
2022	4.1%	6.1%	4.9%
2023	4.9%	5.8%	5.3%

Data source: MMIS data were used in the analysis of Measure 27 and 28.

Aim Three

This section provides the supplemental results for Aim Three.

Table A-46—Measure 30 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	3.638	0.034	11,206.495	<0.001
Timeframe				
Pre-Centennial Care 2.0 monthly trend	0.025	0.001	845.906	<0.001
Level change	0.011	0.044	0.061	0.805
Change in monthly trend	0.023	0.004	27.805	<0.001
Seasonality				
Q2	-0.003	0.005	0.414	0.52
Q3	-0.050	0.006	77.605	<0.001
Q4	-0.013	0.006	5.389	0.02
PHE Timeframe				
Level Change at COVID-19 PHE	2.819	0.034	6,718.211	<0.001
Change in monthly trend at COVID-19 PHE	-0.054	0.004	152.821	<0.001

Data Source: MMIS data were used in the analysis of Measure 30.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Table A-47—Measure 31 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	8.787	0.012	533,578.343	<0.001
Timeframe				
Pre-Centennial Care 2.0 monthly trend	-0.017	0.000	4,261.967	<0.001
Level change	0.703	0.009	5,603.776	<0.001
Change in monthly trend	0.041	0.001	2,016.518	<0.001
Seasonality				
Q2	-0.001	0.002	0.451	0.502
Q3	-0.065	0.002	1,214.402	<0.001
Q4	0.009	0.002	25.135	<0.001
PHE Timeframe				
Level Change at COVID-19 PHE	2.145	0.008	77,897.275	<0.001
Change in monthly trend at COVID-19 PHE	-0.038	0.001	1,746.096	<0.001
Demographics				
Average age	-0.027	0.011	6.392	0.011
Percent female	0.074	0.006	135.654	<0.001
Percent disabled	-0.080	0.006	191.089	<0.001

Data Source: MMIS data were used in the analysis of Measure 31.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Table A-48—Measures 32, 33, and 34 Supplemental Results: BCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-19] Rates

	Percent of Respondents with Positive Rating									
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Member rating of healthcare (Measure 32)										
Adult	75.1% (N=213)	78.2% (N=174)	72.8% (N=217)	78.4% (N=204)	73.8% (N=191)	78.8% (N=118)	75.8% (N=124)	76.0% (N=129)	74.0% (N=127)	71.4% (N=112)
Child	87.4% (N=223)	86.9% (N=206)	85.5% (N=248)	90.6% (N=245)	87.7% (N=236)	86.0% (N=143)	86.1% (N=101)	88.0% (N=100)	84.0% (N=125)	86.1% (N=122)
Member rating of health plan (Measure 33)										
Adult	78.3% (N=304)	79.0% (N=238)	75.4% (N=280)	74.6% (N=280)	74.7% (N=245)	79.0% (N=181)	79.0% (N=200)	84.5% (N=194)	74.3% (N=202)	74.2% (N=182)
Child	86.8% (N=333)	86.1% (N=287)	87.7% (N=317)	89.1% (N=320)	87.2% (N=305)	88.9% (N=234)	85.4% (N=198)	83.1% (N=183)	84.0% (N=188)	85.3% (N=197)
Member rating of personal doctor (Measure 33)										
Adult	82.6% (N=224)	79.4% (N=180)	82.7% (N=225)	81.4% (N=199)	83.8% (N=191)	88.1% (N=135)	82.5% (N=160)	80.7% (N=150)	84.9% (N=159)	78.1% (N=128)
Child	86.5% (N=274)	89.3% (N=233)	90.2% (N=274)	91.6% (N=273)	92.9% (N=253)	90.8% (N=196)	90.7% (N=150)	89.4% (N=141)	91.0% (N=156)	89.1% (N=174)

Data source: Managed care organization (MCO) CAHPS reports were used in the analysis of Measures 32, 33, and 34.
Note: N is the sample size of respondents.

Table A-49—Measures 32, 33, and 34 Supplemental Results: PHP CAHPS Rates

	Percent of Respondents with Positive Rating									
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Member rating of healthcare (Measure 32)										
Adult	71.4% (N=269)	77.5% (N=227)	72.3% (N=271)	71.8% (N=248)	69.4% (N=216)	78.7% (N=183)	76.5% (N=149)	68.7% (N=147)	76.7% (N=150)	73.4% (N=128)
Child	85.7% (N=237)	84.5% (N=206)	87.1% (N=224)	82.0% (N=261)	83.5% (N=272)	87.8% (N=181)	85.5% (N=110)	81.5% (N=124)	84.7% (N=137)	89.4% (N=142)
Member rating of health plan (Measure 33)										
Adult	76.3% (N=355)	80.9% (N=325)	78.6% (N=384)	77.2% (N=346)	78.4% (N=319)	78.7% (N=272)	73.2% (N=231)	78.2% (N=239)	80.2% (N=242)	78.7% (N=202)
Child	88.3% (N=332)	85.2% (N=310)	89.1% (N=348)	86.5% (N=370)	86.9% (N=381)	87.3% (N=307)	88.2% (N=245)	86.8% (N=220)	87.8% (N=254)	88.9% (N=235)

[A-19] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

	Percent of Respondents with Positive Rating									
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Member rating of personal doctor (Measure 33)										
Adult	79.8% (N=277)	83.4% (N=241)	82.9% (N=287)	80.4% (N=265)	79.3% (N=241)	82.1% (N=207)	81.4% (N=177)	79.9% (N=174)	80.1% (N=186)	79.0% (N=143)
Child	84.8% (N=310)	87.2% (N=274)	91.1% (N=291)	89.1% (N=320)	87.7% (N=324)	91.1% (N=259)	92.3% (N=194)	90.4% (N=178)	89.0% (N=200)	90.9% (N=197)

Data source: MCO CAHPS reports were used in the analysis of Measures 32, 33, and 34.
Note: N is the sample size of respondents.

Table A-50—Measure 32 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Adult				
Intercept	75.287	0.837	89.946	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	-0.754	0.349	-2.162	0.083
Level change	4.736	2.045	2.316	0.068
Change in annual trend	-0.229	0.452	-0.506	0.634
PHE Indicator				
COVID-19 PHE	0.611	1.116	0.548	0.608
Child				
Intercept	85.399	0.307	278.145	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	-0.071	0.109	-0.654	0.542
Level change	1.479	1.608	0.920	0.400
Change in annual trend	-0.122	0.538	-0.226	0.830
PHE Indicator				
COVID-19 PHE	0.383	1.099	0.349	0.742

Data source: MCO CAHPS reports were used in the analysis of Measure 32.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency.

Table A-51—Measure 33 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Adult				
Intercept	77.950	0.637	122.374	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	-0.291	0.202	-1.442	0.209
Level change	2.662	1.215	2.191	0.080
Change in annual trend	-0.146	0.340	-0.428	0.686
PHE Indicator				
COVID-19 PHE	-3.013	0.787	-3.830	0.012
Child				
Intercept	87.266	0.235	371.547	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	-0.068	0.082	-0.825	0.447
Level change	-0.296	0.688	-0.430	0.685
Change in annual trend	0.084	0.225	0.371	0.726
PHE Indicator				
COVID-19 PHE	0.256	0.477	0.536	0.615

Data source: MCO CAHPS reports were used in the analysis of Measure 33.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency.

Table A-52—Measure 34 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Adult				
Intercept	81.553	0.057	1437.037	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	-0.165	0.022	-7.618	<0.001
Level change	3.406	0.595	5.726	0.002
Change in annual trend	-1.133	0.184	-6.155	0.002
PHE Indicator				
COVID-19 PHE	-0.837	0.469	-1.785	0.134
Child				
Intercept	87.510	0.320	273.298	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	0.650	0.157	4.150	0.009
Level change	-0.270	0.777	-0.348	0.742
Change in annual trend	-0.850	0.160	-5.314	0.003
PHE Indicator				
COVID-19 PHE	1.784	0.205	8.689	<0.001

Data source: MCO CAHPS reports were used in the analysis of Measure 34.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency.

Table A-53—Measure 35 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	13.981	0.003	28075771.648	<0.001
Timeframe				
Pre-Centennial Care 2.0 monthly trend	0.020	0.001	1557.336	<0.001
Level change	0.075	0.001	2684.721	<0.001
Change in monthly trend	-0.018	0.0005	1603.357	<0.001
Seasonality				
Q2	0.027	0.001	2503.266	<0.001
Q3	0.025	0.001	2570.865	<0.001
Q4	0.045	0.001	7733.482	<0.001
PHE Indicator				
COVID-19 lockdown (Q2 2020)	0.039	0.001	1753.594	<0.001
COVID-19 reopening (Q3 2020–Q1 2021)	0.032	0.001	2808.963	<0.001
Demographics				
Average age	0.183	0.004	1697.956	<0.001
Percent female	-0.527	0.005	11192.325	<0.001
Percent disabled	0.242	0.003	8065.351	<0.001

Data source: MCO Report #35 data were used in the analysis of Measure 35.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Aim Four

This section provides the supplemental results for Aim Four.

Table A-54—Measure 37 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	91.320	7.379	12.376	<0.001
Timeframe				
Pre-Centennial Care 2.0 monthly trend	1.353	0.490	2.763	0.007
Level change	47.508	9.835	4.831	<0.001
Change in monthly trend	0.064	0.525	0.122	0.903
Seasonality				
Q2	1.444	5.213	0.277	0.782
Q3	8.611	5.240	1.643	0.104
Q4	-1.061	5.319	-0.199	0.842
PHE Indicator				
March 2020	-1.133	5.914	-0.192	0.849
April 2020–May 2020	-29.203	8.873	-3.291	0.001
June 2020–March 2021	3.130	7.150	0.438	0.663

Note: PHE: public health emergency; Q: quarter.

Table A-55—Measure 38 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	822.159	247.488	3.322	0.001
Timeframe				
Pre-Centennial Care 2.0 monthly trend	25.566	11.091	2.305	0.024
Level change	7.325	124.491	0.059	0.953
Change in monthly trend	-24.568	9.065	-2.710	0.008
Seasonality				
Q2	40.646	52.566	0.773	0.442
Q3	63.179	40.948	1.543	0.127
Q4	-140.318	42.990	-3.264	0.002
PHE Indicator				
March 2020	14.603	71.625	0.204	0.839
April 2020–May 2020	-148.229	70.558	-2.101	0.039
June 2020–March 2021	83.941	69.864	1.201	0.233
Demographics				
Average age	222.537	300.749	0.740	0.462
Percent female	-361.517	307.872	-1.174	0.244
Percent disabled	-84.088	163.510	-0.514	0.609

Note: PHE: public health emergency; Q: quarter.

Table A-56—Measure 39 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.203	0.018	11.458	<0.001
Timeframe				
Pre-Centennial Care 2.0 monthly trend	0.003	0.001	4.910	<0.001
Level change	-0.001	0.008	-0.129	0.898
Change in monthly trend	-0.002	0.000	-9.757	<0.001
Seasonality				
Q2	0.000	0.002	0.021	0.984
Q3	0.001	0.004	0.392	0.696
Q4	-0.002	0.006	-0.311	0.757
PHE Indicator				
March 2020	0.007	0.003	2.077	0.041
April 2020–May 2020	-0.013	0.003	-4.723	<0.001
June 2020–March 2021	-0.004	0.003	-1.345	0.182
Demographics				
Average age	-0.017	0.016	-1.098	0.276
Percent female	-0.012	0.004	-3.121	0.003
Percent disabled	0.014	0.003	4.717	<0.001

Note: PHE: public health emergency; Q: quarter.

Table A-57—Measure 40 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.343	0.006	56.33	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	0.009	0.003	2.90	0.044
Level change at implementation	<0.001	0.009	0.02	0.986
Change in annual trend	-0.003	0.003	-0.96	0.390
PHE Indicator				
COVID-19 lockdown (2020)	0.002	0.001	2.05	0.109

Data Source: MMIS data were used in the analysis of Measure 40.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Table A-58—Measure 41 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.009	0.009	0.982	0.337
Timeframe				
Pre-Centennial Care 2.0 quarterly trend	0.002	0.002	1.186	0.249
Level change	0.043	0.012	3.508	0.002
Change in quarterly trend	-0.001	0.002	-0.346	0.733
Seasonality				
Q2	-0.008	0.007	-1.236	0.230
Q3	-0.010	0.007	-1.407	0.174
Q4	-0.008	0.007	-1.167	0.256
PHE Timeframe				
COVID-19 lockdown (Q2 2020)	0.018	0.014	1.283	0.214
COVID-19 re-opening (Q3 2020–Q1 2021)	0.018	0.009	2.166	0.042

Data Source: MMIS data were used in the analysis of Measure 41.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Table A-59—Measure 42 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2019				
Intercept	-1.553	0.024	4098.832	<0.001
Post-implementation indicator	-0.133	0.026	25.806	<0.001
Peer support indicator	0.374	0.176	4.536	0.033
Peer support x post-implementation	0.598	0.196	9.285	0.002
Weighted risk score	-0.053	0.003	276.776	<0.001
2020				
Intercept	-1.574	0.025	4039.491	<0.001
Post-implementation indicator	-0.209	0.028	57.052	<0.001
Peer support indicator	0.368	0.176	4.382	0.036

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Peer support x post-implementation	0.440	0.194	5.124	0.024
Weighted risk score	-0.049	0.003	220.573	<0.001
2021				
Intercept	-1.558	0.025	3873.849	<0.001
Post-implementation indicator	-0.303	0.028	117.150	<0.001
Peer support indicator	0.373	0.176	4.500	0.034
Peer support x post-implementation	0.483	0.188	6.601	0.010
Weighted risk score	-0.052	0.003	235.009	<0.001
2022				
Intercept	-1.567	0.025	3848.061	<0.001
Post-implementation indicator	-0.367	0.029	162.626	<0.001
Peer support indicator	0.370	0.176	4.432	0.035
Peer support x post-implementation	0.977	0.187	27.384	<0.001
Weighted risk score	-0.050	0.003	212.870	<0.001
2023				
Intercept	-1.573	0.025	3833.801	<0.001
Post-implementation indicator	-0.357	0.029	150.140	<0.001
Peer support indicator	0.368	0.176	4.391	0.036
Peer support x post-implementation	1.037	0.187	30.755	<0.001
Weighted risk score	-0.049	0.003	200.597	<0.001

Data source: MMIS data were used in the analysis of Measure 42.

Table A-60—Measure 43 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2019				
Intercept	94.202	1.343	70.169	<0.001
Post-implementation indicator	-9.533	1.574	-6.058	<0.001
Peer support indicator	137.585	10.565	13.023	<0.001
Peer support x post-implementation	119.016	12.053	9.874	<0.001
Weighted risk score	-1.433	0.142	-10.079	<0.001
2020				
Intercept	93.055	1.358	68.533	<0.001
Post-implementation indicator	-18.301	1.600	-11.435	<0.001
Peer support indicator	137.256	10.518	13.050	<0.001
Peer support x post-implementation	37.702	11.323	3.330	<0.001
Weighted risk score	-1.221	0.148	-8.228	<0.001

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2021				
Intercept	92.783	1.405	66.051	<0.001
Post-implementation indicator	-16.619	1.689	-9.840	<0.001
Peer support indicator	137.178	10.727	12.788	<0.001
Peer support x post-implementation	18.989	11.538	1.646	0.100
Weighted risk score	-1.170	0.157	-7.432	<0.001
2022				
Intercept	92.737	1.439	64.457	<0.001
Post-implementation indicator	-20.394	1.781	-11.449	<0.001
Peer support indicator	137.165	10.792	12.710	<0.001
Peer support x post-implementation	-5.022	11.385	-0.441	0.659
Weighted risk score	-1.162	0.166	-6.994	<0.001
2023				
Intercept	92.222	1.396	66.063	<0.001
Post-implementation indicator	-23.026	1.704	-13.510	<0.001
Peer support indicator	137.017	10.578	12.953	<0.001
Peer support x post-implementation	-1.394	11.100	-0.126	0.900
Weighted risk score	-1.066	0.159	-6.726	<0.001

Data source: MMIS data were used in the analysis of Measure 43.

Table A-61—Measure 44 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
2019				
Intercept	-0.979	0.027	1300.205	<0.001
Post-implementation indicator	0.015	0.030	0.235	0.628
Peer support indicator	-0.353	0.354	0.993	0.319
Peer support x post-implementation	0.852	0.373	5.228	0.022
Weighted risk score	-0.007	0.003	4.409	0.036
2020				
Intercept	-1.051	0.027	1508.841	<0.001
Post-implementation indicator	-0.024	0.031	0.593	0.441
Peer support indicator	-0.392	0.354	1.223	0.269
Peer support x post-implementation	1.126	0.358	9.896	0.002
Weighted risk score	0.007	0.003	5.134	0.023
2021				
Intercept	-1.065	0.027	1535.094	<0.001
Post-implementation indicator	-0.021	0.032	0.426	0.514
Peer support indicator	-0.400	0.354	1.272	0.259

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Peer support x post-implementation	1.005	0.357	7.937	0.005
Weighted risk score	0.009	0.003	9.575	0.002
2022				
Intercept	-1.053	0.027	1482.238	<0.001
Post-implementation indicator	0.005	0.033	0.026	0.872
Peer support indicator	-0.393	0.354	1.231	0.267
Peer support x post-implementation	0.805	0.357	5.086	0.024
Weighted risk score	0.007	0.003	5.495	0.019
2023				
Intercept	-1.051	0.028	1441.916	<0.001
Post-implementation indicator	0.122	0.032	14.163	<0.001
Peer support indicator	-0.392	0.354	1.224	0.269
Peer support x post-implementation	0.561	0.357	2.474	0.116
Weighted risk score	0.007	0.003	4.652	0.031

Data source: MMIS data were used in the analysis of Measure 44.

Table A-62—Measure 47 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.210	0.007	31.171	<0.001
Timeframe				
Pre-Centennial Care 2.0 quarterly trend	0.0003	0.002	0.218	0.829
Level change	0.001	0.009	0.140	0.890
Change in quarterly trend	-0.001	0.002	-0.389	0.701
Seasonality				
Q2	0.017	0.005	3.250	0.004
Q3	0.017	0.005	3.282	0.004
Q4	-0.002	0.005	-0.372	0.713
PHE Timeframe				
COVID-19 lockdown (Q2 2020)	0.062	0.011	5.759	<0.001
COVID-19 re-opening (Q3 2020–Q1 2021)	0.052	0.006	8.165	<0.001

Data Source: MMIS data were used in the analysis of Measure 47.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Table A-63—Measure 48 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.152	0.007	21.674	<0.001
Timeframe				
Pre-Centennial Care 2.0 quarterly trend	0.003	0.002	1.564	0.133
Level change	0.004	0.010	0.449	0.658
Change in quarterly trend	-0.0005	0.002	-0.275	0.786

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Seasonality				
Q2	0.013	0.005	2.502	0.021
Q3	0.010	0.005	1.919	0.069
Q4	-0.017	0.005	-3.146	0.005
PHE Timeframe				
COVID-19 lockdown (Q2 2020)	0.013	0.011	1.109	0.280
COVID-19 re-opening (Q3 2020–Q1 2021)	0.016	0.007	2.397	0.026

Data Source: MMIS data were used in the analysis of Measure 48.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Table A-64—Measure 49 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.139	0.007	19.810	<0.001
Timeframe				
Pre-Centennial Care 2.0 quarterly trend	-0.006	0.002	-3.638	0.002
Level change	0.0002	0.010	0.025	0.980
Change in quarterly trend	0.011	0.002	6.357	<0.001
Seasonality				
Q2	0.002	0.005	0.301	0.766
Q3	0.002	0.005	0.342	0.736
Q4	-0.010	0.005	-1.918	0.069
PHE Timeframe				
COVID-19 lockdown (Q2 2020)	0.008	0.011	0.686	0.500
COVID-19 re-opening (Q3 2020–Q1 2021)	0.014	0.007	2.028	0.055

Data Source: MMIS data were used in the analysis of Measure 49.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Table A-65—Measure 50 7 Day Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.039	0.006	6.636	<0.001
Timeframe				
Pre-Centennial Care 2.0 quarterly trend	0.002	0.001	1.163	0.258
Level change	-0.011	0.008	-1.404	0.175
Change in quarterly trend	-0.001	0.001	-0.810	0.427
Seasonality				
Q2	0.006	0.005	1.224	0.235
Q3	-0.005	0.005	-1.029	0.315
Q4	-0.010	0.005	-2.090	0.049

Variable	Estimate	Standard Error	Test Statistic	*p*-value
PHE Timeframe				
COVID-19 lockdown (Q2 2020)	-0.008	0.010	-0.818	0.423
COVID-19 re-opening (Q3 2020–Q1 2021)	-0.004	0.006	-0.784	0.442

Data Source: MMIS data were used in the analysis of Measure 50.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Table A-66—Measure 50 30 Day Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.140	0.013	10.849	<0.001
Timeframe				
Pre-Centennial Care 2.0 quarterly trend	0.005	0.003	1.658	0.112
Level change	-0.015	0.018	-0.881	0.388
Change in quarterly trend	-0.003	0.003	-1.119	0.276
Seasonality				
Q2	0.001	0.010	0.149	0.883
Q3	-0.022	0.010	-2.215	0.038
Q4	-0.021	0.010	-2.044	0.054
PHE Timeframe				
COVID-19 lockdown (Q2 2020)	-0.020	0.021	-0.978	0.339
COVID-19 re-opening (Q3 2020–Q1 2021)	-0.005	0.012	-0.410	0.686

Data Source: MMIS data were used in the analysis of Measure 50.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Table A-67—Measure 51 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	6.985	0.077	8,132.985	<0.001
Timeframe				
Time	0.010	0.002	16.454	<0.001
Post period	-0.051	0.033	2.324	0.127
Post period * time	0.000	0.002	0.003	0.954
Demographics				
Average age	-0.172	0.082	4.351	0.037
Percent female	-0.023	0.036	0.417	0.519
Percent with disabilities	0.082	0.019	18.710	<0.001
Seasonality				
Q2	0.004	0.013	0.098	0.754
Q3	0.014	0.013	1.082	0.298
Q4	-0.023	0.013	3.031	0.082

Variable	Estimate	Standard Error	Test Statistic	*p*-value
PHE Indicator				
March 2020	-0.030	0.047	0.403	0.525
April 2020–May 2020	-0.067	0.035	3.694	0.055
June 2020–March 2021	0.003	0.022	0.023	0.879

Data source: MMIS data were used in the analysis of Measure 51.
Note: PHE: public health emergency; Q: quarter.

Table A-68—Measure 52 Supplemental Results: Professional Costs Among Substance Use Disorder (SUD) Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	5.647	0.081	4907.377	<0.001
Timeframe				
Time	0.014	0.003	30.754	<0.001
Post period	0.013	0.035	0.144	0.704
Post period * time	0.000	0.002	0.058	0.810
Demographics				
Average age	-0.103	0.086	1.422	0.233
Percent female	-0.067	0.037	3.232	0.072
Percent with disabilities	0.156	0.020	62.582	<0.001
Seasonality				
Q2	-0.004	0.014	0.097	0.756
Q3	0.006	0.014	0.206	0.650
Q4	-0.015	0.014	1.164	0.281
PHE Indicator				
March 2020	-0.052	0.049	1.120	0.290
April 2020–May 2020	-0.048	0.036	1.776	0.183
June 2020–March 2021	0.016	0.023	0.492	0.483

Data source: MMIS data were used in the analysis of Measure 52.
Note: PHE: public health emergency; Q: quarter.

Table A-69—Measure 52 Supplemental Results: Outpatient (OP) Costs Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	4.885	0.101	2,328.041	<0.001
Timeframe				
Time	0.009	0.003	6.980	0.008
Post period	-0.074	0.044	2.911	0.088
Post period * time	-0.007	0.002	9.562	0.002
Demographics				
Average age	-0.136	0.108	1.604	0.205
Percent female	0.023	0.047	0.246	0.620
Percent with disabilities	0.005	0.025	0.047	0.829

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Seasonality				
Q2	-0.018	0.017	1.109	0.292
Q3	-0.028	0.017	2.568	0.109
Q4	-0.064	0.018	13.160	<0.001
PHE Indicator				
March 2020	-0.087	0.062	1.995	0.158
April 2020–May 2020	-0.215	0.045	22.531	<0.001
June 2020–March 2021	0.005	0.029	0.035	0.852

Data source: MMIS data were used in the analysis of Measure 52.
Note: PHE: public health emergency; Q: quarter.

Table A-70—Measure 52 Supplemental Results: OP-Emergency Department (ED) Costs Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	3.976	0.106	1,396.299	<0.001
Timeframe				
Time	0.019	0.003	32.001	<0.001
Post period	-0.171	0.046	13.821	<0.001
Post period * time	-0.002	0.002	0.428	0.513
Demographics				
Average age	-0.718	0.113	40.104	<0.001
Percent female	0.027	0.050	0.288	0.592
Percent with disabilities	0.091	0.026	12.122	<0.001
Seasonality				
Q2	0.041	0.018	5.273	0.022
Q3	0.105	0.018	33.402	<0.001
Q4	-0.007	0.018	0.159	0.690
PHE Indicator				
March 2020	-0.051	0.065	0.612	0.434
April 2020–May 2020	-0.215	0.048	20.242	<0.001
June 2020–March 2021	-0.094	0.030	9.688	0.002

Data source: MMIS data were used in the analysis of Measure 52.
Note: PHE: public health emergency; Q: quarter.

Table A-71—Measure 52 Supplemental Results: Pharmacy Costs Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	5.461	0.122	2,018.288	<0.001
Timeframe				
Time	-0.006	0.004	2.293	0.130
Post period	-0.142	0.053	7.293	0.007
Post period * time	0.012	0.003	19.138	<0.001

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Demographics				
Average age	-0.050	0.130	0.150	0.699
Percent female	-0.007	0.056	0.016	0.899
Percent with disabilities	-0.003	0.030	0.010	0.919
Seasonality				
Q2	-0.008	0.021	0.168	0.682
Q3	-0.020	0.021	0.909	0.340
Q4	-0.035	0.021	2.726	0.099
PHE Indicator				
March 2020	0.088	0.074	1.390	0.238
April 2020–May 2020	-0.029	0.055	0.279	0.598
June 2020–March 2021	-0.107	0.034	9.678	0.002

Data source: MMIS data were used in the analysis of Measure 52.
Note: PHE: public health emergency; Q: quarter.

Table A-72—Measure 52 Supplemental Results: Inpatient (IP) Costs Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	5.911	0.132	2,011.412	<0.001
Timeframe				
Time	0.008	0.004	4.113	0.043
Post period	-0.036	0.056	0.403	0.525
Post period * time	-0.001	0.003	0.037	0.848
Demographics				
Average age	-0.193	0.139	1.924	0.165
Percent female	-0.018	0.060	0.089	0.765
Percent with disabilities	0.043	0.032	1.783	0.182
Seasonality				
Q2	0.016	0.022	0.505	0.477
Q3	0.023	0.022	1.104	0.293
Q4	-0.025	0.023	1.259	0.262
PHE Indicator				
March 2020	-0.032	0.080	0.166	0.683
April 2020–May 2020	-0.039	0.059	0.448	0.503
June 2020–March 2021	0.049	0.037	1.715	0.190

Data source: MMIS data were used in the analysis of Measure 52.
Note: PHE: public health emergency; Q: quarter.

Table A-73—Measure 52 Supplemental Results: Long-Term Care (LTC) Costs Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	4.127	0.084	2,414.749	<0.001
Timeframe				
Time	0.014	0.003	28.309	<0.001
Post period	-0.100	0.036	7.800	0.005
Post period * time	-0.011	0.002	32.225	<0.001
Demographics				
Average age	-0.106	0.090	1.399	0.237
Percent female	0.096	0.039	6.082	0.014
Percent with disabilities	0.101	0.021	24.469	<0.001
Seasonality				
Q2	0.001	0.014	0.004	0.950
Q3	0.023	0.014	2.614	0.106
Q4	0.012	0.015	0.648	0.421
PHE Indicator				
March 2020	-0.002	0.051	0.002	0.969
April 2020–May 2020	0.024	0.038	0.400	0.527
June 2020–March 2021	0.015	0.024	0.411	0.522

Data source: MMIS data were used in the analysis of Measure 52.
Note: PHE: public health emergency; Q: quarter.

Table A-74—Measure 53 Supplemental Results: Non-SUD Costs Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	6.608	0.081	6,651.491	<0.001
Timeframe				
Time	0.008	0.003	9.011	0.003
Post period	-0.019	0.035	0.299	0.585
Post period * time	0.002	0.002	1.301	0.254
Demographics				
Average age	-0.203	0.086	5.506	0.019
Percent female	0.001	0.037	0.001	0.973
Percent with disabilities	0.087	0.020	19.375	<0.001
Seasonality				
Q2	0.000	0.014	0.001	0.975
Q3	0.009	0.014	0.435	0.510
Q4	-0.021	0.014	2.167	0.141

Variable	Estimate	Standard Error	Test Statistic	*p*-value
PHE Indicator				
March 2020	-0.056	0.049	1.288	0.256
April 2020–May 2020	-0.116	0.036	10.195	0.001
June 2020–March 2021	-0.019	0.023	0.713	0.399

Data source: MMIS data were used in the analysis of Measure 53.
Note: PHE: public health emergency; Q: quarter.

Table A-75—Measure 53 Supplemental Results: SUD-Institution for Mental Diseases (IMD) Costs Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	1.060	0.612	2.999	0.083
Timeframe				
Time	-0.075	0.020	14.643	<0.001
Post period	-0.047	0.262	0.032	0.858
Post period * time	0.130	0.014	86.690	<0.001
Demographics				
Average age	-1.930	0.654	8.700	0.003
Percent female	0.712	0.285	6.235	0.013
Percent with disabilities	-0.386	0.150	6.595	0.010
Seasonality				
Q2	0.019	0.106	0.031	0.860
Q3	-0.055	0.106	0.270	0.604
Q4	0.014	0.109	0.016	0.899
PHE Indicator				
March 2020	0.010	0.377	0.001	0.979
April 2020–May 2020	-0.133	0.278	0.228	0.633
June 2020–March 2021	0.161	0.172	0.873	0.350

Data source: MMIS data were used in the analysis of Measure 53.
Note: PHE: public health emergency; Q: quarter.

Table A-76—Measure 53 Supplemental Results: SUD-Other Costs Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	5.810	0.091	4,085.628	<0.001
Timeframe				
Time	0.015	0.003	27.749	<0.001
Post period	-0.114	0.039	8.596	0.003
Post period * time	-0.005	0.002	5.468	0.019
Demographics				
Average age	-0.097	0.096	1.019	0.313
Percent female	-0.080	0.042	3.633	0.057
Percent with disabilities	0.075	0.022	11.389	<0.001

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Seasonality				
Q2	0.013	0.015	0.702	0.402
Q3	0.023	0.015	2.176	0.140
Q4	-0.027	0.016	3.042	0.081
PHE Indicator				
March 2020	0.022	0.055	0.165	0.685
April 2020–May 2020	0.027	0.041	0.440	0.507
June 2020–March 2021	0.045	0.026	3.109	0.078

Data source: MMIS data were used in the analysis of Measure 53.
Note: PHE: public health emergency; Q: quarter.

Table A-77—Measure 54 Supplemental Results: Professional Costs for SUD Services Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	3.906	0.117	1,121.181	<0.001
Timeframe				
Time	0.019	0.004	25.758	<0.001
Post period	-0.014	0.051	0.074	0.786
Post period * time	0.000	0.003	0.032	0.858
Demographics				
Average age	-0.124	0.125	0.997	0.318
Percent female	-0.144	0.054	7.035	0.008
Percent with disabilities	0.172	0.029	36.129	<0.001
Seasonality				
Q2	-0.006	0.020	0.097	0.756
Q3	0.008	0.020	0.156	0.693
Q4	0.008	0.020	0.145	0.704
PHE Indicator				
March 2020	0.052	0.072	0.521	0.470
April 2020–May 2020	0.125	0.053	5.576	0.018
June 2020–March 2021	0.043	0.033	1.731	0.188

Data source: MMIS data were used in the analysis of Measure 54.
Note: PHE: public health emergency; Q: quarter.

Table A-78—Measure 54 Supplemental Results: OP Costs for SUD Services Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	3.642	0.111	1,081.790	<0.001
Timeframe				
Time	0.010	0.004	7.682	0.006
Post period	-0.165	0.047	12.084	<0.001
Post period * time	-0.013	0.002	27.914	<0.001

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Demographics				
Average age	0.000	0.118	0.000	0.999
Percent female	0.046	0.052	0.787	0.375
Percent with disabilities	-0.017	0.027	0.389	0.533
Seasonality				
Q2	-0.001	0.019	0.006	0.938
Q3	-0.016	0.019	0.728	0.393
Q4	-0.103	0.019	28.392	<0.001
PHE Indicator				
March 2020	-0.057	0.068	0.703	0.402
April 2020–May 2020	-0.205	0.050	16.861	<0.001
June 2020–March 2021	-0.024	0.031	0.575	0.448

Data source: MMIS data were used in the analysis of Measure 54.
Note: PHE: public health emergency; Q: quarter.

Table A-79—Measure 54 Supplemental Results: OP ED Costs for SUD Services Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	1.935	0.144	181.242	<0.001
Timeframe				
Time	0.024	0.005	27.858	<0.001
Post period	-0.168	0.062	7.212	0.007
Post period * time	-0.004	0.003	1.838	0.175
Demographics				
Average age	-0.723	0.154	21.989	<0.001
Percent female	-0.114	0.066	2.967	0.085
Percent with disabilities	0.163	0.035	21.332	<0.001
Seasonality				
Q2	0.075	0.024	9.458	0.002
Q3	0.122	0.025	24.863	<0.001
Q4	-0.013	0.025	0.277	0.599
PHE Indicator				
March 2020	-0.004	0.088	0.002	0.967
April 2020–May 2020	-0.116	0.065	3.222	0.073
June 2020–March 2021	-0.026	0.040	0.415	0.519

Data source: MMIS data were used in the analysis of Measure 54.
Note: PHE: public health emergency; Q: quarter.

Table A-80—Measure 54 Supplemental Results: Pharmacy Costs for SUD Services Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	3.376	0.139	586.926	<0.001
Timeframe				
Time	0.018	0.004	15.888	<0.001
Post period	-0.385	0.060	41.578	<0.001
Post period * time	-0.011	0.003	13.218	<0.001
Demographics				
Average age	0.084	0.146	0.333	0.564
Percent female	-0.103	0.065	2.536	0.111
Percent with disabilities	0.059	0.034	2.981	0.084
Seasonality				
Q2	-0.035	0.024	2.174	0.140
Q3	-0.037	0.024	2.365	0.124
Q4	-0.034	0.024	1.902	0.168
PHE Indicator				
March 2020	0.133	0.085	2.427	0.119
April 2020–May 2020	0.173	0.063	7.510	0.006
June 2020–March 2021	0.086	0.040	4.693	0.030

Data source: MMIS data were used in the analysis of Measure 54.
Note: PHE: public health emergency; Q: quarter.

Table A-81—Measure 54 Supplemental Results: IP Costs for SUD Services Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	5.282	0.129	1,672.061	<0.001
Timeframe				
Time	0.012	0.004	8.506	0.004
Post period	-0.078	0.055	2.025	0.155
Post period * time	-0.002	0.003	0.493	0.482
Demographics				
Average age	-0.155	0.136	1.296	0.255
Percent female	-0.057	0.059	0.921	0.337
Percent with disabilities	0.030	0.031	0.924	0.336
Seasonality				
Q2	0.023	0.022	1.124	0.289
Q3	0.027	0.022	1.524	0.217
Q4	-0.042	0.022	3.641	0.056

Variable	Estimate	Standard Error	Test Statistic	*p*-value
PHE Indicator				
March 2020	0.005	0.078	0.005	0.946
April 2020–May 2020	-0.002	0.057	0.002	0.965
June 2020–March 2021	0.058	0.037	2.479	0.115

Data source: MMIS data were used in the analysis of Measure 54.
Note: PHE: public health emergency; Q: quarter.

Table A-82—Measure 54 Supplemental Results: LTC Costs for SUD Services Among SUD Members

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	3.442	0.102	1,149.396	<0.001
Timeframe				
Time	0.015	0.003	20.607	<0.001
Post period	-0.278	0.043	41.115	<0.001
Post period * time	-0.017	0.002	55.076	<0.001
Demographics				
Average age	0.278	0.108	6.611	0.010
Percent female	0.046	0.047	0.973	0.324
Percent with disabilities	0.095	0.025	14.620	<0.001
Seasonality				
Q2	-0.005	0.017	0.080	0.777
Q3	0.053	0.017	9.322	0.002
Q4	0.026	0.018	2.137	0.144
PHE Indicator				
March 2020	0.044	0.062	0.496	0.481
April 2020–May 2020	0.100	0.046	4.732	0.030
June 2020–March 2021	0.019	0.029	0.418	0.518

Data source: MMIS data were used in the analysis of Measure 54.
Note: PHE: public health emergency; Q: quarter.

Table A-83—Measure 56 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.893	0.002	436.12	<0.001
Timeframe				
Pre-Centennial Care 2.0 annual trend	-0.007	0.001	-6.53	0.003
Level change at implementation	0.018	0.004	4.79	0.009
Change in annual trend	0.010	0.001	7.41	0.002
PHE Indicator				
COVID-19 lockdown (Q2 2020)	-0.013	0.003	-4.54	0.011

Data Source: MMIS data were used in the analysis of Measure 56.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Table A-84—Measure 59 Supplemental Results

Variable	Estimate	Standard Error	Test Statistic	*p*-value
Intercept	0.216	0.005	45.231	<0.001
Timeframe				
Pre-Centennial Care 2.0 quarterly trend	0.007	0.001	6.201	<0.001
Level change	-0.014	0.007	-2.212	0.038
Change in quarterly trend	-0.005	0.001	-4.272	<0.001
Seasonality				
Q2	-0.003	0.004	-0.898	0.379
Q3	-0.0004	0.004	-0.122	0.904
Q4	0.002	0.004	0.657	0.518
PHE Timeframe				
COVID-19 lockdown (Q2 2020)	0.017	0.008	2.202	0.039
COVID-19 re-opening (Q3 2020–Q1 2021)	-0.001	0.005	-0.246	0.808

Data Source: MMIS data were used in the analysis of Measure 59.
Note: COVID-19: coronavirus disease 2019; PHE: public health emergency; Q: quarter.

Table A-85—Measure 61 Supplemental Results: New Mexico Medicaid Overdose Cause-Specific Death Rates

Measure	2018	2019	2020	2021	2022	2023†
Medicaid deaths from overdose	356	373	570	767	716	715
Medicaid population	977,590	950,654	955,343	1,000,934	1,038,334	1,064,075
Cause-specific death rate per 100,000 members	36.4	39.2	59.7	76.6	69.0	67.2

Data source: New Mexico Indicator-Based Information System, US Census, and MMIS data were used in the analysis of Measure 61.
†Data for 2023 are incomplete.

Table A-86—Measure 61 Supplemental Results: New Mexico Statewide Overdose Cause-Specific Death Rates

Measure	2018	2019	2020	2021	2022	2023*
Statewide total deaths from overdose	537	601	788	1024	1049	965**
Statewide population***	2,092,434	2,092,454	2,097,021	2,109,366	2,112,463	2,114,768
Cause-specific death rate per 100,000 New Mexico residents	25.7	28.7	37.6	48.5	49.7	45.6

Data source: New Mexico Indicator-Based Information System, US Census, and MMIS were used in the analysis of Measure 61.
*Data for 2023 are incomplete.
**New Mexico overdose death data for 2023 are preliminary.
***Population totals for 2018–2023 represent five-year ACS estimates.

Table A-87—Measure 61 Supplemental Results: Overdose Proportionate Mortality

Measure	2018	2019	2020	2021	2022	2023†
Statewide						
Total deaths from overdose	537	601	788	1024	1049	965
Total deaths	19023	19537	23842	25313	23653	22241
Percentage of statewide deaths attributable to overdose	2.8%	3.1%	3.3%	4.0%	4.4%	4.3%
New Mexico Medicaid						
Medicaid deaths from overdose	356	373	570	767	716	715
Medicaid total deaths	7508	7554	8877	9342	8474	7749
Percentage of Medicaid deaths attributable to overdose	4.7%	4.9%	6.4%	8.2%	8.4%	9.2%

Data source: New Mexico Indicator-Based Information System, United States Census, and MMIS were used the analysis of Measure 61.
†Data for 2023 are incomplete.

Aim Five

There are no supplemental results for Aim Five.

Measure Specifications

This section contains the measure specifications for each measure assessed as a part of the independent evaluation of Centennial Care 2.0.

Percentage of Centennial Care 2.0 Members enrolled and receiving Community Benefit (CB) services (Measure 1)	
Numerator	Number of long-term services and supports (LTSS) eligible Centennial Care 2.0 members enrolled and receiving CB services during the measurement period. LTSS members enrolled in CB will be defined as those with one of the following setting of care identifiers: • Agency Based CB – Agency Non-Waiver (ANW) or Agency Direct Benefit (ADB) • Self-Directed CB – Self-Directed Non-Waiver (SNW) or Self-Directed Benefit (SDB) Members must be concurrently enrolled in Centennial Care 2.0
Denominator	Number of LTSS-eligible Centennial Care 2.0 members
Comparison Population	N/A
Analytic Approach	Descriptive time series
Measure Steward	N/A
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher or no change
Notes	Number of LTSS-eligible Centennial Care 2.0 members

Percent of members receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) personal care services (PCS) (Measure 2)	
Numerator	Number of Centennial Care 2.0 members under age 21 years receiving EPSDT PCS (identified using EPSDT PCS Billing Code: S5125) with a private duty nurse (provider type 324) during the measurement period
Denominator	Number of Centennial Care 2.0 members under age 21 years
Comparison Population	N/A
Analytic Approach	Descriptive time series
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	Higher or no change
Notes	N/A

Percent of LTSS-eligible members enrolled in CB receiving CB PCS (Measure 3)	
Numerator	Number of LTSS eligible Centennial Care 2.0 members receiving CB PCS during the measurement period
Denominator	Number of LTSS-eligible members ages 21 years or older enrolled in CB
Comparison Population	N/A
Analytic Approach	Descriptive time series
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	Higher or no change
Notes	N/A

Average number of EPSDT PCS per utilizing member (Measure 4)	
Numerator	Number of EPSDT PCS (identified using EPSDT PCS billing code: S5125) among members in the denominator
Denominator	Number of Centennial Care 2.0 members under age 21 years receiving EPSDT PCS (procedure code S5125) with a private duty nurse (provider type 324)
Comparison Population	N/A
Analytic Approach	Descriptive time series
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	Higher or no change
Notes	N/A

Average number of CB PCS per utilizing member (Measure 5)	
Numerator	Number of CB PCS (identified using CB billing codes: T1019 and 99509) among members in the denominator
Denominator	Number of LTSS-eligible members age 21 years or older enrolled in CB receiving CB PCS
Comparison Population	N/A
Analytic Approach	Descriptive time series
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	Higher or no change
Notes	N/A

Percentage of Centennial Care members enrolled in an HH (Measure 6)	
Numerator	Among members identified in the denominator, the number of unique Medicaid members in HH roster files during the measurement period
Denominator	The number of unique Medicaid members with Centennial Care 2.0 enrollment (i.e., paid capitation) during the measurement period
Comparison Population	N/A
Analytic Approach	Descriptive time series
Measure Steward	N/A
Data Source	• MMIS • HH enrollment roster
Frequency	Monthly
Desired Direction	Higher is better
Notes	Members should have concurrent HH and Centennial Care 2.0 enrollment to be counted in the numerator. HH and Centennial Care 2.0 enrollment were captured monthly.

Number of HH members with at least one claim for physical health (PH) service in the calendar year (CY) (Measure 7)	
Numerator	Treatment group: Among members identified in the denominator, the number of unique Medicaid members in HH roster files during the measurement period, and who have at least one PH service claim/encounter Comparison group: Centennial Care 2.0 members not enrolled in an HH (matched) with at least one claim for a PH service in the measurement period
Denominator	Treatment group: The number of unique Centennial Care 2.0 members contained in HH roster files during the measurement period Comparison group: The number of unique Centennial Care 2.0 members who have never participated in the HH program
Comparison Population	PS-adjusted members who never participated in the HH program
Analytic Approach	Differences-in-differences (DiD)
Measure Steward	N/A

Number of HH members with at least one claim for physical health (PH) service in the calendar year (CY) (Measure 7)	
Data Source	• MMIS • HH enrollment roster
Frequency	Annual
Desired Direction	Higher is better
Notes	PH services were identified as a non-behavioral health (BH) claim/encounter. Evaluation and management codes rendered by BH providers were excluded. HCA supplied a list of Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and revenue codes to identify BH claims/encounters and providers.

Adults' access to preventive/ambulatory health services (AAP)–Centennial Care 2.0 population (Measure 8a)	
Numerator	The number of Centennial Care 2.0 members in the denominator who had a preventive/ambulatory care visit during the measurement year (MY)
Denominator	The number of Centennial Care 2.0 members ages 20 years and older who were continuously enrolled with no more than one gap of up to 45 days during the MY
Comparison Population	N/A
Analytic Approach	ITS
Measure Steward	National Committee for Quality Assurance (NCQA)
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Notes	Measure 8a follows NCQA specifications for *Adults' Access to Preventive-Ambulatory Services*.

Adults' access to preventive/ambulatory health services (AAP)–HH population (Measure 8b)	
Numerator	Among members in the denominator for each group, the number of unique Medicaid members who had an ambulatory or preventive care visit during the measurement period
Denominator	Treatment group: The number of Centennial Care 2.0 members ages 20 years and older continuously enrolled in Centennial Care 2.0 with no more than one gap of up to 45 days during the MY. Members must have been enrolled in Centennial Care 2.0 for 11 months during the 2016 and 2017 baseline period, enrolled for three continuous months concurrently in an HH and Centennial Care during the MY, and had no exposure to an HH prior to January 1, 2018. Comparison group: The number of Centennial Care 2.0 members ages 20 years and older continuously enrolled in Centennial Care 2.0 with no more than one gap of up to 45 days during the MY. Members must also have been enrolled in Centennial Care 2.0 for 11 months each year during the 2016 and 2017 baseline period and had no exposure to an HH during or prior to the MY.
Comparison Population	PS-adjusted members who never participated in the HH program.
Measure Steward	NCQA
Data Source	• MMIS • HH enrollment roster
Frequency	Annual
Desired Direction	Higher is better

Adults' access to preventive/ambulatory health services (AAP)–HH population (Measure 8b)	
Analytic Approach	• DiD • ITS with comparison group
Notes	Measure 8b follows NCQA specifications for *Adults' Access to Preventive-Ambulatory Services*, with matching for comparison population. HH enrollment was defined as being in the monthly HH roster files.

Children and adolescents' access to primary care practitioners (PCP) (CAP)–Centennial Care 2.0 population (Measure 9a)	
Numerator	Among members identified in the denominator, the number of Centennial Care 2.0 members with a PCP visit
Denominator	The number of Centennial Care 2.0 members ages 12 months to 19 years. Children ages 12 months to 6 years must be continuously enrolled in Centennial Care 2.0 during the measurement period, and children and adolescents ages 7 to 19 years must be continuously enrolled in Centennial Care 2.0 during the measurement period and the year prior to the measurement period. Members must be continuously enrolled with no more than one gap of up to 45 days in each year.
Comparison Population	N/A
Analytic Approach	ITS
Measure Steward	NCQA
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Notes	Measure 9a follows NCQA specifications for *Children and Adolescents' Access to PCPs*.

Children and adolescents' access to primary care practitioners (CAP)–HH population (Measure 9b)	
Numerator	Among members in the denominator for each group, the number of unique Medicaid members with a PCP visit during the measurement period
Denominator	Treatment group: The number of Centennial Care 2.0 members ages 12 months to 19 years. Children ages 12 months to 6 years must be continuously enrolled in Centennial Care during the measurement period, and children and adolescents ages 7 to 19 years must be continuously enrolled in Centennial Care 2.0 during the measurement period and the year prior to the measurement period. Members must be continuously enrolled in Centennial Care 2.0 with no more than one gap of up to 45 days in each year. Members must also have been enrolled in Centennial Care 2.0 for 11 months during the baseline period of 2016 and 2017, enrolled for three continuous months concurrently in an HH and Centennial Care 2.0 during the MY, and had no exposure to an HH prior to January 1, 2018. Comparison group: The number of Centennial Care 2.0 members ages 12 months to 19 years. Children ages 12 months to 6 years must be continuously enrolled in Centennial Care during the measurement period, and children and adolescents ages 7 to 19 years must be continuously enrolled in Centennial Care 2.0 during the measurement period and the year prior to the measurement period. Members must be continuously enrolled with no more than one gap of up to 45 days each year. Members must also have been enrolled in Centennial Care 2.0 for 11 months during the 2016 and 2017 baseline period and had no exposure to an HH during or prior to the MY.
Comparison Population	PS-adjusted members who never participated in the HH program
Measure Steward	NCQA
Data Source	• MMIS • HH enrollment roster

Children and adolescents' access to primary care practitioners (CAP)–HH population (Measure 9b)	
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	DiD
Notes	Measure 9b follows NCQA specifications *for Children and Adolescents' Access to PCPs*, with matching for comparison population. HH enrollment was defined as being in the monthly HH roster files.

Well-child visits in the third, fourth, fifth, and sixth years of life (W34) (Measure 10)	
Numerator	The number of Centennial Care 2.0 members meeting the denominator criteria who had one or more well-child visits with a PCP during the MY
Denominator	The number of Centennial Care 2.0 members ages 3 to 6 years continuously enrolled in Centennial Care 2.0 with no more than one gap of up to 45 days
Comparison Population	N/A
Measure Steward	NCQA
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	ITS
Notes	Measure 10 follows NCQA specifications for *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life.*

Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD) (Measure 11)	
Numerator	Among members in the denominator for each group, the number of unique Medicaid members who were dispensed an antipsychotic medication and had a diabetes screening test during the MY
Denominator	Treatment group: The number of Centennial Care 2.0 members ages 18 to 64 years with SMI (schizophrenia or bipolar disorder), continuously enrolled in Centennial Care 2.0 with no more than one gap of up to 45 days. Members must also have been enrolled in Centennial Care for 11 months during the baseline period of 2016 and 2017, enrolled for three continuous months concurrently in an HH and Centennial Care 2.0 during the MY, and had no exposure to an HH prior to January 1, 2018. Comparison group: The number of Centennial Care 2.0 members ages 18 to 64 years with SMI (schizophrenia or bipolar disorder), continuously enrolled in Centennial Care 2.0 with no more than one gap of up to 45 days. Members must also have been enrolled in Centennial Care 2.0 for 11 months during the baseline period of 2016 and 2017 and had no exposure to an HH during or prior to the MY.
Comparison Population	PS-adjusted members who never participated in the HH program
Measure Steward	NCQA
Data Source	• MMIS • HH enrollment roster
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	DiD
Notes	Measure 11 follows NCQA specifications for *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, with matching for comparison population. HH enrollment was defined as being in the monthly HH roster files.

Anti-depressant medication management (AMM) effective acute phase treatment–HH population (Measure 12)	
Numerator	Among members identified in the denominator for each group, the number of unique Medicaid members who remained on an antidepressant medication treatment for at least 84 days
Denominator	Treatment group: The number of Centennial Care 2.0 members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression and were continuously enrolled in Centennial Care with no more than one gap of up to 45 days during the measurement period. Members ages 18 years and older must be continuously enrolled in Centennial Care 105 days prior to the index prescription start date (IPSD) through 231 days after the IPSD. Members must also have been enrolled in Centennial Care 2.0 for 11 months during the 2016 and 2017 baseline period, enrolled for three continuous months concurrently in an HH and Centennial Care 2.0 during the MY, and had no exposure to an HH prior to January 1, 2018. Comparison group: The number of Centennial Care 2.0 members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and were continuously enrolled in Centennial Care 2.0 with no more than one gap of up to 45 days during the measurement period. Members ages 18 years and older must be continuously enrolled in Centennial Care 2.0 105 days prior to the IPSD through 231 days after the IPSD. Members must also have been enrolled in Centennial Care 2.0 for 11 months during the 2016 and 2017 baseline period and had no exposure to an HH during or prior to the MY.
Comparison Population	PS-adjusted members who never participated in the HH program
Measure Steward	NCQA
Data Source	• MMIS • HH enrollment roster
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	DiD
Notes	This measure follows NCQA specifications for *Antidepressant Medication Management*, with matching for comparison group. HH enrollment was defined as appearing in the monthly HH roster files.

Anti-depressant medication management (AMM) effective continuation phase treatment – HH population (Measure 13)	
Numerator	Among members identified in the denominator for each group, the number of unique Medicaid members who remained on an antidepressant treatment for at least 180 days
Denominator	Treatment group: The number of Centennial Care 2.0 members ages 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and were continuously enrolled in Centennial Care with no more than one gap of up to 45 days during the measurement period. Members ages 18 years and older must be continuously enrolled in Centennial Care 105 days prior to the IPSD through 231 days after the IPSD. Members must also have been enrolled in Centennial Care for 11 months during the 2016 and 2017 baseline period, enrolled for three continuous months concurrently in an HH and Centennial Care during the MY, and had no exposure to an HH prior to January 1, 2018. Comparison group: The number of Centennial Care 2.0 members ages 18 years of age who were treated with antidepressant medication, had a diagnosis of major depression, and were continuously enrolled in Centennial Care with no more than one gap of up to 45 days during the measurement period. Members ages 18 years and older must be continuously enrolled in Centennial Care 105 days prior to the IPSD through 231 days after the IPSD. Members must also have been enrolled in Centennial Care for 11 months during the 2016 and 2017 baseline period and had no exposure to an HH during or prior to the MY.
Comparison Population	PS-adjusted members who never participated in the HH program

Anti-depressant medication management (AMM) effective continuation phase treatment – HH population (Measure 13)	
Measure Steward	NCQA
Data Source	• MMIS • HH enrollment roster
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	DiD
Notes	This measure follows NCQA specifications for Antidepressant Medication Management, with matching for comparison group. HH enrollment was defined as appearing in the monthly HH roster files.

7-day follow-up after hospitalization for mental illness (FUH)–HH population (Measure 14)	
Numerator	Of members identified in the denominator for each group, the number of unique Medicaid members who had a follow-up visit with a mental health practitioner within seven days after discharge
Denominator	Treatment group: The number of Centennial Care 2.0 members ages 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and continuously enrolled in Centennial care during the measurement period. Members ages 6 years and older must be continuously enrolled in Centennial Care from the date of discharge through 30 days after discharge. Members must also have been enrolled in Centennial Care for 11 months during the 2016 and 2017 baseline period, enrolled for three continuous months concurrently in an HH and Centennial Care during the MY, and had no exposure to an HH prior to January 1, 2018. Comparison group: The number of Centennial Care 2.0 members ages 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and continuously enrolled in Centennial care during the measurement period. Members ages 6 years and older must be continuously enrolled in Centennial Care from the date of discharge through 30 days after discharge. Members must also have been enrolled in Centennial Care for 11 months during the 2016 and 2017 baseline period, enrolled for three continuous months in Centennial Care during the MY, and had no exposure to an HH during or prior to the MY.
Comparison Population	PS-adjusted members who never participated in the HH program
Measure Steward	NCQA
Data Source	• MMIS • HH enrollment roster
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	DiD
Notes	This measure follows NCQA specifications for *7-day Follow Up after Hospitalizations for Mental Illness,* with matching for comparison group. HH enrollment was defined as appearing in the monthly HH roster files.

30-day follow-up after hospitalization for mental illness (FUH)–HH population (Measure 15)	
Numerator	Among members identified in the denominator for each group, the number of unique Medicaid members who had a follow-up visit with a mental health practitioner within 30 days after discharge
Denominator	Treatment group: The number of Centennial Care 2.0 members ages 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and continuously enrolled in Centennial care during the measurement period. Members 6 years of age and older must be continuously enrolled in Centennial Care from the date of discharge through 30 days after discharge. Members must also have been enrolled in Centennial Care for 11 months during the 2016 and 2017 baseline period, enrolled for three continuous months concurrently in an HH and Centennial Care during the MY, and had no exposure to an HH prior to January 1, 2018. Comparison group: The number of Centennial Care 2.0 members ages 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and continuously enrolled in Centennial care during the measurement period. Members ages 6 years and older must be continuously enrolled in Centennial Care from the date of discharge through 30 days after discharge. Members must also have been enrolled in Centennial Care for 11 months during the 2016 and 2017 baseline period, enrolled for three continuous months in Centennial Care during the MY, and had no exposure to an HH during or prior to the MY.
Comparison Population	PS-adjusted members who never participated in the HH program
Measure Steward	NCQA
Data Source	• MMIS • HH enrollment roster
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	DiD
Notes	This measure follows NCQA specifications for *30-day Follow Up after Hospitalizations for Mental Illness*, with matching for comparison group. HH enrollment was defined as appearing in the monthly HH roster files.

Number of HFW beneficiaries enrolled in the program (Measure 16)	
Numerator	The number of members enrolled in the HFW program
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	• MMIS • HFW roster data
Frequency	Monthly
Desired Direction	No desired direction
Analytic Approach	Descriptive time series
Notes	N/A

Percentage of HFW beneficiaries with SED diagnosis in the 11 months prior to enrollment (Measure 17)	
Numerator	Among the members identified in the denominator, the number of members with a SED diagnosis in the 11 months prior to enrollment in the HFW program
Denominator	The number of members enrolled in the HFW program
Comparison Population	N/A
Measure Steward	N/A
Data Source	• MMIS • HFW roster data
Frequency	Monthly
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Notes	N/A

Stakeholders' reported barriers and facilitators to implementation (Measure 18)	
Numerator	N/A
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	Key informant interviews
Frequency	N/A
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Notes	N/A

Percentage of Centennial Care members participating in CR (Measure 19)	
Numerator	Centennial Care 2.0 members participating in CR (i.e., a member who was engaged [registered] and earned points)
Denominator	Total number of enrolled Centennial Care 2.0 members
Comparison Population	N/A
Measure Steward	N/A
Data Source	• Finity • MMIS
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Notes	N/A

Percentage of CR participating members and non-participating members with an annual preventive/ambulatory service (Measure 20)	
Numerator	Treatment group: Total number of members participating in CR with a preventive/ambulatory visit in the twelve-month period Comparison group: Total number of members who never participated in CR with a preventive/ambulatory visit in the twelve-month period (weighted by their PS for CR participation)
Denominator	Treatment group: Total number of members participating in CR during the CY Comparison group: Total number of members who never participated in CR and were enrolled in Centennial Care 2.0 the CY (predicted)
Comparison Population	CR members not participating in CR during the CY (predicted)
Measure Steward	N/A
Data Source	• Finity • MMIS
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	• PS weighting • ITS with comparison group
Notes	N/A

Percentage of CR participating and redeeming, and CR participating and non-redeeming members with an annual preventive/ambulatory service (Measure 21)	
Numerator	Treatment group: Total number of members who are engaged, earned any reward, have redeemed at least one reward (participated and redeemed), and have completed a second preventive/ambulatory visit in the 12 months following an initial preventive/ambulatory visit Comparison group: Total number of members who are engaged, earned any reward, have not redeemed a reward (participated and not redeemed), and have completed a second preventive/ambulatory visit in the 12 months following an initial preventive/ambulatory visit
Denominator	Treatment group: Total number of members who are engaged, earned any reward, have redeemed at least one reward (participated and redeemed), and had an initial preventive/ambulatory visit Comparison group: Total number of members who are engaged, earned any reward, have not redeemed a reward (participated and not redeemed), and had an initial preventive/ambulatory visit
Comparison Population	CR participating members not redeeming CR rewards during the CY
Measure Steward	N/A
Data Source	• Finity • MMIS
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	• Predictive model • ITS with comparison group
Notes	N/A

Live births weighing less than 2,500 grams (low birth weight) (Measure 22)	
Numerator	Treatment group: The number of resident live births in the treatment denominator weighing less than 2,500 grams (low birth weight) Comparison group: The number of resident live births in the comparison denominator weighing less than 2,500 grams (low birth weight)
Denominator	Treatment group: The number of live births among Centennial Care 2.0 members in the reporting period who are Centennial Home Visiting (CHV) participants and had a delivery on or after their first program enrollment date Comparison group: The number of live births among Centennial Care 2.0 members in the reporting period who have never participated in CHV
Comparison Population	CDPS risk score-adjusted members who have never participated in CHV
Measure Steward	Centers for Disease Control and Prevention (CDC)
Data Source	• HCA-supplied list of deliveries and low birth weight deliveries • HCA-supplied list of CHV participants • MMIS
Frequency	Annual
Desired Direction	Lower is better
Analytic Approach	Logistic regression by year controlling for CDPS risk score
Notes	The benchmark comparison was eligible CHV birth outcome with national benchmarks

Total number of providers with value-based purchasing (VBP) contracts (Measure 23)	
Numerator	The number of Centennial Care 2.0 providers with VBP contracts in each CY
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	Annual Supplemental VBP reports provided by managed care organizations (MCOs)
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Notes	N/A

Number/percentage of providers meeting quality threshold (Measure 24)	
Numerator	The number of Centennial Care 2.0 providers with VBP contracts who meet quality metric targets
Denominator	The total number of VBP providers reporting quality metrics
Comparison Population	N/A
Measure Steward	N/A
Data Source	Annual Supplemental VBP reports provided by MCOs
Frequency	Annual

Number/percentage of providers meeting quality threshold (Measure 24)	
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Notes	The denominator was intended to include all Centennial Care 2.0 providers with VBP contracts; however, not all Centennial Care 2.0-contracted VBP provider groups reported quality metrics. Specifically, quality metric data were not available for LTSS providers. As a result, the denominator was altered to the total number of VBP provider groups who reported quality metrics to more accurately reflect the rate of providers meeting quality metrics.

Percentage of total payments that are for providers in VBP arrangements (Measure 25)	
Numerator	The total amount of payments to Centennial Care 2.0 providers with VBP contracts
Denominator	The total amount of payments to Centennial Care 2.0 providers
Comparison Population	N/A
Measure Steward	N/A
Data Source	Annual Supplemental VBP reports provided by MCOs
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Notes	N/A

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 (Measure 26)	
Numerator	The number of Domain 1 SNCP Hospital Quality Incentive measures that maintained or improved the reported performance rate. To identify whether a rate was maintained or improved, the annual performance rate was compared to the improvement target rate. If the rate was lower than the target for measures in which a lower rate was better, then the measure maintained or improved.
Denominator	The number of Domain 1 SNCP Hospital Quality Incentive performance measures
Comparison Population	N/A
Measure Steward	N/A
Data Source	• Department of Health (DOH) Health Information Technology (HIT) • New Mexico Hospital Association
Frequency	N/A
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Notes	No new data was received for the Summative Evaluation Report as this program is no longer operated under Centennial Care 2.0.

Cost per member trend (Measure 27)	
Numerator	The sum of total MCO paid claim/encounter amounts for all IP, LTC, OP, professional, and pharmacy categories of service
Denominator	The sum of all Centennial Care 2.0 member months (MMs) including enrollees who had claims/encounters and those who had no claims/encounters
Comparison Population	N/A
Measure Steward	N/A
Data Source	• MMIS • Capitation Data • CMS-64 Report
Frequency	Monthly
Desired Direction	No significant change from projections
Analytic Approach	Actuarially-adjusted historical control model
Notes	N/A

Cost per user trend (Measure 28)	
Numerator	The sum of total MCO paid claim/encounter amounts for all IP, LTC, OP, professional and pharmacy categories of service
Denominator	The sum of all Centennial Care 2.0 MMs only including members who had claims/encounters
Comparison Population	N/A
Measure Steward	N/A
Data Source	• MMIS • Capitation Data • CMS-64 Report
Frequency	Monthly
Desired Direction	No significant change from projections
Analytic Approach	Actuarially-adjusted historical control model
Notes	N/A

Number of continuous nursing facility level of care (NFLOC) approvals (Measure 29)	
Numerator	The number of nursing facility members enrolled in Centennial Care with a continuous NFLOC approval
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	Summary report of open ended LTC spans
Desired Direction	Higher is better
Frequency	Quarterly
Analytic Approach	Descriptive time series
Notes	Rates were calculated per 10,000 nursing facility members.

Number of telemedicine providers (Measure 30)	
Numerator	The number of unique Centennial Care 2.0 telemedicine providers who offered telehealth services. Step 1: Identify encounters for telehealth services using the following codes: • Any service with a telehealth modifier or place of service (POS) (Telehealth Modifier Value Set or Telehealth POS Value Set) • A telephone visit (Telephone Visits Value Set) • An e-visit or virtual check-in (Online Assessments Value set) • Any service from Table A **Table A—HCA Telemedicine Service Codes** 99441, 99442, 99443, 99451, 99452, D9995 G2010, G2012, G2061, G2062, G2063 Step 2: Calculate the number of unique servicing/rendering providers with at least one encounter from Step 1 with a date of service in the measurement period.
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly and quarterly
Desired Direction	Higher is better
Analytic Approach	• Three period ITS (Centennial Care 2.0 and coronavirus disease 2019 [COVID-19] public health emergency [PHE] break points) • Quarterly descriptive time series stratified by PH, BH, and PH and BH providers
Notes	Value sets are from Healthcare Effectiveness Data and Information Set (HEDIS®[A-20]) MY 2020 technical specifications.

[A-20] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Number of members receiving telemedicine services (Measure 31)	
Numerator	The number of Centennial Care 2.0 members with a telemedicine visit. Step 1: Identify encounters for telehealth services using the following codes: • Any service with a telehealth modifier or POS (Telehealth Modifier Value Set or Telehealth POS Value Set) • A telephone visit (Telephone Visits Value Set) • An e-visit or virtual check-in (Online Assessments Value Set) • Any service from Table A **Table A—HCA Telemedicine Service Codes** 99441, 99442, 99443, 99451, 99452, D9995 G2010, G2012, G2061, G2062, G2063 Step 2: Calculate the number of unique members with at least one encounter from Step 1 with a date of service in the measurement period.
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	Three period ITS (Centennial Care 2.0 and COVID-19 PHE break points)
Notes	Value sets are from HEDIS MY 2020 technical specifications.

Member rating of healthcare (Measure 32)	
Numerator	Summary rates were evaluated based on an 8+9+10 top-box rating system as indicated in the table below. The numerator will be defined as the response score value or numerator compliance for each member answering the following question: "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your healthcare in the last 6 months?" Responses and their corresponding score values and numerator compliance are as follows:

Response Choices	Score Value
0 – Worst health care possible	0
1	0
2	0
3	0
4	0
5	0
6	0
7	0
8	1
9	1
10 – Best health care possible	1

Denominator	The number of Centennial Care 2.0 respondents with a valid response to overall satisfaction with healthcare
Comparison Population	N/A

Member rating of healthcare (Measure 32)	
Measure Steward	NCQA
Data Source	MCO CAHPS Reports
Measurement Period	Annual
Desired Direction	Higher is better
Analytic Approach	ITS
Notes	Rates provided by the MCOs were not independently validated.

Member rating of health plan (Measure 33)	
Numerator	Summary rates were evaluated based on an 8+9+10 top-box ratings system as indicated in the table below. The numerator value will be defined as the response score value or numerator compliance for each member answering the following question: "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?" Responses and their corresponding score values are as follows:

Response Choices	Score Value
0 – Worst health plan possible	0
1	0
2	0
3	0
4	0
5	0
6	0
7	0
8	1
9	1
10 – Best health plan possible	1

Denominator	The number of Centennial Care 2.0 respondents with a valid response to overall satisfaction with health plan
Comparison Population	N/A
Measure Steward	NCQA
Data Source	MCO CAHPS Reports
Measurement Period	Annual
Desired Direction	Higher is better
Analytic Approach	ITS
Notes	Rates provided by the MCOs were not independently validated.

Member rating of personal doctor (Measure 34)	
Numerator	Summary rates were evaluated based on an 8+9+10 top-box ratings system as indicated in the table below. The numerator value will be defined as the response score value or numerator compliance for each member answering the following question: "Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?" Responses and their corresponding score values are as follows:

Response Choices	Score Value
0 – Worst personal doctor possible	0
1	0
2	0
3	0
4	0
5	0
6	0
7	0
8	1
9	1
10 – Best personal doctor possible	1

Denominator	The number of Centennial Care 2.0 respondents with a valid response to overall satisfaction with personal doctor
Comparison Population	N/A
Measure Steward	NCQA
Data Source	MCO CAHPS reports
Measurement Period	Annual
Desired Direction	Higher is better
Analytic Approach	ITS
Notes	Rates provided by the MCOs were not independently validated.

Number of submitted claims through EVV (Measure 35)	
Numerator	The number of Centennial Care 2.0 claims submitted through a web or interactive voice response system, or mobile app
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	MCO report
Frequency	Quarterly
Desired Direction	Higher is better
Analytic Approach	• Descriptive time series • ITS
Notes	N/A

Percent of paid or unpaid hours retrieved due to false reporting (Measure 36)	
Numerator	Number of paid or unpaid hours retrieved due to false reporting
Denominator	Centennial Care 2.0 claims paid and unpaid hours reported
Comparison Population	N/A
Measure Steward	N/A
Data Source	MCO report
Frequency	Quarterly
Desired Direction	Lower is better
Analytic Approach	Descriptive time series
Notes	N/A

Number of providers who provide SUD screening (Measure 37)	
Numerator	The number of Centennial Care 2.0 PH and BH providers who provide SUD screening. Step 1: Identify encounters with any of the following procedure codes: • H0049 – Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening • G0444 – Other BH screening • H2000 – comprehensive multidisciplinary team evaluation • H0002 – American Society of Addition Medicine (ASAM) assessment • H0031 – comprehensive mental health assessment for patients who do not have SMI or SED Step 2: Limit the rendering or servicing providers with encounters from Step 1 to providers serving Centennial Care 2.0 members. Step 3: Calculate the number of de-duplicated rendering or servicing providers in the measurement period.
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	Higher is better
Analytic Approach	ITS
Notes	N/A

Number of individuals screened for SUD (Measure 38)	
Numerator	The number of Centennial Care 2.0 members screened for SUD. Step 1: Identify encounters with any of the following procedure codes: • H0049 – SBIRT screening • G0444 – Other BH screening • H2000 – comprehensive multidisciplinary team evaluation • H0002 – ASAM assessment • H0031 – Comprehensive mental health assessment for patients who are not SMI or SED Step 2: Calculate the number of de-duplicated Centennial Care 2.0 members with encounters from Step 1 in the measurement period.
Denominator	N/A
Comparison Population	N/A
Measure Steward	CMS
Data Source	MMIS
Desired Direction	Higher is better
Frequency	Monthly
Analytic Approach	ITS
Notes	Measure specifications rely on *Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #1: Assessed for SUD Treatment Needs Using a Standardized Screening Tool. No subpopulation categories were reported. HCA supplied codes for identifying SUD screening services.

Percentage of individuals with a SUD diagnosis who received any SUD service during the MY (Measure 39)	
Numerator	The number of Centennial Care 2.0 members among the denominator with a SUD diagnosis who received any SUD service during the MY
Denominator	The number of unique Centennial Care 2.0 members (de-duplicated total) enrolled in the measurement period who receive medication assisted treatment (MAT) or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 12 months before the measurement period
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	Higher is better
Analytic Approach	ITS
Notes	Measure specifications rely on *Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #4: Medicaid Beneficiaries with SUD diagnosis, annually (denominator), and Metric #6: Any SUD Treatment (numerator)

Initiation of alcohol or other drug (AOD) abuse or dependence treatment (IET) (Measure 40)	
Numerator	The number of Centennial Care 2.0 members with SUD diagnosis who initiate AOD treatment through an IP admission, OP visit, telemedicine, intensive OP encounter or partial hospitalization or MAT within 14 days of the index episode start date (IESD)
Denominator	The number of Centennial Care 2.0 adolescent and adult members (ages 13 years and older) with a new episode of AOD abuse or dependence
Comparison Population	N/A
Measure Steward	NCQA
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	• ITS • National or other state benchmarks change over time
Notes	This measure follows NCQA specifications for *Initiation of AOD Abuse or Dependence Treatment*.

Percentage of individuals with a SUD diagnosis who received peer support (Measure 41)	
Numerator	Among members identified in the denominator, the number of Medicaid members who receive peer support services (Peer Support Services Value Set)
Denominator	The number of unique members (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 12 months before the measurement period
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Quarterly
Desired Direction	Higher is better
Analytic Approach	ITS
Notes	The measure denominator is adapted from *Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #3: Medicaid Beneficiaries with SUD diagnosis (monthly).

Engagement of AOD abuse or dependence treatment (IET) (Measure 42)	
Numerator	Among members identified in the denominator, the number of unique Medicaid members who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit
Denominator	Peer Support Services Group: The number of Centennial Care 2.0 adolescent and adult members (ages 13 years and older) with a new episode of AOD abuse or dependence and received peer support services (Peer Support Services Value Set) within 48 days following the IESD Comparison Group: The number of Centennial Care 2.0 adolescent and adult members (ages 13 years and older) with a new episode of AOD abuse or dependence and had never utilized peer support services (Peer Support Services Value Set) within 48 days following the IESD

Engagement of AOD abuse or dependence treatment (IET) (Measure 42)	
Comparison Population	Centennial Care 2.0 members meeting the NCQA eligible population criteria who never utilized peer support services
Measure Steward	NCQA (modified)
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	DiD
Notes	This measure follows modified NCQA specifications for *Initiation and Engagement of AOD Abuse or Dependence Treatment* (engagement indicator).

Average length of stay (LOS) (Measure 43)	
Numerator	Peer Support Services Group: The number of days between the AOD index episode and the last date of treatment (measured in monthly increments), and who received peer support services during this time (Peer Support Services Value Set) Comparison Group: The number of days between the AOD index episode and the last date of treatment (measured in monthly increments), and who did not receive peer support services during this time. For example, if a member had an index episode in January and treatment in January, February, and March, the treatment spans from January through March. If a member had treatment in January and March, the length of treatment only spans January.
Denominator	The number of Centennial Care 2.0 members with an AOD episode, as identified by NCQA Technical Specifications for *Initiation and Engagement of AOD Abuse or Dependence Treatment* (event/diagnosis)
Comparison Population	Centennial Care 2.0 members meeting the denominator criteria and who never utilized peer support services during treatment tenure
Measure Steward	N/A
Data Source	MMIS
Frequency	Annually or Quarterly
Desired Direction	Higher is better
Analytic Approach	• DiD • ITS with comparison group
Notes	N/A

Continuity of pharmacotherapy for opioid use disorder (OUD) (Measure 44)	
Numerator	Among members identified in the denominator, the number of unique Medicaid members who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days
Denominator	Peer Support Services Group: The number of Centennial Care 2.0 members ages 18 to 64 years who had a diagnosis of OUD and at least one claim for OUD medication. Members must have received peer support services (Peer Support Services Value Set) within 180 days after OUD medication Comparison Group: The number of Centennial Care 2.0 members ages 18 to 64 years who had a diagnosis of OUD and at least one claim for OUD medication. Members must not have received peer support services (Peer Support Services Value Set) within 180 days after OUD medication
Comparison Population	N/A

Continuity of pharmacotherapy for opioid use disorder (OUD) (Measure 44)	
Measure Steward	University of Southern California (USC) (National Quality Forum [NQF] #3175)
Data Source	MMIS
Frequency	Annually or Quarterly
Desired Direction	Higher is better
Analytic Approach	• DiD • ITS
Notes	N/A

Continuum of services available (Measure 45)	
Numerator	• The number of different types of BH facilities and BH practitioner types reported by currently contracted MCOs • The number of providers associated with each BH facility and practitioner types
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	MCO Reports–Continuum of Services Data
Frequency	Quarterly
Desired Direction	Higher is better
Analytic Approach	Descriptive data analysis
Notes	This measure is a quantitative data synthesis of the types of services reported by MCOs and the number of providers by facility type.

Number of providers and capacity for ambulatory SUD services (Measure 46)	
Numerator	The number of SUD providers and the total panel size reported by contracted MCOs from 2018 through 2021, compared to projected panel size between 2019 and 2021. Provider panel was identified by calculating the unique number of Medicaid members with a claim/encounter for each provider. Projected panel size was calculated by taking the average panel size among SUD providers in 2018 prior to Centennial Care 2.0 and multiplying by the number of providers in each year during the study period (2019 through 2021). Actual and projected panel size was stratified by existing providers (i.e., those contracted with BCBS or PHP in 2018, prior to Centennial Care 2.0) and new providers (i.e., those not contracted with BCBS or PHP in 2018).
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	• MMIS • MCO SUD provider reports
Frequency	Annual
Desired Direction	Higher is better

Number of providers and capacity for ambulatory SUD services (Measure 46)	
Analytic Approach	Descriptive data analysis
Notes	N/A

Percentage of ED visits of individuals with SUD diagnoses (Measure 47)	
Numerator	The number of ED visits among Centennial Care 2.0 members with an SUD diagnosis. Step 1. Identify members with an SUD diagnosis (monthly), as specified through *Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #3: Medicaid Beneficiaries with SUD Diagnosis (monthly). Step 2. Calculate the number of ED visits among members retained from Step 1. Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following: • An ED visit (ED Value Set). • A procedure code (ED Procedure Code Value Set) with an ED POS code (ED POS Value Set). Do not include ED visits that result in an IP stay (IP Stay Value Set).
Denominator	The number of ED visits among all Centennial Care 2.0 members. Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following: • An ED visit (ED Value Set). • A procedure code (ED Procedure Code Value Set) with an ED POS code (ED POS Value Set). Do not include ED visits that result in an IP stay (IP Stay Value Set).
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Quarterly
Desired Direction	Lower is better
Analytic Approach	ITS
Notes	N/A

Percentage of IP admissions for SUD related treatment (Measure 48)	
Numerator	The number of IP services for SUD-related treatment for Centennial Care 2.0 members. Step 1. Among claims retained in the denominator, identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 2. Calculate the number of IP discharges meeting the criteria in Step 1.
Denominator	The number of IP admissions for Centennial Care 2.0 members. Step 1. Identify all IP stays (acute and nonacute) during the measurement period (IP Stay Value Set). Step 2. Identify and exclude claims for residential treatment using the Uniform Billing (UB) Revenue codes listed below: • 1001 – Residential treatment, psychiatric • 1002 – Residential treatment – chemical dependency Step 3. Identify the discharge date for the stay. Retain only stays with discharge dates that fall within the measurement period.
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Quarterly
Desired Direction	Lower is better
Analytic Approach	ITS
Notes	N/A

Percentage of IP admissions of individuals with SUD for withdrawal management (Measure 49)	
Numerator	The number of IP admissions of individuals with SUD for withdrawal management for Centennial Care 2.0 members. Step 1. Among claims retained in Denominator Step 4, identify claims for withdrawal management (Detoxification Value Set) Step 2. Calculate the number of IP discharges meeting the criteria in Step 1.
Denominator	The number of IP services for SUD-related treatment for Centennial Care 2.0 members. Step 1. Identify all IP stays (acute and nonacute) during the measurement period (IP Stay Value Set). Step 2. Identify and exclude claims for residential treatment using the UB Revenue codes listed below: • 1001 – Residential treatment, psychiatric • 1002 – Residential treatment – chemical dependency Step 3. Identify the discharge date for the stay. Retain only stays with discharge dates that fall within the measurement period. Step 4. Among claims retained in Step 3, identify claims with a principal diagnosis code listed under any of the following Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 5. Calculate the number of IP discharges meeting the criteria in Steps 1, 2, 3, and 4.

Percentage of IP admissions of individuals with SUD for withdrawal management (Measure 49)	
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Quarterly
Desired Direction	Lower is better
Analytic Approach	ITS
Notes	N/A

7- and 30-day IP and residential SUD readmission rates (Measure 50)	
Numerator	• The number of 7-day IP and residential readmission rates for Centennial Care 2.0 users discharged with SUD diagnosis and readmitted to either IP or residential treatment with SUD diagnosis • 30-day IP and residential readmission rates for Centennial Care 2.0 users discharged with SUD diagnosis and readmitted to either IP or residential treatment with SUD diagnosis
Denominator	The number of IP discharges with a principal diagnosis of SUD. Step 1: Calculate the Denominator: Count of Index Hospital Stays Step 1a. Identify all acute IP discharges with any diagnosis in the first 11 months of the MY. To identify acute IP discharges: • Identify all acute and nonacute IP stays (IP Stay Value Set). • Exclude nonacute IP stays (Nonacute IP Stay Value Set). • Determine whether the discharge date for the stay falls in the first 11 months of the MY. IP stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct IP stays. This measure includes acute discharges from any type of acute facility (including BH care facilities). Step 1b. Address acute-to-acute direct transfers as described below in "Additional Guidance." Exclude the hospital stay if the direct transfer's discharge date occurs in the last 30 days of the MY. Step 1c. Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date. Step 1d. Exclude hospital stays for the following reasons: • The member died during the stay. • Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim. • A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. Note: For hospital stays where there was an acute-to-acute direct transfer (identified in Step 1), use both the original stay and the direct transfer stay to identify exclusions in this step. Step 1e. Identify stays with a principal diagnosis for SUD (AOD Abuse and Dependence Value Set). Step 1f. To calculate the count of Index Hospital Stays (i.e., the denominator), count the number of Index Hospital Stays that meet the criteria in Steps 1a-1e.
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Quarterly

7- and 30-day IP and residential SUD readmission rates (Measure 50)	
Desired Direction	Lower is better
Analytic Approach	ITS
Notes	N/A

Total and per member per month (PMPM) cost (medical, behavioral and pharmacy) for members with SUD diagnosis (Measure 51)	
Numerator	The sum of total MCO paid claim/encounter amounts for all IP, LTC, OP, professional and pharmacy categories of service for members flagged with an SUD diagnosis
Denominator	The sum of all Centennial Care 2.0 MMs flagged with an SUD diagnosis based on the following criteria: • The number of unique members (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 11 months before the measurement period, as outlined in the *Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #3: Medicaid Beneficiaries with SUD diagnosis (monthly)
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	No significant change from projections
Analytic Approach	ITS
Notes	The denominator specifications follow *Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #3: Medicaid Beneficiaries with SUD diagnosis (monthly)

Total and PMPM cost (medical, behavioral and pharmacy) for members with SUD diagnosis by SUD source of care (Measure 52)	
Numerator	The sum of total MCO paid claim/encounter amounts stratified by IP, LTC, OP, professional and pharmacy categories of service for members flagged with an SUD diagnosis.
Denominator	The sum of all Centennial Care 2.0 MMs flagged with an SUD diagnosis based on the following criteria: • The number of unique members (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 11 months before the measurement period, as outlined in the *Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #3: Medicaid Beneficiaries with SUD diagnosis (monthly)
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	No significant change from projections

Total and PMPM cost (medical, behavioral and pharmacy) for members with SUD diagnosis by SUD source of care (Measure 52)	
Analytic Approach	ITS
Notes	• The numerator specifications follow CMS's SMI/SED and SUD Evaluation Design Guidance Appendix C. • The denominator specifications follow Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0, Metric #3: Medicaid Beneficiaries with SUD diagnosis (monthly).

Total and PMPM cost for SUD services for members with SUD diagnosis (Measure 53)	
Numerator	The sum of total MCO paid claim/encounter amounts for all IP, LTC, OP, professional and pharmacy categories of service related to SUD claims/encounters only for members flagged with an SUD diagnosis
Denominator	The sum of all Centennial Care 2.0 MMs flagged with an SUD diagnosis based on the following criteria: • The number of unique members (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 11 months before the measurement period, as outlined in the *Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #3: Medicaid Beneficiaries with SUD diagnosis (monthly)
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Measurement Period	Monthly
Desired Direction	No significant change from projections
Analytic Approach	ITS
Notes	• The numerator specifications follow CMS' SMI/SED and SUD Evaluation Design Guidance Appendix C, and Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0, Metric #28 & #29: SUD Spending & SUD Spending Within IMDs. • The denominator specifications follow Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0, Metric #3: Medicaid Beneficiaries with SUD diagnosis (monthly).

Total and PMPM cost for SUD services by type of care (IP, OP [OP], pharmacy [RX], etc.) (Measure 54)	
Numerator	The sum of total MCO paid claim/encounter amounts stratified by IP, LTC, OP, professional and pharmacy categories of service related to SUD claims/encounters only for members flagged with an SUD diagnosis
Denominator	The sum of all Centennial Care 2.0 MMs flagged with an SUD diagnosis based on the following criteria: • The number of unique Centennial Care 2.0 members (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 11 months before the measurement period as outlined in the *Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #3: Medicaid Beneficiaries with SUD diagnosis (monthly)
Comparison Population	N/A

Total and PMPM cost for SUD services by type of care (IP, OP [OP], pharmacy [RX], etc.) (Measure 54)	
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	No significant change from projections
Analytic Approach	ITS
Notes	• The numerator specifications follow CMS' SMI/SED and SUD Evaluation Design Guidance Appendix C, and Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0, Metric #28 & #29: SUD Spending & SUD Spending Within IMDs. • The denominator specifications follow Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0, Metric #3: Medicaid Beneficiaries with SUD diagnosis (monthly).

Percentage of individuals diagnosed with SUD receiving care coordination (Measure 55)	
Numerator	Among members identified in the denominator, the number of Centennial Care 2.0 members in fully delegated care coordination during the measurement period. Fully delegated care coordination is defined as participating in an HH program.
Denominator	The number of unique Centennial Care 2.0 members (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 11 months before the measurement period
Comparison Population	N/A
Measure Steward	N/A
Data Source	• MMIS • HH enrollment roster
Frequency	Quarterly
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Notes for Measure Calculation	Denominator specifications follow *Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #3: Medicaid Beneficiaries with SUD diagnosis (monthly)

Percentage of individuals with SUD receiving preventive/ambulatory health services (AAP) (Measure 56)	
Numerator	The number of Centennial Care 2.0 members with SUD diagnosis receiving preventive/ambulatory health services
Denominator	The number of Centennial Care 2.0 members with SUD diagnosis and meeting eligible population criteria
Comparison Population	N/A
Measure Steward	CMS (modified NCQA)
Data Source	MMIS
Frequency	Annually or Quarterly
Desired Direction	Higher is better

Percentage of individuals with SUD receiving preventive/ambulatory health services (AAP) (Measure 56)	
Analytic Approach	• Trend analysis • ITS
Notes	Measure specifications follow *Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD.

Number of naloxone training and kit distributions (Measure 57)	
Numerator	The number of naloxone training and kit distributions to New Mexico residents
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	• DOH, BHSD Report: Narcan Training and Distribution • Office of Substance Abuse Prevention, Narcan Master List (2022–2018) • Distribution & Training Summary (2023–2024) • State Opioid Response Quarterly Performance Accountability and Reporting System (2023–2024)
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	Descriptive data analysis
Notes	Data provided by DOH/BHSD were not independently validated.

Number of MCO network MAT providers (Measure 58)	
Numerator	The number of MCO network MAT providers
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	• MCO Reports • State Opioid Treatment Authority
Frequency	Annual
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Notes	Data provided by the MCOs were not independently validated.

Percentage of individuals with an opioid use or alcohol use disorder with MAT claims (Measure 59)	
Numerator	Among members identified in the denominator, the number of Medicaid members with a claim for MAT during the MY. MAT claims are identified through one of the following dispensing events: • Alcohol Use Disorder Treatment Medication List • Opioid Use Disorder Treatment Medication List
Denominator	The number of Centennial Care 2.0 members with an AOD/OUD diagnosis OR an MAT dispensing event. Identify members with any claim for any of the following diagnoses or dispensing events during the MY: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Alcohol Use Disorder Treatment Medication List • OUD Treatment Medication List
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Quarterly
Desired Direction	Higher is better
Analytic Approach	ITS
Notes	N/A

Number of providers using the prescription monitoring program (PMP) (Measure 60)	
Numerator	Number of providers who made at least one PMP request in the quarter
Denominator	Number of providers needing 10 or more PMP reports in the quarter
Comparison Population	N/A
Measure Steward	N/A
Data Source	• New Mexico Board of Pharmacy • MCO report
Frequency	Annual
Desired Direction	N/A
Analytic Approach	Descriptive data analysis
Notes	N/A

Rate of deaths due to overdose (Measure 61)	
Numerator	Proportionate mortality and cause-specific death rates were calculated for both the whole New Mexico population and the New Mexico Medicaid population. Proportionate mortality rates are defined as the number of overdose deaths divided by all deaths among the population of interest. Cause-specific death rates are defined as the total overdose deaths divided by the size of the population of interest. Specific numerator and denominator definitions are included below. Proportionate Mortality Rate: The total number of overdose deaths among the denominator. Cause-Specific Death Rate: The total number of overdose deaths among the denominator.
Denominator	Proportionate Mortality Rate: The total number of deaths among New Mexico Residents. Cause-Specific Death Rate: The total New Mexico population.
Comparison Population	Rates were calculated for the overall New Mexico population and for the New Mexico Medicaid population
Measure Steward	N/A
Data Source	• DOH epidemiology reports • Office of Medical Investigator • New Mexico Indicator Based Information System (IBIS) • U.S. Census 5-year American Community Survey (ACS)
Frequency	Annual
Desired Direction	Lower is better
Analytic Approach	ITS
Notes	N/A

Average LOS in an IMD (Measure 62)	
Numerator	Average LOS for Centennial Care 2.0 individuals with SMI/SED in IMDs
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Quarterly
Desired Direction	Statewide average LOS of 30 days in accordance with the STCs
Analytic Approach	Descriptive time series
Notes	N/A

Percentage of members with SMI/SED receiving care coordination (Measure 63)	
Numerator	The number of Centennial Care 2.0 members with SMI/SED receiving care coordination
Denominator	The number of Centennial Care 2.0 members with SMI/SED
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	Higher is better
Analytic Approach	Descriptive time series
Notes	N/A

Number of all-cause ED visits per 1,000 MM among members who met the eligibility criteria of beneficiaries with an SMI/SED. (Measure 64)	
Numerator	The number of ED visits of Centennial Care 2.0 members with SMI/SED
Denominator	The number of Centennial Care 2.0 members with SMI/SED
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	No desired direction
Analytic Approach	Descriptive time series
Notes	N/A

Total and PMPM cost (medical, behavioral and pharmacy) for members with SMI/SED diagnosis (Measure 65)	
Numerator	The sum of total MCO paid claim/encounter amounts for all IP, LTC, OP, professional and pharmacy categories of service for members flagged with an SMI/SED diagnosis
Denominator	The number of Centennial Care 2.0 members (and MMs) with SMI/SED diagnosis
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	No significant change from projections
Analytic Approach	Descriptive time series
Notes	The denominator specifications follow *Medicaid Section 1115 SMI/SED Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Appendix E: Standardized Definition of SMI

Total and PMPM costs (medical, behavioral and pharmacy) for members with SMI/SED diagnosis by SMI/SED source of care (Measure 66)	
Numerator	The sum of total MCO paid claim/encounter amounts stratified by IP, LTC, OP, professional and pharmacy categories of service for members flagged with an SMI/SED diagnosis
Denominator	The number of Centennial Care 2.0 members (and MMs) with SMI/SED diagnosis
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	No significant change from projections
Analytic Approach	Descriptive time series
Notes	The numerator specifications follow CMS' *SMI/SED and SUD Evaluation Design Guidance Appendix C.* The denominator specifications follow *Medicaid Section 1115 SMI/SED Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Appendix E: Standardized Definition of SMI

Total and PMPM cost for SMI/SED services for members with SMI/SED diagnosis (Measure 67)	
Numerator	The sum of total MCO paid claim/encounter amounts for all IP, LTC, OP, professional and pharmacy categories of service related to SMI/SED claims/encounters only for members flagged with an SMI/SED diagnosis
Denominator	The number of Centennial Care 2.0 members (and MMs) with SMI/SED diagnosis
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	No significant change from projections
Analytic Approach	Descriptive time series
Notes	• The numerator specifications follow CMS' *SMI/SED and SUD Evaluation Design Guidance Appendix C, and Medicaid Section 1115 SMI/SED Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #32, #33, and #39: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED – Not IP or Residential, Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED –IP or Residential, & Total Costs Associated With Treatment For Mental Health In an IMD Among Beneficiaries With SMI/SED. • The denominator specifications follow *Medicaid Section 1115 SMI/SED Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Appendix E: Standardized Definition of SMI.

Total and PMPM cost for SMI/SED services by type of care (IP, OP, pharmacy, etc.) (Measure 68)	
Numerator	The sum of total MCO paid claim/encounter amounts stratified by IP, LTC, OP, professional and pharmacy categories of service related to SMI/SED claims/encounters only for members flagged with an SMI/SED diagnosis
Denominator	The number of Centennial Care 2.0 members (and MMs) with SMI/SED diagnosis
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS

Total and PMPM cost for SMI/SED services by type of care (IP, OP, pharmacy, etc.) (Measure 68)	
Frequency	Monthly
Desired Direction	No significant change from projections
Analytic Approach	Descriptive time series
Notes	• The numerator specifications follow CMS' *SMI/SED and SUD Evaluation Design Guidance Appendix C, and Medicaid Section 1115 SMI/SED Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Metric #32, #33, and #39: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED – Not IP or Residential, Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED –IP or Residential, & Total Costs Associated With Treatment For Mental Health In an IMD Among Beneficiaries With SMI/SED. • The denominator specifications follow *Medicaid Section 1115 SMI/SED Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0*, Appendix E: Standardized Definition of SMI.

Number of individuals identified with SMI/SED and number of individuals engaged in SMI/SED treatment (Measure 69)	
Numerator	Number of individuals identified with SMI/SED and engaged in SMI/SED treatment
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	Higher is better
Analytic Approach	Descriptive Time Series
Notes	The proportion of individuals with SMI/SED engaged in SMI/SED treatment was calculated as supplemental information

Number of members diagnosed with SMI/SED conditions by non-BH providers (Measure 70)	
Numerator	Number of members initially diagnosed with SMI/SED conditions by non-BH providers
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	No desired direction
Analytic Approach	Descriptive time series
Notes	The proportion of members initially diagnosed with SMI/SED conditions by non-BH providers was calculated as supplemental information

Number of specialized settings focused on the needs of individuals experiencing SMI/SED (Measure 71)	
Numerator	Number of specialized settings focused on the needs of individuals experiencing SMI/SED
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	Data unavailable
Frequency	Quarterly
Desired Direction	No desired direction
Analytic Approach	N/A
Notes	Data were not provided for this measure.