# DEPARTMENT OF HEALTH

## Developmental Disabilities Waiver Program

January 7, 2002

*Report to*

*the LEGISLATIVE FINANCE COMMITTEE*

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DAVID ABBEY
DIRECTOR



January 7, 2002

Mr. Alex Valdez, Secretary
Department of Health
1190 St. Francis Drive
Harold Runnels Building
Santa Fe, New Mexico 87502

Dear Mr. Valdez:

On behalf of the Legislative Finance Committee (Committee), we are pleased to transmit our report on the audit of the developmental disabilities waiver program.

The audit team interviewed key personnel, examined documents and prepared this report which will be presented at a public hearing of the Committee on January 7, 2002. The contents of this report were discussed with the Department of Health (department) staff at an exit conference held on December 19, 2001. We appreciate the department's cooperation and assistance.

We believe this report addresses the issues the Committee asked us to review and hope the department will benefit from our efforts. Again, thank you for your cooperation and assistance.

Sincerely,

David Abbey
Director

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# EXECUTIVE SUMMARY

# DEPARTMENT OF HEALTH
## Developmental Disabilities Waiver Program
## January 7, 2002

## EXECUTIVE SUMMARY

Pursuant to a request from the Legislative Finance Committee (LFC), the performance auditors have conducted an audit of issues relating to the developmental disabilities (DD) waiver program. The purpose of this audit was to:

- Examine the DD waiver central registry wait list to assess for completeness. Also assess allocation procedures and wait time;
- Examine DD waiver provider records to ensure randomly selected clients are given "freedom of choice" (a federal requirement) of case managers, behavioral therapists, etc., and determine that other required written documentation have been maintained; and
- Examine randomly selected client records of intermediate care facilities for the mentally retarded (ICF/MR) for comparison with DD waiver program.
- Assess the reliability of reporting of performance budget (outcome) measures of the developmental disabilities waiver program;

### Results

**Central Registry.** The department needs to prioritize its resources to correct errors and omissions of data in the central registry. Hundreds of records lack status information, some records contain registration dates prior to birth dates, and approximately 1,300 recipients of DD waiver services are not listed in the registry.

**Recommendation:** Enter and correct data for applicants and recipients of DD waiver services.

**Wait List.** Fifty-eight percent (58%) of registrants waiting for DD waiver services are children under age 21 who may not yet be in need of services or are in need of limited service. Since residential facilities are not provided to children, the cost of services to children can be much less than the cost of adult services.

**Recommendation:** Assess needs of registrants under age 21 to determine availability of other programs and refer them appropriately. Also, establish a mechanism to estimate cost of services for person in wait status.

**Allocation of Services.** Improvements can be made in the process of applying for and allocating services. Currently all applications for DD waiver services must first be submitted to the Human Services Department. They are later forwarded to the Department of Health in Santa Fe which

then distributes them to regional offices where data is entered into the central registry. Services are allocated by the percentage of registrations within each of five regions, then by the earliest registration date within each region.

**Recommendation:** Allow regional offices to accept applications directly. Assess financial eligibility at time of registration to better identify persons who are likely to receive services.

**DD Waiver Provider Review.** Three of eleven case managers need to improve progress notes in ten client files to better address the goals of individual service plans (ISP). One or more freedom of choice documents were missing in 12 out of 48 client files.

**Recommendation:** Provide additional training to providers and increase monitoring in this area. Remind case managers to retain appropriate documentation for five years from the last date of service in compliance with department requirements.

**DD Waiver Contracts.** Case management agencies are only contracted to perform case management services for clients and are prohibited from providing other services. However, we found two instances in which subcontractors of case management agencies were also working for other service type agencies.

**Recommendations:** Re-program the department computer system to accommodate the names of provider employees and subcontractors in order to detect such occurrences.

**Monitoring of DD Waiver Providers.** The department's Office of Internal Audit (OIA) conducted ten audits of residential facilities under the DD waiver program which resulted in $1.1 million in recommended recoupments. The OIA recommended these recoupments because providers lacked documentation supporting services billed. OIA could not recommend a recoupment amount for one provider because the records were in such poor condition. The department has negotiated settlements with three providers in the amount of $103,923. However, the imposition of monetary penalties appears to be inconsistently applied. There is no written documentation to explain why a particular provider was penalized financially and another was not. Another provider was audited by the Human Services Department which recommended $123.0 thousand in recoupment due to inadequate documentation.

**Recommendations:** Complete negotiations with providers and formally document for each audit the reasons for reduced amount of settlements or reasons for not pursuing sanctions. Coordinate with the Human Services Department and the provider for the final settlement of amounts to be recouped. Also expand the scope of some audits to determine additional amounts to be recouped.

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**Cost Effectiveness of the DD Waiver Program.** The DD waiver program met federal cost effectiveness requirements in year four (FY00) of the program due to a change in the method of reporting ICF/MR costs. For FY00, an estimate of ICF/MR costs as if the Los Lunas and Ft. Stanton state institutions were still in operation was allowed. For the prior three years, only actual payments to privately operated ICF/MR facilities were permitted in calculating the cost ceiling.

**Recommendation:** Monitor DD waiver expenditures to ensure cost effectiveness of the program, including review of services being provided to participants.

**Facilities for High Risk Clients.** It is unlikely that the private sector will develop facilities to accommodate high risk clients who pose a danger to themselves, provider staff and/or the public. The state will need to develop or expand existing facilities with appropriately trained staff to accommodate these individuals.

**Recommendation:** Expand the role of existing facilities such as the Las Vegas Medical Center (LVMC) and the Los Lunas Community Program for long-term treatment.

**Performance Budget (Outcome) Measurement.** The Department of Health (department) has made a good start at gathering data for reporting performance of provider staff turnover for the DD waiver and other waiver programs. However, there are problems with survey methodology and cooperation from providers for the independence and integration measures.

**Recommendation:** Better cooperation from providers is needed, as well as improved data gathering and evaluation procedures for the independence and integration measures. Also, utilize questions as those used in the Core Indicators Project to provide a comparability of New Mexico's performance with other states.

**Provider Issues.** The department can help providers by making changes in two computer programs and grant more authority to regional offices to resolve problems. The provider payment system (PPS) is a DOS based program and is not user-friendly and the format of provider listings could be improved. Case managers and other providers are concerned about the completeness of provider listings prepared manually by case managers from quarterly department printouts from the provider program. Providers also feel that regional offices need more authority to assist them with problems such as conflicts between case managers and other providers.

**Recommendations:** Put PPS on a windows platform. Also modify provider listings so that they are given to case managers electronically by type (behavioral therapists, residential providers, etc.) and by region to facilitate client freedom of choice. Give regional offices more authority to resolve problems such as conflicts between case managers and providers.

# REVIEW INFORMATION

# DEPARTMENT OF HEALTH
## Development Disabilities Waiver Program
## January 7, 2002

### BACKGROUND

Medicaid is a jointly funded federal-state program that provides medical assistance to certain low and moderate income persons. The developmental disabilities waiver program is partially funded by Medicaid and is established by a joint powers agreement between the Department of Health (department) and the Human Services Department (HSD), the single state Medicaid agency. The purpose of the program is to provide long-term services that promote quality of life outcomes for developmentally disabled persons and their families. (A developmental disability is an impairment or delay in physical or mental development that occurs before a person reaches age 22 for whom the ability to perform a number of major life activities may be limited.) The developmental disabilities waiver program is administered by the Long Term Services Division (LTSD) which administers programs for persons with disabilities.

The Department of Health is created by Laws 1991, Chapter 25 (Sections 9-7-1 through 9-7-15 NMSA 1978) to serve the citizens of New Mexico through programs designed to prevent disease and disability, promote health and prevent or ameliorate problems of mental health, substance abuse, developmental disabilities and chronic disease.

**Authority for Review**. The Legislative Finance Committee has the statutory authority under Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies and institutions of New Mexico and all of its political subdivisions, the effects of laws on the proper functioning of these governmental units and the policies and costs of governmental units as related to the laws, and to make recommended changes to the legislature. In the furtherance of its statutory responsibility, the LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state law.

**Objective and Scope.** Pursuant to a request from the Legislative Finance Committee (LFC), the performance auditors conducted an audit of issues relating to the New Mexico Department of Health developmental disabilities (DD) waiver program. The purpose of this audit was to:

- Examine the DD waiver central registry wait list, assess allocation procedures and the reasonableness of wait time;

- Examine DD waiver provider records to ensure randomly selected clients are given "freedom of choice" (a federal requirement) of case managers, behavioral therapists, etc., and determine that other required written documentation have been maintained; and

- Examine randomly selected intermediate care facilities for the mentally retarded (ICF/MR) provider/client records for comparison with DD waiver program.

- Assess the reliability of reporting of performance budget (outcome) measures of the DD waiver program;

**Procedures.** LFC procedures included:

- Review of laws, regulations and procedures relating the DD waiver program;
- Interview department and provider staff;
- Examination of selected client case files;
- Examination of provider contracts and surveys; and
- Examination of central registry and allocation procedures.

**Audit Team Members**

La Vonne Cornett, Senior Performance Auditor
Lorenzo Garcia, Senior Performance Auditor
J. Scott Roybal, Performance Auditor
Chan Kim, State Auditor staff
Charles Schroeder, State Auditor staff

**Exit Conference**. An exit conference was held December 19, 2001 with George Parascandola, Deputy Secretary, and Ramona Flores-Lopez, Director, Long Term Services Division.

**Distribution of Report**. This report is intended for the information of the Office of the Governor, Department of Health, Office of the State Auditor, Department of Finance and Administration and Legislative Finance Committee. This restriction is not intended to limit the distribution of this report, which is a matter of public record.

Manu Patel, Manager Performance Audit
Legislative Finance Committee

# FINDINGS AND RECOMMENDATIONS

# DEPARTMENT OF HEALTH
## Developmental Disabilities Waiver Program
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**1. Central Registry. The department needs to prioritize resources to correct errors and omissions of data in the central registry.**

The "central registry" is a comprehensive database containing information for persons requesting services for five waiver programs: developmental disabilities (DD) waiver, disabled and elderly waiver, the medically fragile waiver, intermediate care for the mentally retarded (ICF/MR), and community reintegration programs. With respect to the developmentally disabled, Section 28-16A-15.C NMSA 1978 requires the department to "maintain a central registry of persons who are requesting or receiving support and services". Registrants are classified into one of the following categories:

- Receiving DD waiver services;
- Waiting for services (being in the process of registering or having completed the registration process); or
- In closed status.

However, the department is not maintaining a single, complete central registry. For example, the registry does not list the approximately 500 Jackson lawsuit litigants who were among the first to receive DD waiver services. It also does not include approximately 800 others who began receiving DD waiver services prior to the establishment of the central registry. Tracking of these persons is accomplished through the provider payment system.

As of October 19, 2001, the central registry contained 6,800 registrants for the DD waiver program. LFC auditors noted the following problems:

- Only 1,176 registrants were listed as receiving services although the provider payment system indicates 2,526;
- 744 registrants lacked status identification (closed, waiting for services, etc.). Many of these are thought to result from the conversion from the previous registration system;
- 201 registrants lacked regional identification. 187 were in "closed" status;
- 26 registrants with status notes dated prior to registration date;
- 15 persons had registration dates prior to the indicated birth date;
- One person registered twice in the system under a different social security number; and

- One registrant listed as waiting who should have been closed because registrant and guardian were living out of state, thus not qualifying for services. The department has since closed the registration.

Closed files numbered 3,320 which includes the 1,176 registrants who are receiving services. The other 2,144 cases have been closed for the following reasons:

| Reason | Number |
|---|---|
| Did not respond to mailing (742) or did not provide a forwarding address (72) | 814 |
| Did not complete registration process | 448 |
| Determined medically (409) or financially ineligible (4) | 413 |
| Registrant requested closure | 141 |
| Moved out of state | 108 |
| Deceased | 98 |
| Not identified | 122 |

Note: Persons may move in and out of these categories. For example, a person who is now deceased may have previously been in wait status.

The current Access version of the registry data base was started several years ago and included records converted from an old Fox Pro data base. Department staff who were not with the department at that time indicate that they have discovered a difference in the definition of a "closed" case under the old system versus the current system and the reasons for case closure were not required to be entered into the Fox Pro database. Also, the Fox Pro system did not maintain a detailed record of changes in the status of a person's application as does the current system. Hence, the reason 744 registrants lacked status identification. To obtain that information will require researching hard copy records and entering the data. The department has recently initiated that process, but it is slow and time consuming.

The department is actively making efforts to correct registration records and staff are beginning to implement an internal quality assurance process. The department has contacted each region to obtain that data as well as other data currently lacking in the system. In addition, some programming changes and data checks have been requested to help identify data entry errors and omissions of data.

The department also plans to move to a sequel language database which will assist in providing better and faster reports, as well as improving system security. However, computer staff need more feedback from users to determine what changes and control features are needed. Some data fields appear to be unnecessary in the opinion of LFC auditors. And others appear to be needed such as a "deceased" category in the allocation tab. These changes could be made if identified as needed by system users. (There are only about 20 persons who can enter data into the system.) Program staff indicate other needed upgrades to the system such as call logs and comment areas to facilitate casework. Such data is now kept manually. Upgrade of Windows 98 to Windows 2000 would be needed. But ensuring that original data entry is accurate is critical to the preparation of reliable reports and administration of the program; it should be a top priority.

Exhibit A compares current status of cases with registrations as of October 19, 2001 and for the fiscal years ended June 30, 2001, 2000 and 1999. This data was compiled from both the central registry (for persons waiting to receive services) and the provider payment system (for persons authorized to receive services). Based upon the limitations of the central registry described above, we cannot be sure that these numbers are exact. Similar problems were noted with ICF/MR registrations and cases were closed for similar reasons. ICF/MR registry data is included in Exhibit G.

**Recommendations:**

Modify computer programming to provide additional data cross checks to ensure accuracy of data entry. For example, cross check birth dates and registration dates to ensure that registration date is subsequent to birth date. Prepare cross checks for other identified problems and consider other cross checks which would be useful. Then run edit checks to test data accuracy.

Enter data into the central registry for the 1,350 other persons who are receiving services, including the Jackson litigants. Cross check against the 744 registrants without status identification to avoid duplicate records. Assign a due date to regions to complete data upgrade.

Upgrade from Windows 98 to Windows 2000 to support additional data applications. Add a call log and comment area so that caseworkers can eliminate manual tracking.

Provide proper design documentation of the new system and provide an on-line tutorial for users. Establish quarterly meetings of users to provide feedback to computer staff as to needed reports and controls features.

Maintain program library as historical record of program changes. Also, maintain a user manual for the system which identifies definitions such as a "closed" case. This could be combined with the 1993 LTSD/DD Policies and Procedures manual.

**Department Response:**

Before responding to the individual recommendations in this section, DOH would like to clarify the seeming inconsistencies identified in the LFC audit report. The clarifications are as follows:

- 1,176 registrants listed as receiving services while the PPS indicates 2,526 - - The difference in consumer totals results from the fact that the DD Waiver was initiated in 1984, thus services startup for several consumers preceded the implementation of the statutorily mandated Central Registry. Additionally, several individuals were allocated into services in 1995-1996 through a special legislative appropriation to "convert" eligible individuals from state general fund services to the DD Waiver; these were not allocated from the Central Registry. The other group of individuals not on the central registry but receiving services are Jackson class members.

- 744 registrants lacked status identification - - These are an artifact of the previous version of the Central Registry database, which did not provide a status code consistent with the current database. The status codes of the previous database could not be imported into the current system. However, in all cases these are actually closed cases, reflecting persons in services. A status code (i.e., "closed") has been verified through a review of each consumer's hard copy record by Regional Office staff, and this information has been entered into the Central Registry.

- 201 lacked a region entry - - As noted above, services startup for many consumers preceded the Central Registry. Based on a newly implemented data validation report, Long Term Services Division staff have retroactively assigned a region to each of these consumers based on their current region as reflected in the provider payment system.

Responses to the identified findings are as follows:

- DOH agrees that crosschecks should be included in the Central Registry database and, in fact, the database design included plans for the development of such internal quality assurance measures. Several cross checks were initiated prior to the LFC audit with additional ones added during October – November 2001. Regional Office and Program Development Bureau (PDB) staff were trained on December 11, 2001 in the use of the "validation reports" and have been instructed to run the cross checks weekly to validate

data entry. PDB staff will run the reports monthly to ensure Regional Office implementation.

- DOH will seek to enter the 1,300 individuals retroactively into the Central Registry as time permits during 2002.

- DOH agrees that the upgrade is appropriate but this would require additional legislative funding. DOH will consider this needs in future legislative requests.

- Regarding a call log and comment area addition, a Central Registry record is a medical record by legal standards, and an automated comment section shows be in the form of a contact log in the hard copy record. Central Registry data is not intended to replace the hard copy record. Use of comment sections in a database requires multitasking between data and narratives sections that cannot be easily handled by the memory capacity of the current hardware. However, adding this feature can be considered in any future upgrades to the system.

- DOH agrees that design documentation is needed. This task has been assigned to the Information Management staff, in coordination with the Program Development Bureau and will be completed by July 2002. This would include expansion of the existing online tutorial. Quarterly meetings of users were initiated in May 2001 and it is planned that these will continue. Based on user recommendation at the October 2001 meeting, users will meet monthly for the next quarter, following an orientation at this meeting to the newly developed validation reports.

- DOH agrees that a program library is an essential component of the Central Registry. A system of written work orders for program changes has been developed and implemented.

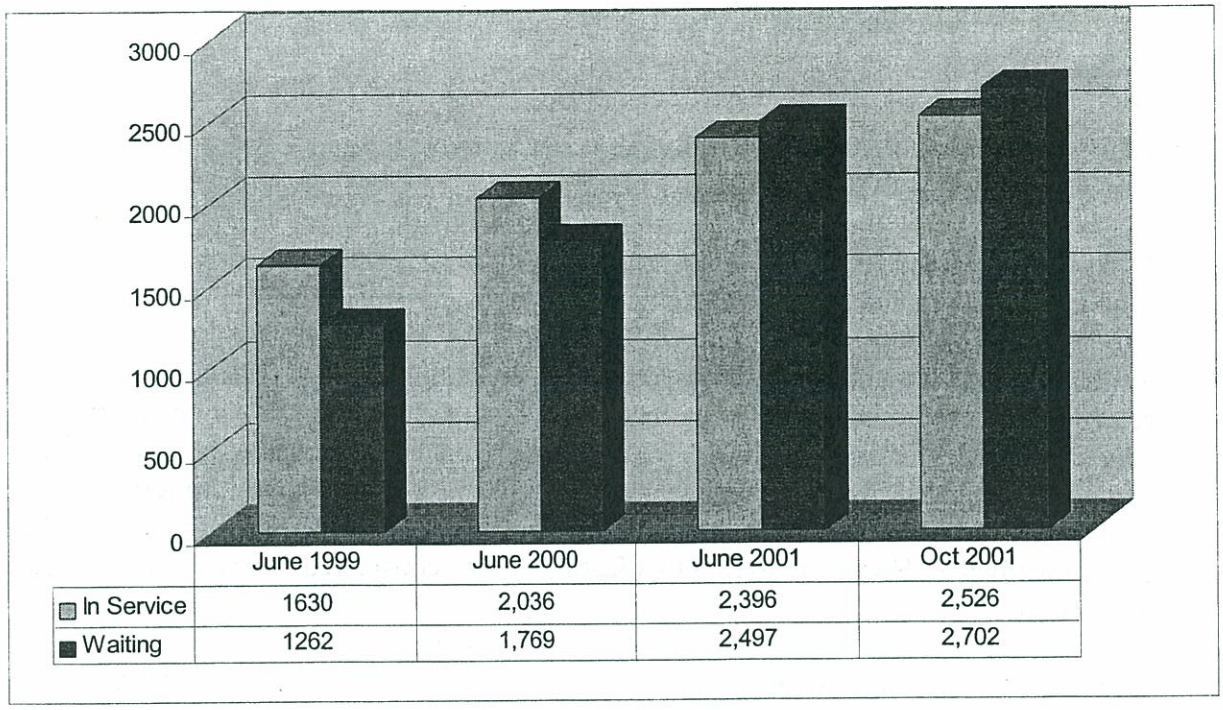
**2. Wait List. Many persons waiting for services are children who may not yet be in need of services or may only need limited service from the DD waiver program.**

The following graph indicates the number of persons receiving and waiting for services at different points in time. More persons are currently receiving DD waiver services than June 30, 1999; however, more people are also waiting for services.

# DEPARTMENT OF HEALTH

## Developmental Disabilities Waiver Program

## January 7, 2002




| Status | October 19, 2001 | June 30, 1999 | Net increase |
|---|---|---|---|
| Receiving services | 2,526 | 1,630 | 896 |
| Waiting for services | 2,702 | 1,262 | 1,440 |

The increase in the numbers of people waiting appears to be due to the number of persons under the age of 21 who are applying for services. As of October 19, 2001 fifty-eight percent (58%) are under the age of 21:

| Age Group | Number | Percentage |
|---|---|---|
| 21 and older | 1,106 | 41% |
| 18 through 20 years of age | 380 | 14% |
| Age 8 through 17 | 778 | 29% |
| Age 5 through 7 | 199 | 7% |
| Age 2 through 4 | 177 | 6% |

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| Age Group | Number | Percentage |
|---|---|---|
| Under 2 | 46 | 2% |
| No date of birth | 16 | 1% |

Despite the increases in registrations, the wait period has actually declined from 1999 and is now between three and four years depending upon region. As of November 2001, allocations were being made for the following registration dates:

| Region (Office Location) | Registration Date |
|---|---|
| Metro (Albuquerque) | September 24, 1997 |
| NE (Taos) | November 11, 1997 |
| NW (Gallup) | June 17,1998 |
| SE (Roswell) | August 24, 1998 |
| SW (Las Cruces) | December 16,1998 |

Doctors and schools are becoming more aware of the program and are getting better at identifying children who may be developmentally disabled. Guardians are also registering their children earlier which helps to ensure that services will be available at the time when they expect to need them. However, early diagnosis may result in mis-diagnosis and a child may be permanently labeled developmentally disabled when he or she may only be developmentally delayed. It can be difficult to assess whether a disability is permanent until a child is older. A delayed individual will be kept in wait status on the central registry until a definite DD determination can be made. A result of early registration is that services are beginning to be offered before registrants are ready for them. As indicated in Exhibit A, 33 persons are now "on hold". They've been offered services, but have declined them at the present time. Currently they are being kept active wait status.

Unlike older registrants, children are usually in need of services which generally exclude expensive residential care, basically needing services such as physical therapy, speech therapy, etc. Thus younger persons are generally less expensive to provide services for than are adults. Also, early intervention can also reduce the level of services required later in life. However, when they come onto the program at a younger age, the cost of services will increase later on when they become adults and are more likely to request residential services. New funding would then have to go to providing those additional services rather than to bringing more registrants into the program. Some states have separate DD waiver programs for children.

The department also indicates that many of the services needed by children are available through other programs such as the "Birth to 3" program, EPDST, Medicaid in the Schools, and Salud!

The central registry does not contain information as to the specific services needed by registrants on wait list or whether the registrants will meet financial eligibility in the future. Thus it is difficult to estimate funds needed to serve persons on the wait list.

**Recommendations:**

Assess needs of registrants under 21 to determine the availability of other programs and refer them as appropriate.

Establish a mechanism to better estimate costs of services for persons on the wait list. Also, plan for future increases in more costly services and consider separate DD waiver program for children.

**Department Response:**

DOH agrees that all applicants, regardless of age, should have information on alternative programs. DOH asserts that is the responsibility of the school system. Children under age 21 have access to school based services. If the child is age 0 – 3, they can receive early intervention services. DOH also offers state general funded respite services for children on the central registry.

It is not cost effective to consider a separate waiver for children. In order to ensure the unique needs of children are met, the DD waiver renewal just approved by the Centers for Medicare and Medicaid Services (CMMS) includes a unique package of services for children. DOH developed these set of services with the input of the Children's Advisory Committee.

Changes in needs are reflected in the manner in which the DOH developed the annual resource allotments. The resource allotments are based on the individual's residential status, level of care, and age.

**3. Allocation of Services. Improvements can be made in the procedures to apply for and allocate services.**

Persons interested in receiving DD waiver services must apply through the Human Services Department (HSD), the designated state Medicaid agency. Applications are then batched and sent to the central office of the department. They are entered into the central registry when the

application is received by the appropriate regional office. Sometimes it takes as much as 45 days from the date of application before it is entered into the central registry. In order to complete the registration process, applicants must be assessed and determined that they meet developmental disability criteria. If they do not, their application is closed. No determination of Medicaid and financial eligibility is performed until the individual is offered services, although some persons may already have been determined Medicaid eligible. (For example, if they are receiving ICF/MR services and want to change to DD waiver services they would already be determined Medicaid eligible since ICF/MR is Medicaid funded.) Thus, there may be persons in wait status who may not qualify for services at the time of application. However, their status may change and they may become eligible by the time services are offered. For example, an individual may be a minor child at the time of application, but an adult without financial resources when services are offered.

As funding becomes available, registrants are "allocated" services in the DD waiver program. In calendar year 2001, the department allocated services to approximately 458 additional persons and began to allocate services to 200 more persons in November 2001. The process of allocation is a difficult one and relies upon the accuracy of the data in the central registry. Based on the amount of additional funding, costs to service individuals are estimated and the number of persons who can receive services is then calculated. However, allocation is not strictly based on the earliest registration dates. In consultation with the Adult Services Task Force, funding has been allocated as follows since 1999:

- 20 percent is held back for crisis services;
- 15 percent is reserved for registrants with elderly care givers; and
- remaining 65 percent is then distributed among the five regions by the percentage of registrants in each region. They are then allocated according to the earliest registration dates in their region.

When a person is selected for allocation, the department sends a letter of notification to the contact person with a request to select a case manager. This is the initial "freedom of choice" selection. (Later on, individuals will have the freedom to chose other providers.) Most people respond quickly; however, some do not and/or some decline services either permanently or temporarily. When letters are returned as "undeliverable" by the post office, the department sends a second letter by certified mail. [Note: at the time of registration, applicants are informed of their responsibility to notify the state of a change of address.] Sometimes it takes as much as 60 days before it is determined that the registrant cannot be located. In that case, the next registrant in the region is selected and the process begins again. LFC auditors observed that as

many as three registrants were selected for one position in 2001. For example, for the allocation begun in February 2001, several allocations were not completed until September 2001. A third allocation of 200 positions began in November 2001.

Since the registration date determines the order in which 65 percent of registrants are offered services, it is critical that data entry be correct and that all registrants are entered into the registry. However, there have been instances where registrants were not entered into the system or were entered incorrectly. When staff become aware of such occurrences, applicant data is entered into the system with the appropriate registration date.

Once the allocation is made, Medicaid/financial eligibility must be determined. [Note: For persons who are receiving ICF/MR services this process would be unnecessary if HSD identified those applicants to the department.] The applicant then meets with the chosen caseworker to develop an individual service plan (ISP) of care. The ISP is submitted to Blue Cross Blue Shield for approval. There may be meetings and/or changes to the plan which may take days, weeks or months. Once the ISP is approved, the client then selects providers within the region as identified by the ISP. Providers may not always be available or a selected provider may not be immediately available.

**Recommendations:**

Have HSD send or fax applications directly to regional offices and/or allow regional offices to take DD waiver program applications to speed up the registration process. Perform Medicaid/financial eligibility determination for registrants at the time of application and modify registry to realistically identify persons who are likely to qualify for services when offered and to help identify potential costs.

Send first notification offering services by certified mail to cut down on wait time and better utilize personnel.

**Department Response:**

DOH is not prepared at this time to shift the registration process from one to several locations. That would not create any improvements in the system and would result in confusion among future registrants. Under the current system, there is one point of accountability – the local Income Support Division Office.

Given the length of time from registration to allocation, it would be a misuse of resources to perform the financial and medical eligibility at time of allocation. This information would have to be provided on a current basis at the point of allocation.

Through the recent experience of HSD, DOH has learned that sending allocations by certified mail does not improve response times. However, DOH will use the LFC recommendation in the next allocation process.

**4. DD Waiver Provider Review. Some providers need to improve progress notes and other documentation in case files to better address the goals of clients' individual service plans (ISP) and meet department documentation requirements.**

LFC auditors examined services and case file documentation for 48 DD waiver clients for the month of April 2001. These clients were located in Albuquerque, Las Cruces, Las Vegas, Los Lunas, Ruidoso, Santa Fe, Silver City and Socorro. Eleven case management agencies for these 48 clients were interviewed and client file documentation examined. LCF auditors also reviewed services for at least one additional provider for each client representing other provider types, including behavioral therapists (24 clients), and some residential and assisted living providers, etc. However, Adelante Development Center in Albuquerque refused to allow LFC auditors access to records documenting client services despite authorization from the department and HSD, the state Medicaid agency. Adelante cited a state statute prohibiting disclosure of confidential client information. (Adelante provides assisted living and other services in a five county area in central New Mexico and billed the department for four individuals in our sample.)

With respect to case management services, our examination indicates:

- Level of care (LOC) assessments were present in 98 percent (47) of client files. For one client, the case management agency was no longer providing services to the client as of November 2001 and could not locate the document;

- Interdisciplinary teams (IDT) had been established for all clients as required;

- One or more "freedom of choice" forms documenting the selection of other providers were missing from 12 client files;

- The department pays a flat monthly fee to case management agencies for each client. Most case management agencies use subcontractors rather than hiring their own employees to perform services. Subcontractors are paid from 80 percent to 85 percent of

the monthly fee paid by the department. The other 15 percent to 20 percent is used for training, supervision and quality assurance of the case managers;

- Full-time case managers are responsible for 18 to 25 clients monthly;
- Case managers in our sample averaged 3.8 hours of service per client for the month of April 2001. The department based it rates on 6.8 hours of service; and
- Individual service plans (ISP) had been established for all clients and all were current. However, progress notes relating to ISPs could be improved.

LFC auditors obtained the services of a consultant who evaluates out-of-state DD providers for the Rehabilitation Accreditation Commission (CARF) to assist LFC auditors in reviewing progress notes of case managers. The consultant indicated that progress notes sometimes did not address the goals of the ISP. For example, case manager notes might indicate that "client is clean and dressed today" or that "client is still in pajamas and has not groomed himself today". Grooming may or may not be a stated goal of the ISP. If grooming is not a stated goal of the ISP, then such "progress" notes are irrelevant.

The consultant also noted that:

- All 11 case managers reviewed have a good awareness of reporting health and safety concerns, but considered case notes stating that "client is doing all right" to be inadequate;
- Of the 24 clients receiving behavioral therapy, case manager progress notes relating to behavioral therapy were deficient for 15 clients;
- Level of service provided by behavioral therapists appeared to be appropriate despite complaints of "over service" by some case managers; and
- A New Vision and N.M. Quality case management agencies have excellent progress reporting and could be used as the standard for other agencies.

Detailed findings of the consultant are summarized in Exhibits B and C. Exhibit B suggests that case management agencies using subcontractors rather than employees prepare better progress notes. All three agencies with employee staff had progress notes which received a rating of poor.

# DEPARTMENT OF HEALTH
## Developmental Disabilities Waiver Program
## January 7, 2002

**Recommendations:**

Revise state statutes to clearly authorize LFC auditors to have access to documentation relating to services paid for by state and federal funds.

Remind case managers to keep case management files current with freedom of choice documentation for all providers and to maintain complete documentation for clients served, even when they are no longer clients for a period of five years as required by the department.

Provide more training of case managers and their employees/subcontractors in writing progress notes. This training should be periodically repeated until progress notes are appropriate for the ISP. Progress notes should consistently and specifically address each goal identified in the client's individual service plan.

Provide a separate section on the case managers home visit/notes form to address client status relating to behavioral therapy plan. Use to consistently address progress on specific targeted behavior, outcomes, incidents, and resolutions as they arise.

**Department Response:**

Regarding access to records, it is the opinion of DOH that the authority already exists based on the agreement with Medical Assistance Division, the single state Medicaid agency. DOH will send out written clarification to providers on this issue.

Regarding retention of records, timeframes for retention of records is in the provider agreements. DOH will send out written clarification to case managers on this issue.

Training on record keeping has been done by DOH. In addition, guidelines on documentation have been mailed to all providers in November 2001. This issue will also be discussed at the next quarterly case management meeting.

The auditor's recommendation on the organization of client files will be sent to all case management agencies and discussed at the next quarterly case management meeting.

**5. DD Waiver Contracts. It is possible for subcontractors to provide both case management and other services to DD waiver clients which violates program regulations.**

Our review of DD waiver provider contract files indicated that:

- The department contract files are consistent between providers and files are generally well maintained;
- None contained copies of required performance outcomes even though contractors appeared to be aware of them; and
- A subcontractor was found to be providing services for a contracted case management agency and behavioral therapy services for another contracted agency. Subsequent discussions with other case management agencies resulted in the finding of a second subcontractor who was similarly providing different services for two agencies.

Department regulations prohibit contractors from providing both case management and other client services. No case management agency was found to have been contracted for both. However, the current computer system only lists provider agencies, not their employees or subcontractors which makes it difficult to monitor subcontractors. Currently, the department would have to look at hard copy documentation and manually compare one provider to another to determine whether case managers were providing other services to clients. With approximately 240 contracts and providers with thousands of employees and subcontractors, that is virtually impossible. Department staff indicated having requested programming modifications to track subcontractors "months ago"; however, those modifications have not been made.

We also noted that the department lacked current insurance documentation for 44 percent of files examined.

**Recommendations:**

Include a dated copy of contract amendments, namely performance measurements, in each provider file.

Complete programming modifications to the DD waiver provider contract computer system so that subcontractors can be monitored. Periodically run sorts to compare case managers, subcontractor and employees of other providers. Listing provider employees and subcontractors by social security number would facilitate matching.

Develop a spreadsheet of providers indicating when their insurances expire. Send monthly notice to appropriate providers reminding them to provide a copy of renewed insurances to the department.

**Department Response:**

DOH will ensure there is a current copy of provider amendments that contain the performance measures in the provider file.

DOH is working to develop an automated system to track all subcontractors with the capability to cross-reference across provider types. This system should be operational by the spring of 2002. DOH will explore the possibility of including the insurance information on this system as well.

**6. Monitoring of DD Waiver Providers. We commend the department for imposition of monetary penalties against providers who have failed to document services billed the department. However, financial sanctions have not been consistently imposed.**

The department's OIA conducted ten audits of residential facilities under the DD waiver program which resulted in $1.1 million in recommended recoupments. The OIA recommended these recoupments because providers lacked documentation supporting services billed. As indicated in Exhibit D, the department has negotiated settlement with three providers in the amount of $103,923. Recoupments would have been recommended against Casa Arriba; however, the records were in such bad shape that an amount could not be determined.

Another DD waiver provider was also audited by the Human Services Department (HSD), the designated state Medicaid/payment agency. That audit indicates that costs from 43 of 55 sample billings for the three month period ended March 31, 2001 were not adequately documented. HSD auditors recommended that $122,999 be recouped.

Although we commend the department for its efforts in imposing monetary penalties, negotiated settlements against several providers were not pursued. There was no written documentation explaining why a particular provider was penalized and another was not.

**Recommendation:**

Complete negotiations with providers who have not been officially sanctioned. When settlements are not imposed, formally document the reasons why sanctions are not being pursued.

Coordinate with HSD to audit thousands of other billings submitted by the provider over the prior three years. Consider similar audits for other large providers.

**Department Response:**

DOH will complete all outstanding fiscal audits by June 2002.

As the DOH now has a formal sanctions committee in place, there is a process to document all actions regarding providers. DOH will document non-action through this process.

DOH will forward the auditor's recommendation to review prior years of billing by ResCare to HSD. DOH does perform on-going fiscal audits, through the Office of Internal Audit. Those audits are both random and at the request of Division Directors.

**7. Cost Effectiveness of the DD Waiver Program. The DD waiver program met federal cost effectiveness requirements in year four (FY00) of the program, but did not meet federal standards for the first three years.**

As a condition for federal approval to operate a section 1915(c) DD waiver program, the department must operate the program at an average cost per individual that does not exceed the cost to operate the ICF/MR program per individual. New Mexico did not meet the "cost neutrality" standard until year four (FY00) of the program when the Center for Medicare and Medicaid Services (CMS) allowed the department to revise the method in which in it calculated cost effectiveness.

The cost neutrality formula is $D+D' \leq G+G'$ whereby D is the direct cost for DD waiver clients and D' represents ancillary costs such as the fee paid for Salud! healthcare per individual per year. G represents ICF/MR direct costs and G' represents ancillary costs such as fee-for-service health care costs. Thus the total cost of providing services under the DD waiver program cannot exceed the total cost under the ICF/MR program. The difference in methodology results from the manner in which ICF/MR costs are calculated. For the first three years of the waiver, ICF/MR costs were identified directly from the provider payment system of the Human Services Department based upon the actual payments to private ICF/MR providers. In year four, CMS, formerly known as HCFA, allowed the department to revise factor G and include an estimate of ICF/MR costs as though the state still operated the Los Lunas hospital and the Ft. Stanton facility. That raised ICF/MR costs and made the DD waiver program cost effective for the first time. The following are the costs for years one through four as reported on HCFA form 372(S):

# DEPARTMENT OF HEALTH
## Developmental Disabilities Waiver Program
## January 7, 2002

| Fiscal year | DD waiver cost | ICF/MR cost | Cost neutral? |
|---|---|---|---|
| FY97 (year 1) | $55,461 | $55,441 | no |
| FY98 (year 2) | $59,492 | $50,969 | no |
| FY99 (year 3) | $59,332 | $50,323 | no |
| FY00 (year 4) | $56,904 | $58,705 | yes |

New Mexico's average annual cost per person is high but is comparable to other states which have eliminated their large state institutions and have been operating a waiver program for several years:

| State | Average Expenditure per Recipient FY00 |
|---|---|
| Connecticut | $67,965 |
| Maine | $59,074 |
| Rhode Island | $58,935 |
| West Virginia | $45,057 |

Note: amounts taken from Exhibit E. New Mexico totals were revised for FY00 and differ from amounts in Exhibit E.

If the department fails to meet cost neutrality standards in the future, CMS could freeze the program as was done to the state's AIDS waiver program several years ago. This would essentially mean that no additional persons could be added into DD waiver services until cost neutrality was achieved. Normally a freeze lasts several years. The following are the department's future estimates of costs which include a three percent annual cost of living adjustment under the new waiver application:

| Program Year / Estimated waiver participants | | DD Waiver estimated cost | ICF/MR estimated cost |
|---|---|---|---|
| 1-FY02 | 3,100 | $68,787 | $81,525 |
| 2-FY03 | 3,400 | $70,946 | $84,052 |
| 3-FY04 | 3,800 | $73,176 | $86,657 |
| 4-FY05 | 4,300 | $75,479 | $89,344 |
| 5-FY06 | 4,600 | $77,857 | $92,114 |

**Recommendation:**

Monitor DD waiver expenditures to ensure cost effectiveness of the program, including review of services being provided to participants.

**Department Response:**

DOH does not have a response in this area.

**8. Facilities for High Risk Clients. The state needs to develop facilities for high risk clients.**

Our interviews with both ICF/MR and DD waiver providers indicate a need for additional providers and facilities for high risk clients. Such persons include the developmentally disabled who have mental instability, abuse drugs and those who exhibit violent and/or aberrant sexual behavior. Providers indicated they have no choice but to house such persons with low-risk clients. Staff and other clients have reportedly been assaulted by such clients. Unless these persons are convicted of a crime, they are less likely to receive appropriate treatment and are a threat to provider staff, as well as the other clients and the public.

UNM, Kaseman and Las Vegas Medical Center (LVMC) currently are the only facilities available; however, they are primarily psychiatric facilities. Providers feel that UNM and Kaseman are disinclined to accept the dually diagnosed, i.e., persons with both mental retardation and mental health issues. LVMC has ICF/MR facilities, but is often full and service for DD persons is limited by state law to 14 months.

A response team has been developed by the department's Los Lunas Community Program (LLCP) to address crisis situations. For example, additional staff may be placed in the home to assist care givers until the crisis subsides. However, LLCP resources are limited and the program also does not address long-term needs of unstable clients.

Providers indicated it appears unlikely that the private sector will develop the needed facilities due to the cost associated with development. Accordingly, Medicaid needs to re-evaluate its reimbursement methodology for ICF/MR to address the disincentive to development of specialized ICF/MR facilities.

**Recommendations:**

Request funding from the governor and the Legislature for the development of secured facilities and specially trained staff for those developmentally disabled persons who are dangerous to themselves and/or others.

Expand the role of existing facilities such as LVMC and the LLCP to include the use of residential treatment centers for the developmentally disabled with behavioral problems.

**Department Response:**

In the *Five Point Plan on the Role of Intermediate Care Facilities for the Mentally Retarded*, DOH and HSD found there was a need for small specialized facilities in New Mexico. Thus, DOH agrees with the recommendation of the LFC of such a need. However, DOH promotes this as a private sector initiative not one limited to the public sector. This is especially true in light of the findings of Judge Parker, which also applies to the private ICF/MR system, that these systems discriminate against persons with severe handicaps.

DOH will take under advisement the future use of the ICF/MR operated by the DOH.

**9. ICF/MR Program. There are substantial differences between fees paid to ICF/MR providers for the same level of care.**

The intermediate care facility program for the mentally retarded (ICF/MR) is supervised by the Human Services Department (HSD) rather than the Department of Health. LFC auditors wanted to compare that program to the DD waiver program. As a result, we reviewed services provided by six ICF/MR facilities. One of the most significant differences in the operation of the two programs is that services are bundled under the ICF/MR program. The ICF/MR facility provides the case manager who helps to coordinate all services through the facility's own employees, subcontracted providers, and/or through the Salud! program. [Case managers in ICF/MRs are referred to as qualified mental retardation professionals, or "QMRP".] The state pays one daily fee regardless of services required. Under the DD waiver program, the case manager must be separate from all other service providers and each provider is paid separately. Another significant difference is that IFC/MR clients have freedom of choice in selecting the ICF/MR but generally not other providers. Under the DD waiver program, clients have freedom of choice of each service provider, including case manager. In our examination of services provided to 29 ICF/MR clients, we also made the following observations:

- ICF/MR residential facilities vary from provider to provider. They can be virtually identical to those provided under the DD waiver program with small numbers of residents, 4 to 5, per home or have as many as 12 occupants per residence;

- Direct care staff are paid $5.55 per hour to $8.50 per hour, with adjustments for evening and night shifts. Facilities told us turnover is a significant problem.

Exhibit F and the table below indicate hourly wages paid in other states for ICF/MR services as of June 2000:

| State | Mean starting wage | Mean average wage |
|---|---|---|
| Arizona | 8.29 | 11.29 |
| Colorado | 9.15 | 12.20 |
| Louisiana | 5.62 | 7.65 |
| Michigan | 12.33 | 15.57 |
| Texas | 7.79 | 8.56 |
| Utah | 7.72 | 8.54 |

Note: Data for New Mexico is not available nor is comparable data for home/community based services.

- Client file maintenance was consistent among facilities and similar to DD waiver case managers. We found the following deficiencies:

| Deficiency | No. of instances | (%) |
|---|---|---|
| No progress notes for April 2001 in case file | 8 instances | (27.6%) |
| No documentation of staff training found for the client | 8 instances | (27.6%) |
| No Level of Care assessment form in client file | 2 instances | (6.9%) |
| No medical record in case file | 1 instance | (3.4%) |
| No signed IDT document in case file | 1 instance | (3.4%) |

- Criminal background checks are being performed; however, one provider did not require fingerprints;

- Individual service plans (ISP) are being developed for clients and interdisciplinary teams (IDT) have been established consistent with the DD waiver program;
- Level of Care assessment is consistent with that used in the DD waiver program;
- Daily record of residents is being maintained without exception. However, LFC auditors found documentation of services such as day habilitation to be difficult to identify and, if found, difficult to relate progress notes to the ISP;
- All facilities provided evidence that training is being provided to direct care staff;
- Different assessment forms are being used. Three use the "ICAP" but feel that it is inadequate. One facility has developed its own "more comprehensive" form;
- Some facilities are accredited. Some are not; and
- Daily reimbursement varies greatly among providers and reserve bed days (maximum of 65 annually) are paid at lower rates:

| Level of Care* | From/To | Annual Cost |
|---|---|---|
| 1 | $117 to $261 | $42,705 to $95,265 |
| 2 | $110 to $210 | $40,150 to $76,650 |
| 3 | $100 to $184 | $36,500 to $67,160 |
| Reserve Bed Days (maximum 65 days) | $100 to $184 | Maximum $6,500 to $11,960 |

*Rates include New Mexico gross receipts taxes. Level 1 is the highest level of care.

Rates are reviewed every three years. Facilities state that they must maintain the same services and staffing level for reserve bed days as for regular days. Staffing (and costs) cannot be reduced because one person is absent.

Exhibit G indicates the current status of the central registry for the ICF/MR program. Exhibits H and E include data as to expenditures of other states for both ICF/MR and community/home based services in other states.

**Recommendations:**

Require providers to pay a minimum hourly wage. Require all facilities to be accredited. Investigate the reasons for wide discrepancy in facility costs and establish minimums and maximums.

Transfer ICF/MR program administration, including adequate staff, to the Department of Health to provide consistency between programs and services to individuals with developmental disabilities and related conditions.

**Department Response:**

DOH does not have a response in this area.

**10. Performance Budget (Outcome) Measurement. The department has made a good start at gathering data for reporting performance of provider staff turnover for DD waiver and other LTSD programs. However, better cooperation from providers is needed, as well as improved data gathering procedures for the independence and integration measures.**

For FY02, the department has identified the following three performance measures for the developmental disabilities (DD) waiver program:

- Provider staff are hired, trained and retained to maintain stable delivery of services so that direct service turnover is less than 50 percent annually;
- At least 80 percent of individuals served use integrated settings; and
- At least 80 percent of individuals served are engaged in daily activities that maximize independence.

The department surveyed all providers as of November 2000 to ascertain baseline data for staff turnover and in January 2001 surveyed case managers of ten percent of all active recipients of waiver services. Response was good for the first survey; however, in both cases, several providers did not respond or responses were incomplete. Providers had been given these performance measures and a stated requirement of their contracts is to provide requested data. The department's letter (Exhibit I) accompanying the second survey (example at Exhibit J) clearly indicated that this data was needed to report to the state Legislature and inform other stakeholders of program outcomes. Despite repeated attempts by the department to obtain cooperation, Desert State Life Management (DSLM) case management agency failed to respond

to the second survey for 25 clients which represented 12.4 percent of the entire sample. Other agencies submitted incomplete responses for 20 (9.9 percent) clients. Poor response could materially affect survey results. LFC auditors found the staffing report to be reliable, but cannot conclude that the *Independence and Integration Analysis* report is reliable. The department planned to use this analysis` to report on the status of the independence and integration performance goals.

In its July 2001 report, *Direct Care Staffing Analysis,* the department accurately reports:

- Turnover at residential facilities exceeded the 50 percent target. Turnover ranges from 34 percent to 70 percent nationally;
- Turnover of other provider types of less than 50 percent; and
- Providers reporting difficulty in finding qualified applicants and low wages as a barrier to staff retention.

Although we found the report to be materially correct, we noted seven data entry errors which would change the reported percentages as follows:

| Provider Type | Department Reported | Adjusted Percentage |
|---|---|---|
| Case managers | 28.6% | No change |
| Residential providers | 57.9% | 57.0% |
| Other providers types | 34.2% | 35.3% |

Sole practitioner responses were eliminated; however, it is unclear if responses from corporations with only one owner-employee were also eliminated. Included in the seven noted errors is duplicate reporting by one provider operating under two different names. Other limitations of this measure include data that is self-reported by providers and is unaudited. Incorrect reporting by a large provider could materially affect results. However, the cost to audit provider data would likely exceed the benefit.

Residential providers, in particular, consistently stated low reimbursement rates (hence low hourly wages) as a barrier to reducing turnover. Wages are lowest for direct care staff of residential service agencies where turnover is reported to be the highest at 57 percent. Turnover is lowest among case managers (28.6 percent) who are among the highest paid providers. Residential providers reported stiff competition from fast food chains and retail stores.

Interviews with three Albuquerque and Santa Fe providers indicate that their DD waiver direct care staff are paid $7.00 per hour to $9.00 per hour.

LFC auditors also reviewed the department's August 2001 report on *Independence and Integration Analysis*. Although the independence and integration measures were found to be consistent with national literature on appropriate goals for DD waiver programs, we were unable to confirm the reliability of data reported for New Mexico. The department surveyed providers for approximately 202 persons served through the DD waiver program and reported on 157 responses. It is unclear whether the department will meet its 80 percent target for these measures in FY02 due to the many limitations of this survey such as:

- Lack of responses by providers for 22 percent of the sample;
- Loss of the survey responses for all but four individuals;
- Survey format designed without consideration as to how to evaluate results, hence no real evaluation of results due to the difficulty of evaluating data;
- Too many persons working on various phases of the project without supervision of a single project manager and staff turnover;
- Available computer data does not support reported numbers and percentages; and
- Providers allowed to determine what activities met the criteria for independence and integration without indicating specific goals, specific activities tied to those goals, or indicating specific progress for each of those goals.

For example, one case manager (CM) may have included a ride in a van to a grocery store with other DD persons as a meaningful life activity while that activity may not have been accepted by another CM. To what extent activities were integrated with non-DD persons cannot be determined by the survey. A CM may have indicated that a client had five goals, but reported the progress on those goals as a three (average progress). However, progress may have been a one for two goals, three for one goal, and a five (maximum achievement) for two goals for an average of three. Additionally, "life" and "fun/relationship" components were made separate reporting areas and thus it is impossible to determine whether 80 percent were more independent and served in integrated settings because responses may be diluted. The two other areas of reporting were "work" and "other" goals. If "life" and "fun/relationship" reporting were combined, the department may have achieved its 80 percent targets for the independence and integration goals. However, as reported, the department does not appear to be achieving it targets. Nevertheless, LFC auditors believe that 80 percent targets are too low. The very nature and purpose of the DD

waiver program is to increase independence and integrate DD persons into community settings because of the way in which services are provided. Thus, the target should be closer to 100 percent.

Twenty states currently participate in the Core Indicators Project (CIP) 2001. CIP is a collaboration of the National Association of State Directors of Developmental Disabilities Services (Alexandria, Virginia) and the Human Services Research Institute (Cambridge, Massachusetts). Questions are numerous, detailed and specific to predefined activities which have been identified as contributing to independence and community integration for DD persons. The CIP survey questions also contain features to determine inconsistency of responses. The Jackson lawsuit monitor has also developed a set of very specific questions designed to assess the existence and achievement of independence and integration which could be utilized. However, neither of these was incorporated into the department's survey.

**Recommendations:**

Have an employee who is knowledgeable of providers review data entry to ensure proper reporting and recording so that data is not duplicated. Also review contracts to eliminate corporations having only one shareholder employee, as well as those of sole practitioners. Separately evaluate their responses.

Analyze staffing data with and without large providers to ensure consistency of results for all providers.

Consider specific designation of increases in legislative appropriations for the purpose of providing raises for direct care staff at residential facilities.

Obtain more detailed information as to the types of activities which are being counted toward independence and integration to ensure their appropriateness. For example, modify the survey whereby case managers must indicate the specific goals of the individual service plan and report individually on the progress of each. This would be more consistent with the staffing survey in which providers checked off strategies used to retain staff. Combine the "live" and "fun/relationship" categories.

Develop more detailed survey/reporting. Utilize questions such as those used in the Core Indicators Project to provide a comparability of New Mexico's performance with other states.

Assign one person with responsibility for all aspects of the independence and integration project. That person should re-design the survey instrument, review reported data to ensure reliability, as

well as the interpretation of results. Obtain the services of UNM and/or other consultant to assist in the design and interpretation of the survey.

Use a document scanner to copy survey responses onto CD-rom for safekeeping.

**Department Response:**

Staff turnover – DOH used the high turnover for residential staff to target $800,000 of appropriations in FY 2002 to address these rates. The adjusted residential rates were effective November 1, 2001. DOH will review the effect of these changes on staff turnover when providers submit the next survey. Data should be available for discussion with the legislature towards the end of the 30-day session.

Independence and integration –

- Control of data entry and original documents will be coordinated in the Santa Fe office.
- DOH is maintaining the current tool, with some clarifications. The data collection methodology will also remain the same as it is the professional opinion of DOH staff that case managers are the best overview of the lives of individuals in service to make a professional judgment regarding independence and integration. As this performance measure is in all provider contracts, DOH will stress that response is not optional but is a contract compliance issue.
- Due to the limitation of contract dollars, DOH is not in a position to hire an outside consultant to assist with design and analysis of the data collection tool to measure independence and integration.

**11. Provider Issues. The department can help providers by making changes in its computer programs and grant more authority to regional offices.**

*Computer Issues*. DD waiver program providers want the department to make changes in two computer systems to reduce administrative burdens on them as follows:

- the provider payment system, and
- the provider listing.

Providers call the provider payment system (PPS) an "antiquated and inefficient" system which runs on an old DOS platform rather than on a user-friendly windows environment. They state

that it requires triple entry of data which is time consuming and requires manual conversion. Budget correction is said to be especially difficult.

Case managers are also concerned about the costs of preparing lists of regional providers for their clients. For example when a client needs a behavioral therapist, case managers must go through the single combined, alphabetical list of all providers and weekly updates to identify choices for clients. Although LFC auditors found no evidence of this, some providers feel that they are not on all case manager lists for their service type. Case managers also say they are concerned about the possibility of leaving a provider off a list and accidently limiting a client's freedom of choice.

Case managers hire staff or contractors to specifically work with these systems. They indicate that computer costs are becoming too expensive and suggest that costs could be substantially reduced if these systems were replaced and/or modified to be user-friendly. Upon request, the department provided LFC auditors with listings of providers by type. Thus it seems possible that a sorted list could be distributed in hard copy or electronic form.

*Other Matters*. Providers praised department regional office staff and think they are knowledgeable, responsive and helpful. However, they felt the Santa Fe headquarters office should grant regional offices more authority for timely decision making. Providers also feel that their input was not solicited for the development of the new DD waiver application. They are concerned that:

- Case managers will be granted too much authority to determine the number of services a client will receive. [Note: some case managers feel that some providers are providing more services than needed.];
- The rate cap being placed on services and the lumping of money may result in prioritization of therapy needs; and
- The requirement for ISPs to be approved within 60 days rests more with Blue Cross Blue Shield, than with them.

Other concerns relate to the amount of paperwork and mandates to attend some department training programs which they feel are unnecessary. Some trainings are either too basic and/or repetitious of other department mandated training.

**Recommendations:**

Convert the provider payment system to a windows based environment complete with "easy budget document correction capability".

Provide access to provider listing in electronic form which can be sorted by provider type and region or provide sorted lists to case managers.

Grant more authority to regional offices. Obtain additional input from providers for the 2001 DD waiver application. Authorize regional offices to resolve differences between case managers and other providers regarding service levels and/or create a hearing unit.

Identify areas where paperwork could be reduced or minimized.

Consolidate short training programs into a one or two day program. Evaluate training programs for effectiveness and relevancy.

**Department Response:**

The provider payment system is very sophisticated in its ability to store information by client detailed budget. Providers are encouraged to submit electronically thus reduce errors or duplicate data entry. The new Medicaid Management Information System will replace the PPS system, when it becomes operational in 2003.

Budget errors can be of several forms, however to ensure integrity of the system, only Blue Cross/Blue Shield, the Medicaid utilization review contractor is authorized to make any changes to approved services.

Regarding the provider lists used by case managers to present choice of servicing providers, or the Secondary Freedom of Choice, DOH is working on automating this process and being in charge of sending the lists to case management agencies. This project should be completed in 2002.

The role of regional offices is critical in addressing local client and provider issues. They provide all the follow-up to confirmed cases of abuse, neglect, and exploitation. They are in the role of working on conflicts among members of the individual's support team. If they are not successful, the LTSD provides access to mediation services. Finally, it is the regional offices that make recommendations to central office regarding providers who need to be reviewed and/or sanctioned.

Reduction of paperwork is always a goal.

# EXHIBITS

## Department of Health
## Status of DD Waiver Registrations

EXHIBT A

ount of Clients — Region

| Period | Status | Metro | NE | NW | SE | SW | Not Identified | Total |
|---|---|---|---|---|---|---|---|---|
| 30-Jun-99 | 1. In Service | 791 | 228 | 146 | 218 | 247 | | 1,630 |
| | 2. Waiting | 652 | 130 | 121 | 122 | 237 | | 1,262 |
| | 3. On Hold | 19 | 6 | 3 | 5 | | | 33 |
| | 4. Closed | 685 | 174 | 182 | 175 | 227 | 51 | 1,494 |
| * | 5. Not Identified | 264 | 95 | 23 | 118 | 72 | 8 | 580 |
| Total | | 2,411 | 633 | 475 | 638 | 783 | 59 | 4,999 |

ount of Clients — Region

| Period | Status | Metro | NE | NW | SE | SW | Not Identified | Total |
|---|---|---|---|---|---|---|---|---|
| 30-Jun-00 | 1. In Service | 1043 | 273 | 174 | 249 | 297 | | 2,036 |
| | 2. Waiting | 887 | 185 | 157 | 188 | 352 | 0 | 1,769 |
| | 3. On Hold | 19 | 6 | 3 | 5 | 0 | 0 | 33 |
| | 4. Closed | 891 | 244 | 212 | 227 | 263 | 78 | 1,915 |
| * | 5. Not Identified | 305 | 138 | 27 | 147 | 92 | 9 | 718 |
| Total | | 3,145 | 846 | 573 | 816 | 1,004 | 87 | 6,471 |

ount of Clients — Region

| Period | Status | Metro | NE | NW | SE | SW | Not Identified | Total |
|---|---|---|---|---|---|---|---|---|
| 30-Jun-01 | 1. In Service | 1269 | 306 | 194 | 279 | 348 | | 2,396 |
| | 2. Waiting | 1,232 | 273 | 234 | 280 | 478 | 0 | 2,497 |
| | 3. On Hold | 19 | 6 | 3 | 5 | 0 | 0 | 33 |
| | 4. Closed | 1,015 | 289 | 216 | 266 | 274 | 80 | 2,140 |
| * | 5. Not Identified | 307 | 138 | 30 | 156 | 100 | 10 | 741 |
| Total | | 3,842 | 1,012 | 677 | 986 | 1,200 | 90 | 7,807 |

ount of Clients — Region

| Period | Status | Metro | NE | NW | SE | SW | Not Identified | Total |
|---|---|---|---|---|---|---|---|---|
| 19-Oct-01 | 1. In Service | 1340 | 322 | 202 | 291 | 371 | | 2,526 |
| | 2. Waiting | 1,310 | 292 | 253 | 315 | 529 | 3 | 2,702 |
| | 3. On Hold | 19 | 6 | 3 | 5 | | | 33 |
| | 4. Closed | 1,016 | 289 | 216 | 269 | 274 | 80 | 2,144 |
| * | 5. Not Identified | 307 | 138 | 30 | 157 | 101 | 11 | 744 |
| Total | | 3,992 | 1,047 | 704 | 1,037 | 1,275 | 94 | 8,149 |

* Not Identified as to status or region.

**Department of Health** **EXHIBIT B**
**Review of Case Manager Progress Notes**
**DD Waiver Program**

| Provider<br>No. of clients | | Progress Notes for Individual Service Plan<br>Very Good | Adequate | Poor |
|---|---|---|---|---|
| **Case Managers who are Employees** | | | | |
| **A.** | 6 clients | 1 | 2 | 3 |
| **B.** | 3 clients | | | 3 |
| **C.** | 4 clients | | | 4 |
| **D.** | 2 clients | 1 | 1 | |
| **Case Managers who are Sub-Contractors** | | | | |
| **E.** | 1 clients | 1 | | |
| **F.** | 5 clients | | 5 | |
| **G.** | 7 clients | 3 | 4 | |
| **H.** | 3 clients | 3 | | |
| **I.** | 4 clients | | 4 | |
| **J.** | 4 clients | 1 | 3 | |
| **K.** | 9 clients | | 9 | |
| | **48** | **10** | **28** | **10** |

**Department of Health**
**Review of Case Manager Progress Notes**
**for Behavioral Therapy (BT) Services**
**DD Waiver Program**

| **Provider** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No. of BT clients | 3 | 2 | 4 | 3 | 3 | 1 | 2 | 0 | 3 | 3 | 24 |
| 1 Illegible handwriting difficult to determine content | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 3 |
| 2 Case file notes do not refer to behavior plan | 0 | 0 | 3 | 1 | 0 | 1 | 2 | 0 | 1 | 1 | 9 |
| 3 Case file notes refer to plan but are inadequate to determine progress | 1 | 1 | 0 | 0 | 0 | 1 | 2 | 2 | 0 | 0 | 7 |
| 4 No followup on critical issues of safety id'd by behavior therapist | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| 5 No evidence of monthly or quarterly report from behavior therapist | 2 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 7 |
| 6 ISP does not state reason for psychotropic meds | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 3 |
| 7 Notes are too brief to determine meaning | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 |
| 8 Unable to ascertain if evaluation recommended by behavior therapist was done | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 1 | 4 |

EXHIBIT C

**Department of Health (DoH)**

## Monetary Sanctions Imposed Against DD Waiver Providers

| Provider Name | Audit Date | Period Covered | Recommended Recoupment | Negotiated Settlement | Amount Recouped as of 11/30/01 |
|---|---|---|---|---|---|
| Alliance BHS of Southern N.M. | June 8, 2000 | FY00 (7/99-4/00) | $ 160,702 | 23,550 | 17,728 |
| Casa Arriba, Inc. | July 2, 2001 | FY01 (12/00-5/01) | 0 | Facility closed | 0 |
| Challenge N.M. | Jan 26, 2000 | FY99 (7/98-6/99) | 95,169 | 21,292 | 0 |
| Coyote Canyon | June 5, 1998 | FY97 (7/96-6/97) | 13,112 | ? | ? |
| Desert Care Corp dba Sun Country Case Mgt | Jan 23, 2001 | FY00/01 (7/99-10/00) | 147 | 0 | 0 |
| Leaders Industries | April 21, 1998 | FY97 (7/96-6/97) | 8,213 | ? | ? |
| McKinley Opportunity | Aug 17, 1999 | FY99 (7/98-4/99) | 9,611 | ? | ? |
| Presbyterian Medical Services (PMS) | Oct 15, 1998 | FY98 (7/97-3/98) | 16,234 | 4,221 | 4,221 |
| Residential Resorts | Feb 5, 2001 | FY00/99 (7/98-6/00) | 293,326 | ** | 0 |
| Southwest NM Services Helping Children | June 15, 1999 | FY98(7/97-6/98) | 501,105 | 76,152 | 76,152 |
| | | | $ 1,097,619 | 125,215 | 98,101 |

**Note:**
"?" indicates DoH has no documentation as to disposition.
** DoH is in process of negotiating a settlement.

EXHIBIT D

## Table 3.7 Summary Statistics on HCBS Expenditures by State for Fiscal Year 2000

| State | HCBS Expenditures ($) | Federal Cost Share | Total Federal HCBS Payments ($) | State % of Federal HCBS Payments | End of Year HCBS Recipients | HCBS Expenditures per End of Year Recipient ($) | Average Daily HCBS Recipients | HCBS Expenditures per Average Daily Recipient ($) | State Population (100,000) | Annual HCBS Expenditure per State Resident ($) |
|---|---|---|---|---|---|---|---|---|---|---|
| AL | 96,422,235 | 0.70 | 67,080,949 | 1.24% | 4,100 e | 23,518 | 3,996 | 24,133 | 44.47 | 21.68 |
| AK | 30,618,719 | 0.60 | 18,309,994 | 0.34% | 665 | 46,043 | 566 | 54,145 | 6.27 | 48.84 |
| AZ | 287,561,709 | 0.66 | 189,560,679 | 3.51% | 11,259 | 25,541 | 10,720 | 26,826 | 51.31 | 56.05 |
| AR | 34,048,499 | 0.73 | 24,804,331 | 0.46% | 2,084 | 16,338 | 1,866 | 18,252 | 26.73 | 12.74 |
| CA | 478,275,304 | 0.52 | 247,124,850 | 4.57% | 28,233 | 16,940 | 29,310 | 16,318 | 338.72 | 14.12 |
| CO | 191,256,954 e | 0.50 | 95,628,477 | 1.77% | 6,330 e | 30,214 | 6,187 | 30,915 | 43.01 | 44.47 |
| CT | 344,991,304 | 0.50 | 172,495,652 | 3.19% | 5,076 | 67,965 | 4,785 | 72,106 | 34.06 | 101.30 |
| DE | 27,432,573 | 0.50 | 13,716,287 | 0.25% | 481 | 57,032 | 468 | 58,617 | 7.84 | 35.01 |
| DC | 277,361 | 0.70 | 194,153 | NA | 67 | 4,140 | 34 | 8,279 | 5.72 | NA |
| FL | 251,835,128 | 0.57 | 142,337,213 | 2.63% | 21,126 | 11,921 | 17,468 | 14,417 | 159.82 | 15.76 |
| GA | 92,058,075 | 0.60 | 55,124,375 | 1.02% | 2,468 | 37,301 | 2,658 | 34,641 | 81.86 | 11.25 |
| HI | 23,000,000 | 0.51 | 11,732,300 | 0.22% | 1,089 | 21,120 | 1,032 | 22,287 | 12.12 | 18.98 |
| ID | 16,279,344 | 0.70 | 11,419,960 | 0.21% | 801 | 20,324 | 655 | 24,854 | 12.94 | 12.58 |
| IL | 140,200,000 | 0.50 | 70,100,000 | 1.30% | 6,787 | 20,657 | 6,644 | 21,103 | 124.19 | 11.29 |
| IN | 73,046,098 | 0.62 | 45,098,660 | 0.83% | 2,081 | 42,563 | 1,818 | 40,190 | 60.80 | 14.57 |
| IA | 88,572,719 | 0.63 | 55,853,957 | 1.03% | 4,603 | 19,242 | 4,361 | 20,313 | 29.28 | 30.27 |
| KS | 169,350,998 | 0.60 | 101,661,404 | 1.88% | 5,442 | 31,119 | 5,281 | 32,068 | 26.88 | 62.99 |
| KY | 60,431,857 | 0.71 | 42,634,675 | 0.79% | 1,279 | 47,249 | 1,159 | 52,141 | 40.42 | 14.95 |
| LA | 95,374,532 | 0.70 | 67,067,371 | 1.24% | 3,629 | 26,281 | 3,301 | 28,893 | 44.69 | 21.34 |
| ME | 108,340,801 | 0.66 | 71,743,278 | 1.33% | 1,834 | 59,074 | 1,722 | 62,916 | 12.75 | 84.98 |
| MD | 296,483,318 | 0.50 | 148,241,659 | 2.74% | 4,959 | 59,787 | 4,310 | 68,798 | 52.98 | 55.98 |
| MA | 423,921,872 | 0.50 | 211,960,936 | 3.92% | 10,375 | 40,860 | 10,527 | 40,272 | 63.49 | 66.77 |
| MI | 310,750,681 a | 0.55 | 171,254,700 | 3.17% | 8,024 | 38,728 | 8,024 | 38,728 | 99.38 | 31.27 |
| MN | 408,223,727 | 0.51 | 210,153,575 | 3.89% | 7,948 | 51,362 | 7,525 | 54,249 | 49.19 | 82.98 |
| MS | 4,421,857 | 0.77 | 3,395,986 | 0.06% | 850 | 5,202 | 700 | 6,317 | 26.45 | 1.55 |
| MO | 198,881,707 | 0.61 | 120,343,321 | 2.23% | 8,238 | 24,142 | 8,082 | 24,608 | 55.95 | 35.54 |
| MT | 33,561,580 | 0.72 | 24,265,022 | 0.45% | 1,206 | 27,829 | 1,068 | 31,439 | 9.02 | 37.20 |
| NE | 82,541,453 | 0.61 | 50,251,237 | 0.93% | 2,318 | 35,609 | 2,306 | 35,794 | 17.11 | 48.23 |
| NV | 12,245,000 e | 0.50 | 6,122,500 | 0.11% | 795 e | 15,403 | 798 | 15,354 | 19.98 | 6.13 |
| NH | 99,742,724 | 0.50 | 49,871,362 | 0.92% | 2,475 | 40,300 | 2,376 | 41,988 | 12.36 | 80.71 |
| NJ | 296,254,000 | 0.50 | 148,127,000 | 2.74% | 6,894 | 42,973 | 6,765 | 43,795 | 84.14 | 35.21 |
| NM | 109,600,000 | 0.73 | 80,358,720 | 1.49% | 2,104 | 52,091 | 1,935 | 56,655 | 18.19 | 60.25 |
| NY | 1,694,409,797 | 0.50 | 847,204,899 | 15.68% | 36,100 | 46,937 | 34,900 | 48,551 | 189.76 | 89.29 |
| NC | 182,951,551 | 0.62 | 114,326,424 | 2.12% | 5,364 | 34,107 | 5,169 | 35,394 | 80.49 | 22.73 |
| ND | 41,961,852 | 0.70 | 29,549,536 | 0.55% | 1,936 e | 21,675 | 1,906 | 22,021 | 6.42 | 65.34 |
| OH | 178,002,921 * | 0.59 | 104,434,314 | 1.93% | 5,624 | 31,651 | 5,475 | 32,515 | 113.53 | 15.68 |
| OK | 147,633,041 | 0.71 | 104,952,329 | 1.94% | 2,983 | 49,491 | 2,889 | 51,102 | 34.51 | 42.78 |
| OR | 232,255,296 | 0.60 | 139,260,275 | 2.58% | 5,824 | 39,879 | 5,662 | 41,020 | 34.21 | 67.88 |
| PA | 677,863,076 | 0.54 | 364,825,908 | 6.75% | 16,830 | 40,277 | 13,475 | 50,307 | 122.81 | 55.20 |
| RI | 145,628,986 | 0.54 | 78,304,706 | 1.45% | 2,471 | 58,935 | 2,432 | 59,880 | 10.48 | 138.92 |
| SC | 111,100,000 | 0.70 | 77,714,450 | 1.44% | 4,370 | 25,423 | 4,222 | 26,318 | 40.12 | 27.69 |
| SD | 49,960,426 | 0.69 | 34,332,805 | 0.64% | 1,991 | 25,093 | 1,981 | 25,220 | 7.55 | 66.19 |
| TN | 159,937,100 | 0.63 | 100,920,310 | 1.87% | 4,311 | 37,100 | 4,313 | 37,083 | 56.89 | 28.11 |
| TX | 269,268,002 | 0.61 | 165,222,846 | 3.06% | 6,406 | 42,034 | 6,232 | 43,207 | 208.52 | 12.91 |
| UT | 74,301,900 | 0.72 | 53,163,009 | 0.98% | 3,152 | 23,573 | 3,005 | 24,730 | 22.33 | 33.27 |
| VT | 60,014,162 | 0.62 | 37,352,814 | 0.69% | 1,684 | 35,638 | 1,612 | 37,230 | 6.09 | 98.57 |
| VA | 144,547,915 | 0.52 | 74,687,908 | 1.38% | 4,635 | 31,186 | 4,107 | 35,195 | 70.79 | 20.42 |
| WA | 183,834,623 | 0.52 | 95,281,485 | 1.76% | 8,984 | 20,462 | 8,575 | 21,440 | 58.94 | 31.19 |
| WV | 87,636,000 | 0.75 | 65,534,201 | 1.21% | 1,945 | 45,057 | 1,898 | 46,173 | 18.08 | 48.46 |
| WI | 273,005,532 | 0.59 | 160,472,652 | 2.97% | 9,547 | 28,596 | 8,961 | 30,466 | 53.64 | 50.90 |
| WY | 44,143,517 | 0.64 | 28,269,508 | 0.52% | 1,226 | 36,006 | 1,169 | 37,762 | 4.94 | 89.40 |
| US Total | 9,644,457,821 | | 5,403,844,960 | 100.00% | 291,003 | 33,142 | 276,417 | 34,891 | 2,814.22 | 34.27 |

* Residential Facility waiver implemented in Fiscal Year 1999

a = FY 1999 data

e = estimate

57.1%

75.8%↑

## Wages and Benefits

Table 1.30 shows that in June 1998, the starting wage for direct care workers in state residential settings was $8.68 per hour while the mean wage was $10.87. By June 2000, the starting wage for direct care workers had risen to $9.19 (an increase of 5.9%) while the mean wage had increased to $11.57, an increase of 7.1% in two years. The average reported wages decreased in seven states (by -0.5% in Georgia to -12.5% in Mississippi). In the other states, average reported wages increased, including increases ranging from 0.6% in Illinois to 29.9% in Indiana.

Wages for direct support staff members varied widely across the states. Starting wages ranged from $5.62 per hour in Louisiana to $14.86 per hour in Connecticut. Average reported wages for direct support staff members ranged from $7.65 per hour in Louisiana to $19.18 per hour in Connecticut. Starting wages were below $7.00 per hour in five states and above $12.00 per hour in three states. Average wages were below $8.00 per hour in three states and above $15.00 per hour in five states.

The number of hours direct support workers had to work to be eligible for paid time off (e.g., sick, vacation, holiday) ranged from 6.0 to 40.0 hours per week. The average nationally was 23.0 hours per week. A person employed halftime could earn paid leave in 31 of 40 reporting states.

Figures 1.9 and 1.10 show graphically the differences between states in average wages paid to direct care workers (aides and technicians) and in turnover of those same workers.

## Staffing Outcomes

Several different staffing outcomes were measured in the surveys of large public residential facilities. As Table 1.31 shows, in 2000 the average state facility reported direct support staff turnover rates of 27% with a range from 7.2% in Pennsylvania to 56.1% in Louisiana. Eight states (Arizona, Georgia, Kentucky, Louisiana, Mississippi, Nebraska, Texas and Wyoming) reported turnover rates of more than 40%. Only three states reported turnover rates of less than 10% per year for direct support workers. Between 1998 and 2000, eight states reported declines in their turnover rates for direct care workers, while 33 states reported increases. Overall, turnover increased 24.8% between 1998 and 2000 (increasing from an average of 20.3% to an average of 27.0%). The biggest increases were in Oregon (increasing from 6.5% to 28%) and in Washington (increasing from 7.0% to 23.7%).

## Table1.30 Wages and Benefits of Personnel in June 2000

| | 1998 | | 2000 | | | Change 1998 to 2000 | |
|---|---|---|---|---|---|---|---|
| State | Mean Starting Wage ($) | Mean Wage ($) | Mean Starting Wage ($) | Mean Wage ($) | Hours for Eligibility for Paid Leave | Starting Wage | Average Wage |
| AL | 6.37 | 8.14 | 6.96 | 8.80 | 32 | 9.3% | 8.1% |
| AK | NA | NA | NA | NA | NA | NA | NA |
| AZ | DNF | DNF | 8.29 | 11.29 | 20 | DNF | DNF |
| AR | 6.68 | 9.39 | 7.71 | 9.60 | 30 | 15.4% | 2.2% |
| CA | 13.00 | 15.56 | 14.45 | 18.99 | 20 | 11.2% | 22.0% |
| CO | 8.95 | 10.07 | 9.15 | 12.20 | 16 | 2.2% | 21.2% |
| CT | 13.83 | 17.12 | 14.86 | 19.18 | 18 | 7.4% | 12.0% |
| DE | 9.11 | 11.39 | 9.52 | 11.75 | 30 | 4.5% | 3.2% |
| DC | NA | NA | NA | NA | NA | NA | NA |
| FL | 7.29 | 9.90 | 8.31 | 11.07 | 35 | 14.0% | 11.8% |
| GA | 8.50 | 10.55 | 8.44 | 10.50 | 26 | -0.7% | -0.5% |
| HI | 9.24 | 11.38 | NA | NA | NA | NA | NA |
| ID | 7.85 | 11.30 | 10.31 | 11.59 | 20 | 31.3% | 2.6% |
| IL | 8.15 | 12.36 | 8.87 | 12.43 | 20 | 8.8% | 0.6% |
| IN | 7.05 | 9.38 | 8.87 | 12.18 | 38 | 25.8% | 29.9% |
| IA | 10.96 | 13.50 | 11.56 | 13.83 | 30 | 5.5% | 2.4% |
| KS | 9.24 | 11.20 | 8.50 | 10.98 | 12 | -8.0% | -2.0% |
| KY | 6.28 | 7.26 | 8.63 | 9.52 | 25 | 37.4% | 31.1% |
| LA | 5.62 | 7.46 | 5.62 | 7.65 | 29 | 0.0% | 2.5% |
| ME | NA | NA | NA | NA | NA | NA | NA |
| MD | 7.57 | 10.22 | 8.16 | 11.75 | 20 | 7.7% | 15.0% |
| MA | 9.91 | 11.60 | 10.26 | 12.04 | 20 | 3.5% | 3.8% |
| MI | 12.50 | 14.99 | 12.33 | 15.57 | 20 | -1.4% | 3.9% |
| MN | 9.54 | 13.71 | 11.54 | 15.51 | 9 | 21.0% | 13.1% |
| MS | 6.63 | 9.01 | 6.95 | 7.89 | 27 | 4.9% | -12.5% |
| MO | 6.47 | 7.52 | 7.23 | 8.31 | 20 | 11.8% | 10.5% |
| MT | 6.85 | 8.52 | 7.21 | 8.99 | DNF | 5.3% | 5.5% |
| NE | 8.10 | 10.09 | 8.59 | 9.63 | 40 | 6.0% | -4.6% |
| NV | 10.15 | 13.92 | 10.36 | 15.05 | 13 | 2.1% | 8.1% |
| NH | NA | NA | NA | NA | NA | NA | NA |
| NJ | 9.27 | 13.06 | 9.58 | 13.25 | 27 | 3.3% | 1.4% |
| NM | NA | NA | NA | NA | NA | NA | NA |
| NY | 10.52 | 13.30 | 10.12 | 13.25 | 21 | -3.8% | -0.4% |
| NC | 8.54 | 9.30 | 8.75 | 10.55 | 28 | 2.5% | 13.5% |
| ND | 8.09 | 9.33 | 7.36 | 8.65 | 20 | -9.0% | -7.3% |
| OH | 11.29 | 12.42 | 11.81 | 13.41 | 10 | 4.6% | 8.0% |
| OK | 6.83 | 7.60 | 6.83 | 8.34 | 20 | 0.0% | 9.7% |
| OR | 9.21 | 10.70 | 9.80 | 11.00 | 8 | 6.4% | 2.8% |
| PA | 9.53 | 13.69 | 10.12 | 14.11 | 21 | 6.2% | 3.1% |
| RI | NA | NA | NA | NA | NA | NA | NA |
| SC | 6.53 | 7.59 | 6.80 | 7.88 | 33 | 4.1% | 3.8% |
| SD | DNF | 7.58 | 8.59 | 9.73 | 32 | DNF | 28.7% |
| TN | 7.17 | 9.08 | 8.24 | 8.57 | 36 | 15.0% | -5.7% |
| TX | 6.77 | 7.46 | 7.79 | 8.56 | 6 | 15.0% | 14.7% |
| UT | 7.31 | 8.50 | 7.72 | 8.54 | 40 | 5.6% | 0.5% |
| VT | NA | NA | NA | NA | NA | NA | NA |
| VA | 8.21 | 9.44 | 8.96 | 10.39 | 28 | 9.1% | 10.1% |
| WA | 10.50 | 13.88 | 10.46 | 14.52 | 25 | -0.4% | 4.6% |
| WV | NA | NA | NA | NA | NA | NA | NA |
| WI | 9.14 | 11.51 | 11.47 | 14.32 | 17 | 25.5% | 24.4% |
| WY | 6.95 | 7.50 | 6.94 | 8.95 | 10 | -0.1% | 19.3% |
| Total | 8.68 | 10.81 | 9.19 | 11.57 | 23 | 5.9% | 7.1% |

DNF = did not funished

NA = not applicable

**EXHIBIT G**

# ICF/MR Central Registry
## As of October 19, 2001
## Administered by Human Services Department

| Region | No. Registrants |
|---|---|
| Metro | 62 |
| NE | 16 |
| NW | 11 |
| SE | 57 |
| SE | 13 |
| Not identified | 4 |
| | 163 |

### Status of Registrants

| | |
|---|---|
| Started Registration | 22 |
| Completed Registration | 85 |
| | 107 |
| Closed Cases | 36 |
| Not identified | 20 |
| | 163 |

### Reason for Closures

| | |
|---|---|
| Placed into ICF/MR | 10 |
| Did not respond | 9 |
| Did not complete registration | 7 |
| Deceased | 5 |
| Requested closure | 3 |
| Moved out-of-state | 1 |
| Not identified | 1 |
| | 36 |

# Table 3.4 Summary Statistics on ICF-MR Expenditures for Persons with MR/DD by State for Fiscal Year 2000

| State | ICF-MR Expenditures ($) | Federal Cost Share | Total Federal ICF-MR Payments ($) | End of Year ICF-MR Residents | ICF-MR Expenditures per End of Year Resident ($) | Average Daily Residents in ICFs-MR | ICF-MR Expenditures per Daily Resident ($) | State Population (100,000) | Annual Expenditure per State Resident ($) | State % of Federal ICF-MR |
|---|---|---|---|---|---|---|---|---|---|---|
| AL | 63,946,199 | 0.70 | 44,487,371 | 633 | 101,021 | 651 | 98,228 | 44.47 | 14.38 | 0.79% |
| AK | 0 | 0.60 | 0 | 0 | 0 | 0 | NA | 6.27 | 0.00 | 0.00% |
| AZ | 17,010,609 | 0.66 | 11,213,393 | 173 | 98,327 | 195 | 87,234 | 51.31 | 3.32 | 0.20% |
| AR | 121,239,605 | 0.73 | 88,323,052 | 1,766 | 68,652 | 1,759 | 68,925 | 26.73 | 45.35 | 1.57% |
| CA | 387,213,341 | 0.52 | 200,073,133 | 11,158 | 34,703 | 11,217 | 34,520 | 338.72 | 11.43 | 3.55% |
| CO | 17,985,707 | 0.50 | 8,992,854 | 138 | 130,331 | 145 | 124,039 | 43.01 | 4.18 | 0.16% |
| CT | 230,624,610 | 0.50 | 115,312,305 | 1,276 | 180,740 | 1,294 | 178,226 | 34.06 | 67.72 | 2.04% |
| DE | 32,544,972 | 0.50 | 16,272,486 | 253 | 128,636 | 256 | 127,129 | 7.84 | 41.53 | 0.29% |
| DC | 70,280,093 | 0.70 | 49,196,065 | 840 | 83,667 | 797 | 88,181 | 5.72 | 122.85 | 0.87% |
| FL | 281,143,157 | 0.57 | 158,902,112 | 3,440 | 81,728 | 3,416 | 82,302 | 159.82 | 17.59 | 2.82% |
| GA | 110,219,342 | 0.60 | 65,999,342 | 1,645 | 67,003 | 1,620 | 68,037 | 81.86 | 13.46 | 1.17% |
| HI | 7,975,547 | 0.51 | 4,068,327 | 96 | 83,079 | 96 | 83,079 | 12.12 | 6.58 | 0.07% |
| ID | 53,210,529 | 0.70 | 37,327,186 | 592 | 89,883 | 584 | 91,114 | 12.94 | 41.12 | 0.66% |
| IL | 649,195,470 | 0.50 | 324,597,735 | 10,310 | 62,968 | 10,487 | 61,905 | 124.19 | 52.27 | 5.76% |
| IN | 258,454,594 | 0.62 | 159,569,866 | 5,423 | 47,659 | 5,647 | 45,768 | 60.80 | 42.51 | 2.83% |
| IA | 191,252,400 | 0.63 | 120,603,763 | 3,028 | 63,161 | 2,640 | 72,444 | 29.26 | 65.36 | 2.14% |
| KS | 66,924,380 | 0.60 | 40,174,705 | 853 | 78,458 | 841 | 79,577 | 26.88 | 24.89 | 0.71% |
| KY | 83,523,742 | 0.71 | 58,926,000 | 1,120 | 74,575 | 1,147 | 72,819 | 40.42 | 20.67 | 1.04% |
| LA | 347,438,513 | 0.70 | 244,318,762 | 5,620 | 61,822 | 5,626 | 61,756 | 44.69 | 77.74 | 4.33% |
| ME | 35,306,066 | 0.66 | 23,379,677 | 298 | 118,477 | 301 | 117,296 | 12.75 | 27.69 | 0.41% |
| MD | 58,820,123 | 0.50 | 29,410,062 | 525 | 112,038 | 548 | 107,336 | 52.96 | 11.11 | 0.52% |
| MA | 210,037,470 | 0.50 | 105,018,735 | 1,266 | 165,906 | 1,306 | 160,825 | 63.49 | 33.08 | 1.86% |
| MI | 27,883,649 | 0.55 | 15,366,679 | 269 | 103,657 | 271 | 102,892 | 99.38 | 2.81 | 0.27% |
| MN | 208,714,012 | 0.51 | 107,445,973 | 2,775 | 75,212 | 2,920 | 71,477 | 49.19 | 42.43 | 1.91% |
| MS | 158,201,464 | 0.77 | 121,498,724 | 2,487 | 63,611 | 2,467 | 64,127 | 28.45 | 55.61 | 2.15% |
| MO | 99,798,131 | 0.61 | 60,387,849 | 1,371 | 72,792 | 1,381 | 72,265 | 55.95 | 17.84 | 1.07% |
| MT | 17,425,050 | 0.72 | 12,598,311 | 130 | 134,039 | 135 | 129,074 | 9.02 | 19.31 | 0.22% |
| NE | 48,861,869 | 0.61 | 29,747,106 | 648 | 75,404 | 650 | 75,172 | 17.11 | 28.55 | 0.53% |
| NV | 28,496,213 | 0.50 | 14,248,107 | 252 | 113,080 | 278 | 102,504 | 19.98 | 14.26 | 0.25% |
| NH | 1,660,413 | 0.50 | 830,207 | 24 | 69,184 | 25 | 66,417 | 12.36 | 1.34 | 0.01% |
| NJ | 380,579,725 | 0.50 | 190,289,863 | 3,487 | 109,142 | 3,510 | 108,427 | 84.14 | 45.23 | 3.37% |
| NM | 27,815,226 | 0.73 | 20,394,124 | 405 | 68,680 | 353 | 78,797 | 18.19 | 15.29 | 0.36% |
| NY | 2,129,387,466 | 0.50 | 1,064,693,733 | 10,109 | 210,643 | 10,179 | 209,194 | 189.76 | 112.21 | 18.98% |
| NC | 396,863,370 | 0.62 | 247,999,920 | 4,520 | 87,802 | 4,611 | 86,069 | 80.49 | 49.30 | 4.40% |
| ND | 49,980,530 | 0.70 | 35,196,289 | 625 | 79,969 | 614 | 81,402 | 6.42 | 77.83 | 0.62% |
| OH | 558,612,234 | 0.59 | 327,737,798 | 7,691 | 72,632 | 7,484 | 74,641 | 113.53 | 49.20 | 5.81% |
| OK | 103,178,346 | 0.71 | 73,349,486 | 1,801 | 57,289 | 1,859 | 55,502 | 34.51 | 29.90 | 1.30% |
| OR | 24,519,821 | 0.60 | 14,702,085 | 60 | 408,664 | 62 | 395,481 | 34.21 | 7.17 | 0.26% |
| PA | 496,918,629 | 0.54 | 267,441,606 | 4,944 | 100,509 | 5,041 | 98,575 | 122.81 | 40.46 | 4.74% |
| RI | 6,292,079 | 0.54 | 3,383,251 | 18 | 349,560 | 31 | 202,970 | 10.48 | 6.00 | 0.06% |
| SC | 171,931,801 | 0.70 | 120,266,295 | 2,176 | 79,013 | 2,212 | 77,727 | 40.12 | 42.85 | 2.13% |
| SD | 17,999,207 | 0.69 | 12,369,055 | 231 | 77,919 | 231 | 77,919 | 7.55 | 23.84 | 0.22% |
| TN | 234,719,370 | 0.63 | 148,107,922 | 1,511 | 155,340 | 1,566 | 149,885 | 56.89 | 41.26 | 2.63% |
| TX | 728,986,838 | 0.61 | 447,306,324 | 13,453 | 54,188 | 13,204 | 55,210 | 208.52 | 34.96 | 7.93% |
| UT | 53,199,473 | 0.72 | 38,064,223 | 758 | 70,184 | 771 | 69,001 | 22.33 | 23.82 | 0.67% |
| VT | 1,661,352 | 0.62 | 1,034,025 | 12 | 138,446 | 12 | 138,446 | 6.09 | 2.73 | 0.02% |
| VA | 183,139,808 | 0.52 | 94,628,339 | 1,868 | 98,041 | 1,843 | 99,370 | 70.79 | 25.87 | 1.68% |
| WA | 133,127,030 | 0.52 | 68,999,740 | 948 | 140,429 | 955 | 139,400 | 58.94 | 22.59 | 1.22% |
| WV | 47,088,484 | 0.75 | 35,212,768 | 444 | 106,055 | 444 | 106,055 | 18.08 | 26.04 | 0.62% |
| WI | 254,700,314 | 0.59 | 149,712,845 | 2,865 | 88,901 | 2,879 | 88,468 | 53.64 | 47.49 | 2.65% |
| WY | 16,054,327 | 0.64 | 10,281,191 | 106 | 151,456 | 113 | 142,074 | 4.94 | 32.51 | 0.18% |
| US Total | 9,902,142,700 | | 5,639,460,769 | 116,441 | 85,040 | 116,674 | 84,870 | 2,814.22 | 35.19 | 100.00% |

NA = not applicable

EXHIBIT I

NEW MEXICO
DEPARTMENT OF
HEALTH

J. Alex Valdez
Secretary

Gary E. Johnson, Governor

Jack Callaghan, Ph.D.
Deputy Secretary

George Parascandola
Deputy Secretary

Ramona Flores-Lopez
Director

January 4, 2001

TO: Case Management Agency Directors

FROM: Ramona Flores-Lopez, Division Director

SUBJECT: Data Collection for Performance Measures

It is time for agencies that provide DD Waiver Case Management services to report data to LTSD on certain performance measures. The baseline data on these measures are intended to inform all of us – state employees, service providers, legislators, advocates and other stakeholders – on how the system is working for individuals with developmental disabilities.

The attached documents provide you with the instructions and forms for reporting on two performance measures:

- The percentage of ISPs that contain strategies to promote or maintain independence such as daily living skills, work and functional skills.

and:

- Percentage of individuals who have opportunities to spend time weekly in settings in which typical peers are present.

The Department of Health has selected a random sample of individuals served by the DD Waiver and identified their case management provider agency. The sample is identified only by Social Security Number. Please ascertain which individual you serve by this SSN# identifier and arrange for completion of the 4-page survey by the individual's case manager.

These responses are **not** a reflection of the case manager's performance. Case managers are encouraged to be open and truthful in completing the forms. There is not a right or wrong answer — what is important that an accurate baseline be established with these survey responses.

I would like to remind you that your current provider agreement includes a requirement to submit data in a format prescribed by LTSD during this fiscal year on specified performance measures. In addition to this sample, we will be conducting another survey of the DD Waiver population later in this fiscal year.

All completed forms are due by delivery, FAX or mail, postmarked January 31, 2001. If you have any questions, please contact Marilyn Price at 827-0683 or David Aragon at 841-5525.

Cc: LTSD Management Team
Donna Elliot, Deputy Secretary

Long Term Services Division • 1190 St. Francis Drive, Suite N 3050 • P.O. Box 26110 • Santa Fe, New Mexico 87502-6110
(505) 827-2574 • FAX: (505) 827-2455

Example

EXHIBIT J

NEW MEXICO DEPARTMENT OF HEALTH

# LTSD PERFORMANCE MEASURES
## Have Fun / Develop Relationships

| Provider Name | ABC Provider | Provider Number | ### |
|---|---|---|---|
| Client SSN | 585 - XX - XXXX | Date | 20 Jan 01 |

**Type of Residential Service:** Home Base ☐ Assisted Living ☐ Supported Living ☐ Supervised Living ☐ None ☒

| 1 | 2 | | 3 |
|---|---|---|---|
| | Number of Goals | | |
| ADL | NA 0 1 2 **3** 4 5 | ☒ | Ratings: 5 4 **(3)** 2 1 |
| IADL | NA 0 1 2 3 4 **5** | ☒ | Ratings: 5 4 **(3)** 2 1 |
| Community Relationships | NA **0** 1 2 3 4 5 | ☒ | Ratings: 5 4 3 2 1 |
| Assistive Devices | Does this individual use assistive devices? ☐ Yes ☒ No | | |

**Legend for Client Progress**

5= More than expected
4= Somewhat more than expected
3= As expected
2= Somewhat less than expected
1= Much less than expected