

**Rebalancing Long-Term Care Systems in New Mexico:
Experience up to July 31, 2005**

Abbreviated Report

submitted to the

**Centers for Medicare & Medicaid Services (CMS),
Advocacy and Special Initiatives Division
CMS Project Officer, 9/1/2004 to 4/15/2006, Mary Beth Ribar
CMS Project Officer, 4/15/2006 to present, Dina Elani**

Researchers on the Project

University of Minnesota

School of Public Health

Rosalie A. Kane, PhD, P.I,

Robert L. Kane, MD, Co-PI

Reinhard Priester, JD, Project Coordinator

Donna Spencer, Data Manager

Center for Community Integration

K Charlie Lakin, EdD, Investigator

School of Social Work

Terry Lum, PhD, Data Analyst

CNAC Corporation

Linda Clark-Helms, CNAC Project Director

National Academy for State Health Policy, Portland, ME

Robert Mollica, Investigator

PAS Research Center, University of California, San Francisco

Charlene Harrington, PhD, RN, Investigator

Martin Kitchener, PhD, Investigator

Consultants

Charles Reed, Olympia, Washington

Dann Milne, Denver, Colorado

The overall project is being conducted through a Task Order under a CMS Master Contract between CMS and the CNA Corporation, Arlington, VA, and subcontracts and consultant agreements between CNAC and the various researchers. The 3-year study calls for case studies of the experience of 8 states—other states in the study are: Arkansas, Florida, Minnesota, Pennsylvania, Texas, Vermont, and Washington. The baseline case study covers a period through July 31, 2005. Updates will be prepared for the period ending July 31, 2006 and 2007.

A slightly earlier version of this Abbreviated Report was presented for discussion at a CMS Open Door Forum, February 22, 2006. The statements and opinions in the report are those of the writers and do not necessarily reflect the views of CMS or any of its staff, or the State liaisons to the project, or any other state staff or persons who spoke to us from participating states. We thank the New Mexico State Liaison to the study, Debbie Armstrong, then the Secretary, New Mexico Aging and Long-Term Services Department.

Table of Contents

Highlights..... 1

Context..... 2

Real Choice Systems Change (RCSC) Grants..... 3

Programs and Services..... 3

Featured Management Approaches..... 4

 Self-directed Mi Via Waiver..... 4

 Personal Care Option 4

 State Reorganization and Interagency Long Term Care Committee 6

 Behavioral Health Collaborative..... 6

Quantitative Markers of Rebalancing..... 7

 Changing Patterns in Nursing Home Use as Marker of Rebalancing..... 7

 Balance between Institutional and Community Care..... 9

Conclusion 11

 Issues for Future Observation 12

Rebalancing Long-Term Care Systems in New Mexico: Abbreviated Report

Highlights

As of 2004 reporting, New Mexico was catapulted to the 2nd ranking state for rebalancing of expenditures with 67.6% of its long-term care dollars spent on community care, second only to Oregon's 70.5%.¹ Highlights of New Mexico's strategies include:

- Early establishment of HCBS waivers in place and steady increases in their funding in the 1990s and the early 21st century.
- Adding a Personal Care Option (PCO) to the Medicaid state plan in 1999, targeted to enable consumers who might otherwise be in nursing homes to stay at home. In contrast to many states that use Medicaid PCO as bridge funding for people who do not meet nursing home eligibility, New Mexico intended it to be an explicit rebalancing strategy.
- Developing the PCO in either a consumer-delegated or a consumer-directed mode (in the former, an agency hires and manages care personnel; guarantees coverage during the hours needed, and provides supervisory oversight).
- Specifying minimum salaries for personal care workers under the option substantially in excess of prevailing wages. As a result, personal care spending in New Mexico has nearly equaled Medicaid spending for nursing home care in 2004, but the wages of personal care workers have become vastly improved.
- Creating a new consumer-directed Medicaid program (*Mi Via*, for "my way"), which will be available in all four existing waiver programs and for persons with specific brain injury diagnosis.
- Elevating aging to a Cabinet level in 2004 with the formation of the Aging and Long Term Services Department (ALTSD). The ALTSD Secretary is the designated chair for an Inter-agency Long Term Care committee that is responsible for designing and implementing a coordinated service delivery system. The new ALTSD, and two other Cabinet level departments -- Health (where the programs for Developmental Disability are presently housed) and Human Services (where Medicaid is housed) -- closely collaborate on LTC and related issues.

¹ This abbreviated report is a synopsis of a much longer report on rebalancing long-term care systems in New Mexico, performed under contract between the University of Minnesota and CNAC Corporation through a Master Contract between CMS and CNAC. The full-length report, which contains organizational charts, references, and much more detail, appears on the website [HCBS.org](http://www.hcbs.org) and on the University of Minnesota Principal Investigator's Website <http://www.hpm.umn.edu/LTCResourceCenter/>. Similar abbreviated and full case studies have been prepared for the States of Arkansas, Florida, Minnesota, Pennsylvania, Texas, Vermont, and Washington. The case study covers a period up to July 31, 2005; subsequent reports will update the information as of July 2006 and 2007.

- Establishment of a Behavioral Health Collaborative through efforts of the 3 major departments (Aging and Long-Term Services, Health, and Human Services) and 15 other state agencies. This collaborative collectively bid a managed care contract for behavioral health. This effort is seen as a model for other inter-agency collaboration in managed care efforts, now underway.

Context

- New Mexico is an extremely rural state, with many frontier areas. Management of long-term services is complicated by distances, and the inclusion of numerous tribal jurisdictions within the state. New Mexico also has an exceedingly diverse population in terms of race and ethnicity. Another theme in New Mexico is a strong orientation to consumer rights within the aging network and disability services. An ongoing lawsuit triggered the eventual closure of state institutions for developmental disabilities; the Protection & Advocacy Program and the Arc of New Mexico play strong roles in facilitating community integration.
- All New Mexico's long-term care programs must be placed in the context of a state that is making a concerted effort to solve problems of the uninsured in the state, increase employment and economic development, and improve transportation and other infrastructure.
- Long waiting lists for waiver services are a weak point of the system, as is a somewhat time-consuming process of establishing financial eligibility and involving physicians to establish functional eligibility. Access issues are related both to the somewhat cumbersome process for approval, and lack of waiver slots. The access processes to the D&E waiver have been greatly improved through the activities of a state-wide Aging and Disability Resource Center. Presumptive eligibility at present is available for children but not adults. The problem of insufficient waiver slots is mitigated by the availability of the personal care option (an entitlement program without any waiting lists), and various state-funded programs that can be used for those waiting access to the waivers.
- The rapid growth and high cost of the PCO program has been of some concern to state officials, leading to a changed process of establishing eligibility through an independent process under contract with Lovelace Health System and subcontract with a state-wide network of home health nurses. In New Mexico, case management is seen as a service for which consumers exercise free choice rather than an administrative mechanism, and, thus, other utilization management was needed.
- New Mexico presently has less than optimal ability to link data sets, track consumers across programs, or to readily determine acuity levels of persons served. The new Aging and Disability Resource Center must access at least 7 systems to gather data about service use. The State has given high priority to creating a Social Service Information Technology Architecture to better and more proactively managed its system.

Real Choice Systems Change (RCSC) Grants

New Mexico has received three RCSC grants, including its Aging and Adult Resource Center, with funding totaling \$2,333,900.² The state's 2 RSCS awards were a \$1.3 million Real Choice grant in 2002 and a Family-to-Family Health Care Information and Education Center grant for \$150,000 in 2004. The primary goals of the Real Choice grant were to establish a statewide Service Delivery Options Training Program (SDOTP) to help individuals obtain appropriate LTC services and a statewide Network for Long-Term Care Policy Change (NLTCPC) program to train advocates to help create and sustain systems change.

Programs and Services

New Mexico covers personal care services under the Medicaid state plan and operates 4 HCBS waivers (see Table 5.1 for summary of waivers). ALTSD administers the Disability and Elderly (D&E) waiver, the Aging Medicaid Personal Care Option, the Traumatic Brain Injury Program (soon to seek waiver status), the planning for the Self Directed Waiver, the PACE program, and a variety of state-funded and Older-American's Act programs. The Department of Health administers the Developmental Disability waiver, the Medically Fragile waiver, the HIV-AIDS waiver, and the state nursing homes.

Mi Via is a self-directed program being developed by ALTSD and the departments of Health and Human Services under a cash and counseling grant from the Robert Wood Johnson Foundation. Existing waiver participants will be eligible to transition to this new self-directed waiver. The state will issue an RFP to select a fiscal intermediary to manage payroll, withholding, reporting and payment functions. Participants will be able to purchase case management services as part of their service plan. Separate waivers will be prepared for people with developmental disabilities and people with disabilities and elders.

In addition to the Personal Care Option (profiled below), noteworthy Medicaid state plan and state-funded community LTC services include:

- The Traumatic Brain Injury (TBI) Program provides short-term services – case management, life skills training and crisis/interim services. (TBI has unusually high prevalence in New Mexico.) Funded by a \$5 fee added to each moving traffic violation, the program serves about 560 people a year and is ear-marked by the legislature for expansion into a waiver program.
- The Community Based Gap Fund covers assistive devices, environmental modifications, initial housing costs, personal assistance, respite, and support services, which include a variety of medical, health, and supportive care services.

² New Mexico received a Systems Change grant for \$1,385,000 in 2002, Family-to-Family Health Care Information and Education Center grant for \$150,000 in 2004, and an Aging and Disability Resource Center Grant for \$798,945 in 2004, the latter from the Administration on Aging. In October 2005 (after the time period covered in this baseline study), New Mexico received a Systems Transformation Grant of \$2,736,384 to further work on system change over a five year period. Work under that award will be described in the subsequent case study.

- A PACE program in the Albuquerque area is administered by Total Community Care. In April 2005, the program served 227 beneficiaries and had a waiting list of 105 applicants. Eligible applicants must be age 55 or older, meet the nursing home level of care but capable of living in the community and have monthly income below \$1,737.

Featured Management Approaches

Self-directed *Mi Via* Waiver

Consumer direction is already embedded in New Mexico's Medicaid personal care option (see below). The "Consumer Direction Act" passed in 2003 is unusual evidence of state seriousness about the intent to build consumer direction into all personal care programs. The language states that ". . . each administering department or agency shall by rule provide a program permitting a consumer or surrogate to direct personal assistance services through the hiring, supervision, and training of an attendant or attendants paid through a fiscal intermediary under contract with the department." Agencies were instructed to submit reports to the legislature annually comparing their consumer-directed delivery system to other modes of service delivery.

At this writing, New Mexico is well under way to developing a self-directed waiver, *Mi Via*, which will allow those in the existing waivers to opt for consumer direction. Hearings have been conducted all over the state and the Self-Directed Waiver Advisory Group is now addressing critical issues of design and implementation. The major questions seem to concern how far the program will be allowed to give individuals choice and what kinds of controls will be placed on the program's growth, both because of quality concerns and a wish to maintain consumer-delegated programs under the waivers at some particular level. Another issue concerns whether the entire self-directed waiver program should be operated by ALTSD or whether the DD components should for a time remain in the DOH.

Personal Care Option

In 1999, Personal Care Option (PCO) program was added to New Mexico's Medicaid state plan services. PCO serves consumers who are 21 years of age or older and meet the nursing home level of care. Covered benefits include assistance with bathing, hygiene and grooming; eating; mobility; self administration of medications; skin care; cognitive functioning; household services; individual bowel and bladder services; meal preparation; support services; and minor maintenance of assistive devices. Consumers have the option to self-direct their care or to "delegate" service delivery to an agency. New Mexico has 135 agencies that may be selected, 35 of which are in Albuquerque. Both options allow consumers to identify a family member, friend or other individual to provide personal care services.

Participation and spending far exceeded the initial projection of \$10 million by 2004. In FY 2001, the program served 3,158 beneficiaries. By 2003, the program served 7,652 consumers at a cost of \$150 million. In FY 2004, spending reached \$178 million for 8,783 consumers, just \$1 million less than was spent on Medicaid nursing home care. Figure 1 graphs the program's rapid enrollment growth from 2001 to the projected 2006 figures.

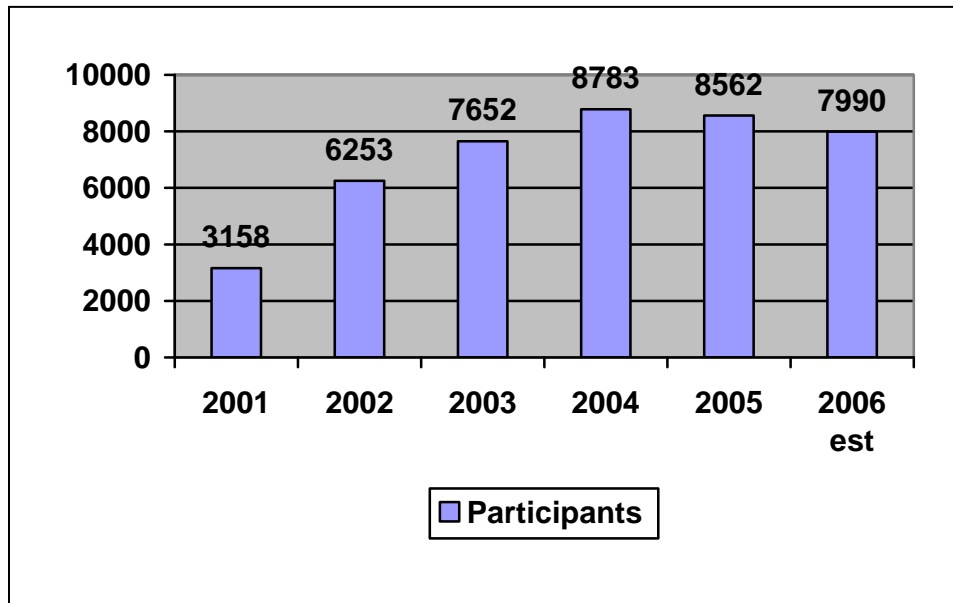


Figure 1. Growth of Personal Care Option, 2001-2006

When the PCO began, the minimum wage mandated for the worker was \$9.00 an hour; this was reduced in 2005 to \$8.00 an hour. As originally developed, the agencies received \$18 an hour for consumer-delegated care, whereas they received only a flat \$200 a month for fiscal management of consumer-directed care. Under the strong incentive of \$9.00 an hour for overhead, personal care agencies were highly motivated to expand caseloads, and these agencies also had the responsibility to enroll consumers in the program. Notwithstanding these incentives for consumer-delegated PCO, some success has been shown in the Consumer-Directed model.

In 2003, a review by the Human Services Department provided the basis for recommendations to improve the program, including:

- Clarification of the functional/medical eligibility criteria;
- Establish an independent assessment process;
- Combine assessment, quality assurance and utilization review functions;
- Standardize the assessment tools;
- Revise the medical assessment form to capture more functional information and how it relates to the person's medical conditions;
- Train providers on the consumer directed model; and
- Reduce the capitated rate without reducing the number of hours of service.

In 2005 the rates for agencies offering consumer-delegated services was reduced to \$13.50 an hour for the first 100 hours in a year, and 11.50 for any additional hours (from which the direct provider would receive a minimum of \$8.00 per hour). With these changes, the consumer-delegated care can no longer be said to bring windfall profits to agencies, and it renders the agency payment closer to the \$200 a month for fiscal intermediary services. The direct care

worker is still guaranteed a reasonable minimum wage. If the worker received benefits, these would come out of the agency overhead.

The PCO is now an important plank for rebalancing long-term care in New Mexico. However, in the 5 years since the program has been operational, state policy-makers have taken steps to cut back on what were probably much too high rates for agencies and to rationalize the initial assessment and access.

State Reorganization and Interagency Long Term Care Committee

Legislation elevating the state unit on aging to a cabinet level department passed the legislature in the late 1990s, but was vetoed by the governor. In 2003, a newly elected governor issued an Executive Order establishing the Aging and Long Term Services Department (ALTSD) as a cabinet level department. In 2004, the legislature codified the new department. ALTSD was established to “create a single, unified department to administer all laws and exercise all functions formerly administered by the state agency on aging and to administer laws and exercise functions of the human service department, the department of health and the children, youth and families department that relate to aging, adults with disabilities or long term care services.” (NMSA 9:32:2) As responsibility for programs were transferred to ALTSD from other departments, the number of staff increased from 40 to 232 and the direct budget from \$35 million to \$300 million in FY 2004. The ALTSD is scheduled to submit to the legislature in November 2005 a five-year plan for the organization and delivery of long term care services.

New Mexico has established several mechanisms to coordinate policy and program activities. In 1998, the Long Term Care Services Act created an Interagency Committee on Long Term Care Services charged with designing and implementing a coordinated service delivery system. Members of the Committee included representatives for numerous state agencies as well as consumers and disability advocates. As part of the re-organizations, the Secretary of ALTSD was assigned as Chair of this Committee.

Behavioral Health Collaborative

Policy leaders in New Mexico had been highly conscious of fragmentation and inadequacies in providing services to consumers with mental health challenges. In 2003, Governor Richardson, determined to model the spirit of Inter-Agency collaboration around mental health and behavioral health services, issued an executive order which created the Behavioral Health Collaborative to create a single behavioral health service delivery system throughout the state. Representatives from 18 different state entities form the Collaborative: the Secretary of the Children, Youth and Families Department and the Secretary of the Human Services Department serve as co-chairs.

The Collaborative serves as the policy and management body for services that affect people with behavioral health needs and is charged with:

- Inventorying all expenditures for mental health and substance abuse services;
- Creating a single behavioral health care and services delivery system that promotes mental health, emphasizes prevention, early intervention, resiliency, recovery and rehabilitation and funds are managed efficiently, and ensures availability of services throughout the State;

- Paying special attention to regional, cultural, rural, frontier, urban and border issues, and seeking and considering suggestions of Native Americans;
- Contracting with a single, Statewide services purchasing entity;
- Monitoring service capacities and utilization in order to achieve desired performance measures and outcomes;
- Making decisions regarding funds, interdepartmental staff, grant writing and grants management;
- Comprehensive planning and meeting State and federal requirements; and
- Overseeing systems of care, data management, performance and outcome indicators, rate setting, services definitions, considering consumer, family and citizen input, monitoring training, assuring that evidence-based practices receive priority, and providing oversight for fraud and abuse and licensing and certification.

Six agencies – Medical Assistance, Aging and Long Term Services, Children’s Services, Health, Corrections and Housing – pooled and awarded \$350 million appropriated for behavioral health services to a managed care organization. That organization, Value Options, is responsible for contracting with providers or groups of providers to provide behavioral health services and for managing all aspects of care including financial oversight, determining client eligibility, utilization management, and quality management. Thirteen local Collaboratives were established to identify problem areas and service gaps. These local Collaboratives serve to develop strong local voices to guide behavioral health planning and services.

Quantitative Markers of Rebalancing

Changing Patterns in Nursing Home Use as Marker of Rebalancing

To assess the potential effect of HCBS on nursing home use, we examined the MDS data on all New Mexico nursing homes for the years 2002, 2003, and 2004. We reasoned that if HCBS was having an effect, the case mix in nursing homes should become higher, i.e., the level of disability (both functional and cognitive) should increase. Because nursing homes serve at least two streams of clients, one requiring post-acute care (PAC) after discharge from hospitals and another the more traditional long-term resident, we examined the case mix at two points in time: admission and three months after admission. The former would include the PAC population, but the latter should be a more direct reflection of long-term care that HCBS was intended to defray.

Table 1 shows the changes in the NH case mix on admission and 3 months after admission for 2002, 2003, and 2004; the latter is a better test of the long stay population. Between 2002 and 2004, the functioning level of elders admitted to NHs in NM deteriorated slightly from the average ADL score of 13.11 in 2002 to an average ADL score of 13.71 in 2004, suggesting that nursing homes were serving people with higher acuity (the possible score of the ADL variable is between 0 and 24: a higher score means higher ADL dependence). Moreover, the proportion of residents admitted with no ADL dependencies, or very few, decreased. During the same period of time, the cognitive functioning of elders admitted into NHs improved slightly. The average CPS score went down from 1.69 in 2002 to 1.53 in 2004 (the possible score for CPS is between 0 and 6: a higher CPS score means lower cognitive functioning). Moreover, the rate of persons with no cognitive impairment or mild impairment increased.

Table 1. Change in NH Case Mix at Admission and 3 Months Post Admission in New Mexico, 2002-2004

	2002	2003	2004
At Admission			
Mean ADL	13.11	13.26	13.71
Mean CPS	1.69	1.69	1.53
3 Months Post Admission			
Mean ADL	11.06	11.95	11.99
Mean CPS	2.36	2.38	2.28

The ADL functioning at 3 months after admission deteriorated slightly over the 3 year period. The average ADL scores in 2002, 2003, and 2004 were 11.06, 11.95, and 11.99 respectively, suggesting more disability over time. Moreover, the proportion of persons with no ADL dependencies decreased, although the rate for few dependencies changed little. For cognitive functioning, the CPS scores improved slightly between 2002 and 2004. The CPS score in 2002 was 2.36, dropped slightly to 2.38 in 2003 and further dropped to 2.28 in 2004. However the proportion with no cognitive impairment changed little. This pattern suggest that HCBS may have achieved part of its goal of deflecting client with lower ADL needs to other sources, but the same effect was not seen for cognition.

Balance between Institutional and Community Care

Figure 2 graphs the changes in the numbers of participants, showing visually the growth in the PCO under the State Plan with no concomitant reduction in the numbers served under waivers or in nursing facilities, the latter remaining flat. D & E waivers had a brief growth spurt but the fell back to baseline and then grew more slowly, while MR/DD waivers have grown steadily.

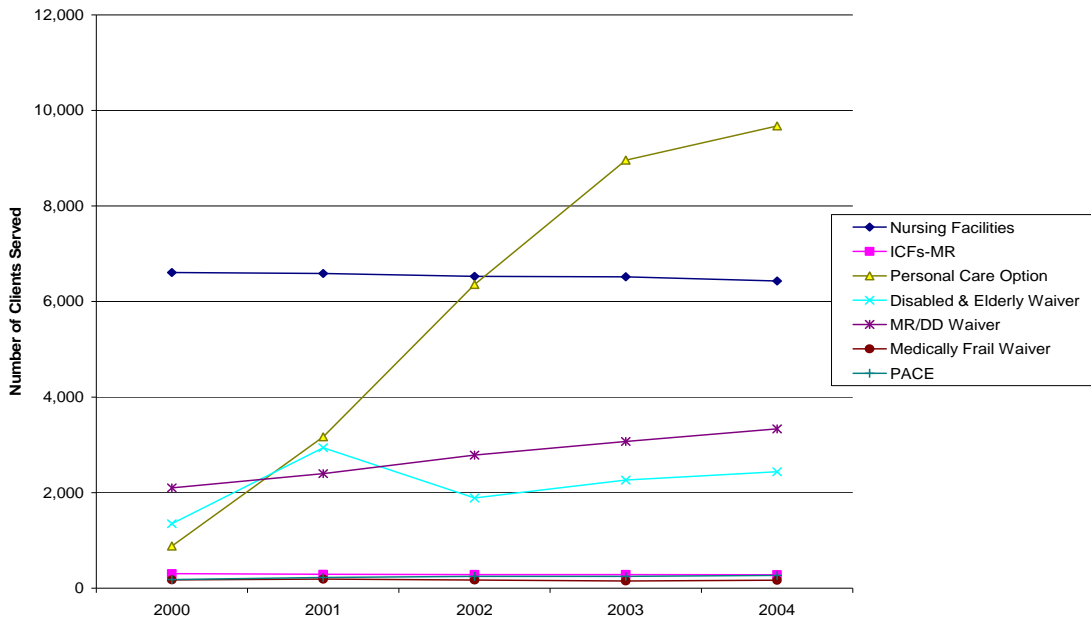


Figure 2. Clients Served in Selected New Mexico Programs, 2000-2004

Figure 3 traces expenditures for HCBS and institutional services. The growth in expenditures under the Personal Care Option is apparent, but there is also growth in the MR/DD waiver programs. Nursing home funding has remained stable. The disabled and elderly waiver grew from 2002 to 2004 but nowhere near as fast as the MR/DD waiver.

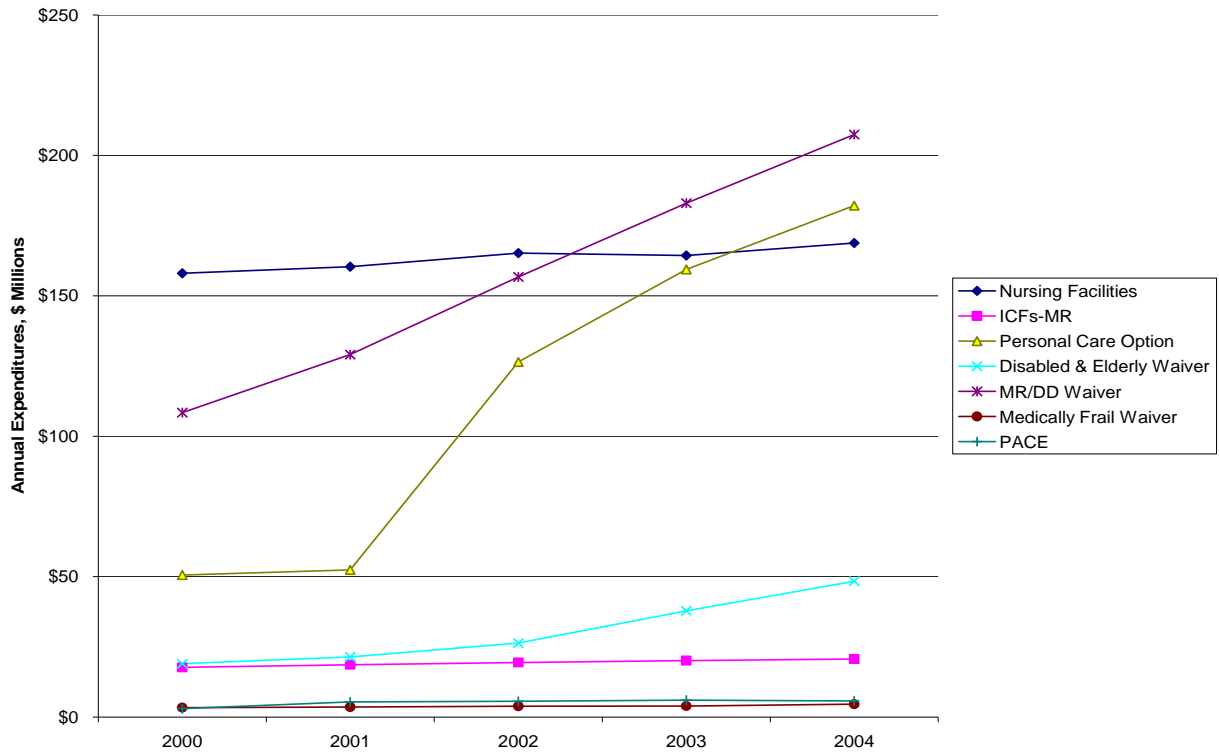


Figure 3. Expenditures for Selected New Mexico Programs, 2000-2004.

Figure 4 examines the costs of various HCBS programs per person served. This figure represents people served at any time during the year; some may not be covered for the full year. The growth in the Personal Care Option was actually associated with a dramatic decrease in the cost per case. Expenditures per person in ICF-MRs remain the most highest and continue to grow. MR/DD waiver services are more expensive per client than nursing homes and continue to grow while nursing costs per case remain steady. Disabled and elderly waivers have grown slowly since 2001. The Medicaid component of PACE was almost as expensive as nursing home care in 2001 but fell subsequently.

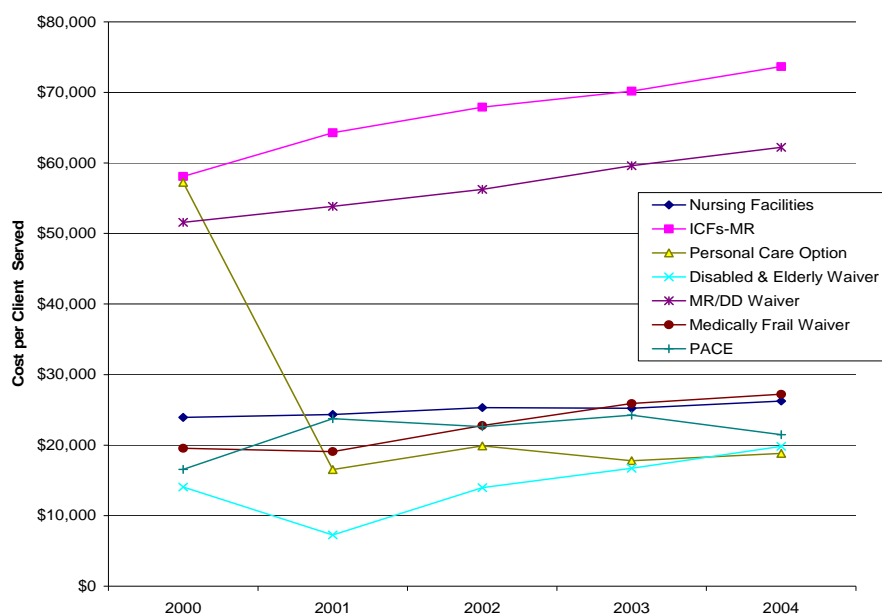


Figure 4. Per Capita Expenditures for Selected New Mexico Programs, 2000-2004.

Conclusion

New Mexico adopted several strategies to support the shift of LTC resources to community services. Developing health and long-term support programs for the rapidly growing aging population has been a priority since 2000. Governor Richardson, who took office in 2002, gave particular urgency to aging and disability issues, and created the ALTSD in his first legislative session. With the mandate from and support of Governor Richardson, the agencies responsible for long term care programs demonstrate a high level of collaboration. The Behavioral Health Collaborative is a showcase for that strategy.

The Medicaid personal care option became a major vehicle to shift dollars to the community. At the outset, the program resulted in an unexpectedly high growth of Medicaid costs. In response, the program was transferred to the ALTSD and changes were made in the assessment, authorization and reimbursement practices to improve management and targeting of the program

and to reduce incentives against the consumer directed mode. The program's mandated wage for personal care workers, combined with the inclusion of family members as eligible providers, has resulted in an adequate supply of such workers in this very rural state.

Issues for Future Observation

New Mexico has made remarkable progress in rebalancing and, with the catalyst of its new System Transformation Grant, has potential for further progress. As we continue to observe the evolution of the New Mexico system over two more years, the following are of interest:

- The continued growth and management of the personal care option and its inter-digitation with waiver services.
- The continued evolution of a structure in state government and the decisions about where the MR/DD programs should be located administratively.
- The resolution of legal issues remaining for the plaintiffs in the developmental disability suit, and the extent to which the MR/DD programs develop less reliance on day habilitation and a stronger track record of regular job development.
- The operational decisions for the *Mi Via* self-directed waiver, how *Mi Via* is implemented and grows, and the reaction of home care providers to that waiver.
- The development of stronger information systems to guide the programs.
- The experience and effectiveness of the Behavioral Health Collaborative in providing timely and effective mental health services for the subset of long-term care consumers who need them.
- The way New Mexico implements its present plans to expand capitated models for both institutional and community services, especially for seniors, and how those developments relate to the planned growth of consumer directed services.
- The refinement of active quality promotion activities within the framework of services New Mexico has created.
- The extent to which assisted living and housing with services plays a larger role in rebalancing for low-income consumers.