

Rebalancing Long-Term Care Systems in New Mexico

Long Version Report prepared by the Rebalancing Research Group

Submitted to the Centers for Medicare and Medicaid Services

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The overall project was 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 called for case studies of the experience of 8 states—other states in the study are: Arkansas, Florida, New Mexico, Pennsylvania, Texas, Vermont, and Washington. The baseline case study covers a period through July 31, 2005. An abbreviated version of this case study is also available at

http://www.hpm.umn.edu/lcresourcecenter/research/rebalancing/attachments/baseline_state_case_studies/New_Mexico_abbreviated_baseline_case_study.pdf

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 Arkansas State Liaison to the study, Debbie Armstrong, Cabinet Secretary, New Mexico Aging and Long-Term Services Department.

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Rebalancing Long-Term Care in New Mexico

Summary of Highlights

Community Service Expansion

The State of New Mexico significantly increased Medicaid spending for home and community-based services (HCBS) between 1999 and 2005, largely by adding a personal care option to its Medicaid state plan in 1999. In contrast to the way many states use a personal care option as a bridge for those not meeting nursing home eligibility, New Mexico intended the optional personal care to be used to enable consumers who might otherwise be in nursing homes to stay at home. Additionally, New Mexico has had long-standing HCBS waivers in place as well for seniors and people with physical disability and for people with developmental disability, and has steadily increased funding for those waivers in the 1990s and the early 21st century. As of 2004 reporting, New Mexico was catapulted to the 2nd ranking state in terms of the proportion of all its long-term care expenditures spent on community care as opposed to institutional care; New Mexico's proportion on HCBS was 67.6%, second only to Oregon's 70.5%.¹

Strong Consumer-Directed Emphasis

From the outset, consumers could use the Personal Care Option in either a consumer-delegated or a consumer-directed mode of service. In the latter, the agency retained only a minimal function with reference to managing the payroll, whereas in the former, the agency hired the workers and provided case management and oversight. In the former, an agency performed hiring and management of care personnel, guaranteed coverage during the hours needed, and provided supervisory oversight. In both models, the employed worker may be a relative of the consumer. (In consumer-delegated personal care, such a related worker is formally hired by the

¹ Table distributed in May 2005 by Brian Burwell, The Medstat Group, 125 Cambridge Park Drive, Cambridge, MA 02140 in annual memo on state by state Medicaid expenditures. The institutional part of the expenditures includes nursing facilities and ICF-MRs, and the community expenditures includes Medicaid waivers, state plan personal care, and state plan home health services

agency.) New Mexico is now creating a new consumer-directed Medicaid waiver (*Mi Via*, for “my way”), which will be available to consumers in all waiver programs. This plan is under development, aided by New Mexico’s selection in 2004 to be part of the expansion of the Cash and Counseling expansion.

Improving Jobs for Personal Care Workers

The state specified minimum salaries for the workers under both the consumer-delegated and consumer-directed models of the personal care option. For both models, this mandated salary was substantially in excess of the minimum wage and prevailing wages. Thus, the personal care option, which is described in more detail in Section III, was decidedly to enhance consumer control and worker well-being, as well as an explicit strategy in rebalancing long-term care. As a result of this policy and the generous allocations of allowable service hours, personal care spending in New Mexico has nearly equaled Medicaid spending for nursing home care in 2004. In 2005, the State introduced front-end independent assessment for eligibility (performed by a state-wide contractor) as part of an accountability effort to assure that the program is well targeted

Closing State Developmental Disabilities Institutions

Two law suits on behalf of people with developmental disabilities were instrumental in the shift of resources to community services, and the elimination of large state institutions for people with mental retardation. The state successfully developed very small MR-ICFs, e.g. with 4 to 6 places, and a supportive housing program to assist in that response. However, extensive waiting lists due to limited funding have slowed the state’s progress in further integrating the provisions for people with mental retardation into the community. Moreover, some commentators believe that within community care, too much reliance is placed on supportive housing and day-

rehabilitation centers. In an unusual arrangement, the Arc of New Mexico serves as guardian for a large number of former state hospital residents now in the community.

State Reorganization

In 2004, the Aging and Long Term Services Department (ALTSD) was created by legislation and executive order, elevating aging and long-term care to a Cabinet level, and assigned responsibilities previously in several other departments. This new organization has close collaborative relationships with the Department of Health and the Human Services Department. The ALTSD operates the Medicaid personal care program, the Medicaid Disabled and Elderly waiver, the Traumatic Brain Injury Program, the PACE program, and the Aging Network Services, whereas the Department of Health operates developmental disability programs. The assumption of functions for the new department has been gradual, the most recent acquisition being the Adult Protective Services program, which moved to ALTSD in 2005. An Interagency Long Term Care Committee is developing and monitoring a 5-year plan to restructure the organization and delivery of services to take account of the new agency.

Behavioral Health Collaborative and Other Inter-Agency Cooperation

New Mexico is characterized by strong inter-agency cooperation at the state level. In general, the new ALSA, the Department of Health (where the programs for Developmental Disability are presently housed), and the Department of Human Services (where Medicaid is housed) closely collaborate on LTC and related issues. More broadly, 15 agencies, including the 3 just mentioned, recently collaborated to create a Behavioral Health Collaborative, also highlighted in Section III. This effort culminated by multiple organizations, all of which fund behavioral health programs, developing an MOU to use their pooled funds to contract with a managed care organization to provide behavior health, a contract that was let shortly before our site visit. Other cooperative efforts, too new to characterize, are underway to demonstrate a

managed care capacity for long-term care for people dually eligible for Medicare and Medicaid; the intent is that the ALTD oversee quality and ensure that consumer directed options are available within this managed care program.²

Section 1. Context for Rebalancing

Demographics and Economics

With 1.9 million people in 2004 and 11.9% of the community-dwelling population at or above age 65, in 2004 New Mexico was ranked 39th in population aging (Table 1). Only 1.1% of New Mexico's community-dwelling population was over age 85. But New Mexico's total population is growing (a projected increase of 41.7% between 2002 and 2020, compared to 26.3% for the United States), and its population is rapidly aging. Projections are that by 2020 New Mexico will rank 4th nationally in the percentage of residents over age 65. The proportion over age 65 will increase to 14.1% in 2010 and 26.4% in 2030. Seniors most needing long-term support services - i.e., those over age 85 - will increase from 1.3% of the population in 2000 to 1.9% in 2010 and 3.6% in 2030. New Mexico's population is highly diverse. It includes 48%, who describe themselves as having Hispanic or Latino origin, and almost 30% who describe themselves as non-white; 9% are Native American.

The statistics in Table 1 show that the New Mexico population reports greater disability than in the US population as a whole for adults and seniors. Just fewer than 11% of people age 65 and older have self-care limitations; in other available data for the population over age 65, 21.6%

² Note: The team site-visiting New Mexico on July 6-8, 2005 included Robert Mollica, National Academy for State Health Policy; Rosalie Kane and Robert Kane from University of Minnesota, and Charlene Harrington from the University of California at San Francisco. This report is based on information gathered before, during, and after the site visit. In the baseline case study, we created a historical record and context for a period up to July 31, 2005, with the intent of up-dating the case study twice, as of July 31, 2006 and July 31, 2007. We thank our New Mexico study liaison, Debbie Armstrong, Secretary, New Mexico Aging & Long Term Services Department, and the many individuals in the public and private sector who provided us with insights for the report. The conclusions drawn are those of the authors and do not necessarily reflect any officials in New Mexico or at CMS

have mobility limitations, 18.5% have sensory limitations, and 10.9% have cognitive or mental limitations. Except for cognitive disability, which is almost the same as for seniors in the United States, seniors in New Mexico are slightly more disabled than those in the United States as a whole, and particularly so for mobility or sensory disabilities.³ About half of New Mexicans over age 85 live alone.

Table 1. Demographic Features Linked to LTC Needs in New Mexico and the United States

Population Characteristic	New Mexico	United States
Total Population, 2004	1,903,280	293,655,404
Percent of Persons Age 65+, 2004	11.7%	12.1%
Percent of Persons Age 85+, 2004	1.1%	1.3%
Percent of growth of population over 65 from 1900 to 2002	41%	14.2%
Percent of Population non White, 2003	29.3%	24.4%
Percent of population Hispanic or Latino ethnicity	43.3%	13.9%
Urbanicity, 2003 (population in MSA). ^a	56.8%	81.7%
Persons per square mile (2000)	15	79.6
Community Population age 5-20 with disability, 2004 ^a	6.4%	6.6%
Community Population, age 21-64 with a disability, 2004. ^a	14.9%	12.1% ^{%%}
Community Population 65+ with a disability, 2003 ^a	45.8%	39.9%
All non-elderly persons with a disability, 2003 ^a	12.2%	10.9%
Men per 100 women over age 85, 2002. ^b	55.1	47.9
Persons with over 65 with Self-Care Difficulty, 2003 ^b	10.8%	9.2%
Persons over age 85 living alone, 2003. ^b	49.6%	50.2%

^a These statistics come from the US Census Bureau, American Community Survey, which excludes people living in institutions - e.g. nursing homes. A broad definition of disability is used, i.e., persons who report a disability in employment, mobility, and/or personal care. <http://www.census.gov/acs/www/Products/Ramlomg/index.htm>.

^b More detailed analyses regarding older people are found in Gibson, et al, Reference 2. We also utilized statistics available on the Website of UC San Francisco's Center for Personal Assistant Services, <http://www.pascenter.org/home/index.php>

New Mexico is among the poorest states in the union; per capita income ranked 47th nationally in 2004 at \$26,191 (see Table 2). Eighteen percent (18%) of the state's population lives in poverty, compared to the national average of 12.7%. The percentage of people with disabilities living in poverty is greater than poverty in the general New Mexico population, though less than the comparable population with disabilities in the United States as a whole.

Over 21 percent of New Mexico residents lack health insurance compared to 15.1 percent

³ Mary Jo Gibson, Steven R. Gregory, Ari N. Houser and Wendy Fox-Grage. Across the States: Profiles of Long Term Care. Sixth Edition. AARP. Washington, DC. 2004.

nationally.⁴ One in every 3 New Mexicans receives support of some kind from the Bureau of Income Support (e.g., cash assistance, Medicaid, food stamps, heating fuel assistance). New Mexicans not only receive benefit from state and local government, but also contribute to government with substantial taxes. In 2004, New Mexico ranked 5th highest among states in “tax burden” as a percent of personal income. Slightly over 50% of state and local revenues in New Mexico were derived from regular and special sales taxes, 25% from individual income tax, and only 1.3% from property taxes. The breakdown between state and local revenue sources in New Mexico was 73% state to 27% local. New Mexico has a favorable federal match for Medicaid spending of 74.3% in 2005 and 71.1% in 2006. In 2005, New Mexico proposed \$473,638,100 in Medicaid funding, which would be matched by more than \$1.6 billion of federal spending. Nonetheless, any change in the federal match means a stretch for the New Mexico state budget.⁵ In 2004, an enhanced match of 77.3% was available for New Mexico; when the match reverted in 2005, it is estimated that New Mexico needed an addition \$80 million to sustain its Medicaid program at the previous rate.⁶

⁴ Mills, R J & Bhandari, S (2003). Health Insurance Coverage in the United States, 2002. (Economics and Statistics Administration, U.S. Census Bureau, Current Population Reports, P60-22, pp. 1-23. Washington, D.C. Department of Commerce. Website at: <http://www.census.gov/prod/2003pubs/p60-223.pdf> Last visited October 11, 2005.

⁵ The Rockefeller Institute of Government in Albany, NY generates reports on state and local revenues and expenditures, most of which are on its website at: <http://rfs.rockinst.org/>. Also state summaries can be found on Websites maintained by the Bureau of Economic Analysis, US Department of Commerce, including: <http://www.bea.doc.gov/bea/regional/bearfacts/statebf.cfm>. Both last visited November 1, 2005.

⁶ Pham, E & Parker, E (2004). Decline in Federal Match Rate Hits States Hard. (Report of Children’s Defense Fund, July 15, 2004). On web at: http://www.childrensdefense.org/childhealth/medicaid_match_rate.pdf Last visited November 5, 2005.

Table 2: Economic Characteristics in New Mexico and the United States

Economic Characteristic	New Mexico	United States
State Taxes Per Capita, 2004	\$2,103	\$2,024.85
Median household income, 2003	\$41,661	\$44,684
Mean personal income per capita (2004)	\$20,615	\$24,020
Percent of Population in Poverty (average 2002-2004)	17.3%	12.6%
Population unemployed in Labor Force, 2003	4.8%	5.0%
Persons without health insurance (3 year average, 2001-2003)	21.3%	15.1%
Households with cash public assistance, 2004.	2.7%	2.4%
Medicaid participation as % per population, 2003	23%	18%
Community dwelling persons age 65 in poverty, 2004.	14.3%	9.7%
Community dwelling persons age 5-17 with disability in poverty, 2004.	35.2%	27.0%
Community dwelling persons age 18-64 with disability in poverty, 2004	28.1%	24.5%
Community dwelling persons age 65 + with disability in poverty, 2004	15.3%	13.1%
Community dwelling persons 5-17 with disability to 200% of poverty, 2004	63.1%	51.1%
Community dwelling persons age 18-64 with disability up to 200% of poverty	57.9%	46.9%
Community dwelling persons 65+ with disability up to 200% of poverty	48.0%	43%
Community dwelling persons 5-17 with disability up to 300% of poverty	80.9%	68.1%
Community dwelling persons age 18-64 with disability up to 300% of poverty	71.1%	63.5%
Community dwelling persons age 65 + with disability up to 300% of poverty	67.3%	63.4%

Sources: See References 3 and 4, respectively for health insurance coverage data, state and local tax data, and health insurance data. The numerator for the Medicaid coverage rate per 1000 population was drawn from a special study funded by the Kaiser Family Foundation in 2003,⁷ and the denominator from the American Population Survey, US Census Bureau; in interpreting the rates, note that the denominator excluded the population in institutions whereas the numerator includes all Medicaid recipients.

Geography

New Mexico is a large state of 121,356 square miles, with sparsely populated, stretches of high desert area, and regions that are officially designated as “frontier” areas. Population density overall is 15 persons per square mile, compared to 79.6 in the United States. The state is divided into 33 counties (see Figure 1 for map). Somewhat square in shape, the state shares long borders with Arizona to the west, Colorado to the north, Texas to the east, and an international border with Mexico to the south. On the east it shares a short border with the Oklahoma panhandle, and on the northwest, it meets Utah in the four corners area.

⁷ Ellis, ER, Smith, VK & Rousseau, DM (2004). Medicaid Enrollment in 50 States, June 2003 Update. (Health Management Associates, Lansing, MI and Kaiser Commission on Medicaid and the Uninsured, prepared for Kaiser Family Foundation, October 2004). On website: <http://www.kff.org/medicaid/upload/Medicaid-Enrollment-in-50-States-June-2003-Data-Update-Report.pdf> Last visited, December 1, 2005.

Twenty-one (21) separate tribal jurisdictions are located within New Mexico, including the New Mexico section of the Navajo Nation (with 3 chapters of tribal government) in the northwestern corner, 2 Apache reservations, and 19 Pueblo tribes. Thus, the State's planning for aging and disability has the added complexity of collaboration with the individual tribal governments, the Bureau of Indian Affairs and the Indian Health Service.

New Mexico's population is skewed to a few populous counties. Almost 600,000 people live in Bernalillo County in Central New Mexico, where Albuquerque is located. After that, urban areas diminish sharply in size. According to most recent census data, Las Cruces, the principal city in Southwestern New Mexico in Dona Ana county, was the next largest city with 76,900 people; the capital, Santa Fe, less than an hour's drive from Albuquerque, had 66,476 people; Roswell, the principal city in Southeastern New Mexico in Chaves County had a population of 44,228; and Farmington, principal city San Juan county at the gateway to the Navajo reservation in Northwestern New Mexico, had a population of 41,420. Gallup, the principal city in McKinley County, which is surrounded by the Navajo Reservation, has a population of 20,209. The vast bulk of the Navajo reservation is in Arizona to the west, requiring inter-state cooperation for aging and disability services in that area.

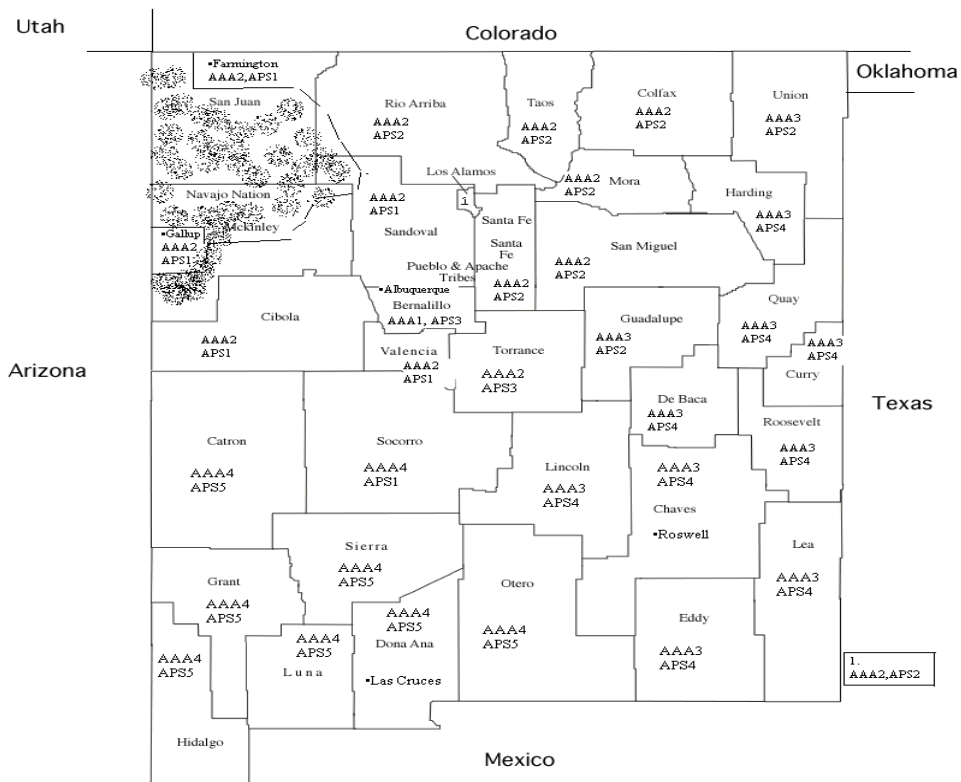


Figure 1. State Map with Counties, AAA Regions, and Adult Protective Service Regions

Rebalancing Status in Brief

In fiscal year 2004, 67.6% of Medicaid long term care funds were spent on home and community based services compared to 42% in FY 2000. New Mexico led all states in the percentage of Medicaid funds spent on home and community based services for elders and adults with physical disabilities in FY 2004 at 55.2%, a dramatic increase from only 13% in FY 2000. The increase was due primarily to the coverage of personal care under the Medicaid state plan. Community spending for people with development disabilities rose from 81% in FY 2000 to nearly 90% in FY 2004. Looking just at the balance of expenditures for older people, New Mexico has been on a trajectory towards increased community care for more than a decade. According to 1996 data, New Mexico was rated very high in likely public demand for long-term care, was rated high in commitment to utilization of HCBS for older people, was 9th lowest

among states in the supply of nursing home beds per 1000 people over age 85, and showed above average control of both nursing home utilization and expenditures.⁸ In the subsequent decade, the progress continued with reference to older people and overall.

Political Climate

In 1999, the legislature enacted a bill to create a Cabinet level department for aging and disability, but the measure was vetoed by then-Governor Johnson due to cost implications. Nonetheless developing health and long-term support programs for the rapidly growing aging population has been a priority since 2000, under a number of legislative mandates. Governor Richardson, who took office in 2002, gave particular urgency to aging and disability issues, and created the ALTD in his first legislative session. He also placed emphasis on the reduction of uninsured persons in the state and in control of Medicaid expenditures.

The State Legislature is an all volunteer body, which is paid only a stipend for expenses. Its sessions are short. In odd years, the legislature meets for 60 days and in even years for 30 days; the shorter session is intended to be limited to budget and fiscal matters. Much work is accomplished in the Interim from June through November, when major committees meet monthly and special legislative task forces meet; the Interim Legislative Health and Human Services Committee is particularly important for long-term care. The legislature is staffed by a non-partisan Legislative Council Service, which assists in drafting bills. Staff of the Legislative Council work closely with executive branch agencies to prepare reports and materials for the Interim work; this mechanism provided expertise and continuity.

Through the mechanism of reports to the legislature and special audits, the Legislature has carefully monitored Medicaid (including its Personal Care Option), the Human Service

⁸ Ladd, RC, Kane, RL., & Kane, RA (1999). State LTC Profiles Report, 1996. (Report Submitted to DHHS Assistant Secretary for Planning and Evaluation, April 1999). Minneapolis, MN: Balancing Long-Term Care, Division of Health Services Research and Policy, School of Public Health, University of Minnesota.

Department, the Department of Health, and the orderly development of the new ALTD. The new department has a report due to the legislature in October 2005 to present recommendations for its next 5 years. In general, the legislature is supportive of community care. It has informed itself on national trends and worked to meet the spirit as well as the letter of the Olmstead decision. For example, in 2003 specific legislation has been enacted in support of consumer directed care. Despite a 70% federal Medicaid match, concern over Medicaid expenditures is an ever-present. In the current climate, managed care is a favored solution for a wide range of public programs, but the goal is to maximize consumer autonomy and consumer direction within managed care arrangements, and it is planned that ALTD will exercise authority over managed long-term care plans.

Vision and Values for LTC

Various vision statements can be found within legislation and executive agency plans. Relevant wording is found in the 5-year plan developed by the New Mexico Aging and Long-Term Services Department (ALTSD) in 2002, before the elevation to cabinet status. The title included the phrase “More Than Bricks and Mortar,” suggestion the centrality of community care. The goal of the plan was worded as follows:

. . . to advance and deliver a statewide, comprehensive health and social services system that **effectively and efficiently** serves disabled people, seniors, and their families by:

- Providing **an array of coordinated services and options** that enable people to make **informed choices about how and where they live and to reduce the need for institutional care**;
- Maintaining or improving the health and functional status of aging and disabled adult populations;
- **Promoting and protecting the rights and dignity** of seniors and people with disabilities; and
- Helping people obtain and maintain economic security. [Emphasis added.]

The document gives explicit recognition to the goals of rebalancing, reducing institutional care, promoting choice, and protecting dignity and rights. As is typical in New Mexico documents, it also recognized the need for efficient solutions, and the interlocking of health and income needs with long-term support. The document goes on to enunciate strategies that include (among many specific plans): promoting family care-giving; developing a non-profit managed care initiative integrating acute, primary, and long-term care; implementing a statewide resource center; establishing a transportation infrastructure; developing affordable housing options; developing a support system for people with traumatic injuries, which have high incidence in New Mexico; reducing financial exploitation; establishing an Office of Division of Disabled Adult and Elder justice; and expanding employment opportunities for older people or people with disabilities. Taken together, the document expresses a strong commitment to a vision of community care and choice for elders and people with disabilities combined with a realistic approach for getting there in the light of unique New Mexico challenges.

The ALTSD is preparing a new state strategic plan for Aging and Long-Term Services for the legislature. The draft document contains a succinctly worded vision for ALTSD: “Older people, persons with disabilities, and their families are empowered to live independently, productively, and with dignity.” The purpose statement reads: “To achieve the highest quality of life for older adults, persons with disabilities, and their families by enhancing autonomy, health, economic well-being, community involvement and personal responsibility.” Finally, the mission reads: “To establish a continuum of social supports and health services to meet the needs of individuals and maximize their independence, enabling them to live successfully on their own terms in their own communities.” Once again, a clear enunciation of a vision for community integration is accompanied by attention to health status and economic well-being.

Leadership

State aging programs are led by a group with diverse but complementary skills, some leaders of whom have had considerable tenure in the New Mexico government. Michelle Lujan Grisham, previously head of the Agency on Aging, was appointed secretary of the Department of Health in 2004. Ms. Grisham, a lawyer, had 14-year tenure with the State, and over the years has evinced a strong interest and expertise in programs protecting the legal rights of older people. Deborah Armstrong, the Secretary for ALTSD, formerly served under Ms. Grisham in the Agency for Aging. Pamela S. Hyde was appointed Secretary for the Human Services Division in 2002. She has substantial and varied experience in Arizona, Washington, and Ohio, and was both state Medicaid and state mental health director for Ohio. An appointee to the President's New Freedom Commission on Mental Health, she has substantial expertise in that field and had helped New Mexico identify its gaps in behavioral health prior to joining the executive branch. The Deputy Director of HSD for Medicaid was formerly the director of the Income Support Division at HSD. In summary, New Mexico has assembled a cohesive leadership team committed to the goals of rebalancing and community care, and collectively reflecting substantial content knowledge and experience in relevant state government agencies.

State Government Organization for Long-Term Care

Three (3) Cabinet-level Departments have a role in managing long term care services in New Mexico – the Department of Aging and Long Term Services, the Department of Human Services, and the Department of Health (see Figure 2). The Aging and Long Term Services Department (ALTSD) was established in 2002. Through its Aging and Long-Term Care Division, it manages the disabled and elderly waiver, the personal care option, and the planning for the new consumer-directed waiver. ALTSD is also the state unit on aging and its Aging Network Division, managing the administration of AOA money and overseeing its services.

The Consumer and Elder Rights Division continues a particularly strong tradition of attention to elder rights that has for decades characterized New Mexico’s state unit on aging. Finally, the Adult Protective Services Division, recently added, rounds out the portfolio. 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.

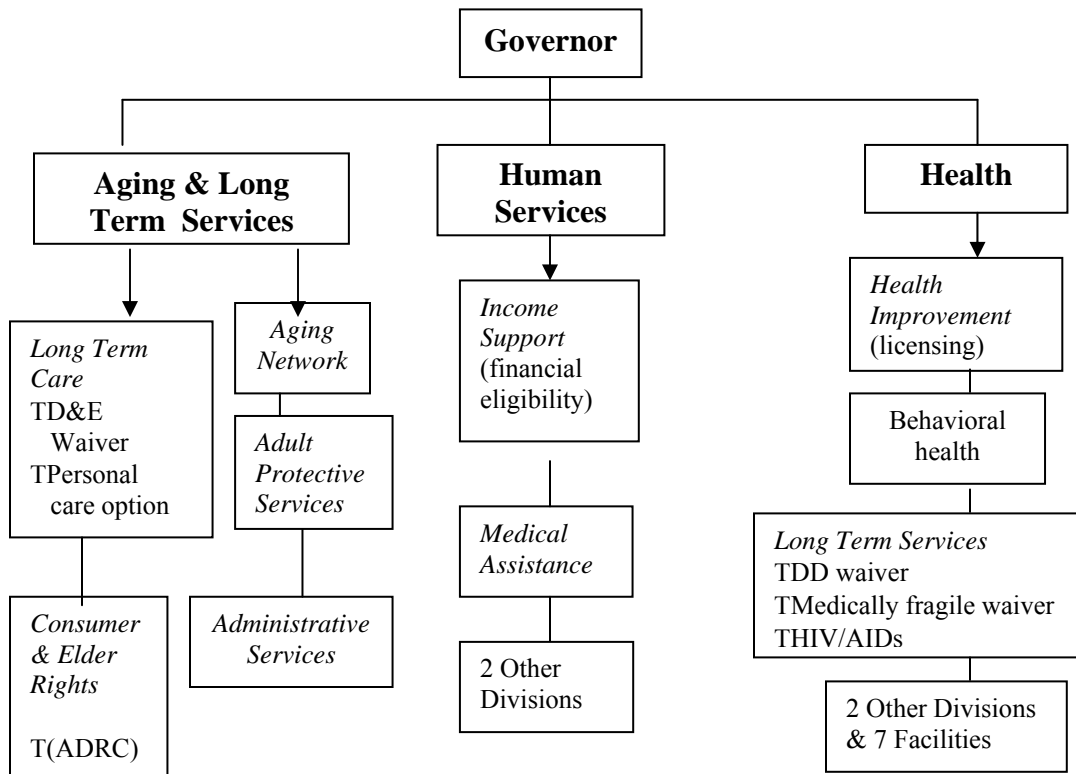


Figure 2. State Government Organizational Structure for Long-Term Care as of July 2005

Three (3) divisions within the Department of Health are involved in long term care. The Division of Health Improvement licenses and oversees nursing homes, residential care settings and home health agencies, the Long Term Services Division manages the HCBS waivers for people with developmental disabilities, and the Behavioral Health Services Division manages services for Medicaid beneficiaries with behavioral health needs. Finally, the Human Services

Department (HSD) includes the Medical Assistance Division (Medicaid program) and the Income Support Division, which has an important role in establishing eligibility.

Local Organization for Long-Term Care

As Figure 1 showed, New Mexico is organized into 33 counties. But New Mexico does not heavily rely on a county or regional infrastructure to manage LTC and long-term support services. Rather, access to and management of services has been organized centrally and delivered through a network of contracting case management providers (separate but overlapping lists are used for Disabled and Elderly, and for Developmental Disabilities). This approach is meant to assure free choice of case management provider and to maximize access across a large and rural state. Financial eligibility is determined by the Income Support Division (ISD) of the Human Services Office, which maintains 39 regional field offices (at least one in each county) to process applications for a wide range of services, including cash benefits, Medicaid, food stamps, and heating assistance. The easily accessed Website identifying the branch ISD locations carries a banner describing the office as “Serving 1 in 3 New Mexicans.”

As is discussed below in Section III, a layer of organization has recently been added to access the personal care option, which entails a contract with a managed care organization to conduct and review initial assessments statewide; that MCO, in turn, has contracted with a state-wide network of home health nurses from one home health agency (Gentiva), which performs the face-to-face assessments. Gentiva is, therefore, precluded from delivering services under the Personal Care Option if the agency has performed an intake assessment. The State has a number of initiatives underway (also described below) to make it easier for the consumer to find information about services and reach the right entry points.

The State is divided into 6 Area Agencies on Aging (AAA), 2 of which serve Native Americans. Area 1 is comprised only of Bernalillo County (where Albuquerque is located), and

Areas 2, 3, and 4 divide up the remaining counties. Area 5 serves the Navajo Nation and it is run by the Tribe from Window Rock, Arizona, across the border, and Area 6 serves the 19 Pueblos and 3 Apache tribal areas in New Mexico. The AAAs operate vigorous programs, administering a variety of senior centers and related services, family caregiver programs, Alzheimer's programs, ombudsman programs, and consumer information and rights efforts. The model of collaboration that evolved in New Mexico includes major service and advocacy roles for AAAs, but no role in the authorization of waiver or Medicaid services or provision of case management for those programs. Adult Protective Services is administered through 5 state regions, with roughly a region in each of the 4 quadrants of the state plus 1 in a 2-county metro area. (Both AAA and Adult Protective Service regions were shown on Figure 1.) The Long-Term Services Division in the Department of Health has 5 regions for administering its developmental disability programs, again organized into the Metro area and 4 quadrants, but with slightly different boundaries than AAAs or protective services regions.

Litigation Related to Rebalancing

New Mexico officials tend to agree that litigation beginning more than a decade before the Olmstead decision facilitated rebalancing. In July 1987, parents of 21 people with developmental disability filed a class action to correct what they claimed were unconstitutional conditions at New Mexico's two state institutions for people with DD (*Jackson v. Fort Stanton*, 757 F.Supp. 1243 (D.N.M. 1990)). The district court agreed that the defendants had discriminated against people with severe disabilities by unnecessarily segregating them and by subjecting them to unacceptable living conditions, and ordered the parties to negotiate corrective action plans. This order set in motion a series of events that over the next 10 years would completely transform New Mexico's DD service system. The parties cooperatively developed

plans for improving the institutions and for establishing an adequate infrastructure for the community-based DD service system.

Despite 5 years of effort, the defendants were unsuccessful in correcting the deficiencies at the institutions and transferring residents to the community. In response, plaintiffs filed a motion in 1996 to hold the defendants in contempt of court, alleging ongoing abuse, neglect, and lack of adequate care at the institutions and the on-going unnecessary segregation of persons with DD. This led to New Mexico's decision to close the institutions. The last resident moved out in 1998. Parties to the suit entered into a Joint Stipulation that ended the lawsuit. Among other provisions, the stipulation requires the state to create regional offices, establish a staff training program, improve behavioral services, and have a "Community Monitor" conduct annual audits of the state's services and programs for persons with DD (i.e., the class members of the lawsuit).

A class action lawsuit (*Lewis et al. v. New Mexico Department of Health et al.*) was filed in 1999 by the state's P&A agency and the Arc of NM on behalf of persons on the waiting lists for HCB waiver services and persons in ICF/MRs or nursing homes who would benefit from HCB waiver services. The court upheld the plaintiffs' right to access HCBS with "reasonable promptness." Following several rulings on and appeals of procedural issues, the plaintiffs requested summary judgment in July 2002, noting at the time that the state had waiting lists for both the developmental disability waiver and the elderly waiver even though the number of persons enrolled in the waivers remained below the state's federally approved caps. In August 2003, the court found New Mexico in violation of Medicaid's "reasonable promptness" requirement. Although this requirement extends only so far as funds and waiver slots are available, the court admonished the state to step up its efforts to use all available funds to provide HCBS under its waivers to as many individuals as possible. In a subsequent ruling, the court also ordered the state to determine eligibility for waiver slots within 90 days and to allocate

waiver slots as soon as they become available. An estimated 300 to 500 individuals were expected to be moved off the waiting lists as a result. Plaintiffs filed a motion in September 2004 arguing that the state was not offering waiver services up to the agreed on limit. As a result, the court added a list of 401 additional provisions that the state needed to fulfill in the next 6, 12, or 18 months were added to bring it into compliance. The primary areas specified were the development of individual service plans, behavior services and supported employment services. The state moved to dismiss the motion and the case remains open.

Advocacy Environment

Consumer advocacy organizations related to developmental disability and disability in general played a major role in the downsizing and eventual closing of state institutions for MR/DD and the inclusion of consumer direction in the personal care option program. Arc of New Mexico historically and at present plays a particularly active advocacy role. The Protection and Advocacy System (P&A), founded in 1979 through the federal law and Executive Order of the Governor, serves as the state's only legal rights center for people with disabilities. Working with its board, it monitors legislation, conducts hearings, and annually sets its priorities for training, advocacy, and legal action. The P & A goals and priorities approved for 2005-2006 include a series of efforts related to the rights of those with mental illnesses (including adults and children who are incarcerated), housing discrimination issues, alternatives to guardianship, expansion of community care and rehabilitation services, issues related to education and to the workplace, as well as general emphasis on access to community services.⁹ The Developmental Disabilities Planning Council, an association of agencies, maintains an active profile and works closely with P & A. A wide range of disability-specific advocacy organizations operates in New

⁹ New Mexico Protection and Advocacy maintains a website with extensive information, much of it in Spanish as well as English, at <http://www.nmpanda.org/indextext.html> Last visited November 1, 2005.

Mexico. AARP participates in advocacy efforts related to disability efforts, but our impression was that long-term support is not at the top of the AARP agenda and that no particular constituency forms a pressure group for more community care for elderly people. The National Alliance for the Mentally Ill was reportedly strong, with its state leader also active nationally.

As part of the establishment of ALTSD, a Policy Advisory Committee (mandated in statute) was formed, and in turn created a Long-Term Services sub-committee, which has met regularly since August 2004. This Committee includes both provider and consumer stakeholders.

Another large and somewhat overlapping stakeholder group, the Self-Directed Waiver Subcommittee, was formed jointly by ALTSD and HSD in 2003. This group has met monthly since January 2005 to prepare the application for a consumer-directed services waiver.

Providers also have a strong voice at the planning table, to some extent counter-balancing consumers. New Mexico's 5 Centers for Independent Living (CIL) constitute provide a strong consumer voice, while also providing services. Each CIL has evolved somewhat differently. During our site visit, we met with representatives of the San Juan County Center for Independence, founded in 1999 and located in Aztec, New Mexico. This Center conducts vigorous and successful efforts to assist people of all ages, including many very old people, to access Home and Community Based Services and leave nursing homes. For example, the organization has successfully helped seniors leave off-reservation facilities and return to the Navajo reservation. Its director has particular expertise and experience in self-advocacy for people with brain injuries.

Service Provider Environment

New Mexico has a relatively low supply of nursing home beds. As indicated, all state institutions for people with mental retardation and developmental disability have closed. The state presently has 40 ICF/MRs serving 281 consumers (i.e., an average occupancy of 7

residents). The State operates several long-term care institutions, including a State Veterans Home in Truth or Consequences, a long-care unit in the state mental hospital in Los Vegas, and the Fort Bayard long-term facility. (At the time of our case study, the Governor had appointed a group of Cabinet secretaries to examine quality in the latter.) New Mexico licenses adult residential care settings, and assisted living services, which are defined as packages of services to meet the individual needs of Medicaid waiver recipients living in the licensed settings.¹⁰ In 2004, 446 adult residential care settings were licensed, but at this time, no data were available on their size, or the number of Medicaid waiver clientele housed there.

Table 3. Supply of Nursing Homes and Residential Care Facilities 2002-2004

Date	Nursing Homes		ICF/ MRs		Adult Residential Care	
	# facilities	# served	# facilities	# served	# facilities	# served
2000	81	6,607	39	305	255	Not available
2001	80	6,589	42	290	Not collected for 2001	
2002	79	6,526	42	286	305	Not available
2003	81	6, 517	41	281	Not collected for 2003	
2004	79	6, 429	40	281	446	Not available

Source: Data on nursing homes and ICF/MRs were supplied by the state of New Mexico, and data on the number of licensed adult residential care facilities are from Mollica & Johnson-LaMarche, 2005. The Mollica reports were done every 2 years only.

For the Disabled and Elderly (D & E) Waiver, ALTSD had 42 case management providers and 67 direct service providers under contract as of June 14, 2005; some of the latter also provide case management. A similar, though somewhat smaller and occasionally overlapping list of case managers and providers is maintained for the Developmental Disability waiver and another partially overlapping list of providers for toddler and early childhood developmental services. The New Mexico Association for Home and Hospice Care lists 120 home care members that provide the gamut of Medicare-certified and other home care, case management, and related

¹⁰ Mollica, R & Johnson-LaMarche, H (2005). State Residential Care and Assisted Living Policy, 2004. (Report under contract from U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy submitted by Research Triangle Institute, March 31, 2005) Portland, ME, National Academy for State Health Policy. On website. <http://aspe.hhs.gov/daltcp/reports/04alcom.htm> Last visited, November 6, 2005.

medical equipment and infusion agencies. The organization draws its leadership from 5 geographic regions; some but not all of its members chose to offer the Medicaid personal care option benefit, which is also provided by home care agencies outside the membership.

Approximately 70 home care agencies are Medicare certified or serve private pay. The 5 Independent Living Centers mentioned under advocacy also provide services in their regions.

Historical Evolution of LTC

Table 4 shows the progression of the development of HCBS in New Mexico. The table illustrates how state public policy initiatives in the legislature and executive branches, law suits and reactions to law suits, and strategic use of grant funding have interacted in New Mexico's accomplishments. By 1987, the two large Medicaid waiver programs had been established and the influential Jackson law suit filed. Ten years later, the Salud program was established to operate the Medicaid acute care program through 3 Managed Care Organizations. In 1999, the Medicaid Personal Care Option was created, and since that time, the rebalancing efforts have been steady and effective.

Table 4. Milestones in Development of Long-Term Care System in New Mexico

Year	Milestone
1983	<ul style="list-style-type: none"> • Received HCBS DD waiver
1985	<ul style="list-style-type: none"> • Received HCBS Disabled & Elderly (D & E) Waiver.
1987	<ul style="list-style-type: none"> • Jackson Suit filed.
1997	<ul style="list-style-type: none"> • Received 1915b Waiver and initiated Salud Program—i.e., Medicaid managed care program
1999	<ul style="list-style-type: none"> • House Joint Memorial 18 –established personal care option program • Lewis v. NM Dept of Health (filed Jan 1999) alleging NM violated ADA by refusing Medicaid services to qualified people with disabilities. Decision for plaintiffs issued August 3, 2003. • Medicaid Personal Care Option Program implemented on 9/1/1999
2002	<ul style="list-style-type: none"> • Senate Joint Memorial 54 initiated task force to develop Olmstead plan • Senate Bill 379 established the Medicaid Reform Committee; Recommended • Interim Olmstead plan issued (October 16, 2002) • Real Choice Systems Change grant (\$1,385,000)
2003	<ul style="list-style-type: none"> • Senate Bill 839 –Consumer Direction Act, requiring CD option in all LTC programs • Senate Bill 332 – directed Human Services Dept to undertake set of studies, analyses, and pilot project focused on Medicaid reform • Establishment of Aging and Long-term Care Department (formerly the state agency on aging) • \$905,000 HRSA grant to increase health insurance coverage in New Mexico.
2004	<ul style="list-style-type: none"> • House Bill 271 – Created the Interagency Behavioral Health Purchasing Cooperative • Audit of personal care option program – after expenditures reached \$155 million in • FY2003, 15 times over estimate • Systems Change grant – Family to Family Information and Ed centers (\$150,000) • NGA “Rebalancing Grant” (used to help fund legislatively mandated ALTSD Plan) ADRC grant (\$798,900) • Cash and Counseling grant from RWJF (3-year grant \$359,153)
2005	<ul style="list-style-type: none"> • New Mexico awarded RCSC Systems Transformation Grant in September 2005

Figure 3 presents New Mexico’s history in broader time periods and more detail. The original version of this figure was designed by ALTSD to illustrate how the legislature, the governor’s office, the relevant departments, and the stakeholder groups have worked together on various initiatives in New Mexico. Some of these efforts have concerned service expansion and some have concerned quality enhancement. The somewhat busy figure illustrates the shifting partnerships around particular efforts, the heavy involvement of stakeholders, who sometimes work directly with the legislature and sometimes with executive agencies

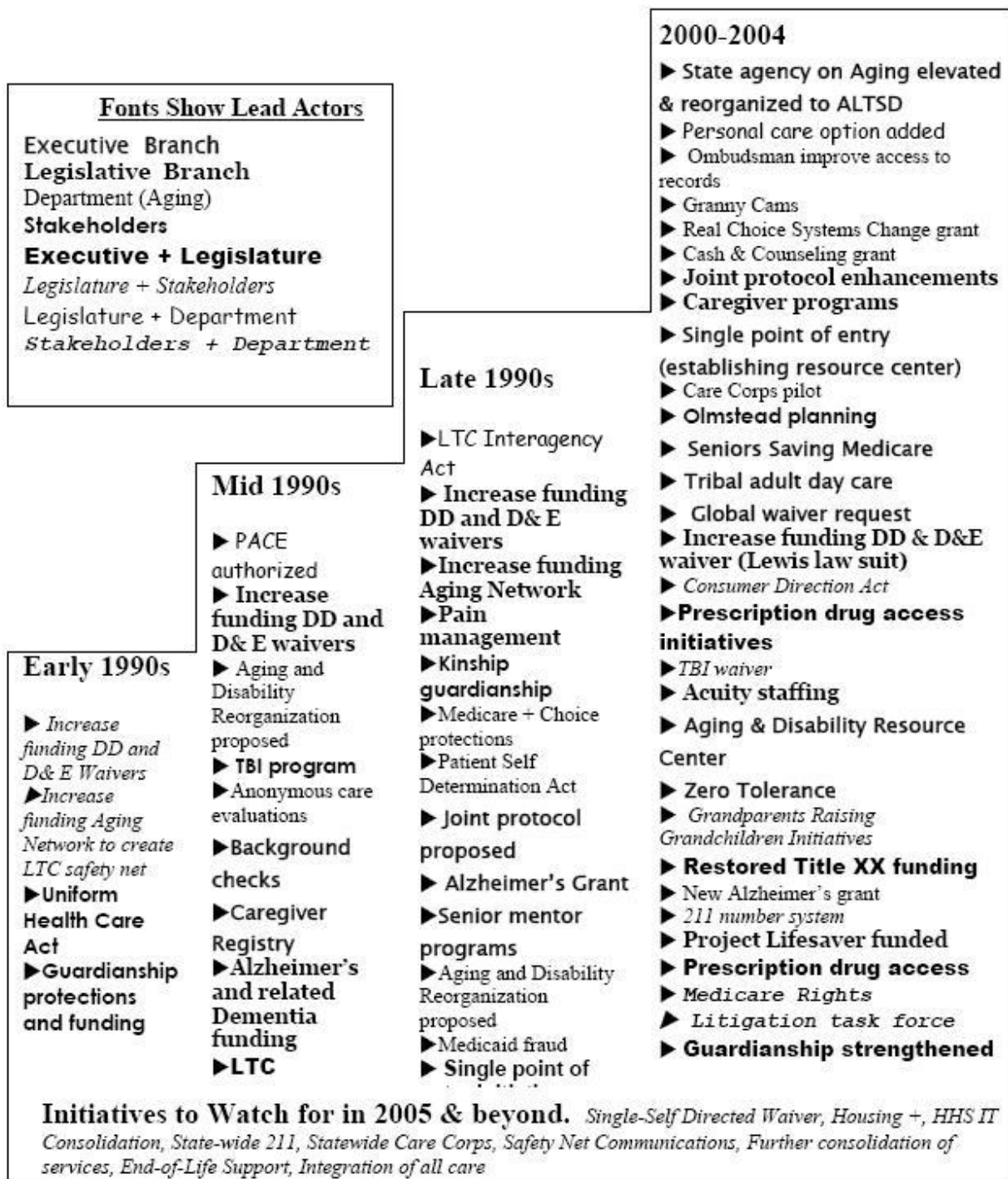


Figure 3. How the Long-Term Care System in New Mexico Evolved, 1990-2004.

Adapted from a figure developed by ALTSD in 2004.

Programs and Services

New Mexico covers personal care services under the Medicaid state plan and operates 4 HCBS waivers (see Table 5 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 Consumer Directed Waiver, Mia Via, 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.

Medicaid Waivers

Disabled and elderly waiver. New Mexico received approval of the Disabled and Elderly Medicaid waiver in 1985. Medical eligibility is based on general criteria for the nursing facility level of care criteria and one or more clinical status factors. To be generally eligible for the nursing home level of care criteria require, the individual must be unable to perform 2 or more activities of daily living (ADLs) without consistent, ongoing, daily provision of some or all of the following levels of service: skilled, intermediate, and/or assistance. The functional limitations are secondary to a condition for which general treatment plan oversight of a physician is medically necessary. The clinical factors are medications, respiratory therapy and supplemental oxygen, ventilator care, ostomy care, management of decubitus ulcers, dressings, specialized rehabilitative or restorative care by qualified therapists, and "other" services such as organic brain damage, dementia, and spinal cord injury.

ALTSD contracts with 42 case management agencies. Case management agencies must have a current business license issued by state, county or city government and must comply with all applicable federal, state, and waiver regulations, policies and procedures regarding case management services; designate a case manager supervisor for clinical oversight and supervision

of case management services; and have an internal quality assurance system to review clinical records and billing statements on a periodic basis to ensure that services are tracked and billed appropriately.

A case manager from the selected agency makes a home visit, makes sure an appointment is arranged with the physician. The completed assessment form is sent to Blue Cross/Blue Shield for a level of care determination and approval of the care plan. Once the level of care and the service plan are approved, the beneficiary receives a second Freedom of Choice form to select a provider agency. Case management agencies may also provide covered waiver services.

Table 5. Medicaid HCBS Waivers in New Mexico

Waiver	Administered by:	Year begun	Enrollees in 2004	Waiting List	Eligibility & services
Developmental Disabilities (DD)	Department of Health	1983	3,335	3400	Consumers with dual clinical diagnosis of developmental disability (acquired before age 22) combined with either mental retardation or a related condition resulting in a significant loss of function in three or more life areas. Consumers meeting state definition of DD. Wide range of services.
Disabled & Elderly Waiver (D&E)	ALTSD	1985	2,438	6765	Services include mobility assistance, personal emergency response system, nutritional counseling, home health care, chore/home maintenance services, home improvement, respite care, social day care, home delivered meals and medical/social services.
HIV/AIDS Waiver	Department of Health	2000	25	None	Persons with HIV/AIDS living at home. Services are homemaker, private duty nursing, and case management.
Medically Fragile Waiver	Department of Health		168	None	Consumers with both DD and a medically fragile condition & live in own homes; Services may include: case management, home health services (nursing; aides; and OT, PT, Speech therapy), nutritional counseling, private duty nursing, psychosocial counseling and respite care.
Mia Via	ALTSD	Pending	n.a.	n.a.	n.a.

The program served an average of 1,850 participants a month in FY 2005 and maintains a registry of those interested in waiver a service that averages 6,765 names. The average wait for a waiver slot is 22-48 months. More detail is provided on accessing the waiver in Section II.

Developmental Disabilities waiver. The Department of Health manages a developmental disabilities waiver that serves 3,600 participants and has a waiting list of 3,400 individuals. New applicants are screened to be sure that they meet the state's definition of developmental disability. The Department's goal is to determine a person's eligibility within 90 days of allocating a waiver slot. Applicants that meet the definition receive a request for service packet that includes a letter of interest, a Freedom of Choice form for selecting a case manager, and a waiver refusal form. Once received, the Department issues a waiver slot within three working days and sends copies of the approval to the Income Support Division, the case management agency, the regional office and the medical utilization review staff. The case manager helps the applicant complete the official level of care form which is sent to a physician. The case manager completes the adaptive behavior scale and the health assessment tool which is submitted to the utilization review agency. Once approved, the approval is sent to the regional office and Income Support Division worker. Financial and medical eligibility is determined within 45 days.

Once eligible, the case manager convenes an interdisciplinary team within 45 days to develop an Individualized Service Plan. The team includes the individual and service providers. Waiting lists are maintained by region and date of application. In the Developmental Disability system, case management agencies may not also be service providers.

Medically Fragile waiver. This program serves adults and children who are medically fragile – a chronic physical condition that results in a prolonged dependency on medical care that requires daily nursing intervention; and have a developmental disability, developmentally delayed or are at risk of development delays. Services include case management by a registered nurse, private duty nursing, home health aid, physical therapy, speech therapy, occupational therapy, psycho-social counseling, nutritional counseling and institutional respite services.

HIV/AIDS waiver. This waiver serves individual who have been diagnosed with AIDS or an AIDS related condition. Services include case management, homemaker/personal care services and private duty nursing.

“Mia Via.” Mi Via is a self-directed program being developed by the Department of Human Services, the Department of Aging and long Term Care Services, and the Department of Health under a cash and counseling grant from the Robert Wood Johnson Foundation. The program will establish a service budget and facilitate choice and control over the types of services and supports that will be purchased. Existing waiver participants will be eligible to transition to what will be a new self-directed waiver. “Consultants” will be available to present the program, help participants develop a service plan and purchase services. 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 and physical disabilities and elders.

Table 6 compares service provision under the 4 waivers and the Traumatic Brain Injury Program (the latter described below).

Table 6. Services in 4 Waiver Programs & Traumatic Brain Injury Programs

Service	Program				
	Disabled and Elderly waiver	Development Disabilities Waiver	AIDs waiver	Medically Fragile Waiver	Traumatic Brain Injury
Adult day health	•				
Assisted living	•	•			
Assisted living intensive	•	•			
Behavior therapy		•			
Bowel/bladder service	•	•			
CA coach		•			
CA peer mentorship		•			
CA Information/training		•			
CA Stipend		•			
CA Family counseling		•			
Case management	•	•	•	•	•
Case management assessment	•	•	•	•	
Community membership		•			
Crisis intervention					•
Day habilitation		•			
Habilitation day care		•			
Emergency response	•				
Home health aide				•	
Home modification	•	•			
Home based living		•			
Homemaker/companion	•		•		
Life skills training					•
Non medical transportation		•			
Nursing (LPN)	•	•	•	•	
Nursing (RN)	•	•	•	•	
Nutrition counseling		•		•	
Occupational therapy	•	•		•	
OT certified assistance		•			
Personal care services	•	•			
Psycho-social counseling		•		•	
Physical therapy	•	•		•	
PT assistant		•			
Respite	•	•		•	
Speech/language therapy	•	•		•	
Supervised living		•			
Supported employment		•			
Supported employment – group		•			
Supported employment – intensive		•			
Supportive living		•			

State Plan and State Funded Services

TBI Program. The Traumatic Brain Injury Program is a state funded program that provides short term services – case management, life skills training and crisis interim – people whose

injury results from “an assault to the brain from an outside physical force.” Case management helps participants apply for and arrange services. Life skills training offers coaching assistance to perform routine tasks of daily living and help with socialization skills. Crisis/interim services are limited to \$25,000 in any single year and \$75,000 lifetime and cover environmental and automobile modifications, transportation, respite care, therapies, medications and durable medical equipment. The program is funded by a \$5 fee which is added to each moving traffic violation. The program serves about 560 people a year. The legislature has ear-marked it for expansion into a waiver program, after which the state match will come from current funding sources. New Mexico has a particularly high rate of accidents and traumatic brain injuries.

Community-based gap funds. The state-funded Community Based Gap Funds covers case management services and crisis/interim services, which include, but are not limited to: homemaker/companion, personal services, in-home respite, nursing – RN, Nursing – LPN, speech therapy, occupational therapy, physical therapy, assistive device evaluation and training, prescription drugs, transportation, emergency living expenses and environmental modifications

Section II. System Assessment

In this section, we briefly profile selected system functions, using identical headings to those in each state-specific case study. Section III, which follows, highlights selected New Mexico programs or initiatives that are especially noteworthy and innovative management approaches for rebalancing.

Access to Services

ALTSD implemented an Aging and Disability Resource Center in January 2005 to provide statewide comprehensive information and assistance to elders, adults with disabilities and their families. Center staff offers the public information on long term support services, benefits counseling, prescription drug options counseling, long term support service options, eligibility

screening, assistance gaining access to services and care coordination. Between January and June, the Center served over 6,000 people and established a data base of over 4,500 service providers. The Center will eventually determine eligibility for publicly funded programs. At present, the Resource Center maintains the registries of those waiting assessment for HCBS waivers.

The long list of those awaiting services is a weak point of the system, and one that the State is presently addressing. Two separate problems can be identified; lack of funding for waiver slots; and a somewhat cumbersome process for approval, which involves the Income Support Division for financial assessment (typically taking 90 days), a functional assessment, and a physician signature; the need for the doctor's signature can be particularly delaying.

Presumptive eligibility is available for children but not adults. On the other hand, the problem of insufficient waiver slots is mitigated by the availability of the personal care option program and various state-funded programs that can be used for those awaiting access to the waivers. The personal care option is an entitlement program without any waiting lists, but whose financial eligibility limits is lower than the waivers.

The waiting list for the D & E waiver is divided into 3 groups: emergency applicants, community reintegration applicants, and regular applicants. For example, consumers who have had a fall, a change in their medical condition, or a disruption in their informal caregiving systems would fall into the prioritized emergency group to receive waiver services as slots become vacant. Applicants who have been in a nursing home for more than 30 days and wish to relocate to the community are placed on the community re-integration list, for which some additional funds and services are available.

Individuals who are placed on the registry receive a phone call from staff at the Resource Center every six months to see if they are still interested in the program when a slot becomes

available. New slots are allocated by the date of registration or for emergencies. Between 78 and 98 consumers a month are added to the waiver because of emergency allocations, and regular allocations which had been frozen for 3 years.

The freeze on regular slots ended in FY 2005, A when ALTSD received funding for an additional 600 slots. The Resource Center mailed letters to 1,454 individuals between October 2004 and March 2005, in order of their date of application. The letters include an application for waiver services that is completed by a physician, a Medicaid financial application and a form to select a case management agency. Applicants who do not respond to the letter and request to select a case management agency are contacted by the resource center calls within 30 days. Fifty five percent of the individuals responded to the letter. (See table 3). The average application takes 95 days to process from the time a letter is mailed to the receipt of services. All told, in FY 2005, letters were mailed to 291 beneficiaries on the community re-integration list and 769 beneficiaries on the emergency list. About half returned the materials and 20% received waiver services.

Array of Services

New Mexico has developed full panoply of services for older people, adults with disabilities, and children and adults with MR/DD, including consumer-direct services. In senior services, attention has been given to volunteer and employment opportunities, family caregiver programs, and a variety of wellness programs. In DD, the number of people receiving supported employment services has steadily increased, supportive living services, personal care, and family support services has steadily increased. Table 7 shows the growth in service capacity for the DD sector. Supportive living and supportive employment are the largest items, but a growing amount of money is expended on services to families, though cash payments were not then used in the system.

Table 7. Services & Spending for Individual and Family Support in MR/DD, 1992-2003

	Year 1992	Year 1995	Year 1998	Year 2000	Year 2002
Total \$ expended	\$5,887,541	\$31,138,391	\$71,976,232	\$78,637,681	\$102,648,751
Total individual support \$	\$5,270,366	\$29,527,126	\$64,096,679	\$69,310,014	\$85,370,916
Supported employments \$	\$2,413,636	\$2,654,277	\$6,314,294	\$6,363,632	\$6,817,884
Supported employment # served	436	892	1072	1122	1,020
Supported living \$	\$2,856,730	\$25,872,849	\$57,782,385	\$59,182,164	\$73,276,434
Supported living # served	370	892	1,072	1,128	1,158
Personal assistance \$	n.a.	n.a.	n.a.	\$3,764,218	\$5,276,598
Personal assistance # served	n.a.	n.a.	n.a.	259	298
Total family support \$	\$617,175	\$1,611,265	\$7,879,553	\$9,372,667	\$17,277,835
Cash subsidy/payment \$	0	0	0	0	0
Other family support \$	\$617,175	\$1,611,265	\$7,879,553	\$9,372,667	\$17,277,835
# families served	610	1,592	1,351	1,737	2,252

Source: Adapted from Coleman Institute, *State of the States*, 2003.

Service capacity is also expanding to meet the needs of children and adolescents with physical and psychological disabilities, though professional expertise is somewhat sparse and concentrated in the urban corridor. Some mental health and developmental services are available for children in every county, but we were told that the state has only a handful of child psychiatrists and psychologists, and they are all in the urban area. Transportation services are a continual challenge in this large and sparsely populated state.

Taking all together, New Mexico has developed a wide array of services, and particularly has stimulated a good supply of personal care attendants.

Quality Approaches

According to New Mexico authorities, at present each organizational entity (i.e., departments and their various divisions) conduct their own quality assurance activities with little interchange among the programs, even when multiple jurisdictions have shared programmatic responsibilities for various groups. Through its Division of Health Improvement, the Department of Health conducts the usual licensing, surveying, complaint investigation, and other quality management activities. Indeed, New Mexico has initiated some particularly vigorous investigatory activities, including the use of older people posing as prospective applicants to identify access issues. (In

general, all Departments within New Mexico are concerned with preventing fraud or inappropriate utilization, at the same time as they pursue positive quality.) The Aging and Disability Resource Center managed by ALTSD collects and collates information about the needs expressed by callers and part of its scope is to develop a quality evaluation system that includes process and outcome information, the latter including direct consumer satisfaction data. The Human Services Department also has a Quality Assurance Bureau directed at its own performance. New Mexico leadership is concerned that the various quality efforts lack integration. In the next 5 years, New Mexico intends to develop a cross-cutting, data-driven quality assurance and quality improvement capacity and to link long-term care quality initiatives across all 3 Executive Departments concerned with long-term services.¹¹

Data Capacity

New Mexico currently does not have a relational database system and, therefore, lacks the capacity to link clients' assessment and service utilization information. Although the oversight and management of NM's HCBS waivers has historically been divided across different state departments, all Medicaid claims are routed through the Human Services Department, in which the Medicaid Director resides. Medicaid claims information is therefore centralized. But currently it is impossible to link data across units of ALTSD or among ALTSD, HSD, and DOH. Indeed, state agencies have considerable difficulty identifying the characteristics, including acuity levels, of those using various HCBS services.

The Resource Center, which generates the most consumer information on long-term care uses 3 different datasets, which are incompatible and technically impossible to merge: ESP, a database with client and provider data, which is licensed from the Atlanta Regional Commission

¹¹ This self-analysis is drawn from the "Systems Readiness Assessment" in New Mexico's successful application for a 5-year Systems Transformation Grant, submitted to CMS in July 2005.

and guides I & R activities; CR2, locally created software to manage the D & E waivers; and BridgeRX, a copyrighted web-based program to facilitate enrollment in pharmacy assistance programs. Other units in ALTSD use the SAMS database from Synergy Software Technologies to collect Aging Network provider utilization data and report budget-related performance indicators. Furthermore, the Human Service Division uses 2 different major software systems to collect and report data on Medicaid clients and manage their claims. ALTSD believes that its Resource Center would need access to at least 7 major incompatible data bases to assemble information about a single New Mexican who is using services, and perhaps some other smaller “homemade” data sets as well.¹²

Acknowledging this problem, New Mexico is planning a solution. In the 2005 legislative session, House Bill 2 (Section 27) required the creation of social services information technology architecture. Core participants in the project will go beyond the departments already mentioned (ALTSD, DHS, and HSD) to include the Departments of Labor, Veteran Affairs; and Education/Vocational Rehabilitation, and the Developmental Disabilities, the Commission for the Deaf/Hard, and the Commission for the blind.

Consumer Direction

Consumer direction is embedded in New Mexico’s Medicaid personal care option, which is profiled in Section III. The enactment specific legislation in 2003 called “the Consumer Direction Act” 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

¹² This section is also adapted from the text of New Mexico’s successful application for a 5-year Systems Transformation Grant, submitted to CMS in July 2005.

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 consumer-directed waiver, Mia Via, which will allow those in the existing waivers to opt for consumer direction. Hearings have been conducted all over the state, large numbers of stakeholder groups have expressed their opinions, and advocacy has led to inclusion of more consumer groups. The Self-Directed Waiver Advisory Group, which is meeting intensively, is surfacing basic and important issues, including how “quality” should be defined in the context of consumer direction, whether consumers should be required to accept a “counseling” function, how much money will be withheld from consumer control of any mandated fiscal intermediary or counseling functions, how many consumers will be permitted to transfer to the self-directed waiver, what criteria would be used to determine that consumers may be self-directing, and what kinds of non-medically necessary services and goods may be purchased with the cash allowance. As this program evolves, the major questions seem to concern how far it will go in authorizing cash payments 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 of concern is 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.

Institutional Downsizing

We have not identified any particular state policies (such as, for example, financial incentives) to encourage the nursing home industry - already relatively small - to downsize. Some attrition has occurred naturally. During the site visit, stakeholders representing nursing

homes complain that their reimbursements have not grown sufficiently to keep up with inflation. They claim that in New Mexico, average Medicaid reimbursements fall well below the cost of giving care. Moreover, at a time when CNAs and housekeepers in nursing homes were earning under \$7.00 an hour, personal care workers were mandated to receive \$9.00 an hour under the new personal care option, creating a difficult situation in competing for labor.

The state has been supportive of industry efforts to advance culture change in New Mexico nursing homes, and to evolve models that are friendlier to the preferences of consumers. Pinon Management Company, based in Colorado, has been contracted to provide training related to changing nursing home cultures.

Mental Health Linkages

Policy leaders in New Mexico are highly conscious of fragmentation and inadequacies in providing services to consumers with mental health challenges. Governor Richardson is determined to model the spirit of Inter-Agency collaboration around mental health and behavioral health services. Behavioral health, though managed in a sub-cabinet agency, was elevated to cabinet level status. With the help of a SAMSA grant, a plan was developed to transform the delivery of mental health and substance abuse services in the state. After enabling legislation and almost two years of Inter-Agency planning, a contract was let to use funds from multiple agencies for a single HMO, Value Options, to provide behavioral health services on a capitated basis. See Section III for more detail.

Acute Care Linkages and Managed Care

Since 1997, the bulk of New Mexico's Medicaid program for acute care has been operated through a managed care program, called Salut (Spanish for "health"); which consumers may elect one of 3 managed care plans (i.e., Lovelace, Molina or Presbyterian).

The State sponsors a PACE program in the Albuquerque area which 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 also capable of living in the community and have monthly income below \$1,737.

Participants must live within 30 minutes of Total Community Care, the PACE provider site.

In 2005, the Human Services Department issued an RFP to select two managed care plans to help redesign the long term care system and redirect funding from institutional to community services. The RFP notes that 35% of the Medicaid beneficiaries, accounting for 56% of the budget, are not currently enrolled in managed care plans. The evolving program is expected to control costs, and improve access, quality of care and consumer satisfaction. The program would serve beneficiaries who are dually eligible for Medicaid and Medicare. The benefit package includes Medicaid acute care cost sharing, and Medicaid long term care services – nursing home, personal care, home and HCBS. The program would be implemented through a combined 1915 (b) and (c) waiver. Ultimately, New Mexico hopes to incorporate under managed care much of long-term care (particularly for older people) including waiver services. Many details must be worked out, including establishing rates, developing standards and a monitoring capacity, and incorporating consumer-direction into the models.

Housing Linkages

No central authority for housing planning exists in New Mexico. Affordable housing initiatives, in so far as they exist are undertaken by Local Housing Authorities. The Resource Center indicates that approximately 20% of its calls include issues related to housing. In the 2005 Legislative Session, the Governor created a Housing Trust Fund with an Advisory board, which was located in the Mortgage Finance Authority. The Secretary of ALTSD is giving attention to how her department might work with the Mortgage Finance Authority to pilot new

models for housing for those needing long-term support. At present, it is difficult to determine the specific nature and extent of New Mexico’s housing problems.

Section III. Featured Management Approaches

Personal Care Option

In 1999, personal care was added as a Medicaid state plan service. The personal care program serves consumers who are 21 years of age or older and meet the nursing home level of care. Consumers have the option to “delegate” service delivery to an agency or to self-direct their care. 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 4 graphs the rapid growth in participants in the Medicaid personal care program from 2001 to the projected 2006 figures. Currently, we cannot break this data down by consumer-delegated versus consumer-directed models, whether the personal care provider is a family member, and needed characteristics of the consumer.

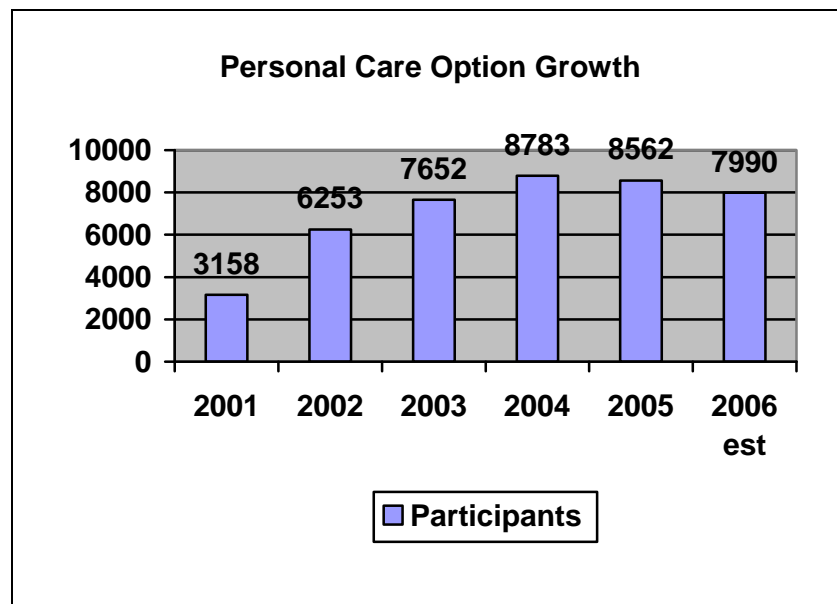


Figure 4. Growth of Personal Care Program 2001-2006.

Caregivers in both options must be 18 years of age or older and pass a nationwide criminal history check. The personal care workers employed by agencies must receive 12 hours of training, pass a competency test within 3 months of hire, and demonstrate CPR capability. The services or tasks that are covered 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. New Mexico has 135 agencies that may be selected for consumer-delegated personal care, 35 of which are in Albuquerque.

When the Personal Care Option began in 1999, the minimum wage mandated for the worker was \$9.00 an hour; this minimum wage remained in effect until 2005, when it was reduced to \$8.00. 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. During the site visit, we heard anecdotes about agencies taking out advertisements for clientele, and about agencies urging family caregivers to sign up as their employees and begin being paid for the care of a relative. We also heard success stories of agencies that piloted self-directed care. Especially notable was the track record of the Center for Independent Living in San Juan county, which was spectacularly successful in establishing consumer-directed care arrangements for people of all ages, and helping older people move out of nursing homes with that care.

In 2003, the Human Services Department formed a committee to review the program's growth and make recommendations to reduce costs. The committee consisted of state agency staff, consumers and providers. The committee's 2003 report provided the basis for changes that were adopted to improve the program. The major recommendations included:

- 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.

Assessments and eligibility was initially determined by the provider agencies without benefit of a standardized assessment tool. This problem was remedied in April 2004 when an assessment tool was developed and a requirement introduced that completed assessments be sent to Blue Cross/Blue Shield for review of the level of care determination and the service plan.

The application and eligibility determination process was further revised in September 2004. Consumers could then apply for personal care services by calling an automated toll free number and entering their social security number to receive an application package if they are over 20 years and nine months of age, are a Medicaid beneficiary and do not live in a nursing home or receive D&E waiver services.

ALTSD further developed a Third-Party Assessment process, which was meant to establish equitable entry to the benefit and data on the clientele. Initially, the 3 Salud vendors provided that assessment, but in 2005, after a bidding process, Lovelace Health Systems became the sole

contractor to manage the assessment and reassessment process. Lovelace, in turn, contracts with Gentiva, a statewide network of home health agencies, to complete the in-person assessments. Once the package is sent to the applicant's home, staff from Lovelace contact the individual, explain the program and advise the applicant to bring the form to their primary care physician. The physician completes the physical exam information and sends it to the Lovelace case manager for determination of the level of care. If the person meets the nursing home level of care, the case manager from the Gentiva home health agency schedules an in-home visit to complete an assessment, allocate services and develop a daily and weekly service plan. The plan of care is returned to Lovelace for review. When approved, the plan of care is sent to the provider agency if the consumer selects the delegated option and to the consumer if they chose the self-directed option. About 4% select the self-directed option. Workers in the self-directed option were paid an hourly rate of \$10.50 compared to \$18 for agency workers. Agencies now receive \$13.50 for the first 100 hours and \$11.50 an hour for hours above 100.

Lovelace receives \$450 per consumer and pays Gentiva \$150 for each assessment. Gentiva agencies involved in the assessments are not permitted to provide personal care services. Fiscal intermediaries receive \$200 a month to manage payroll functions.

In 2005 the rates for agencies offering consumer-delegated services was further 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). 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. To summarize, the Personal Care Option became an important plank for rebalancing long-term care in New Mexico. 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. The program continues to grow.

State Reorganization and Interagency Long Term Care Committee

History of Re-Organization

Legislation elevating the state unit on aging to a cabinet agency was passed by 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 agency. In 2004, the legislature codified the new agency. The agency 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)

Responsibility for management of the Disabled and Elderly Waiver and the Personal Care Option was transferred to ALTSD from the Department of Health and the Human Services Department respectively. ALTSD also manages a PACE program, Information and Assistance, the waiting list for D&E waiver services and the state funded Traumatic Brain Injury program. In July 2005, responsibility for Adult Protective Services was transferred to ALTSD. The transfers increased the number of staff from 40 to 232 and the direct budget from \$35 million to \$300 million.

The legislature directed ALTSD to develop a five year plan for the organization and delivery of long term care services which will be submitted to the legislature in November 2005. The report will include sections on access, capacity, financing, quality and workforce challenges

facing the state; promising practices and techniques being used in other states to rebalance systems; policy options and recommendations.

In 2004, the Department of Health developed a strategic plan for services for people with developmental disabilities. The goals of the plan were to increase the number of persons served, to provide timely eligibility determination and to provide timely access to services. In FY 2005, the legislature approved \$4 million in additional funds to provide access to waiver services for 240 people. The Department contracted for an actuarial study to more accurately predict service costs for new waiver participants to improve budget forecasting.

Inter-Agency Committee on 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. The Committee was charged with designing and implementing a coordinated service delivery system. Members of the Committee included the State Agency on Aging, the Human Services Department, the Department of Health, Children, Youth and Families Department, Labor Department, Governor's Committee on Disability, the Developmental Disabilities Planning Council, and the Department of Insurance. In 2002, membership was expanded to include low income consumers with a disability, various disability organizations, the State Mortgage Finance Agency, the Department of Transportation and the Department of Finance and Administration. Also, as part of the re-organization, the Secretary of ALTSD was assigned as Chair of this Committee.

Behavioral Health Collaborative

In 2003, Governor Richardson issued an executive order which created an 18-member Behavioral Health Collaborative to create a single behavioral health service delivery system throughout the state. Participating agencies and organizations include: Aging and Long-Term

Services Department; Administrative Office of the Courts; Children, Youth and Families Department; Corrections Department; Department of Finance and Administration; Department of Health; Department of Labor; Department of Transportation; Developmental Disabilities Planning Council; Division of Vocational Rehabilitation; Governor's Commission on Disability; Governor's Health Policy Coordinator; Health Policy Commission; Human Services Department; Indian Affairs Department; Mortgage Finance Authority; Public Education Department; and the State Public Defender's Office. 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 behavioral health providers or groups of providers; regional compliance; training; establishing local systems of care; providing financial management and oversight; client outcomes; assuring consumer, family and citizen input; determining client eligibility; enrollment of recipients; service development, coding and configuration; legal issues; single client identifier for data; rate setting; utilization management (UM); trending UM data; utilization criteria; predictive modeling and disease management guidelines; prior authorization for “high end” services; 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.

Section IV. Quantitative Markers of Re-Balancing

Change in Nursing Home Users Over Time

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 HCBS was intended to defray.

Methods

To create the new admission sample we used all MDS admission assessment records in 2002, 2003 and 2004 to calculate the NH Case Mix at admission. The numbers of new admissions in 2002, 2003 and 2004 were 7,710, 8,300, and 7,849, respectively. This included multiple admissions of the same individual in the same or different NH.

For the 3 months after admission sample, we used MDS quarterly records in 2002, 2003 and 2004 to calculate NH Case Mix at 3 months after admission. First, we selected all MDS quarterly records into a separate data file. Then we merged this data file with the admission records data files using both a unique resident ID and a unique facilitate ID. Then, we calculated the day-difference between the admission date and the assessment date of the quarterly data file. The first quarter assessments were identified if the day-difference was between 75 days and 105 days. Finally, we used these first quarter assessment records in our case mix analysis

We calculated the ADL score following the method developed by Morris and colleagues for the MDS ADL Long-Form.¹³ Specifically, we used variables G1AA (bed mobility), G1BA (transfer); G1EA (locomotion on unit), G1GA (dressing), G1HA (eating); G1IA (toilet use), and G1JA (personal hygiene). The original coding for these variables were between 0 and 4 (0 for independent, 1 for supervision, 2 for limited assistance, 3 for extensive assistance, and 4 for total dependence) and a number 8 was used when the activity did not occur during the entire 7 days of assessment. We recoded the number 8 (activity did not occur during the entire 7 days) as 4 (total dependence). We finally created a summation score of total ADL dependence by adding the

¹³Morris, J. N., B. E. Fries, et al. (1999). "Scaling ADLs within the MDS." Journals of Gerontology. Series A, Biological Sciences & Medical Sciences. **54A**(11): M546-M553.

value of these 7 variables. Therefore, the possible score of our ADL variable is between 0 and 28. A higher score means higher ADL dependence.

We used the Cognitive Performance Scale (CPS) developed by Morris and colleagues to measure the cognitive functioning of elders in NH.¹⁴ The CPS was calculated using variables from section B (B1: Comatose; B2A: Short term memory), section C (C4: making self understood), and section G (GHA: eating) of the MDS. The possible score of CPS is between 0 and 6. A higher CPS score means lower cognitive functioning.

Results

Table 8 shows the changes in the NH case mix on admission. Between 2002 and 2004, the functioning level of elders admitted to NHs in New Mexico 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. 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. Moreover, the rate of persons with no cognitive impairment or mild impairment increased.

Table 9 shows the NH case mix 3 months after admission for 2002, 2003 and 2004. Here again 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

¹⁴ Morris, J. N., B. E. Fries, et al. (1994). "MDS cognitive performance scale." Journal of Gerontology: Medical Sciences 49(4): M174-M182.

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 suggests HCBS may have achieved that part of its goals of deflecting the clients with lower ADL needs to other sources, and the same effect was not seen for cognition.

Table 8: Change in NH Case Mix in New Mexico Based on Status at Admission

	2002	2003	2004
ADL score	%	%	%
0	6.8	6.3	5.2
1	1.8	1.8	1.6
2	3.0	2.3	2.6
3	2.1	2.2	1.8
4	3.0	3.2	2.8
5	2.7	2.6	2.4
6	3.7	3.5	3.0
7	2.7	3.3	2.9
8	3.6	3.9	3.7
9	3.5	3.4	3.5
10	4.8	4.8	4.8
11	4.2	4.2	4.3
12	6.2	6.3	5.5
13	4.5	4.8	4.9
14	4.4	4.3	4.4
15	4.5	4.0	4.5
16	3.9	4.0	4.4
17	4.1	3.7	4.8
18	4.5	5.1	5.6
19	4.1	4.2	4.4
20	3.4	3.2	3.5
21	2.8	2.9	2.9
22	2.4	2.5	2.6
23	2.2	2.1	2.2
24	2.2	2.6	2.6
25	1.6	1.6	1.5
26	1.6	1.4	1.6
27	1.4	1.4	1.6
28	4.3	4.4	4.3
Mean ADL	13.11	13.26	13.71
N*	7,709	8,300	7,848
CPS score			
0	37.7	37.5	40.8
1	15.2	13.3	13.5
2	14.7	14.9	15.0
3	19.1	22.3	20.7
4	3.8	3.6	4.5
5	5.7	5.3	3.2
6	3.9	3.1	2.2
Mean CPS	1.69	1.69	1.53
N*	7,705	8,295	7,843

Table 9: Change in NH Case Mix in New Mexico for Residents 3-Months Post-Admission

	2002	2003	2004
ADL score	%		
0	10.3	8.5	8.4
1	3.6	2.9	3.4
2	4.2	5.6	4.4
3	2.4	3.1	3.4
4	4.5	4.1	4.0
5	2.5	3.3	3.5
6	3.3	4.5	3.8
7	3.0	3.2	3.8
8	3.3	3.4	3.1
9	4.7	3.4	3.8
10	4.9	4.4	4.8
11	3.4	3.0	3.4
12	4.5	4.8	4.2
13	3.9	3.4	4.4
14	3.8	4.4	3.8
15	3.0	3.4	3.0
16	4.3	3.5	3.7
17	3.1	3.0	3.9
18	3.3	4.1	3.4
19	2.5	3.5	3.5
20	2.3	3.5	2.6
21	2.4	2.7	2.4
22	2.7	1.9	3.0
23	2.1	1.9	1.7
24	2.2	2.2	2.1
25	1.8	1.2	1.1
26	2.2	1.5	1.9
27	1.8	1.9	1.3
28	4.2	3.9	4.5
Mean ADL	11.06	11.95	11.99
N	1,348	1,875	1,838
CPS score			
0	18.0	16.8	18.2
1	16.0	13.4	12.3
2	16.1	19.0	20.1
3	30.2	32.5	33.9
4	4.5	5.7	6.5
5	11.4	9.5	5.8
6	3.9	3.2	3.2
Mean CPS	2.36	2.38	2.28
N	1,348	1,875	1,838

Community Care Utilization and Costs

For all 8 states in the rebalancing project, we have attempted to show the number of consumers and the expenditures for all Medicaid waiver and state plan long-term care services since the Year 2000 (Table 10). We also sought to describe those participants by program on relevant parameters (Table 11). People over 65 used almost 2/3 of the personal care option services. Expectedly, people over 65 also used most of the nursing home care, but that percent dropped from 89.5% in 2000 to 84% in 2004. The high proportion of ethnic minority participants and those living in frontier areas is notable. Unfortunately, characteristics such as ADL status and other indicators of intensity of service were unavailable for comparison by program.

Table 10. Utilization and Costs of Long-Term Care Programs in New Mexico, 2000-2004

Number of consumers during year ^b	Medicaid State Plan			Medicaid Waivers				Other PACE
	NFs	ICF-MRs	Personal Care Option	Elderly & Disabled	DD	Medically Frail	HIV/AIDS	
Yr. 2000	6,607	305	883	1,350	2,102	173	51	182
Yr. 2001	6,589	290	3170	2,941	2,398	188	47	226
Yr. 2002	6,526	286	6,357	1,886	2,787	169	42	249
Yr. 2003	6,517	281	8,960	2,264	3,071	151	37	248
Yr. 2004	6,429	281	9,676	2,438	3,335	168	25	266
Expenditure during year^c								
Yr. 2000	\$158,046,901	\$17,710,471	\$5,055,523	\$18,990,443	\$108,417,119	\$3,380,956	\$545,120	\$3,015,291
Yr. 2001	\$160,391,165	\$18,640,815	\$52,373,383	\$21,392,474	\$129,099,397	\$3,589,503	\$576,873	\$5,369,547
Yr. 2002	\$165,204,795	\$19,422,965	\$126,436,727	\$26,340,222	\$156,743,042	\$3,848,592	\$484,560	\$5,634,544
Yr. 2003	\$164,377,346	\$20,070,350	\$159,391,546	\$37,851,753	\$183,004,043	\$3,911,106	\$352,168	\$6,015,250
Yr. 2004	\$168,799,774	\$20,696,116	\$182,089,349	\$48,372,280	\$207,434,824	\$4,569,495	\$329,627	\$5,712,500

^a Persons served represent the total number of unduplicated clients during year . ^b Year is based on the state's fiscal year. ^c Expenditures under Medicaid State Plan services and HCBS waivers include both State and Federal dollars . At this point data, we could not develop comparable data for: Medicaid home health, Medicaid hospice, Medicaid targeted case management, Older Americans Act Programs, the Infant/Toddler Early Intervention program, the Traumatic Brain Injury Program, and the GAPS program. New Mexico has 0 State MR/DD institutions.

Figure 5 graphs the changes in the numbers of participants, showing visually the tremendous growth in the Personal Care Option 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 they fell back to baseline and then grew more slowly, while MR/DD waivers have grown steadily.

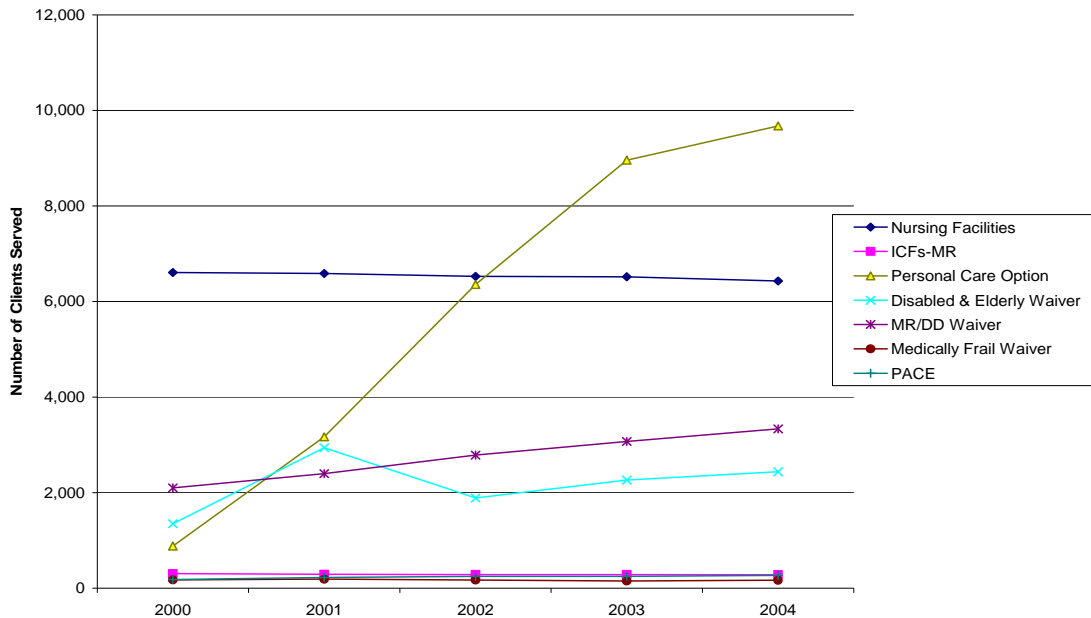


Figure 5. Clients Served in Selected New Mexico Programs, 2000 to 2004

Note that this figure represents people served at any time during the year; some may not have been covered for the full year.

Figure 6 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.

Table 11. Characteristics of Users of Selected Medicaid Participants in 2000 and 2004

Demographic	Nursing Facilities		ICFs-MR		Personal Care		DE Waiver		MR/DD Waiver		Medically Frail Waiver		HIV/AIDS Waiver	
	2000	2004	2000	2004	2000	2004	2000	2004	2000	2004	2000	2004	2000	2004
Age														
<16 years	<0.1	<0.1	2.3	2.8	0.0	0.0	0.7	0.7	9.0	9.8	76.6	75.4	0.0	0.0
16-64 years	10.5	14.0	89.1	88.3	36.1	41.9	29.7	26.1	88.6	87.7	23.3	24.6	98.0	100.0
65+ years	89.5	86.0	8.6	8.9	63.9	58.1	69.6	73.2	2.5	2.5	0.0	0.0	2.0	0.0
Race/Ethnicity														
White	61.1	59.0	62.6	63.3	45.5	34.6	39.5	43.8	49.0	45.3	52.1	47.9	50.0	56.0
Hispanic	26.2	26.9	28.9	26.7	27.6	25.7	48.9	46.2	39.2	41.5	26.9	32.3	40.0	40.0
African American	1.5	1.5	0.3	0.3	2.6	2.2	1.1	1.6	1.4	1.5	0.0	0.0	6.0	4.0
American Indian/Alaskan	9.4	10.8	4.0	4.6	9.4	22.7	7.5	7.9	9.7	11.0	18.0	16.2	4.0	0.0
Asian/Pacific Islander	0.1	<0.1	0.0	0.0	<0.1	0.7	<0.1	<0.1	0.1	0.2	0.0	1.2	0.0	0.0
Other	1.8	1.8	4.3	5.0	14.8	14.2	2.9	0.5	0.6	0.4	3.0	2.4	0.0	0.0
Gender														
Female	66.4	65.6	43.7	48.4	74.1	70.3	71.0	70.0	40.4	42.3	52.7	51.5	10.0	16.0
Male	33.6	34.4	56.3	51.6	25.9	29.7	29.0	30.0	59.6	57.7	47.3	48.5	90.0	84.0
Urbanicity														
Frontier	19.8	19.2	24.2	23.8	26.9	21.3	32.8	23.2	11.7	10.7	10.8	7.8	8.0	4.0
Rural	44.4	43.6	21.2	23.5	46.8	50.4	40.8	40.1	36.0	34.1	45.6	42.5	34.0	36.0
Urban	35.8	37.2	54.6	52.7	26.3	28.3	26.4	36.7	52.4	55.2	43.7	49.7	58.0	60.0

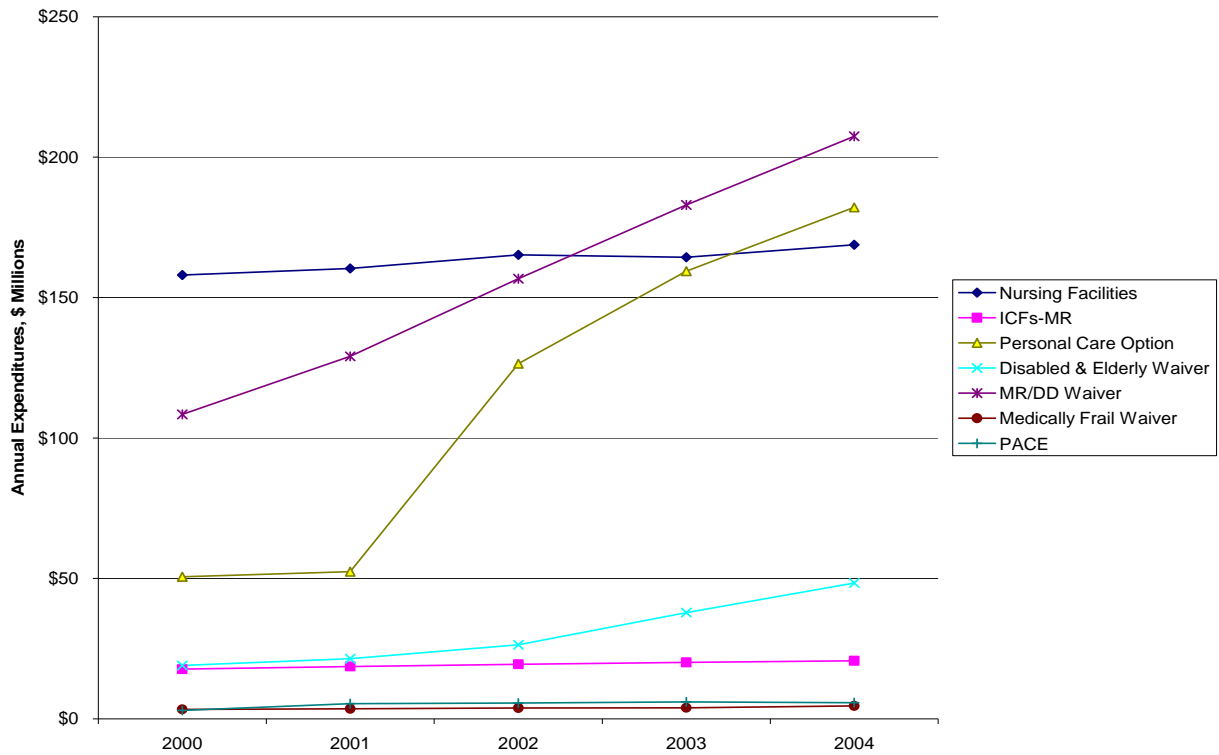


Figure 6. Expenditures for Selected New Mexico Programs, 2000 to 2004

Figure 7 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. Persons served in ICF-MRs remain the most expensive 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.

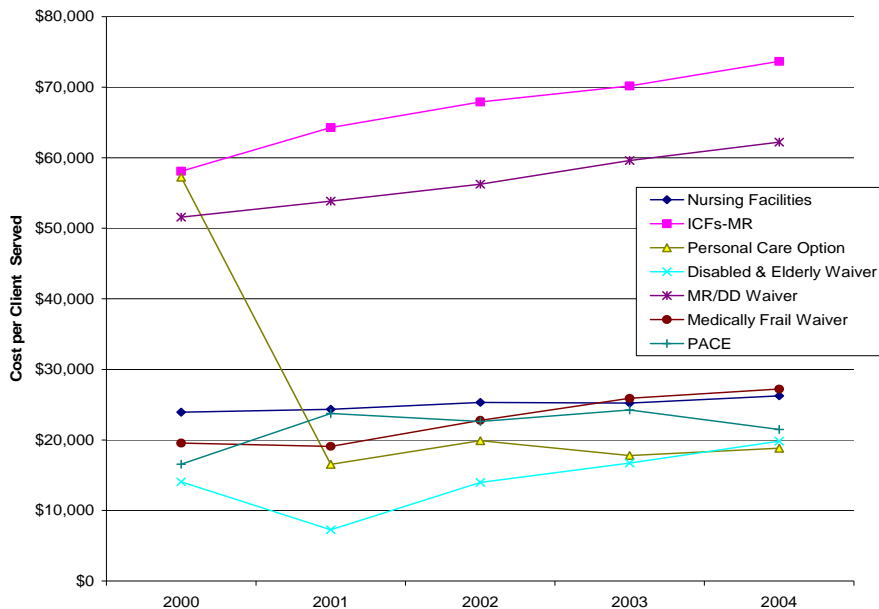


Figure 7. Per Capita Expenditures for Selected New Mexico Programs, 2000-2004

Conclusion

General Conclusions

New Mexico adopted several strategies to support the shift of resources to community services.

- With the mandate from and support of Governor Richardson, the agencies responsible for long term care programs demonstrated a high level of collaboration. Key informants reported that the Governor's support and the willingness of cabinet secretaries to collaborate to develop an effective structure and system effectively set aside turf struggles. The Behavioral Health collaborative is a showcase for that strategy; and other collaborative initiatives are underway, including those related to a Social Services Information Technology architecture.
- Progress is assisted by strategic planning and reports to the legislative committees. For example, a five year strategic plan is being devised by the Aging and Long Term Services Department that will chart the course toward further reorganization and consolidation of functions. Recommendations to implement the plan will be submitted to the legislature in late 2005.

- In 1999, a new Medicaid personal care option for consumers certifiable for nursing homes became a major vehicle to shift dollars to the community. At the outset, the program resulted in an unexpectedly high growth of Medicaid costs. 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.
- A decent wage for personal care workers was built into the program, and with this wage and the inclusion of family members as eligible providers, personal care workers were in adequate supply in this very rural state.
- A strong vision statement can readily be identified and the vision is contained in New Mexico's statutes, including a law mandating consumer direction.
- Participation of consumer stakeholders is strong and growing. Active consumer participation in program planning provides a counter-balance to provider stakeholders. A strong consumer interest has developed in the planning for Mi Via, the waiver for self-directed services.
- New Mexico has planned well its use of federal and foundation grants in its process of rebalancing.

Issues for Future Observation

New Mexico has made remarkable progress in rebalancing. As we continue to observe the evolution of the New Mexico system over two more years, the following is of interests:

- The continued growth and management of the personal care option and its interdigitation 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 Jackson plaintiffs 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, the way that program is implemented and grows, and the reaction of home health and home care providers to that waiver.
- The development of stronger information systems to guide the programs.

- The experience and effectiveness of the Behavioral Health Collaboratives 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.