

**Rebalancing Long-Term Care Systems in New Mexico:
Case Study as of December 2007**

**Submitted to the
Centers for Medicare & Medicaid Services (CMS),
Advocacy and Special Initiatives Division
CMS Project Officer, Kate King**

Rosalie A. Kane, PhD

Robert Mollica, EdD

Reinhard Priester, JD

May 2008

Revision, June 26, 2008

The overall Rebalancing Research is being conducted through a Task Order under a CMS Master Contract between CMS and the CNA Corporation, Arlington, VA, and subcontracts and consultant agreements between CNAC and the various researchers. Rosalie A. Kane is the principal investigator from the University of Minnesota and Elizabeth Williams is the CNAC project director. This final case study for the State of New Mexico covers a period through December 2007. 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 Deborah Armstrong, who, as Secretary of the New Mexico Aging and Long-Term Services Department (ALTSD), was liaison to the study until her resignation in December 2007, and we are grateful to Karen Wells, Director of Policy and Planning at ALTST who assumed the liaison function for the remainder of the project.

Table of Contents

Introduction and Background 1
 General Background 1
 Summary of Early Rebalancing Case Studies 1
State Initiatives..... 2
 Update on Previously Identified Initiatives 2
 Personal Care Option (PCO)..... 2
 Consumer-directed waiver—Mi Via..... 3
 Behavioral Health Collaborative..... 8
 New Initiatives 9
 Coordinated Long-Term Services Initiative 9
 Money Follows the Person..... 12
Goals, Objectives and Accomplishments 13
State Organization..... 14
Access 15
Service Array 17
Quality Initiatives..... 17
Housing 18
Future of Nursing Homes..... 19
Integration of Acute and Long-Term Care 19
Conclusions..... 20

Figures and Tables

Figure 1. Transition from Fragmented to Coordinated System of Long-Term Services..... 10
Figure 2. Medicaid Spending in New Mexico, 2004 to 2006 13
Table 1. Comparison of Mi Via and Disabled and Elderly Waiver 5

Preface

In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study in up to 8 States to explore the various management techniques and programmatic features that States have put in place to rebalance their Medicaid long-term care (LTC) systems and their investments in long-term support services towards community care. The States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in this 3-year Rebalancing Study. For the study, CMS defined rebalancing as reaching “a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services (i.e., Nursing Facilities [NF] and Intermediate Care Facilities for the Mentally Retarded [ICFs-MR]) and those used for community-based supports under its State Plan and waiver options.” CMS further clarified that a balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The products for the study include 3 iterations of State-specific case studies that qualitatively and quantitatively examine each State’s management approaches to rebalance its long-term care systems, six crosscutting topic papers on issues in rebalancing, and a series of 5 Chartbooks presenting quantitative analyses of Medicaid expenditures for consumers in HCBS versus nursing homes, as well as Medicare expenditures for individuals dually eligible for Medicaid and Medicare. A list of these products with web links for completed documents is provided in the Appendix.

For the final case studies—in this instance for the State of New Mexico, we concentrated on the perspective of State officials on accomplishments in rebalancing their long-term support systems for all clientele, and the future directions for the State. We also updated particular strategies that we had highlighted in the 2005 case study and the 2006 Updates. The report is based on comprehensive review of web and print materials, a site visits conducted by Rosalie Kane and Robert Mollica on December 12 to December 14, 2007, supplemented by telephone interviews before and after the site visit as needed.

Rosalie A. Kane, Project Director
kanex002@umn.edu

Executive Summary

New Mexico is ranked second among states in the proportion of long-term support expenditures on home and community based services in relationship to institutional services. The State has continued its initiatives to enhance consumer direction; most notably the Mi Via consumer-directed waiver began enrolling consumers in November 2006 from all waiver programs (Elderly and Disabled, Developmental Disabilities, Children's Mental Health, and AIDS) as well as people with Traumatic Brain Injuries. Introduced through a vigorous social marketing campaign the Mi Via program is jointly sponsored by The Aging and Long-Term Services Department, the Health Department, and the Human Services Department. A Tri-Agency group that also includes the state entity that does the assessment and the contracted counseling agency meet regularly to review quality issues and make policy determinations about coverage and unusual expenditures under the budgets.

This case study highlights the following:

- The Behavioral Health Cooperative, established as a purchasing cooperative by 15 state agencies continues to evolve and is working out quality issues identified in its early period.
- The State's planning towards a Medicaid Managed Care Initiative called Community Long-Term Care (CLTC). For the eligible populations (which exclude Developmental Disability), all Medicaid services except Behavioral Health (which continues to be carved out) will be covered through mandatory enrollment in CLTC; enrollees will have a choice between two managed care organizations. Participants dually eligible for Medicare and Medicaid may opt to have their entire acute care and long-term services managed by CLTC. Stakeholders have been involved in meeting with the CLTC managed care organizations and giving input.
- The still under-development new assessment protocol and rate-setting formulas,
- Enhanced access to information about long-term supports through the Aging and Disability Resource Center (ADRC), which has incorporated access to adult protective services into its purview. The ADRC is forming alliances with organizations across the state including senior centers, centers for independent living, and hospital discharge units, to help disseminate information.

Rebalancing Long-Term Care Systems in New Mexico: State Case Study as of December 2007

Introduction and Background

General Background

New Mexico is a state with a large land mass and remote under-populated areas; it has an ethnically diverse population of almost 2 million people, many of whom have low incomes. At the time that we began the Rebalancing Research, New Mexico had already completed the process of closing its state institutions for people with intellectual disability and related developmental disabilities (ID/DD), with the last state facility closing in 1995. In 1999, the State had added a Personal Care Option (PCO) to its State Medicaid Plan, utilizing this vehicle to create home and community-based services (HCBS) options, including consumer directed HCBS services. Wages offered under this program were designed to create a living wage for persons providing the services and family members were allowed as providers in the PCO program. Largely as a result of this initiative, by 2005 New Mexico had moved to 2nd place in state LTC expenditures on HCBS as opposed to institutional care.

In 2004, New Mexico had created a new cabinet level Aging and Long-Term Services Department (ALTSD) as a focal point for long-term support planning and service delivery. The Cabinet Secretaries of ALTSD, the Health Department (where the Medicaid agency is located), and the Human Services Department (where the Developmental Disabilities waiver was located) worked closely together to improve long-term support programs in New Mexico.

Summary of Early Rebalancing Case Studies

Management strategies in New Mexico that we tracked included: the PCO program; the development of a consumer-directed waiver program called Mi Via; general cooperative strategies among ALTSD, the Department of Health, and the Department of Human Services;

and cross-departmental managed care initiatives for behavioral health and for long-term care. Short and long baseline case studies on rebalancing in New Mexico were released in 2005, and an update of activities in New Mexico between July 2005 and July 2006 was released in April 2007.¹

State Initiatives

Update on Previously Identified Initiatives

Personal Care Option (PCO). The PCO program continues to be a major plank in New Mexico's ability to provide long-term support in the community. The program expenditures grew steadily from \$65, 5678,791 in 2001 to \$178,004,793 in 2004. With concerted efforts to curb over-expenditures on the part of home health agencies and to encourage the consumer-directed model, the expenditures were reduced by 10% for 2005, but 2006 expenditures were up again to slightly above the 2004 levels at \$178, 347, 684. The sense in New Mexico is the program is now stabilized and the growth is attributed to meeting true need. In 2006, New Mexico ranked 3rd among states in personal care expenditures per capita at \$91.53, surpassed only by New York at \$127.50 per capita and Alaska (a state where unit expenditures are always high) at \$124.21 per capita.

When we asked state officials about the elements of the New Mexico PCO program that were particularly successful, several informants cited its development process, the fact that a consumer directed component was included from the beginning, and the fact that family members can be paid as personal care providers under most circumstances. Another unusual element in the PCO

¹ Links to the short case study *Rebalancing Long-Term Care Systems in New Mexico: Experience up to July 31st, 2005* and to the update report, *A Year in State Management Practice for Rebalancing Long-Term Care Systems: Update of Activities in 8 States, July 2005 to July 2006* are on the CMS New Freedom website, last visited on April 8, 2008 at http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage. A long baseline case study on New Mexico is on the website of the Long-Term Care Resource Center at University of Minnesota, at http://www.hpm.umn.edu/lcresourcecenter/on_going_research/Rebalancing_state_ltc_systems_case_studies.htm.

program is that eligibility requires nursing home certifiability so that it is truly a program open to low-income people who qualify categorically for Medicaid and SSI but who also have heavy care needs.

Consumer-directed waiver—Mi Via. Mi Via, a “cash and counseling” self-directed program under development at the time of our baseline study, was implemented in November 2006. This self-directed option is available to participants in four waivers--Disabled and Elderly (D &E), Developmental Disabilities (DD), Medically Fragile (MF) Children and AIDS -- as well as for participants in the non-waiver traumatic brain injury program, which was launched with several planning grants and is partially funded through traffic fines.

Announcing the program, ALTSD Secretary Debbie Armstrong said: “Individuals who choose to participate in Mi Via, a self-directed program, will have more choices, control, and freedom to design their own service plans to meet their functional, medical, and social needs. The State of New Mexico is committed to providing home and community-based services for the elderly and disabled, moving them away from institutional care as appropriate. Mi Via will give many of our disabled and elderly residents control over the type of services they receive in home and community settings.”

With the help of a Robert Wood Johnson Foundation grant, vigorous social marketing was used to launch Mi Via. Letters explaining the program were sent to 7,600 HCBS waiver participants, to individuals who were on the waiting list for the traumatic brain injury program, and to Independent Living Centers. A booklet – Mi Via, Is It Right for You? – was prepared and all program materials were posted on the Mi Via web site, <http://www.mivianm.org/>. Tables were developed that compare waiver services and Mi Via for different populations. See Table 1 for an example. Also on the website and available separately on CDs is a particularly effective

video, MiVia: Choosing Self-Direction. Available in English, Navaho, Spanish and Keres (the Pueblo Native American language) and with captioning for persons with hearing impairment, the video depicts examples of a wide range of consumers in a variety of settings including rural areas and tribal ceremonies who use the program and describes the kinds of services and goods that they purchased. For instance, one participant with an intellectual disability reports using some of his budget to attend Bible college, and a woman with multiple sclerosis who spends about 20 hours a day in bed used some of her budget of an aquatic pool and some for a new mattress. Enthusiastic testimonials are provided to the flexibility and control offered by the consumer direction program. Among the expenditures that are explicitly permitted are transportation for non-medical reasons, automobile repair, home modification, health club expenditures, furnishings, and small appliances.

By December, 2007, 727 participants returned Freedom of Choice forms selecting Mi Via and 227 people were actively using their budget. State officials expect that between 10-15% of individuals who are eligible for Mi Via will participate. Participation has been lower among individuals with developmental disabilities perhaps because individual budgets would be less and participants have to pay taxes on the amount of the budget.

Table 1: Comparison of Mi Via and Disabled and Elderly Waiver

Comparison questions	Mi Via Waiver	Disabled and Elderly Waiver
How can I qualify for the waiver program?	You must receive notice of available funding, and meet the Medicaid financial guidelines and need a medical level of care, as determined by the state.	You must receive notice of available funding, meet the Medicaid financial guidelines, and need a medical level of care, as determined by the State
Who is the leader in the waiver program?	You are the leader, and you decide if you also want your family and any other persons to be involved.	You and your Interdisciplinary team, including your case manager, other professionals, your family and others involved in your care, share the lead.
What services are included?	<p>You decide what services you need. This means you can choose to buy any services, supports or goods or those services, supports or goods will:</p> <ul style="list-style-type: none"> • Help you meet your functional, medical and/or social needs and live your life successfully; • Help you to reach the goals you have set for yourself; • Not be prohibited by Federal and State laws and regulations, including the State’s Procurement Code; and Do one or more of the following: <p>The service or item would make it easier for you to do things that are hard because of your disability;</p> <p>The service or item would increase your safety in your home environment; and/or</p> <p>The service or item would lessen your need for other publicly funded services.</p>	<p>You decide what services you need. This means you can choose to buy any services, supports or goods or those services, supports or goods will:</p> <ul style="list-style-type: none"> • Help you meet your functional, medical and/or social needs and live your life successfully; • Help you to reach the goals you have set for yourself; • Not be prohibited by Federal and State laws and regulations, including the State’s Procurement Code; and • Everyone receives case management services. <p>You and your Team will decide your services from the following categories: Homemaker for adults; Adult Day Health; Respite; Environmental Modifications; Private Duty Nursing for Adults; Physical, Occupational Therapy and Speech and Language Therapy for Adults; Assisted Living; Emergency Response</p>

Table 1: Comparison of Mi Via and Disabled and Elderly Waiver

Comparison questions	Mi Via Waiver	Disabled and Elderly Waiver
<p>How much funding is available for my services and who decides how it will be spent?</p>	<p>You decide how to spend the amount of funding available for you. This amount for the first year will be approximately 90 percent of what the State spent for your services last year after subtracting case management costs.</p> <p>For example, if the State spent \$1,961 per month last year, including \$186 per month for case management, your Mi Via monthly budget would be: \$1,961 (your Waiver services costs) less \$186 (case management cost) less \$177.50 (10 percent discount) = \$1,579.50. If you believe this amount is not sufficient to meet your needs, you will be able to request more.</p> <p>If you are new to waiver programs, your initial budget would be based on what the State spends for persons similar to you (e.g., medical condition, age, gender, etc.).</p> <p>While the amount available is less than the Disabled and Elderly Waiver, your consultant and financial agent services are at no cost to you. And, most importantly, since you are controlling how the money will be spent, you may actually have more buying power.</p>	<p>The amount of funding available is determined by your Team through the Individualized Service Plan (ISP) process. As of FY 2005, this amount, on average, for individuals receiving services through the Disabled and Elderly Waiver program was \$1,961 per month.</p>
<p>Who can help me with implementing my approved plan and budget?</p>	<p>Your consultant can help you, if you request it, to implement your approved Service and Support Plan. The Mi Via Financial Agent will help you implement your approved budget by paying your workers and keeping track of your expenses.</p>	<p>You and your Team implement your ISP and budget.</p>
<p>How much flexibility and control will I have about services I receive?</p>	<p>You direct your services. You will have flexibility and control over the types of services and supports you purchase, who will provide the services, where and when you will receive those services and supports, and how much your workers are paid.</p>	<p>Self-direction, as defined in Mi Via, is not included. You have choice about the services and providers, but you do not control who is hired and how much your service workers are paid.</p>
<p>What learning and training activities are included?</p>	<p>You will receive information about Mi Via and how it works from multiple sources: your consultant, one-on-one learning, peer support, and you can study on your own, using the State Agencies' websites, Mi Via Participant Guidebook, worksheets and other materials.</p>	<p>You receive information about the Disabled and Elderly Waiver program through the client's "rights and responsibilities." This includes information about confidentiality, incident reporting, selecting providers, and services offered through your case manager and direct service providers.</p>

Each individual's budget is based on an assessment of their care needs. The assessment is completed by a registered nurse from a third party assessor (TPA), which currently is contracted to a managed care entity, Lovelace Health Care, in Albuquerque, which in turn purchases local

assessments from nurses throughout the state. The Individual Budget Allotment is annualized and the range varies by population and waiver. The allotments for participants transferring from the AIDS, D&E, DD or MF waiver are based on paid HCBS waiver claims incurred by the participant during a twelve month period, beginning with the most recent sixteen months of service minus the first four months of service to ensure that claims have been paid. Case management costs are deducted and the annual budget is set at ninety percent of the remainder. For participants with no prior waiver cost experience, the annual budget is calculated based on algorithms developed by the state for recipients of the same waiver population (AIDS, D&E, DD, MF) with similar characteristics as the Mi Via participant. The budget for participants with brain injuries is based on the mean average expenditure for individuals with brain injuries across all waivers, less case management, and calculating ninety percent of the remainder.

Unspent amounts may be carried over from month to month but amounts unspent at the end of the plan year are returned to the state to serve new participants. Participants can request an increase in funding if their level of care changes or they lose supports. The spending plan is approved by the TPA and addresses physical, social, emotional, and community needs. A majority of the workers employed by participants are relatives, neighbors or friends.

The program has somewhat complex operations. Public Partnerships Limited based in Boston is the Fiscal Intermediary Agency. The Consultant Contract Agency, which provides advice and counseling functions, explanations about the program, and education for participants, is Consumer Directed Personal Care (CDPC). This agency presently performs this function for a number of States; from its Albuquerque office it contracts with 9 consultants across the state. Mi Via allows participants to pay a spouse and a parent under certain circumstances such as for a medically fragile child in rural area with limited access to service providers.

Mi Via is considered a collaborative tri-agency program of ALTSD, the Health Department, and the Human Services Department. A group with representatives from the three governmental agencies, the program's contracted fiscal intermediary, and the program's contracted consultant agency review unusual requests and fulfill a quality assurance function. This group would also need to approve requests to pay a parent as well as any unusual budget items. Although labor intensive, informants felt this mechanism was worthwhile particularly at the beginning of the program when agencies were learning about the kinds of issues that might arise in the program.

Starting in November, 2007, direct caregivers received coverage for workers compensation. Health insurance is available through "Insured New Mexico," a public/private health insurance plan. Participants can negotiate coverage with their employer and an hourly rate to cover the cost of about \$75 a month.²

Behavioral Health Collaborative. Approved in 2004 and implemented in 2005, the Behavioral Health Collaborative is a combined purchasing program of 15 governmental agencies who invested together in a managed care approach to consolidating and rationalizing behavioral health efforts in the state. ValueOptions of New Mexico is the single state entity awarded the contract to manage the approximately \$400 million behavioral health program. The Behavioral Health Collaborative was meant to be a model for collaborative purchasing for acute and long-term care.

The vision for the program included the development of a local mental health collaborative in each of the state's 13 judicial districts and for the Navajo Nation and other Native American tribes. These collaboratives, all of which were formed in 2006 and 2007, were meant to identify issues and problems in the local area and help set priorities. During the first year of

² Regulations for Mi Via are available at: http://www.hsd.state.nm.us/mad/pdf_files/provmanl/prov83146.pdf.

implementation, advocates criticized ValueOptions for the quality of its case management, its failure to hire local personnel, and its quality assurance. By the end of 2007 however, ValueOptions had received much more positive evaluation from consumers and on quality parameters. Also, the management of the program was transferred in 2007 from the Department of Health to the Department of Human Services for better coordination with health care programs in the state.

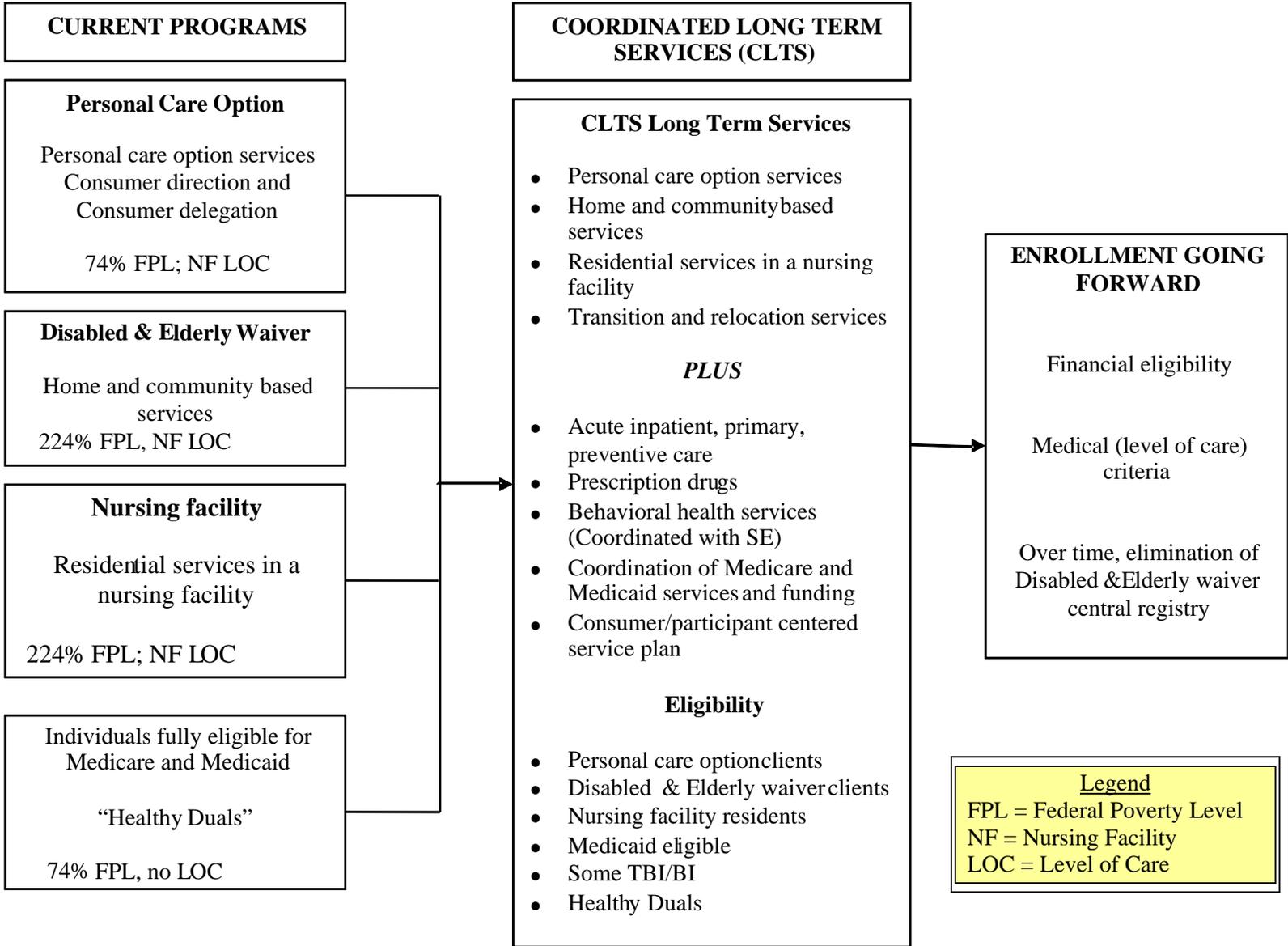
Among the issues identified in the program's first years were: insufficient residential services for children; problems associated with children going out-of-state for residential treatment and returning with inadequate followup; transportation deficits; housing issues in general; and lack of mental health programs for seniors. A Transformation State Incentive Grant from SAMSA (the Substance Abuse and Mental Health Services Administration) is used to build the state infrastructure of community behavioral health. Programs for seniors have been part of the effort, including the development of peer counseling initiatives.

New Initiatives

Coordinated Long-Term Services Initiative. The Aging and Long Term Services Department (ALTSD) will implement a Coordinated Long Term Services (CLTS) project in July 2008 as a collaborative interagency effort between ALTSD and Human Services. The program aims to offer Medicaid beneficiaries access to a "seamless and invisible continuum of care that includes all acute care, primary care, long term care, hospice, and nursing facility services." All Medicaid services for seniors and persons with disabilities, except behavioral health services, will be delivered through two Managed Care Organizations (MCOs), Evercare and AMERIGROUP. (People with developmental disabilities are not part of CLTS.) Both MCOs will be designated as a Medicare Special Needs plan and beneficiaries may elect to receive Medicare services through

the plan or the fee for service system. Enrollment will be mandatory for Medicaid service. CLTS will operate under §1915 (b) and (c) waivers. Beneficiaries who are eligible for long term care waiver services will be able to choose between the CLTS program and Mi Via, the consumer directed option. See Figure 1 for a graphic on how CLTS is expected to reduce fragmentation in the system.

Figure 1: Transition of Fragmented System to Coordinated System of Long-Term Services



ALTSD will issue an RFP to select a third party assessor to determine functional level of care for §1915 (c) waiver services. A new uniform assessment tool will be developed for use in CLTS. Considerable efforts are being made to engage stakeholders in the planning process; AMERIGROUP in particular is conducting state-wide meetings to solicit consumer input. The rate-setting plans are still being worked out; the hope is to develop incentives for community care and for consumer-directed care. CLTS is seen as a vehicle for attacking the institutional bias and bringing about further rebalancing toward community care.

Money Follows the Person. In 2006 the New Mexico legislature enacted House Bill 353, the “Money Follows the Person in New Mexico Act,” which held that “an elderly or disabled individual who is identified and assessed as eligible for community-based living shall be allowed to choose, from among all service options available, the type of service that best meet’s that individual’s need.” Further “the individual’s medical assistance funds shall be made available for the individual for the service option the individual selects, not to exceed the cost of the service.” Section 4 instructed the ALTSD to “identify and provide adequate information to a medical individual residing in a nursing home and, if appropriate, the individuals’ representative, of the opportunity for the individual to receive community-based services and supports.” In practice, New Mexico appropriates institutional and community long term care funds in a single line item and the state has the flexibility to spend funds on nursing facility or home and community based services, which should make implementation of the act easier.

In the ensuing year, advocates complained that the State failed to implement the Act. There seemed to be some ambiguity about whether the Act was contingent on New Mexico’s becoming part of the national Money Follows the Person demonstration: New Mexico had applied and not been funded in the first round of applications but had decided not to pursue a revised application

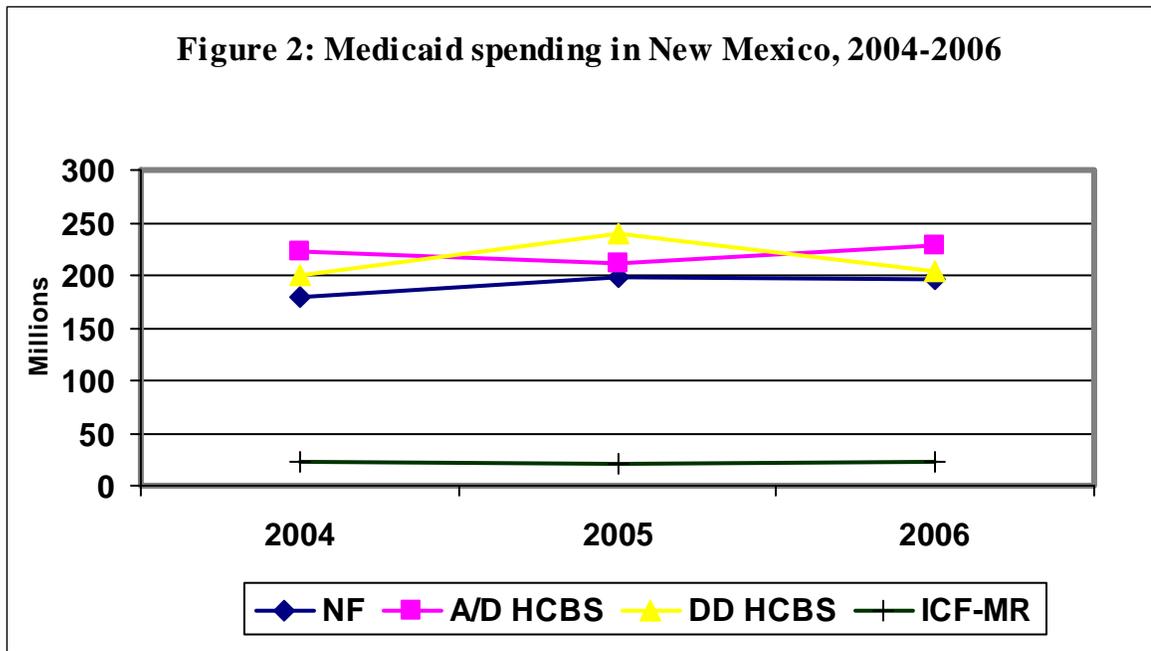
for the second round. At the point of this case study, the State has announced that the implementation of the Money Follows the Person Act will take place as part of CLTS. In a July 2007 statement posted on the ALTSD website, New Mexico renewed its commitment to Money Follows the Person, which it describes as “a system of flexible financing for long-term services and supports that enables available Medicaid funds to move with an individual from an institutional setting, such as a nursing facility or other institution to a home” and asserts that it will build and maintain “a MFP system within the CLTS program that provides accessible home and community-based options, offers easy access to choice of culturally responsive, appropriate, and quality long-term services, and empowers people to live independently, productively, and with dignity.” CLTS is perceived as the vehicle to remove the institutional bias in the system. Until the CLTS implementation in July 2008, the nursing home ombudsman program was charged with identifying nursing home residents who want to move from the nursing facility to home and community based services, and helping them to transition to home and community-based services through the Disabled and Elderly Waiver Reintegration program.³

Goals, Objectives and Accomplishments

New Mexico ranks 2nd in the nation in the percent of Medicaid funds spent on home and community based services with 66.8%. Over 90% of Medicaid spending for individuals with developmental disabilities is spent in the community and 53.7% of spending for elders and adults with disabilities is spent in the community.⁴ Spending on home and community based services for elders and adults with disabilities totaled \$227.8 million in FY 2006 and exceeded nursing facility spending of \$196.4 million. See Figure 2.

³ See ALTSD website posting dated July 9, 2007, last visited, May 13, 2008 at <http://www.nmaging.state.nm.us/MFP.html>

⁴ Burwell, B; Sredl, K; and Eiken, S. Medicaid Long Term Care Expenditures in FY 2006. Thomson Healthcare: August 2007.



State Organization

The Aging and Long Term Services Department continued to evolve and is now comprised of seven (7) divisions. The Administrative Services Division provides fiscal, human resources, clerical, record keeping and administrative support to the Department in the areas of personnel, budget, procurement, contracting, and capital projects. The Adult Protective Services Division, which had moved to ALTSD in 2005, investigates reports of abuse, neglect and/or exploitation; protective placement; caregiver services; and legal services. An Aging Network Division manages programs in senior centers, congregate meal sites, adult day care programs, volunteer programs, employment program host agencies, and the Senior Olympics. The Consumer and Elder Rights Division offers programs assure elderly and disabled citizens of New Mexico protection of their rights through direct counseling, information and referral, care coordination, prescription drug medications, legal advocacy, the Ombudsman program, and quality management activities and the Aging and Disability Resource Center.

The Elderly and Disability Services Division administers the Disabled & Elderly Waiver (D&E) program, the Personal Care Option (PCO) program, the Mi Via self-directed waiver program, the Program of All-inclusive Care for the Elderly (PACE), the GAP program, and the Brain Injury program. The Office of Faith-Based Initiatives and Community Initiatives helps provide access to federal grant funding for New Mexico's faith-based organizations. The Office of Indian Elder Affairs New Mexico has two state Planning and Service Areas designated specifically to serve Native American Indian populations and tribal service providers.

The Secretary positions in ALTSD and Health both changed in 2007; the founding Secretary of ALTSD, Debbie Armstrong, resigned effective mid-December and Governor Richardson named as her successor Cindy Padilla, Deputy Secretary in the Department of Environment. The Secretary of Health, Michelle Lujan Grisham, an individual with a lot of experience in long-term supports, had resigned in June 2007; a physician with a public health background was named as her successor. The effects of these personnel changes on interdepartmental collaboration were not known at the time of this report.

Access

New Mexico received a Systems Transformation Grant from CMS in 2005 to improve access to long term supports; develop a comprehensive quality management system and transform information technology to support systems change. The state planned to improve access to long term supports by expanding its aging and disability resource center (ADRC). The ADRC is operated by the Consumer and Elder Rights Division within ALTSD. The Division manages five programs: ADRC; Benefits Counseling; ombudsman; HIV/AIDS advocacy office; and the Geriatric Behavioral Health training program, which offers training for providers and department staff.

The ADRC, based in Santa Fe serves as a single entry point statewide for all populations for benefits counseling and information and assistance. It also maintains the registry for applicants for the Disabled and Elderly Home and Community Based Services Waiver. Staff receives 200-400 calls a day and they also make home visits when necessary. Adult Protective Service intake functions were transferred to the ADRC in 2007 to improve the linkage to the service system which increased the number of individuals who received follow up when abuse or neglect was not confirmed but a service need was identified. In an unusual organizational approach, access to the adult protective services is also managed through the ADRC.

ADRC staff conducts quarterly surveys of people who call for information and assistance to ask how long they waited, their overall satisfaction, would they recommend the service, and whether their needs were met. Staff is working on a marketing plan, and they note a temporary increase in calls following new outreach activities. The ADRC web site (www.nmresourcedirectory.org) has a social service directory of resources that may provide information about a range of services and providers. The site received 20,000 hits since January 2007. The resources list may be expanded to services from the Veterans Administration. A self-assessment and a care planning tool may also be added.

Rather than create other physical sites for ADRCs, the intent is to create partnerships with other organizations throughout the state. Among the possible partners are senior centers, Centers for Independent Living, various tribal entities, and hospital discharge planning units. Benefit counselors from the ADRC go out to such programs and conduct training and focus groups. Senior Centers are perceived as an important resource for outreach in this rural station; we were told that in New Mexico, “senior centers can be found in communities where there may not even be a gas station.”

Beyond access to information about services, New Mexico has been challenged to organize access to services in a largely rural state. This has been achieved by contracts to managed care organizations to manage access to the PCO benefit and the waiver programs. Access to community services for those living in institutions is facilitated by a Community Reintegration initiative that allows consumers who are Medicaid beneficiaries and have lived in a nursing facility for 30 days to receive an immediate allocation of an HCBS waiver slot from the registry. State officials report that approximately 350 persons a year move to the community through the community reintegration program.

Service Array

New Mexico is challenged to develop a wide array of services in the non-urban areas in the State. The approach has been to emphasize consumer direction and flexible services through the personal care options and waiver programs. Service gaps that have received particular attention in the last several years are transportation services, and assistive devices. Some advocates would like to see more adult day health in the state.

Quality Initiatives

The Division of Health Improvement in the Health Department has major responsibility for quality initiatives. Within that Division are the Health Facility Licensing and Certification Bureau, which licenses, among others, hospitals, nursing homes, personal care boarding homes, and group homes for persons with developmental disabilities; the Incident Management Bureau, and the Quality Management Bureau. The Caregiver's Criminal History Screening Program, also housed in the Division has updated its procedures and disqualifying offenses and enhanced its training under a 3-year Background Check Pilot Program Grant from CMS to the State, which was awarded in 2005.

The Incident Management Bureau investigates and makes public on its website the results of investigations of all abuse allegations and incidents occurring in long-term care programs, including waiver programs. It also provides training on risk management. In 2005 the Incident Management Bureau undertook a comparative study of Incident Management in all States and concluded that New Mexico has one of the most transparent, accessible, and usable information systems to report and track incidents.⁵

The Quality Management Bureau is responsible for surveying organizations providing community care, including residential settings, waiver providers, and case management organizations. In May 2007, this Bureau released new draft standards and interpretive guidelines for surveys. Participant rights and respect for participant preferences figure highly in the material.⁶

In 2006, the legislature passed funding to create a unit that will focus on inspections of adult residential care facilities. The added staff will allow the licensing agency to inspect facilities more frequently. Survey reports are posted as links to each facility on the Department of Health's web site. Another initiative is to pull out regulations dealing with behavioral health needs from Residential Care Facilities rules and handling them separately.

Housing

Housing has been recognized as a need within the Behavioral Health Collaborative. In a 2007 report, "the Collaborative recognizes that a significant barrier to recovery and community integration is the lack of decent, safe, and affordable housing with flexible and effective

⁵See CaLhoun, L. E. (2005). Incident Management Across the U.S. on web, last visited May 9, 2008 at http://dhi.health.state.nm.us/elibrary/imbdocs/Ntnwd_ANE_Rsrch_DD.pdf. Data trends by provider are displayed on the Bureau's website at <http://dhi.health.state.nm.us/imb/index.php>, last visited May 9, 2008.

⁶ Standards are posted on the Quality Management Bureau website at <http://dhi.health.state.nm.us/qmb/index.php>, last visited May 9, 2008.

supports.” The Technical Assistance Collaborative (TAC) has developed a report for New Mexico that emphasizes the need for permanent supportive housing. People with serious mental illness or co-occurring disorders and young people transitioning out of foster care or juvenile justice systems have been identified by the Collaborative as its two priority groups for access to housing.⁷ According to state staff, a need for 35,000 housing units for behavioral health needs was identified.

Future of Nursing Homes

New Mexico is revising its nursing home regulations with the intent of releasing final revisions in 2008. The key areas that will be changed are medication administration and requirements for administrators (how hospice is handled in licensed facilities). The ALTSD has been supportive of the culture change movement in Nursing Homes and in 2005 contracted with Piñon Management Company in Colorado to conduct training sessions about culture change in various areas of the state.

New Mexico is not highly supplied with nursing home beds. In 2005, the State ranked 45th in the proportion of beds per 1,000 people over age 65 (which was 30); despite the low supply the occupancy rate was 87%. No particular goals have been set for the number of nursing homes or nursing home beds desired in the future; rather New Mexico is pursuing a strategy of making community care available.

Integration of Acute and Long-Term Care

One PACE site with an enrollment about 342 participants operates in the Albuquerque area. The program is operated by Total Community Care which is sponsored by St. Joseph Senior Care. Total Community Care was awarded full PACE provider status in June 2004. The program is

⁷ For report of Technical Assistance Collaborative, Behavioral Health Needs and Gaps in New Mexico, see website at http://www.tacinc.org/Pubs/NM_needs_gaps.htm, last visited May 9, 2008.

capped by the Medicaid and has a waiting list of 160 people. Enrollment is limited to 3 members per month, one of which must be diversion or relocation from a nursing facility.

The Coordinated Long Term Services program, described above, plans to integrate all Medicaid services through managed care organizations that are also Medicare Special Needs Plans. For dually eligible participants who choose the Special Needs Plan to access Medicare services, the program offers an integrated model of care.

Conclusions

Since the Rebalancing Research project has been tracking long-term supports in New Mexico, the State has been moving deliberately towards creating community options for all populations needing long-term support and incorporating consumer direction into these options. The formation of the Aging and Long-Term Services Department (ALTSD) has forwarded these initiatives, and informants expect the high level of interagency cooperation to continue despite changes of leadership in both ALTSD and the Health Department. The Developmental Disabilities programs, including the Developmental Disabilities Waiver, remains in the jurisdiction of the Health Department for the time being, though it could move to ALTSD at some time in the future. The move of Adult Protective Services to ALTSD has been smooth. The State is moving ahead to implement its managed care program, Community Long-Term Care (CLTC) in July 2008, and this is expected to be a vehicle for enhancing consumers' ability to choose community services. Housing and transportation issues are a high priority in developing the array of services, particularly for participants with behavioral health issues. Key informants in New Mexico attribute current success in rebalancing to the development of the Personal Care Option Program with a consumer directed emphasis and the creation of the Mi Via consumer-directed waiver.