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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

January 10, 2025

Dana Flannery
Medicaid Director, Medical Assistance Division
New Mexico Human Services Department
State Capitol
Room 400
Santa Fe, NM 87501

Dear Director Flannery:

The Centers for Medicare & Medicaid Services (CMS) completed its review of New Mexico's Final Report for the Personal Care Services (PCS) COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "New Mexico Turquoise Care" (Project No: 11W 00285/6). This report covers the demonstration period from January, 2019 to December, 2023. CMS determined that the Final Report, submitted on December 20, 2024 is in alignment with approval letter, and therefore, approves the state's Final Report.

In accordance with STC #140, the approved Final Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Final Report on Medicaid.gov.

We appreciate the state's commitment to evaluating the PCS COVID-19 PHE amendment under these extraordinary circumstances. We look forward to our continued partnership on the New Mexico Turquoise Care 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: 2025.01.10 04:44:44 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Dana Brown, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

New Mexico Medicaid Managed Care Centennial Care 2.0 Program

Section 1115 Waiver Demonstration Expanded Allowances for Legally Responsible Adults and Personal Care Services

Evaluation Report
December 2024

Table of Contents

List of Tables

List of Figures

Executive Summary

The 2019 novel coronavirus (COVID-19) public health emergency (PHE) created a shortage of traditional health care providers to deliver medically necessary services, including home- and community-based services (HCBS) for New Mexico's Medicaid beneficiaries. To mitigate this shortage, the New Mexico Health Care Authority (HCA) received Centers for Medicare & Medicaid Services (CMS) approval on July 1, 2020, for a waiver that allowed for the financial compensation of caregivers, known as legally responsible individuals (LRIs), who provide personal care services (PCS) to children and adults receiving evaluative and community-based (CB) services. This waiver program supported family caregivers and allowed some of New Mexico's highest-risk Medicaid members to stay in their homes or community rather than entering an institutional setting during and after the PHE.

HCA contracted with Island Peer Review Organization (IPRO), the state's external quality review organization (EQRO), to conduct an independent evaluation of amendments to New Mexico's Section 1115 demonstration in response to the PHE. This report provides IPRO's independent evaluation of the expansion of PCS covered by the state's Medicaid managed care organizations (MCOs), Blue Cross and Blue Shield (BCBS®) of New Mexico, Presbyterian Health Plan, Inc. (PHP), and Western Sky Community Care® (WSCC). The evaluation utilized multiple methods to measure and assess the impact of the PHE waiver program on Medicaid members' access to necessary PCS.

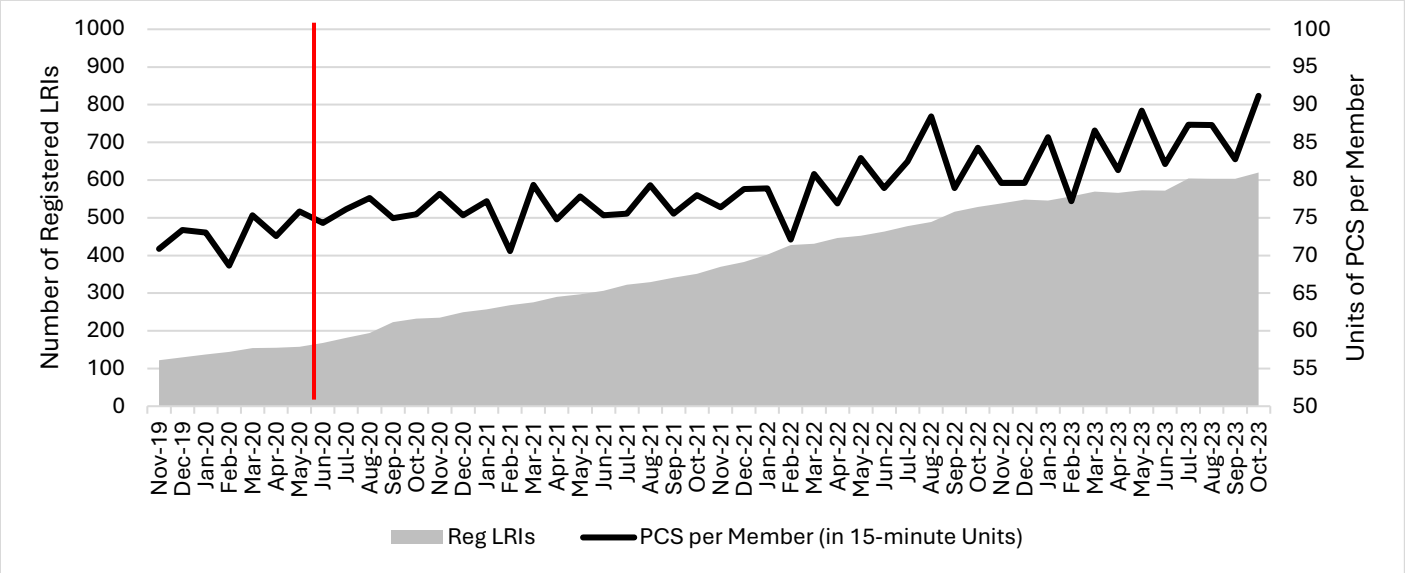

Figure 1: Number of LRIs and Number of PCS Units per Member Light gray shading indicates the number of registered LRIs per month. The thick black line indicates the unadjusted PCS rate per member in 15-minute units. The thick red line indicates the separation between pre-waiver implementation and post-waiver intervention. LRI: legally responsible individuals; PCS: personal care services.

The evaluation showed that the implementation of the waiver, as a response to the PHE, increased access to PCS for members, therefore demonstrating alignment with New Mexico's objective to enhance access to HCBS. Data showed that the number of LRIs increased from the pre-waiver implementation period to the post-waiver period, resulting in a growing PCS workforce, including registered LRIs submitting claims, which may indicate improved access. Additionally, the unadjusted rate of PCS over the measurement period increased overall, starting at 70.9 units per member per month (PMPM) in November 2019, reaching 76.2 units PMPM in

the first month of waiver implementation (July 2020), and ending at 91.2 units PMPM in October 2023 (**Figure 1**).

In actual care time, a member went from receiving 1,064 minutes (17.7 hours) of home-based care prior to waiver implementation to 1,368 minutes (22.8 hours) of care per month by the end of the measurement period (October 2023).

Adults receiving PCS with CB services from an LRI went from receiving an average of 2.8 minutes (< 0.1 hours) of PCS per month from their LRI to 13.2 minutes (0.2 hours) of care per month, and children receiving PCS through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits went from receiving an average of 51.0 minutes (0.9 hours) of PCS per month from their LRI to 243.0 minutes (4.1 hours) of care per month. A greater increase was seen in EPSDT PCS rates throughout the measurement period. Both populations contributed to the total rate of PCS shown in **Figure 1**.

Analyses also confirmed a statistically significant increase in average PCS delivery after waiver implementation, with an estimated increase of 5.6 units of PCS PMPM, equivalent to an additional 84 minutes of care PMPM.

CB members receiving PCS received on average an additional 0.4 units (6 minutes = 0.1 hours) of home-based care from an LRI PMPM, and EPSDT members received on average an additional 9.8 units (147 minutes = 2.5 hours) of home-based care from a LRI PMPM. This demonstrates the significant increase in PCS during the first year after waiver implementation. The increase continued throughout the entire measurement period with the final measurement period (March 2023–October 2023) showing an average of 86.6 units of PCS delivered PMPM, equivalent to 1,299 minutes (21.7 hours). An average of 0.9 units of PCS was delivered by LRIs PMPM to CB members, equivalent to 13.5 minutes (0.2 hours) and an average of 16.2 units of PCS was delivered by LRIs PMPM to EPSDT members, equivalent to 243 minutes (4.1 hours), showing more expansion for EPSDT PCS than CB PCS. However, the continued increase in PCS rates across post-waiver periods suggests the program implementation had a sustained positive effect in the state overall.

The evaluation showed that New Mexico's waiver program aligned with the primary goals of the state and CMS to expand access to high-quality services and support the continued health of members. By recognizing and providing compensation to caregivers or LRIs for providing care services in their communities, the waiver addressed PHE workforce shortages and enabled many high-risk Medicaid beneficiaries to obtain needed care during a critical time. The ability for LRIs to provide PCS to members increased the PCS workforce and improved members' access to services. These findings demonstrate the waiver's success in meeting state goals of improving access to care and promoting HCBS.

Background

Section 1115 of the Social Security Act (SSA) allows states to develop demonstration projects that implement evidence-based interventions to enhance care quality and health outcomes in place of traditional Medicaid care delivery systems. These Section 1115 demonstration waivers allow states greater flexibility to design and improve their Medicaid programs. New Mexico's Medicaid program, administered through the HCA, formerly the Human Services Department (HSD), provides healthcare to the state's eligible populations. HCA's overall mission is to transform lives with the intent of providing high-quality services to promote the independence of its citizens. Centennial Care was approved as a Section 1115 demonstration waiver in 2014 and continued to evolve into Centennial Care 2.0[1], until the state's transition to Turquoise Care in July 2024.

New Mexico's Centennial Care 2.0 demonstration aimed to build upon the original goals of Centennial Care in the development of a health care delivery system "where every Medicaid member has a dedicated health care team that is accessible for both preventative and emergency care that supports the whole person—their physical, behavioral, and social drivers of health." This evaluation focuses on Medicaid managed care activities that were part of Centennial Care 2.0, approved by CMS, and effective January 1, 2019, through December 31, 2023.

Centennial Care 2.0 Demonstration

On March 13, 2020, the United States government declared a federal emergency under Section 501(b) of the *Robert T. Stafford Disaster Relief and Emergency Assistance Act* (42 U.S.C. 5121–5207) in response to the outbreak of COVID-19. The Department of Health and Human Services (HHS) declared COVID-19 a national PHE. Under the authority of Section 1135 of the SSA, the HHS Secretary exercised the right to modify and waive certain federal Medicare and Medicaid requirements.

The COVID-19 PHE created a shortage of traditional health care providers to deliver medically necessary services, including HCBS for activities of daily living. To mitigate this shortage, New Mexico sought and received approval from CMS on July 1, 2020, to financially compensate LRIs providing PCS to children receiving EPSDT benefits, as well as adults receiving CB services, referred to as members, under Section 1135 authority. This compensation supported family caregivers and allowed Centennial Care 2.0 members to stay in their homes or community rather than receive care in an institutional setting.

As part of the approval of the PHE demonstration amendments found in **Appendix A**, New Mexico received the authority to reimburse claims for LRIs delivering PCS to members. On May 11, 2023, the COVID-19 PHE Section 1135 authority expired. New Mexico submitted a request to CMS and received approval to continue payments to LRIs providing PCS for the 6 months following the end of the PHE to ensure the "no gaps in care" provision. CMS determined that this program is likely to support the Medicaid statute and, when relevant, the Children's Health Insurance Program (CHIP) statute, by making it easier for Medicaid beneficiaries to access quality healthcare. New Mexico requested and received approval for a temporary extension to continue these payments long-term, effective November 12, 2023, and was granted authority for LRIs to continue providing PCS to members.

Evaluation Purpose

To comply with *Title 42 Code of Federal Regulations Section 431.424 Evaluation requirements* and the STCs outlined by CMS, HCA contracted with IPRO, the state's EQRO, to conduct an independent evaluation of the amendments to New Mexico's Section 1115 demonstration in response to the PHE (Project No: 11-W-

[1] For more information on New Mexico's Centennial Care and Centennial Care 2.0 demonstrations, click here (https://www.hca.nm.gov/wp-content/uploads/To-CMS_Amendment-2-Application_FINAL_v3.pdf).

00285/6). This report provides IPRO's independent evaluation of the effect of PCS provided by the state's Medicaid MCOs: BCBS of New Mexico, PHP, and WSCC. The purpose of this evaluation is to demonstrate the impact of these waivers on members' access to necessary PCS and report those findings to CMS and HCA.

The evaluation aims to address the following hypotheses:

- The ability for LRIs to provide PCS to individuals receiving care services in the home or community will increase the PCS workforce.
- The ability for LRIs to provide PCS to individuals receiving care services in the home or community will improve members' access to CB or EPSDT services.

The following research questions will be answered:

- Are members able to receive the same or more PCS after the implementation of this benefit?

Methodology

The evaluation employed statistical analyses to assess and better understand the rates of registered LRIs and delivered PCS before and after the implementation of the waiver. The primary analysis conducted was a constant regression within a retrospective single interrupted time series (ITS) design. This approach allowed for the detection of immediate changes in outcomes at the point of program implementation, in this case July 2020, and captured changes and trends by comparing PCS delivery before and after the implementation date. The time series was segmented into two distinct periods: pre- and post-waiver implementation, with data analyzed in monthly increments. This analysis showed changes in the number of PCS units delivered per eligible member at evenly spaced time points before and after implementation. A measurable increase in the average amount of PCS delivered per member after the time of implementation would indicate an immediate effect in contrast to a gradual change over time.

T-tests and regression analyses were used to assess significant differences between pre- and post-implementation periods, isolating the effects of the waiver from other concurrent state initiatives. Additionally, sensitivity analyses were performed to ensure the robustness of findings, including checks for data quality, outlier effects, and alternative model specifications. This evaluation approach helped to better assess the true impact of the waiver. Once the model identified a distinct seasonal pattern, outliers were tested for significance, and a constant regression analysis was used to assess significant differences in PCS delivery between pre- and post-implementation periods.

The target population for this evaluation consisted of eligible members residing in the community and receiving PCS through either the CB or EPSDT program. Members residing in institutions were excluded from this waiver; the full exclusions list can be found in **Appendix B**. The analysis was conducted at the member level. LRIs were measured as individuals registered and submitting claims, and PCS was measured in units. One unit of PCS = 15 minutes of care support in the home.

The evaluation period covered November 2019–December 2023, capturing pre- and post-implementation periods of the waiver, while the measurement period evaluated PCS rate trends through October 2023. Data collection was segmented into monthly intervals to identify short- and long-term effects of the waiver. This evaluation focuses on process and outcome measures to assess the waiver's impact on PCS utilization and LRI participation. Outcome measures are detailed in **Table 1**.

Table 1: Evaluation Measures

Evaluation Question	Outcome Measures	Data Source	Analytic Methods
Are members able to receive the same or more CB or EPSDT PCS after the implementation of this benefit?	• Units of PCS delivered by an LRI • Units of PCS delivered by all provider types	Administrative data provided by MCOs	Retrospective Single ITS analysis
Is the percentage of members receiving CB or EPSDT PCS the same or higher after the implementation of this benefit?	• Units of HCBS PCS delivered by any provider type to LTSS-eligible members • Number of LTSS-eligible members residing in the community	Administrative data provided by MCOs	Retrospective Single ITS analysis

Evaluation Question	Outcome Measures	Data Source	Analytic Methods
Does providing payment for LRIs to provide PCS to individuals receiving CB or EPSDT services increase the PCS workforce?	• Number of registered LRIs • Number of registered LRIs providing PCS to LTSS-eligible members residing in the community	Administrative data provided by MCOs	Data and results interpretation

CB: community-based; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; PCS: personal care services; LRI: legally responsible individual; MCO: managed care organization; ITS: interrupted time series; HCBS: home- and community-based services; LTSS: long-term services and supports.

Data were submitted directly by the state's MCOs, including WSCC, PHP, and BCBS of New Mexico. The MCOs provided monthly data on EPSDT and CB PCS units delivered and counts of eligible members receiving PCS. Data validation procedures included consistency checks and cross-verification with other administrative records to ensure accuracy and completeness.

Results

Prior to the implementation of New Mexico's PHE waiver program, there was limited evidence of LRIs registering and providing PCS to program members in need of PCS. MCO data for November 2019 showed a total of 122 total registered LRIs, and 90 with submitted and paid claims for PCS delivery between all three plans (WSCC, PHP, and BCBS). Once the program was implemented on July 1, 2020, the data demonstrated a continual increase in the number of LRIs registered and submitting claims. Throughout July 2020, 126 out of 181 registered LRIs submitted claims and received payments for providing PCS. By the end of the first year of program implementation, 234 out of 322 registered LRIs submitted claims and received payments for PCS provision. This indicates an increase in both the number of registered LRIs and the number of registered LRIs actively submitting claims for PCS. By the end of the measurement period (October 2023), 362 out of 620 registered LRIs submitted claims and received payments for PCS, and at the end of the demonstration (December 2023), 404 out of 655, demonstrating sustained increases.

Figure 2 shows monthly registration and participation trends for LRIs and PCS rates. The light grey area represents the number of LRIs registered per month, while the dark grey area indicates the number of registered LRIs submitting claims for PCS each month. Overlaid on the area chart is a black line, which shows the number of PCS units provided PMPM, offering a clear visual of service provision in relation to registration and claim submission trends.

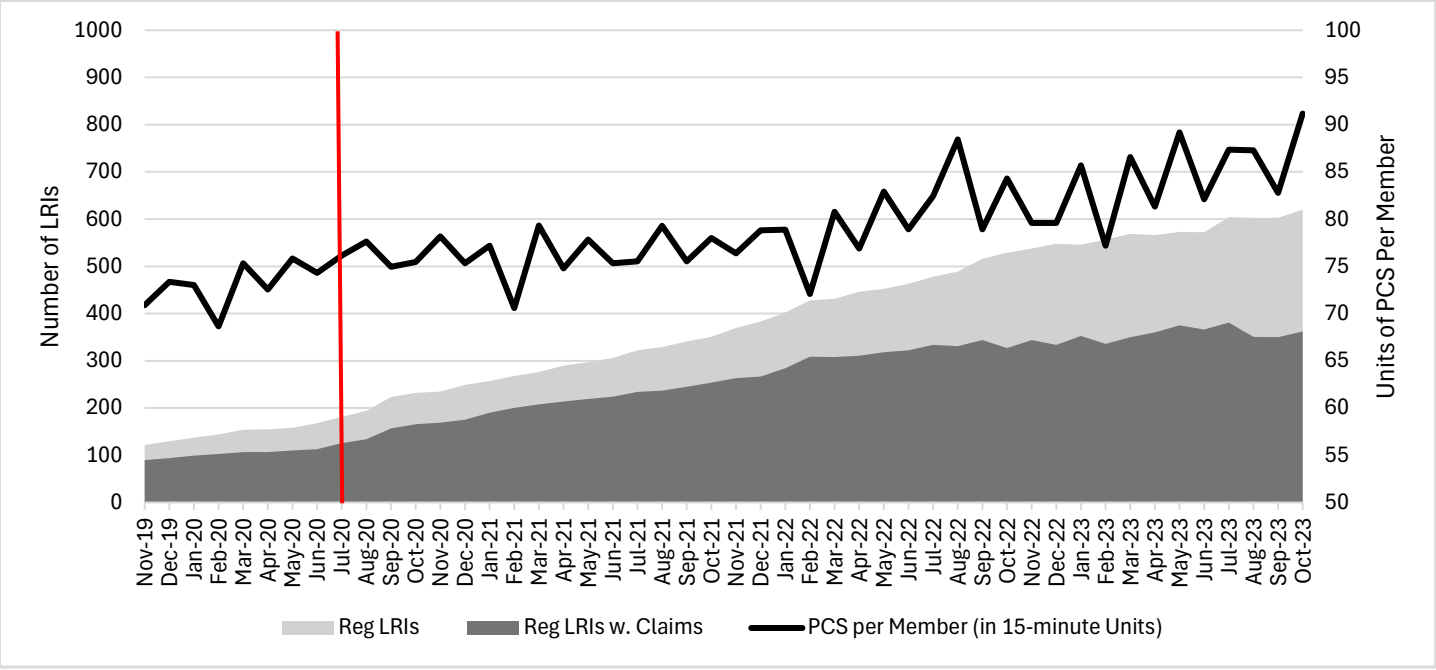

Figure 2: Number of LRIs and Rate of PCS Units Delivered per Member, Nov 2019–Oct2023 Light gray shading indicates the number of registered LRIs, and dark gray shading indicates the number of registered LRIs that received payment for PCS provision. The thick black line indicates the unadjusted PCS rate per member in 15-minute units. The thick red line indicates the separation between pre-waiver implementation and post-waiver intervention. LRI: legally responsible individual; PCS: personal care services.

The unadjusted rate of PCS over the measurement period started at 70.9 units PMPM in November 2019, reached 76.2 units PMPM in the first month of implementation, and ended at 91.2 units PMPM in October 2023 (**Figure 2**). In actual care time, a member went from receiving 1,064 minutes (17.7 hours) of home-based care to 1,368 minutes (22.8 hours) of care per month. CB members went from receiving an average of 2.8

minutes (< 0.1 hours) of PCS from their LRI to 13.2 minutes (0.2 hours) of care per month, and EPSDT members went from receiving an average of 41.9 minutes (0.7 hours) of PCS from their LRI to 287.7 minutes (4.8 hours) of care per month.

Figure 3 again shows the unadjusted rate of PCS over the measurement period, while adding average rates for distinct time periods. This was evaluated using a constant regression model, which measures discrete changes leveraging the time series. The data was segmented into three distinct time periods to appropriately measure changes in the rates of PCS PMPM over time. Each time period, denoted with a *T* variable in the model, represents a pre- or post-waiver period, including the 6-month temporary extension of the waiver following the end of the PHE.

- Pre-waiver period (T_0): November 2019–June 2020
- Post-waiver period (T_1): July 2020–April 2023
- Temporary extension of waiver (T_2)**:** May 2023—October 2023

The time segments, $T_{0,1,2}$, are separated by the red and blue vertical lines in **Figure 3**. Once adjusted, the point of waiver implementation (July 2020) is observed to determine the difference in the average rates of PCS delivered between periods; this is known as testing the point of jump discontinuity. There was a significant increase in the average rate of PCS PMPM after the waiver was implemented, as well as after the waiver extension.

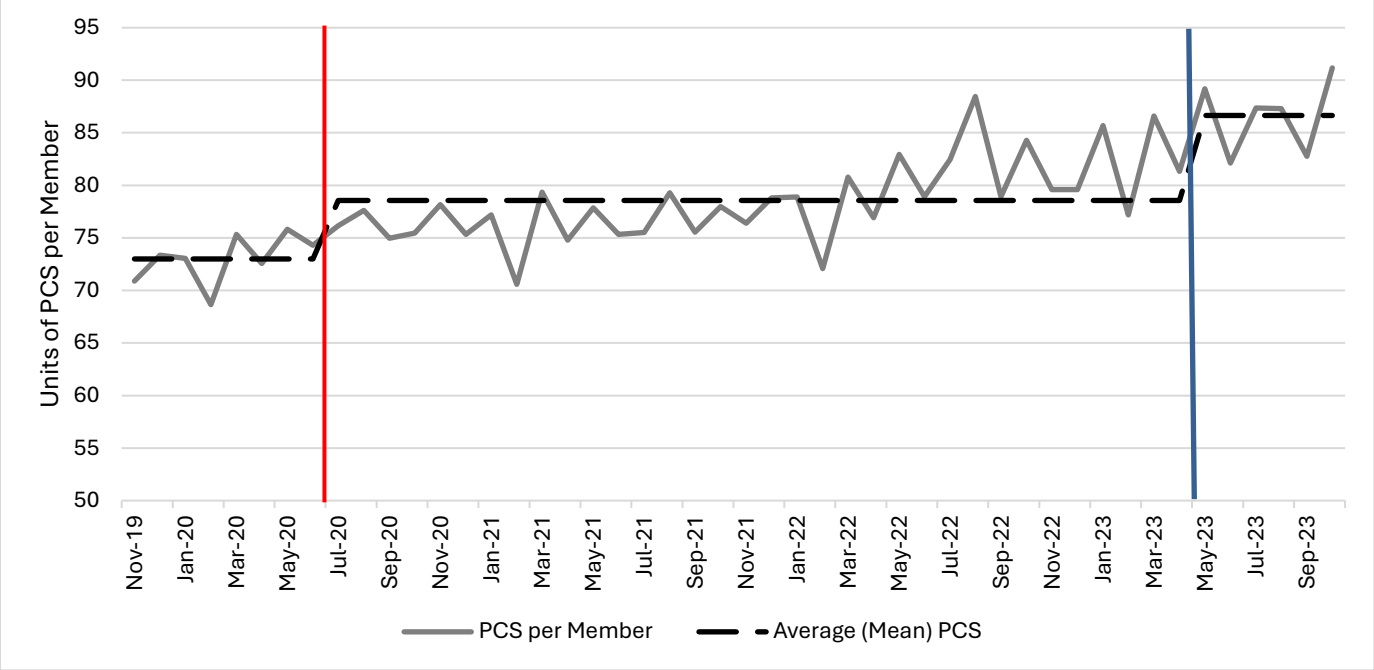

Figure 3: Unadjusted and Mean Rate of PCS Units by Waiver Period, Nov 2019–Oct 2023 The gray line indicates the unadjusted PCS rate per member in 15-minute units. The dashed black line indicates the average (mean) PCS rate per member in each waiver measurement period. The vertical red line indicates the key implementation date between pre-waiver implementation and post-waiver intervention. The vertical blue line indicates the implementation date of the temporary waiver extension. LRI: legally responsible individual; PCS: personal care services.

Table 2 shows the results of the statistical analysis; the estimated average difference in PCS delivered after waiver implementation (T_1: July 2020–April 2023) was 5.6 units PMPM, equivalent to 84 additional minutes of PCS PMPM, which was statistically significant. The increase in PCS rates continued through the temporary

extension of the waiver with the final period (T_2: March 2023–October 2023) showing an average PCS of 86.6 units (1,299 minutes = 21.7 hours), also a statistically significant jump. The appropriateness of model fit over time is also represented, with an *R*-squared of 0.272 in the post-waiver period (T_1) for overall PCS delivery, and 0.373 during the temporary extension of the waiver (T_2). This indicates that the piecewise constant regression effectively measured the unadjusted changes PCS delivery rates over time.

Table 2: Statistical Results of Piecewise Constant Regression

Pre-Waiver Implementation		Post-Waiver Intervention	
	Pre-Waiver T_0	**Post-Waiver T_1**	**Temporary Extension T_2**
Time Period	Nov 2019–Jun 2020	Jul 2020–Apr 2023	May 2023–Oct 2023
Mean PCS (Standard deviation)	73.0 (± 2.4)	78.6 (± 2.4)	86.6 (± 1.9)
Mean difference PCS	-	+ 5.6	+ 8.0
p-value[1]	-	< 0.001	< 0.001
R-squared[2]	-	0.272	0.373
Mean CB PCS by LRI (Standard deviation)	0.3 (± 0.1)	0.6 (± 0.2)	0.9 (± 0.1)
Mean difference CB PCS by LRI	-	+ 0.3	+ 0.3
p-value[1]	-	< 0.001	< 0.001
R-squared[2]	-	0.390	0.287
Mean EPSDT PCS by LRI (Standard deviation)	3.4 (± 1.2)	12.2 (± 3.5)	16.2 (± 2.0)
Mean difference EPSDT PCS by LRI	-	+ 8.8	+ 4.0
p-value[1]	-	< 0.001	< 0.001
R-squared[2]	-	0.556	0.161

[1] Statistical term that tests for significance; values under 0.05 are interpreted as statistically significant.
[2] Statistical term that tests for model fit; the closer the value is to 1.00 the stronger the fit is.
PCS: personal care services; CB: community-based; LRI: legally responsible individual; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment.

Measuring the rate of PCS PMPM also revealed a seasonal pattern in the data. A trend was observed that indicated a repeated and discrete decrease in PCS delivery in February of each year, as shown in **Figure 3**. To account for seasonality, outlier points were assessed utilizing Grubbs' test. The data points approached but did not reach significance and remained in the final analysis. Average PCS rates were unaffected by this seasonal pattern.

Figure 4 shows unadjusted rate of PCS delivered by an LRI to eligible EPSDT and CB members. An increase in PCS delivered per member is observed after waiver implementation (July 2020) and continues throughout the primary demonstration (July 2020–April 2023).

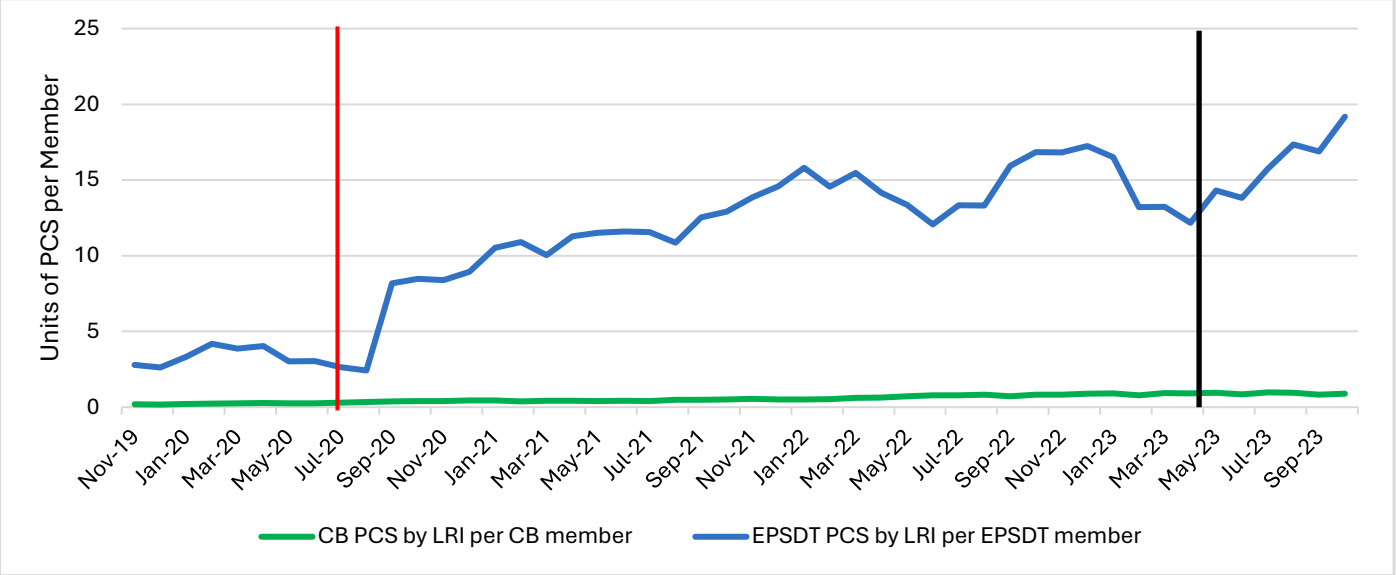

Figure 4: Unadjusted Rate of Units of PCS Delivered to CB and EPSDT Members, Nov 2019–Oct 2023. The blue line indicates the unadjusted EPSDT PCS rate delivered by LRIs per member. The green line indicates the unadjusted CB PCS rate delivered by LRIs per member. The vertical red line indicates the key implementation date between pre-waiver implementation and post-waiver intervention. The vertical black line indicates the implementation date of the temporary waiver extension. LRI: legally responsible individual; PCS: personal care services; CB: community-based; EPSDT: Early and Periodic Screening, Diagnostic, and Treatment.

After waiver implementation (July 2020), CB members receiving PCS received on average an additional 0.3 units (5 minutes = 0.1 hours) of home-based care from their LRI each month, and EPSDT members received on average an additional 8.8 units (132 minutes = 2.2 hours) of home-based care from their LRI each month (**Table 2**). The increase continued throughout the entire measurement period with the final measurement period (March 2023–October 2023) showing an average of 86.6 units of PCS delivered PMPM, equivalent to 1,299 minutes (21.7 hours); an average of 0.9 units of PCS delivered by an LRI PMPM to CB members, equivalent to 13.5 minutes (0.2 hours); and an average of 16.2 units of PCS delivered by an LRI PMPM to EPSDT members, equivalent to 243 minutes (4.1 hours; **Figure 4**). The continued increase in PCS rates across post-waiver periods suggests the program implementation had a sustained positive effect, particularly for the EPSDT population.

Discussion

New Mexico's Centennial Care 2.0 demonstration waiver aimed to enhance care delivery for Medicaid beneficiaries by promoting access to services that address physical, behavioral, and social drivers of health. This evaluation demonstrates that financially compensating LRIs for providing PCS successfully expanded access to care during a critical period marked by the COVID-19 PHE. The implementation of this benefit increased access to PCS for community-based members, demonstrating alignment with the waiver's objective to enhance access to services. The continued rise in PCS rates across the two post-waiver periods suggests the program implementation had a sustained positive effect. The evaluation results support the evaluation hypotheses, showing the waiver increased the LRI workforce and improved adult and child members' ability to access PCS in the community.

First, the data showed that the number of LRIs increased from the pre-waiver implementation period to the post-waiver period. Before the waiver, just 90 LRIs submitted and were paid for PCS claims in one month. By the end of the PHE in May 2023, 375 out of 573 registered LRIs submitted claims and received payments for their care. This demonstrated both a growing PCS workforce and a growing number of registered LRIs actively submitting claims, indicating improved access.

Second, to evaluate the impact of the waiver on PCS delivery, the rate of total PCS provided PMPM and PCS provided by LRIs PMPM was analyzed. The results showed a significant increase in PCS delivery after waiver implementation (July 2020–April 2023) and throughout the temporary extension (May 2023–October 2023); on average a member received an additional 5.6 units of PCS per month after waiver implementation and an additional 8.0 units, equivalent to 120 minutes (2.0 hours) of PCS per month during the temporary extension, compared to the initial waiver period. A significant increase was also demonstrated for EPSDT members receiving PCS through an LRI, with EPSDT members receiving on average an additional 8.8 units of PCS delivered by an LRI per month after waiver implementation, equivalent to 132 minutes (2.2 hours) and an additional 4.0 units, equivalent to 60 minutes (1.0 hours) of PCS delivered by an LRI per month during the temporary extension, compared to the initial waiver period. CB members received on average an additional 0.3 units of PCS delivered by an LRI per month after waiver implementation, equivalent to 5 minutes (0.1 hours), and an additional 0.3 units of PCS delivered by an LRI per month, equivalent to 5 more minutes (0.1 hours) during the temporary extension compared to the initial waiver period. This increase persisted throughout the PHE (July 2020—April 2023) and the temporary extension period (March 2023–October 2023) and was demonstrated in overall PCS rates as well as average PCS delivered by LRIs to CB and EPSDT members, specifically. The substantial increase in PCS delivered by LRIs to EPSDT members suggests that this waiver significantly increased the amount of home-based care for children receiving EPSDT benefits, while also enabling family members to be paid as LRIs for the crucial care and services they provided.

The sustained increase in PCS rates aligns with the primary goals of the Centennial Care 2.0 demonstration, which sought to expand access to high-quality services and support the independence of New Mexico's Medicaid beneficiaries. The waiver addressed a critical workforce shortage during the PHE by training and compensating LRIs for providing PCS. This authority allowed program members to receive care in their homes or communities, reducing the need for institutional care. These findings demonstrate the waiver's success in meeting state goals of improving access to care and promoting HCBS.

CMS acknowledged additional challenges with implementing waiver programs under Appendix K policy amendments, including uncertainty regarding the duration of the PHE and related waiver authorities, limited state administrative infrastructure that hinders sufficient data collection and monitoring, and delays in provider payments. These uncertainties affected state agencies, PCS providers, and HCBS recipients throughout the PHE. Other limitations also impacted the program, including the simultaneous implementation

of electronic visit verification (EVV), challenges with communication, and competing priorities during the nationwide PHE.

EVV is a technology used to electronically confirm that PCS and home health care services are provided according to CMS and Medicaid requirements. EVV systems must verify specific details, including the type of service provided, the date and time of service, the service location, and the identity of both the recipient and the caregiver. While EVV helps to ensure compliance with Medicaid requirements and reduces the risk of fraud, its implementation during the waiver rollout, alongside the ongoing PHE, introduced additional operational complexities that may have impacted provider participation and data collection. This may have had an impact on the observed proportion of registered LRIs submitting and receiving payment for PCS.

Additionally, MCOs may have had varying interpretations of the initial letter of direction (LOD), which may have led to inconsistencies in how PCS provision data was collected and reported. Despite multiple efforts made by IPRO and HCA to obtain accurate and complete data, significant barriers persisted. One notable challenge was the difficulty MCOs experienced in obtaining data from PCS agencies, particularly for EPSDT data. Many PCS agencies were either unresponsive or faced limitations in recordkeeping, contributing to potential gaps in the reported data and limiting the ability to fully assess the impact of these waivers. These barriers should be considered when interpreting the findings of this report. The data collected by MCOs from PCS agencies may be incomplete due to inconsistencies in reporting processes and lack of standardized data collection tools. These limitations hinder the accuracy and timeliness of monitoring and reporting required for program evaluation.

Despite these challenges, the evaluation demonstrates that the waiver had a positive and sustained impact on PCS delivery for community-based members. The observed and statistically significant increase in PCS rates PMPM demonstrates that the intervention was effective in addressing the “no gaps in care” provision and supporting family caregivers. The temporary extension granted by CMS in November 2023 to extend this program after the end of the PHE ensures that this vital support for caregivers and beneficiaries will continue, reinforcing Medicaid’s mission to enhance health outcomes for low-income individuals through innovative, flexible approaches to care delivery.

Recommendations

New Mexico demonstrated its ability to offer and implement innovative and effective programs to meet the needs of its Medicaid population, particularly its members with long-term services and supports (LTSS) needs. As the state continues to support LRIs in providing PCS to community members, there remain opportunities to strengthen effectiveness. In alignment with CMS requirements for EVV, the state should consider enhancing its monitoring and continual auditing of the MCOs’ PCS reporting. In addition to refining its understanding of how LRIs are submitting claims, there is an opportunity to create stronger accountability for entities and other stakeholders that manage EPSDT PCS. This should be prioritized in the implementation of EVV.

Additionally, New Mexico should consider further analyzing the varying impact the waiver had on expanding PCS for certain populations. While PCS access was expanded overall, rates were driven primarily by the increase in PCS rates for members receiving EPSDT services. The state has the opportunity to take a closer look at how members with CB services are accessing and engaging with LRIs and how PCS is monitored for that population.

Appendix A

Appendix B

Members excluded from Centennial Care 2.0 demonstration:

- qualified Medicare beneficiaries;
- specified low-income Medicare beneficiaries;
- qualified individuals;
- qualified disabled working individuals;
- non-citizens only eligible for emergency medical services;
- Program of All-Inclusive Care for the Elderly (PACE) participants;
- individuals residing in intermediate care facilities for individuals with an intellectual disability;
- individuals eligible for family planning services only;
- medically fragile 1915(c) waiver participants for HCBS; and
- developmentally disabled 1915(c) waiver participants for HCBS.