Report
to
The LEGISLATIVE FINANCE COMMITTEE

Departments of Health and Human Services
Evaluation of Developmental Disabilities Program
June 9, 2010

Report #10-11

State of New Mexico
LEGISLATIVE FINANCE COMMITTEE

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David Abbey
Director

June 9, 2010

Dr. Alfredo Vigil, Cabinet Secretary
Department of Health
1190 St. Francis Dr.
Santa Fe, New Mexico 87502

Ms. Kathryn "Katie" Falls, Cabinet Secretary
Human Services Department
2009 S. Pacheco
Santa Fe, New Mexico 87504

Dear Secretaries Vigil and Falls,

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the Program Evaluation: Developmental Disabilities Waiver Program.

The evaluation team reviewed program costs and outcomes, adequacy of program oversight, and the accuracy and timeliness of information used to manage the program. The report will be presented to the Committee on June 9, 2010. Exit conferences were conducted to discuss the contents of this report with your staff on May 27, 2010.

The Committee would like an action plan to address the findings and recommendations from the departments within 30-days from the date of the hearing. Staff will continuously monitor your progress.

I believe this report addresses issues the Committee asked us to review and hope the New Mexico Department of Health and Human Services Department will benefit from our efforts. We very much appreciate the time and cooperation we received from you and your staff.

Sincerely,

David Abbey, Director

Cc: Ms. Katrina Hotrum, Deputy Secretary, DOH
Ms. Mikki Rogers, Director, Developmental Disabilities Supports Division, DOH
Ms. Charissa Saavedra, Deputy Secretary, HSD
Ms. Carolyn Ingram, Director, Medical Assistance Division, HSD

Table of Contents

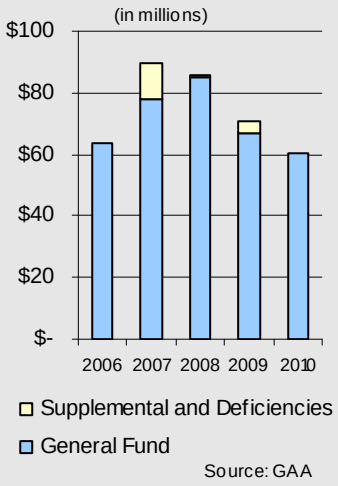
Page No.

EXECUTIVE SUMMARY

DD waiver Program Complications

- Multitude of regulations and standards,
- Administered by two state departments,
- 3,792 DD waiver enrollees,
- 4,555 awaiting DD waiver enrollment,
- 300 contracted providers,
- An unresolved class action lawsuit ,
- Critical budget issues and
- A changing FMAP.

Appropriations 2006 - 2010

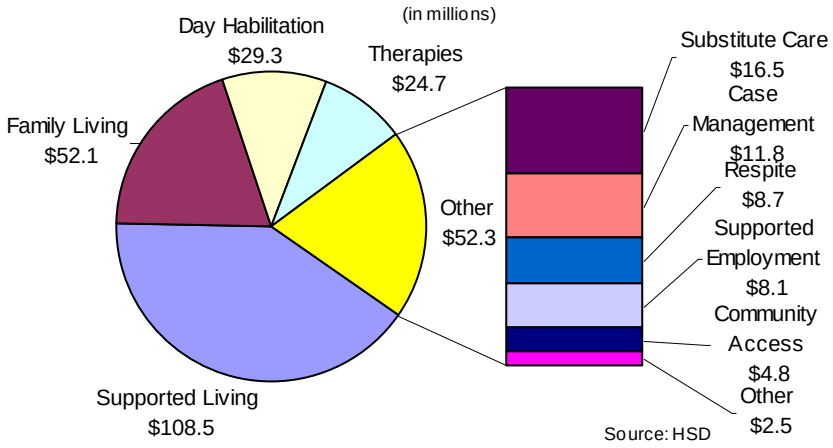


Although the developmental disabilities waiver (DD waiver) is an emotionally charged issue for all stakeholders, the criticality of the present budget situation with increasing costs and growing waiting list requires action. The departments and the Legislature, through focused efforts, have the opportunity to revamp the program to one which contains costs, delivers the right services to the right individuals and allows those waiting for waiver services to enter the system more quickly.

Program administration is shared by the Human Services Department (HSD) and Department of Health (DOH) through a joint powers agreement (JPA). The Developmental Disabilities Division (DDSD) of DOH has been designated as general manager for the DD waiver. Both departments have policies, practices, and system designs which conflict with the operations of a high quality, cost effective system.

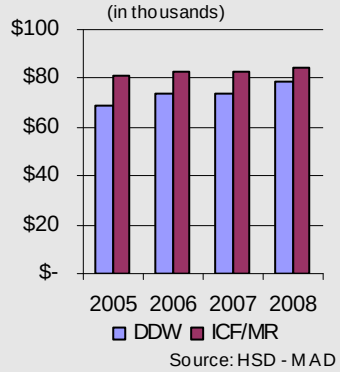
The DD waiver offers a broad array of community-based services, in lieu of institutional care, to individuals with a developmental disability. The three most costly services are supported living, family living, and day habilitation. The total cost for all services in FY08 were $267 million, the most recent complete year of cost data available.

DD Waiver Spend by Category FY08



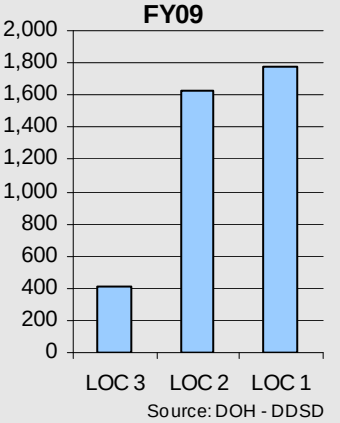
The Legislative Finance Committee (LFC) evaluation team reviewed the program costs and outcomes, adequacy of program oversight, and the accuracy and timeliness of information used to manage the program.

DDW and ICF/MR Average Cost per Individual FY05 - FY08



Source: HSD - MAD

DDW Clients Served by Level of Care FY09



Source: DOH - DDSD

Level of Care

The intensity of services required for an individual based upon a functional and psychosocial assessment.

Annual Resource Allotment

The amount of funding for services as determined by the level of care, where an individual resides, and their age.

FFS and Capitation Payments for Waiting List Individuals FY05 - FY09

(in millions)

Fiscal Year	Total Spend
2005	$23.8
2006	$21.4
2007	$29.4
2008	$33.9
2009	$37.4
Total Spend	**$145.9**

Source: HSD - MAD

KEY FINDINGS

Spending Levels For The Existing DD Waiver Program Enrollment Are Becoming Unsustainable. In FY08, the state spent $71.4 thousand per person for DD waiver services and an additional $7.4 thousand for regular Medicaid services, such as physical health, prescriptions, hospital services, ranking NM in the top 10 most expensive programs in the country. While the DD waiver program costs an estimated seven percent less than institutional care, the program's cost growth increasingly puts the waiver in jeopardy of not meeting federal cost-neutrality requirements. Supplemental and deficiency appropriations have been required to maintain existing DD waiver costs.

DD Waiver Program Lacks A Needs-Based Assessment Tool And Utilization Review Process To Ensure Participants Receive The Right Care At The Right Time. The assessment process is inadequate to gauge appropriate levels of care (LOC) and annual resource allocations, (ARA), both of which are major cost drivers. New Mexico's distribution of level of care places most individuals in the highest level. DOH's existing assessment tool is outdated and not used by any other state, appears to result in increasing the levels of care, and is no longer supported by the vendor. Other states have implemented more recently developed assessment tools which have a stronger focus on tying needs to resource allocations. An array of their levels of care distribution shows most individuals are assessed at a more moderate level of care. A rate validation study, assuring the existing reimbursement system structure is relevant to actual provider costs has not been completed since December of 2000. The LOC, a key determinant used to set the annual resource allotment (ARA), is established by a case manager and not reviewed or approved by the department. With no recent rate or other state comparison studies, it is unclear how service funding criteria was established for the annual resource allotments.

The Number of Individuals Being Placed on the Waiting List Considerably Outpace Allocations To The DD Waiver Causing Individuals With Unknown Needs To Wait Seven To Eight Years For Waiver Services. Of the 4,555 individuals on the waiting list, 2,676 received services funded by the Medicaid program, either through managed care or fee-for–service plans in FY09. This information was generated by HSD from encounter data submitted by the managed care organizations. The evaluation team expresses concern about the validity of the encounter data. Managed care organizations' (MCOs) capitation payments, per member per month payment to MCOs by HSD, for individuals on the waiting list exceeded the MCO submitted encounter costs by $91.1 million from FY05 through FY09. Encounter costs are the reimbursements paid to providers by the MCOs for the delivery of services. If the information is not correct, the opportunity for DOH or

DOH Proposed Cost Savings
January 2010

- *Reduce ARAs, service, outlier rates,*
- *LOC in reimbursement determination for family living services,*
- *Eliminate respite services,*
- *Include substitute care in the ARA and*
- *Improve utilization review process.*

FMAP

Federal medical assistance percentage is federally matched funds for state expenditures for certain social services.

Exceptions

Increases in the units of service for therapies and supported employment and are funded outside the ARA.

Outliers

Staffing services provided to individuals with severe physical, behavioral or medical diagnoses at a frequency, duration and intensity that exceed those described within the DD waiver and are funded outside the ARA.

HSD to assess the needs of waiting list individuals, identify those who have received services and forecasting future DD waiver costs is compromised. If the information is accurate, there would appear to be resources available to more quickly move individuals to waiver status.

Increased Program Oversight, Improved Cost Management, And Benefit Redesign Will Be Necessary To Maintain Or Expand The DD Waiver Program. Multiple state agencies and contractors are responsible for oversight and management of the DD waiver program and services. Fragmented management of the system complicates effective oversight of program operations, results in overspending budgets, causes information gaps and inaccuracies and prevents expansion of services to people in need. Inadequate oversight of utilization review allows use of services beyond the annual resource allocation (ARA), causing significant increases in program costs.

In the fall of 2009, DOH attempted to implement cost saving measures which were rescinded after encountering major opposition. The State has not fully re-evaluated the DD waiver program benefit design to ensure it meets modern-day needs at an affordable cost. Other states have implemented different system and benefit designs to ensure fair and cost-effective allocation of resources for services. Immediate opportunities for cost containment include the following:

- Curb goods and services to very specific goals outlined in individual service plans or eliminate the benefit,
- Contractually obligate providers to a portion or all the cost associated with environmental modifications to homes they own,
- Require utilization review of all exceptions and outliers by the contractor for utilization review or the Developmental Disabilities Services Division,
- Require DDSD approval of all initial and annual LOC (level of care) and ARA (annual resource allotment) determinations,
- Realign therapist and therapy assistant rates,
- Evaluate substitute and respite reimbursement models from other states,
- Include level of care in family living reimbursement determinations,
- Eliminate unnecessary documentation requirements for providers and streamline all necessary documentation,
- Transfer Los Lunas Community Programs, except crisis services, to community providers and
- Establish case management visit requirements based upon need.

Longer term opportunities include: implementation of an effective assessment process, integrated information system and the completion of a rate validation study.

Enhanced Performance Reporting To The Legislature And Public Could Help Build On Positive Benefits Initially Provided Through The DD Waiver Program And Federal Consent Decrees. DOH has a highly structured quality monitoring system and has received most favorable national rankings for outcome performance**.** Federal requirements and the Jackson federal consent decree result in the state collecting massive amounts of information on service, compliance, spending, performance and quality information. According to providers and family members of DD waiver clients, Jackson lawsuit (JLS) corrective action plans have not all been positive. The ability of the state to disengage from the lawsuit is complicated. Other states have faced lawsuits similar to New Mexico. In FY09, nearly $5 million of direct costs on the Jackson lawsuit support consultants and court monitors, of which about eight percent pays for plaintiff legal fees. Although the state is responsible for both the plaintiff and defendant legal fees for the JLS, these are not the primary cost drivers of the lawsuit.

DOH and HSD lack useful management reports that aggregate key information on the DD waiver program and appear overwhelmed by data collection activities. DOH provides limited information to the Legislature about the DD waiver program but lacks any meaningful performance measures in the General Appropriation Act.

KEY RECOMMENDATIONS

The Legislature may wish to consider establishing a subcommittee of the Health and Human Services Committee (HHS) to monitor all DDSD operational performance and progress for disengagement from the Jackson lawsuit, or at minimum request semi-annual reports from DOH.

DOH and HSD should:
Develop and submit a comprehensive cost-benefit analysis to the Department of Finance and Administration (DFA) and the LFC of a rate validation study, implementation of an effective assessment process and an integrated information system.

Develop a contingency budget plan for presentation to DFA and LFC, by December 2010, if it becomes evident the FMAP will decrease and general fund shortfalls will occur.

Update the joint powers agreement between departments to represent best practices.

DOH should:
Move forward immediately with cost saving strategies using the information recently gathered from stakeholders, their experience, and

this report. Ensure utilization review is based upon established criteria and is conducted by the utilization review contractor or DDSD for levels of care (LOC), annual resource allotments (ARAs), exceptions, outliers, and goods and services; include substitute care in the ARA; consider LOC in the establishment of family living rates; and establish single rate for integrated and office therapy services, adjust therapy assistant rate, and consider changes in mandated number of case management visits.

Perform reviews of a certain number of waiting list clients at the top of the list in each region to determine medical and financial eligibility, service needs which could be provided through other funding sources and use of traditional Medicaid plan services. This information will be important for identifying assistance for those on the waiting list and forecasting future funding needs.

Require state staff to perform all initial individual assessments and determination of all LOCs and ARAs. Realign the case management rate schedule to account for decreased responsibilities.

Urge the JLS court officials to focus on measurement of goal outcomes, eliminating the specific action plans from court documents, and allow the department to develop and implement plans to meet outcome expectations.

Include performance measures in FY12 General Appropriations Act.

HSD should:
Validate the financial data contained in the MCO spending report and make available to the Legislature MCO data from which rates are actually developed, information on Medicaid managed care contract rates, complete actuarial rate certification letters, and amounts paid by MCOs by cohort.

Amend the contract with the utilization review agency expanding the duties to include review and approval authority for all exceptions and outliers, and initial and annual assessment reviews.

Medicaid waivers are granted to states from the Centers for Medicare and Medicaid Services (CMS). Waivers were created to allow states to provide home and community-based programs for targeted populations as an alternative to institutionalization. Federal regulations reinforce this intent by stating individuals considered for waiver services would have been admitted to an institutional setting if not for the availability of community-based services. Regulations further direct that community-based services must not cost more than services provided in intermediate care facilities for the mentally retarded (ICF/MR) operated in the waiver state.

The Developmental Disabilities Waiver for New Mexico was approved in 1984 and will expire June 2011.

Services within waivers differ among states. CMS determines whether the service array proposed by a state meets the regulations and intent of the federal waiver programs. States are given authority to set their own provider reimbursement rates. In addition to waiver services, individuals are eligible for all services provided through the traditional Medicaid plan.

Developmental Disability Waiver (DD waiver) services can be provided to individuals who meet medical and financial eligibility. Financial eligibility in New Mexico is based upon client income, whether an adult or a child. Medical eligibility is defined as a severe chronic disability, other than mental illness which:

- Is attributable to a mental or physical impairment, including the result of trauma to the brain or a combination of mental and physical impairment,
- Manifested before the person reaches 22 years of age,
- Expected to continue indefinitely,
- Results in substantial limitations in three or more of major life activities,
- Reflects the need for interdisciplinary treatment and natural supports that are of lifelong or extended duration,
- Are individually planned and coordinated and,
- Meets criteria for a level of care provided in an intermediate care facility for the mentally retarded (ICF/MR).

FAST FACTS

Waiver enrollees and applicants: As of April 2010, there were 3,792 individuals receiving service through the NM DD waiver. Another 4,555 individuals are awaiting allocation to the waiver.

Funding: Services are funded through state general fund appropriations and federal Medicaid matching dollars. Supplemental appropriations were necessary from FY07-FY09.

Expenses: Total costs for DD waiver services in FY08 were over $267 million (the last complete information available).

Providers: DOH and HSD contracts with community providers for service provision. The Developmental Disabilities Division (DDSD) does not provide direct services.

Services: Services provided through the DD waiver are case management, personal care, residential and day habilitation, supported employment, community access, environmental modification, behavior support consultation, non-medical transportation, nutritional counseling, personal plan facilitation, tier III crisis support (intervention by trained staff for an individual

experiencing a behavioral or medical crisis), goods and services, private duty nursing and dental care as well as physical, speech and occupational therapies. DD waiver clients are also eligible for traditional Medicaid funded services.

Other: In 2008, the average cost for each of the 273 individuals served in 30 ICF/MRs was $84.3 thousand

ORGANIZATION

The Human Services Department (HSD) was granted a DD waiver from the Centers for Medicare and Medicaid Services (CMS). Through a joint powers agreement (JPA), administration of the waiver is shared between HSD and the Department of Health. DOH serves as the operational manager of the DD waiver, while HSD retains overall program oversight and maintains the relationship between the state Medicaid program and the federal government. HSD also is the sole state department which contracts with a utilization review agency. DDSD has been charged by DOH to effectively administer a system of person-centered community supports and services that promotes positive outcomes for all stakeholders with a primary focus on assisting individuals with developmental disabilities and their families to exercise their right to make choices, grow and contribute to their community. This includes functioning as the day-to-day operational management for the DD waiver. The division operates a central office in Albuquerque and five regional offices located in Las Cruces, Roswell, Santa Fe, Gallup, Taos, and Albuquerque.

FUNDING

As a Medicaid program, the DD waiver is funded through the state general fund with federal matching dollars.

EXPENSES

In addition to the actual cost for services of over $267 million in FY08, the general operations of DDSD are approximately $50 million.

Objectives.

- Review the costs of DD waiver program and related performance outcomes.
- Assess the departments' oversight of the program to ensure access to cost-effective, high quality care.
- Review the department's management of the central registry and waiting list and whether people are transitioned into services in a timely manner.

Scope and Methodology.

- Review applicable laws, rules and regulations.
- Review Legislative Finance Committee (LFC) files.
- Review statewide policies and procedures regarding the DD waiver.
- Interview Department of Health (DOH), Human Services Department (HSD), family and community living providers, therapists, case management and direct care agencies to gain a thorough understanding of the DD waiver environment.
- Evaluate the assessment and re-evaluation processes to determine if service is appropriate to need.
- Analyze program service, cost, central registry and waiting list data.

- Conduct other state surveys to obtain information regarding the cost, administration and oversight practices for states with similar DD waivers.
- Evaluate the system impact of the Jackson Lawsuit and provide an update on the disengagement process.

Authority for Evaluation. The Legislative Finance Committee (LFC) 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. The LFC is also authorized to make recommendations for change to the Legislature. In 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.

Evaluation Team.
Charles Sallee, Program Evaluation Manager
Pam Galbraith, Program Evaluator, Lead Evaluator
Lawrence Davis, Program Evaluator

Exit Conference. The contents of this report were discussed with the Department of Health, Deputy Secretary Katrina Hotrum, Developmental Disabilities Services Division Mikki Rogers, Medical Assistance Division Deputy Director Julie Weinberg, and Human Services Department Secretary Katie Falls.

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

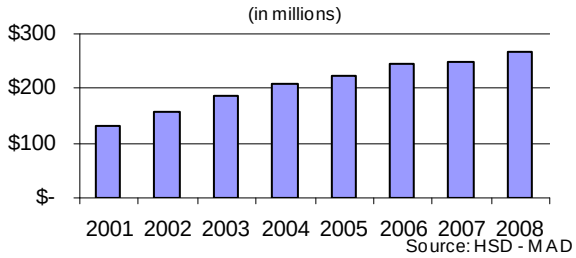
Manu Patel

Manu Patel, CPA
Deputy Director for Program Evaluation

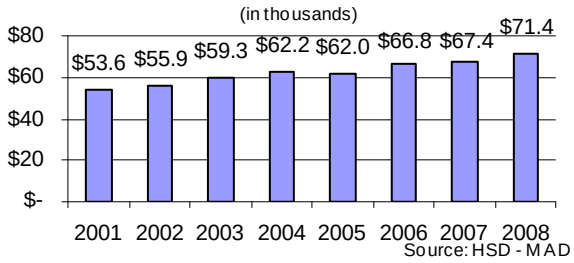
SPENDING LEVELS FOR THE EXISTING DD WAIVER PROGRAM ENROLLMENT ARE BECOMING UNSUSTAINABLE

In FY08, the state spent $71.4 thousand per person for DD Waiver services and an additional $7.4 thousand for regular Medicaid services, ranking NM in the top 10 most expensive programs in the country. From FY01 through FY08, the average cost per client increased 33 percent. The total cost of services increased 104 percent in the same time period, despite minimal provider rate increases. The graphs show the total program costs, excluding traditional Medicaid funded services.

Graph 1. DDW State and Federal Spending FY01 - FY08

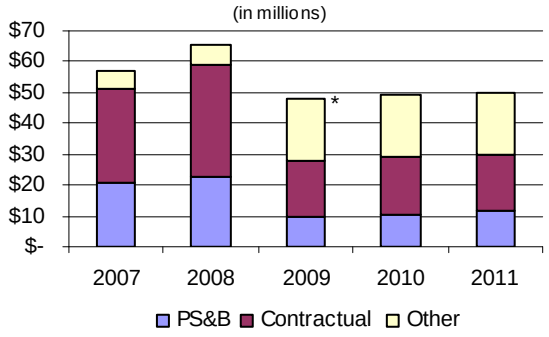


Graph 2. Average Cost per Individual FY01 - FY08



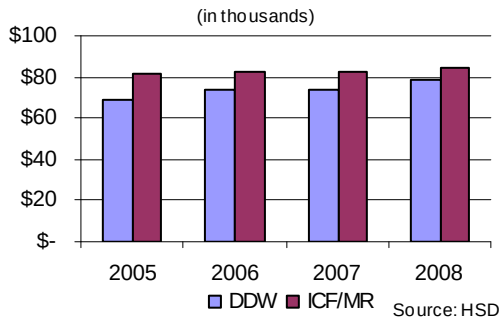
The average cost per individual on the DD waiver does not include personnel and divisional operational costs. The significant decrease in FY08 resulted from the transfer of the Los Lunas Community Programs (LLCP) to the DOH Office of Facilities Management.

Graph 3. DDSD Operation Funding FY07 - FY11



*LLCP was moved to DOH's Facilities budget Source: GAA

Graph 4. DDW and ICF/MR Average Cost per Individual FY05 - FY08

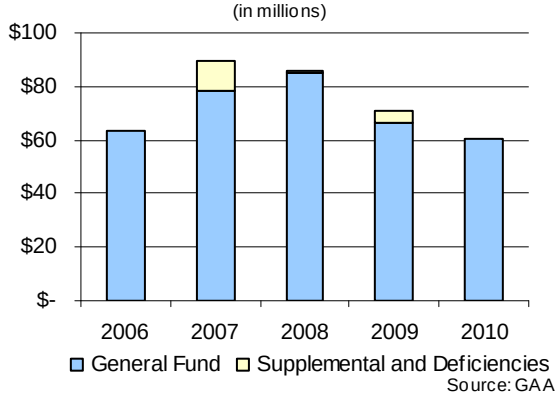


While DD waiver program costs an estimated seven percent less than institutional care, the program's cost growth increasingly puts the waiver in jeopardy of not meeting federal cost-neutrality requirements. Federal regulations mandate medical eligibility screening must support the assumption that without waiver services the client would require admission to a level of care provided in an intermediate care facility for the mentally retarded (ICF/MR) and the average cost for DD waiver services must be cost-neutral in comparison to New Mexico's ICF/MRs. In 2008, the average cost of the 273 ICF/MR clients, served in 38 private and one state-operated ICF/MRs in New Mexico, was $84.3 thousand. In the same year, the average cost for the DD waiver individuals was $78.8 thousand including waiver and traditional Medicaid, such as physical health, prescriptions, and inpatient hospital care.

If the cost of DD waiver services exceeds ICF/MR costs, CMS may intervene in the operation of the waiver for failure to meet the cost neutrality regulation. Currently, DD waiver costs are rising faster than ICF/MR costs and may have reached the critical point of exceeding ICF/MR costs within the past two years. HSD has not yet finalized the FY09 federal report stating DD waiver and ICF/MR costs.

Supplemental and deficiency appropriations have been required to maintain existing DD waiver costs. In addition to regular appropriations, DOH has received a total of $16.4 million in supplemental and deficiency funding from FY07 though FY09 in order to support program shortfalls. Additional appropriations were not needed in FY10 or FY11 with the increases in the federal Medicaid funding match.

Graph 5. Appropriations 2006 - 2010



Source: GAA

The federal medical assistance percentage to the New Mexico Medicaid program for the DD waiver is in danger of a drastic decrease if Congress does not act. The American Recovery and Reinvestment Act of 2009 (ARRA) increased Medicaid funding to states for 27 months in an effort to relieve state funding during the U.S. economic downturn. Total program costs for FY11 are budgeted at $311.6 million. If the FMAP enhancement is extended by Congress at 80.49 percent, the state general fund need will be $60.8 million. The FY11 general fund appropriation is $60.56 million. However, if no congressional action is taken the state would have a $16.9 million shortfall from the FY11 budgeted appropriation, with an even greater deficit in FY12.

RECOMMENDATIONS

HSD and DOH should:

Work with the Department of Finance and Administration and the Legislature, prior to December 2010, to development a contingency plan, for possible FMAP decreases.

DD WAIVER PROGRAM LACKS A NEEDS-BASED ASSESSMENTS TOOL AND UTILIZATION REVIEW PROCESS TO ENSURE PARTICIPANTS RECEIVE THE RIGHT CARE AT THE RIGHT TIME

The assessment process is inadequate to gauge appropriate levels of care and annual resource allocations, both of which are major cost drivers. The method by which benefits are managed leads to loss of system control and increased costs. DOH has relinquished authority to contracted case managers by allowing them to function in a role which has significant financial impact on the program. Case manager duties, as defined by DOH, place them in a near autonomous position in the system, with minimal oversight. Contracted case management agencies are the entities which validate financial and medical eligibility, develop individual budgets, conduct the initial and annual assessments of level of care needs and continued waiver eligibility, assist clients in the identification of necessary services, aids individuals in selection of providers, monitor utilization and individual budgets, and provide, in conjunction with DOH, quality assessment and oversight of direct care provider services.

Table 1. Major Cost Drivers

• Enrollment increases
• Lax utilization review
• Inadequate process and tools for individual needs assessments
• Level of care designation
• Complicated program oversight

Source: LFC analysis

DOH's existing assessment tool is obsolete and no longer supported by the vendor. Several states have implemented, or have been implementing processes for level of care designations and resource allocations that focus on prospective individual budgeting and use of assessment tools. Effective assessments tools capture support needs and consider both behavioral and medical challenges.

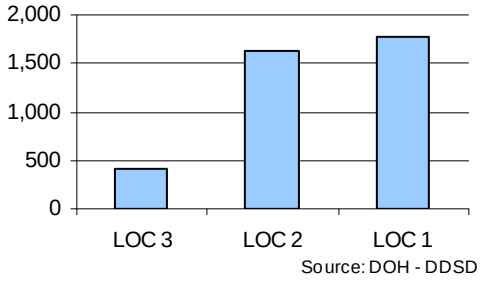
The Supports Intensity Scale (SIS) is an assessment tool that has been implemented or is being considered by at least 14 states, including New Mexico. The SIS divides the population into six funding bands, differing from the three-tier system in New Mexico. This creates a narrower range of dollars which can be applied to an individual client. The data generated through administration of the SIS provides a foundation for establishing prospective, realistic individual budget allocations. According to Jon Fortune, Senior Research Analyst, Human Research Institute, "Louisiana, using the SIS as an informal guide for their waiver, has saved money. States like Colorado and Oregon feel they have used the SIS to better match existing dollars to people's support needs. All states using the SIS feel that they have found a best fit resource allocation model. The waiver spending in New Mexico is upside down with 85 percent of the people receiving a lot of financial support. States rightly expect a few people to cost a lot and most people to cost much less. The results in other jurisdictions have been reliable between different interviewers and psychometrically consistent."

A rate validation study, assuring the existing reimbursement system structure is relevant to actual provider costs, has not been completed since December of 2000. This information is key to the implementation of a new assessment and budgeting process. The objective of the 2000 study was to provide the department with cost-based financial information and a comprehensive rate analysis to evaluate the established rate structure and review policy and procedure issues. Rate validation studies ensure that the state is paying providers reasonable rates for services rendered. According to Section 28-16A-16(F) NMSA 1978 contingent on appropriations, the department shall conduct an independent biannual cost study for the purpose of establishing payment rates. Since the last study was conducted by Myers and Stauffer LC in 2000, it is unclear how the department has derived or justified current DD waiver rates.

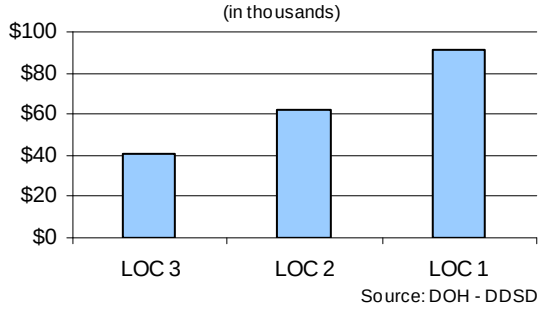
The level of care (LOC), a key determinant used to set the annual resource allotment (ARA), is established by a case manager and not reviewed or approved by the department.

DOH uses three levels of care to identify the intensity of services needed by a client, with a LOC 1 being assigned to people with the greatest need and thus highest costs. The graphs show LOCs for individuals on the New Mexico DD waiver and average costs by LOC for FY09.

Graph 6. DDW Clients Served by Level of Care for FY09



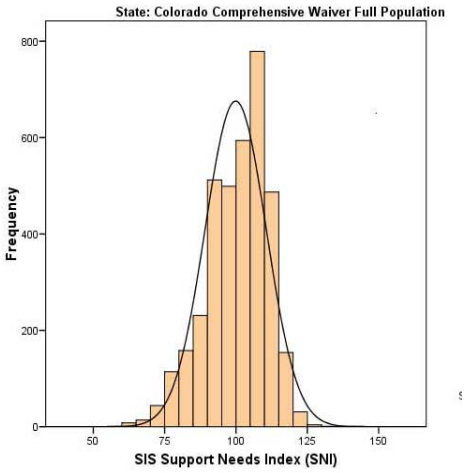
Graph 7. Average Cost Per Individual by LOC for FY09



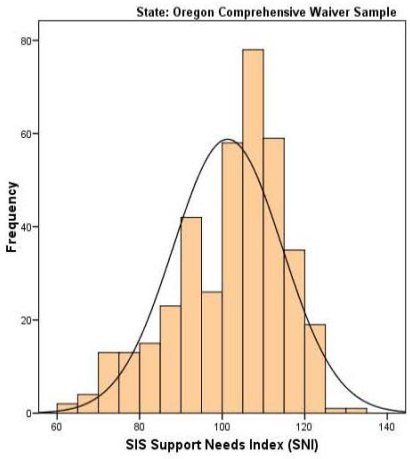
The New Mexico distribution of clients by level of care differs significantly from other states. DOH does not review the assessment, determination of level of care, or the assignment of the ARA prior to the case manager's submission to the utilization review agency. The present utilization review agency, as of January, had not issued any denials for services, accepting all case management approved LOC, ARA, and service authorizations.

The graphs published by the Human Services Research Institute, demonstrate waiver LOC determinations from four other states.

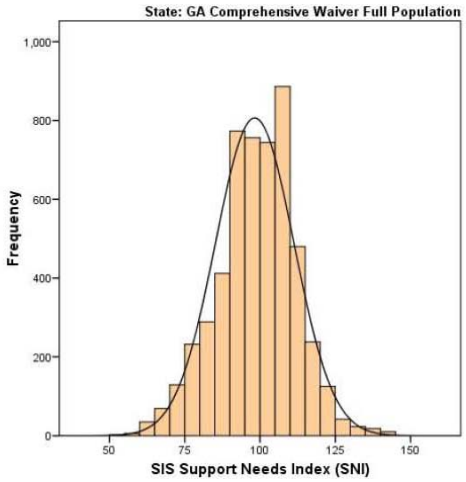
Graph 8. Colorado



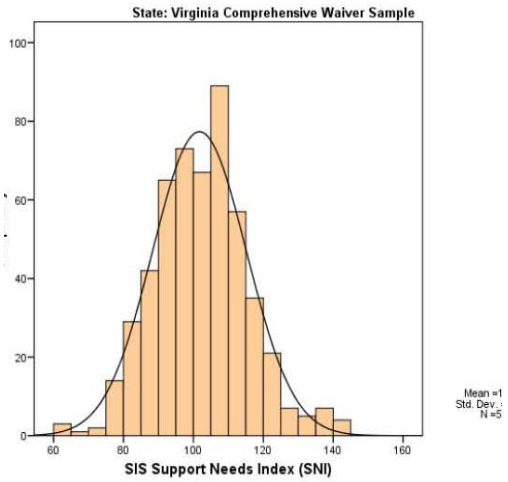
Graph 9. Oregon



Graph 10. Georgia



Graph 11. Virginia



These four states have distributions with most clients in the data set near the center, creating an average level of care in the moderate range. The New Mexico distribution demonstrates most clients are classified in the highest level of care available. It is unlikely that New Mexico has a population of people with developmental disabilities far needier than other states. Possible reasons for this distribution include: reliability of case manager assessment process, including ICF/MR eligibility and/or inadequacy of outdated assessment tools. During interviews, some providers indicated case managers were willing to negotiate increases in levels of care.

With no recent rate or other state comparison studies, it is unclear how service funding criteria was established for the annual resource allotments. Based upon the individual's age, LOC, residential status and one of five service categories with a corresponding funding limit, an ARA is assigned to the client by the case manager. *This allocation does not include all expenses dedicated for the care of an individual within the ARA.*

Table 2. Annual Resource Allotments by Service Category and LOC

Service Category	Level 1	Level 2	Level 3
Children's Services	$32,495	$26,795	$21,453
Young Adult Services	$43,958	$41,434	$38,910
Young Adult Community Living Supports (24 hour service)	$23,577	$19,771	$16,300
Adult Services	$45,956	$40,803	$36,527
Adult Community Living Supports (24 hour service)	$36,436	$27,847	$24,055

Source: DDSD

Services are funded inside or outside an ARA. It is unclear how the decision was made for inclusion or exclusion. Services funded within or outside of an ARA can be found below.

Table 3. Services Within the ARA

Therapies	Physical, Occupational, Speech/Language, Behavioral
Community Inclusion	Provides connection to and membership in the same community life chosen by the general population: day habilitation, supported employment, community access
Personal Plan Facilitation	Offers opportunity to explore and develop a comprehensive personal plan in consultation with persons they choose
Goods and Services	Up to $1000 per year. Must promote the client's individual service plan.
Case Management	Development and coordination of services plan
Private Duty Nursing	Provide nursing interventions
Supplemental Dental Care	One routine cleaning beyond what is allowed in Medicaid
Personal Care Services	Assists individual with activities of daily living
Respite and Substitute Care	Provides relief for care givers
Nutritional Counseling	Designing plans to meet the unique food and nutritional needs presented by individuals with developmental disabilities.
Non-Medical Transportation	Transportation to waiver and non-waiver services identified in ISP

Source: DD Waiver Service Standards

Table 4. Services Outside the ARA

Environmental Modifications	Limited to $5000 every 5 years. May be to a client's own home or a home owned and operated by a provider.
Community Living Services	Independent, Family Living, and Supported Living
Therapy and supported employment Outlier and Exception Services	Exceptions are increase in service units for supported employment and therapies Outliers are services of a frequency, duration and intensity that exceeds what is typical (staffing related). Exceptions are increase in therapy and supported employment units of services
Tier 3 Crisis	Intensive supports to an individual experiencing a behavioral or medical crisis

Source: DD Waiver Service Standards

RECOMMENDATIONS

HSD and DOH should:
Complete a cost-benefit analysis of the purchase of an assessment tool, integrated information system and a rate validation study for Department Finance and Administration (DFA) and the Legislature.

Investigate how other states place dollar values on ARAs.

DOH should:
Require DOH staff to perform all initial individual client assessments, including determinations of LOCs and ARAs, and adjust case management reimbursement accordingly.

Review all other case management annual assessments, LOCs and ARA, prior to submission to utilization review agency.

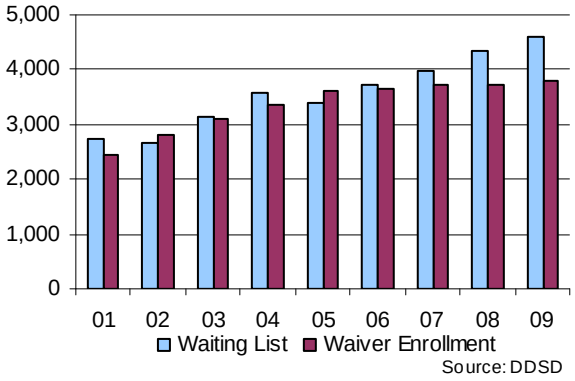
HSD should:
Amend the contract with the utilization review agency to allow for a more comprehensive utilization review process.

THE NUMBER OF INDIVIDUALS BEING ADDED TO THE WAITING LIST CONSIDERABLY OUTPACES ALLOCATIONS TO THE DD WAIVER CAUSING INDIVIDUALS WITH UNKNOWN NEEDS TO WAIT SEVEN TO EIGHT YEARS FOR WAIVER SERVICES

Determining unmet need by examining the size of the DD waiver waiting list makes planning difficult. As of May, 2010, there were 4,555 DOH-identified individuals on the waiting list. DOH does not perform routine reviews, lacks accurate information on the status of individuals on the waiting list, does not engage in pre-planning for people near the top of the list, and struggles to forecast potential costs of new clients. Information that would aid in predicting costs of future allocations is not collected from individuals on the waiting list, even those who are close to allocation. Data could include verification of:

- financial eligibility,
- preferred care option: DD or MiVia Waiver, ICF/MR, allocation hold, decline waiver services,
- medical status,
- services being received through traditional Medicaid and
- options for other funding sources.

Graph 12. DDW Waiting List vs. Waiver Enrollment FY01 - FY09



Source: DDSD

Allocations are awarded to regions based upon the number of clients on that region's waiting list. Once a region receives allocations, individuals are sent invitations to begin the enrollment process on a "first-come, first-served" basis. For example, if DOH was issuing 100 invitations to individuals to begin the allocation process and the northern region had 10 percent of the entire waiting list; the region would be allocated 10 allocation slots.

As of March 2010, approximately 65 percent of waiting list individuals received services through Medicaid programs. The total cost of these services for FY09, was $44.9 million (Medicaid payments of $37.4 million, state general fund of $7.5 million). Another 1,300 eligible clients did not receive traditional Medicaid services in FY09. In addition, five hundred and seventy-two individuals on the waiting list were not eligible for Medicaid services.

Table 5. Total FFS and Capitation Payments for Waiting List Individuals FY05 - FY09
(in millions)

Fiscal Year	Total Spend
2005	$23.8
2006	$21.4
2007	$29.4
2008	$33.9
2009	$37.4
Total Spend	**$145.9**

Source: HSD/MAD

The Legislature has appropriated increasing amounts of funding to help reduce the waiting list, but increased per person costs and changes in federal funding make expansion difficult and costly. The Legislature has expressed major concerns regarding the number of individuals on the waiting list and has attempted to include appropriations within DOH budget, specifically for expansion of the DD waiver. Of the $12.7 million proposed for waiver expansion, the administration vetoed all but $7.6 million. The table summarizes the Legislative efforts made in the past five years. Although the number of waiting list individuals to be served was vetoed for 2009, the appropriated dollars were not reduced.

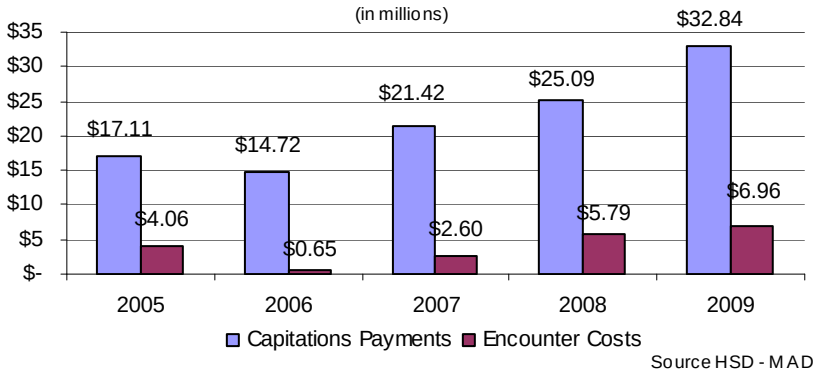
Table 6. Legislative Proposed Funding to Reduce DD waiver Waiting List

Appropriation Year	Estimated Addition of Clients	Amount	Fund	Action
2006	250	$ 5,000,000	Appropriation contingency fund	Line item vetoed
2007	-	-	-	-
2008	-	-	-	-
2009	216	$5,400,000	General fund	Partial veto*
2010	No estimate	$2,250,000	General fund	Appropriated

* Vetoed number of clients not dollar appropriation. Source: GAAs

Managed care organizations' (MCOs) capitation payments for individuals on the waiting list exceeded the MCO submitted encounter costs by $91.1 million from FY05 through FY09. For example, in 2009, HSD paid $32.8 million in MCO capitation payments for waiting list clients. Of this amount, the state received encounter data supporting only $7 million in services to waiting list individuals. HSD expressed low confidence that the encounter cost data submitted since 2008 by MCOs is accurate and complete. HSD stated certain factors make encounter reporting problematic such as, incomplete or non-submitted data, MCO sub-capitation rate agreements between the MCO and their providers (which are not required to have a payment attached), complete hospital stays and a month of home health visits may appear as single encounters. Accurate encounter data is important to monitor service delivery, quality and set rates for MCOs. The graphs below illustrate the capitation and encounter cost submission data for waiting list individuals for fiscal years 2005 through 2009. However, Coordinated Long-Term Services encounter costs, through which some encounters were paid, have not been reported to the state. From FY07 through FY09, administrative costs paid to the behavioral health MCO totaled $149 thousand.

Graph 13. Total Capitation Payments and Encounter Costs FY05 - FY09



Source HSD - MAD

The department stated "capitation rates are actuarially sound, based on utilization and cost experience for individuals in specific categories of eligibility and age groups. The cost data used to develop rates is supplied by the MCOs, but not from the encounter data". However, based on the data received, it is unclear how the state is assured that the capitation rates are sound. LFC has previously expressed concerns regarding the quality of encounter data, lack of auditing, and the access to full rate information within LFC's *Human Services Department – Program Evaluation of Medicaid Managed Care (Physical Health)* report, issued January 14, 2009. Recently, HSD has agreed to move forward with a confidentiality agreement allowing HSD to share more MCO data with LFC staff.

RECOMMENDATIONS

HSD should:
Share with the Legislature detailed MCO data that is actually used to develop rates, validate the financial data contained in MCO spending reports, Medicaid managed care contracts and rates, complete actuarial rate certification letters, and amounts paid by MCOs by client type. Hold the MCOs accountable for complete data, including sub-capitation rates paid by MCOs to contracted providers.

DOH should:
Perform routine reviews of waiting list clients to determine medical and financial eligibility, service needs, compliance with other eligibility criteria such as, residency status, in order to improve forecasting of future funding needs. The number of individuals on the waiting list may prevent a review of the entire waiting list but reviews could be limited to a specified number of individuals at the top of the list in each region. Use of traditional Medicaid services could serve as one criterion by which to establish need.

INCREASED PROGRAM OVERSIGHT, IMPROVED COST MANAGEMENT, AND BENEFIT REDESIGN WILL BE NECESSARY TO MAINTAIN OR EXPAND THE DD WAIVER PROGRAM

Multiple State agencies and contractors are responsible for oversight and management of the DD waiver program and services. Although the DD waiver was granted to HSD by CMS, the daily operational management of the program was given to the New Mexico Department of Health (DOH) through a joint powers agreement (JPA). This agreement was initiated in 2002 and amended in 2009. Although the JPA was amended, many of the departmental responsibilities cited are not present practice. The JPA identifies DOH as the responsible party to review and submit billings to HSD/MAD, conduct prior approval on all services and be responsible for accuracy of all information for federal reporting requirements. In actual practice: providers submit billings directly to HSD/MAD, prior approvals for most services are relegated to case managers and HSD generates information for federal reporting requirements from their payment processing system.

Table 7. Department and Contractor Major Responsibilities

HSD responsibilities	• Contracting with providers and the utilization review agency, • Receiving provider requests for reimbursement, • Reimbursing providers, • Reporting to the federal government and • Operation of provider reimbursement system.
DOH responsibilities	• Conducting operational program management, • Contracting with providers, • Approving service exceptions beyond the authority of same managers, • Approving requests for outlier services, • Conducting provider site visits and • Developing DD waiver standards.
Case management responsibilities	• Coordinating client services, • Leading development of service plans, • Conducting initial and annual level of care assessments, • Determining annual resource allocations, • Approving service exceptions within their authority, • Approving level of care and annual resource allocations every two out of three years, • Monitoring provider adherence to annual resource allocation and authorized service levels and • Determining eligibility for admission to ICF/MRs.
Utilization review agency responsibilities	• Approving specified levels of care and service plans and • Inputting service unit authorizations into the Medicaid payment system.

Source: JPA, UR contract and DD waiver standards

The scope of responsibilities of the utilization review agency is very limited per the contract with HSD. The contract states, "The individual service plans (ISPs) are approved by the recipient's case manager. There are only three instances in which the case manager needs to review for medical necessity. The contractor will enter the case manager approved plan as written into the MAD 046 directly into the Omnicaid system". No denials have been issued since July 2009.

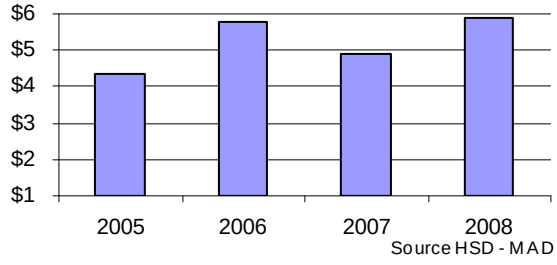
Fragmented management of the system complicates effective oversight of program operations, results in overspending budgets, causes information gaps and inaccuracies and prevents expansion of services to people in need. Collaboration between DOH and HSD needs improvement to ensure accurate information is available for policymakers. During this evaluation, information for levels of care, eligibility, member counts and financial data often did not reconcile between departments. The majority of the financial data reported within this

report was taken from HSD's Medical Assistance Division (MAD) federally mandated reports. Conflicting data creates confusion among the general public, legislators, and other stake holders who make strategic decisions about the welfare of the program. For example, DOH waiver enrollment includes MiVia waiver enrollees and HSD's does not. Also, financial information regarding service costs for DD waiver enrollees from the departments could not be reconciled.

Waiver enrollee lists are maintained in the regions, while the waiting list is maintained at the central office. Changes in waiver enrollment can occur due to: additions to the waiver, case closures or suspensions, death, non-residency status, loss of Medicaid eligibility, or moves to another waiver. DOH only tracks deaths and moves to other waivers. All other data regarding closure of cases must be obtained from HSD. It is unclear as to the frequency of DD waiver enrollment reconciliation between the agencies. As stated by DDSD, the only way for a true reconciliation to occur is for the calculation by agencies to be conducted on the same day at the same time.

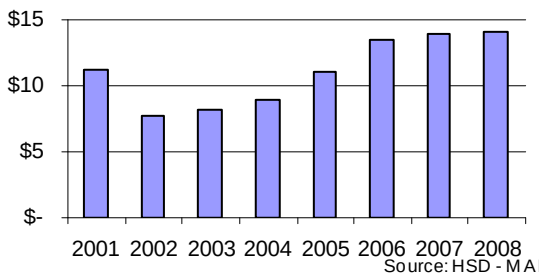
The management system allows use of services beyond the annual resource allocation (ARA) causing significant increase in program costs. These expansions have allowed individuals to access a broader array of services at higher intensities and frequencies than originally budgeted. Exceptions allow an increase in unit of service. For example, therapies and supported employment exceptions cost approximately $6 million in FY08. Outlier spending is only allowed in supported living and day habilitation services. Outliers occur when funding is provided for individuals whose physical or behavioral health needs require increased frequency, duration or intensity of staffing from what is typically provided. In FY08, outliers cost were $14.1 million. Recently, DDSD has moved approval for outlier services from case managers to DDSD staff. The graphs illustrate exception and outlier costs.

Graph 14. Exception Spending
FY05 - FY08
(in millions)



Source HSD - MAD

Graph 15. Outlier Spending
FY01 - FY08
(in millions)



Source: HSD - MAD

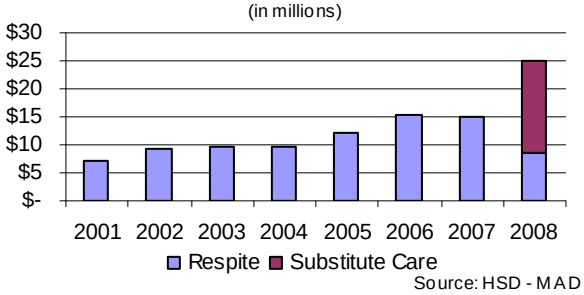
DD waiver exception requests for therapy services are made to the case manager, who is authorized by the department to approve increased units. If a request is beyond a cap set for case managers, the approval must be given by DDSD. In the community, in general, clinical interventions are reviewed by a utilization review agency or a discipline professional to justify a service.

In four years nearly $19.5 million dollars over the original ARA budgets has been spent on therapy exceptions. Before a therapy exception can be requested, DD waiver standards require that $6 thousand must have been spent from the ARA for one or all therapies.

Direct care providers expressed concern regarding the expense of therapy services caused by the ability to increase frequency of services without scrutiny for clinical necessity from an authorizing agency. The perception is that therapy can continue indefinitely in spite of the client reaching maximum benefit. Per the Human Resource Institute's experience with 60 waivers in other states, approximately 25 percent of waiver clients receive therapy services. Over 70 percent of New Mexico's DD waiver clients receive therapy services. From the therapists' standpoint, if they determine the need for therapy services has diminished or is no longer needed, they may be thwarted in efforts to "fade-out" a service by family members or guardians, with a threat to change providers. DDSD has recently mandated that all therapy plans include a "fade-out" strategy, but there was insufficient information at the time of this evaluation to measure the impact of therapy "fade-out" plans.

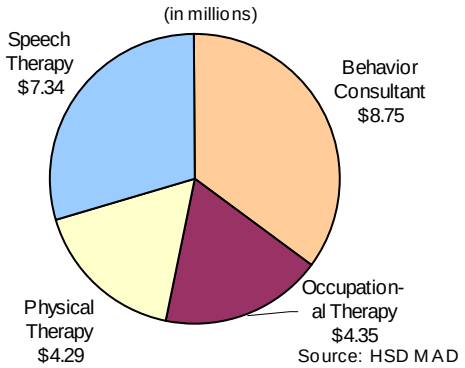
In addition to reimbursement as a family living provider, a family receives additional dollars for up to 1,000 hours of substitute care. Substitute and respite care are intended to allow relief for primary caregivers. Payment for the substitute care can be paid to a family member living in the same home as the primary care giver and client, such as another parent. The graph to the right illustrates total respite and substitute care from FY01 through FY08. The $10 million spike in FY08 may have been caused by allowing an increase in substitute care hours from 750 hours to 1,000 hours. The primary care giver can request additional relief hours, but five dollars per hour will be deducted from the family living provider's reimbursement and the relief worker cannot be a member of the household.

Graph 16. Respite and Substitute Care Costs FY01 - FY08



Most therapists provide their services in a community setting which allows an enhanced reimbursement rate. In FY08, 87 percent of therapies were delivered in community settings and not at therapists' offices. Many of these therapists do not have an office and the associated overhead. An in-office therapy visit is approximately $55 per hour and community site visits average $95 per hour. DD waiver standards promote community setting therapy visits. However, therapists, especially those working in rural areas, are limited by the number of clients they can see in a day because of the travel time between clients. The graph shows FY08 spending by therapy type.

Graph 17. FY08 Therapy Service Spending

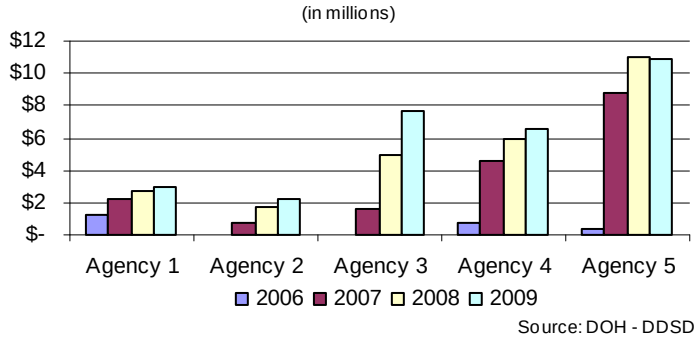


The department requires a minimum of 12 monthly case management visits per year except for children, who receive quarterly visits. Family members stated resources are not used effectively by mandating the monthly visits. Other states have also established case management client standards which are less than those required by DDSD.

The department may be unaware of possible conflicts in the system which could produce financial advantages for certain contactors and may not be in the best interest of individuals served. While conducting field work, multiple allegations were made about the solicitation of individuals from case manager and provider agencies. Although the evaluation team did not make an attempt to confirm such allegations, this may be an area of potential abuse for the department to review. Moving clients between providers may cause major disruptions in the stability of their lives.

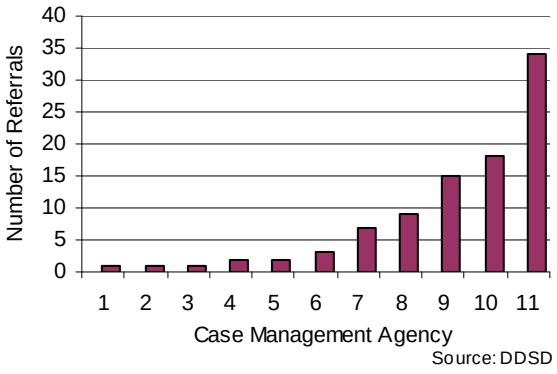
A small number of new providers have experienced extraordinary business growth from FY06 to FY09. Approximately 150 DD waiver allocations have been awarded from FY06 to FY09. Despite the limited number of new enrollees in these years, five organizations have expanded their client base by approximately 430 individuals (assuming a per client cost of $70 thousand). Three organizations began operations in 2006 and two opened in 2007. The graph illustrates the amount of reimbursement growth from FY06 through FY09. It appears unusual that a new provider would experience this volume of business in the first few years of operation.

Graph 18. DD Waiver Reimbursement Growth for New Provider Agencies FY06 - FY09



The evaluation team discovered another situation which could be a conflict of interest which may not be in the best interest of clients. To abide by the freedom of choice mandate, the case management provider agency should only supply limited information to the client regarding direct care providers, such as the location and specialty services offered and the availability of the provider, but must allow the client to choose without undue influence. Although not specifically identified by the department as a case management agency conflict of interest, the evaluation team discovered two instances where a spouse is owner of a direct provider agency and the other spouse is owner of a case management agency which raises concern for a potential conflict of interest. For example, a direct care provider serves 93 clients, of which 36.5 percent were referred from the spouse's case management agency. Number 11 on the graph represents those clients received by the direct care provider from the spousal-owned case management agency. During the same time period, the total reimbursements to the direct care provider increased 80 percent, or $2.5 million.

Graph 19. A Direct Care Provider



In the fall of 2009, DOH attempted to implement cost saving measures which were rescinded after encountering major opposition. DOH's cost saving proposal would have primarily impacted family living providers. The proposal would have paid family living providers based upon level of care, the same reimbursement rule applies to independent and supported living. DOH also proposed that claims for substitute care in family living be paid within the ARA. Concern was expressed by direct care providers and case management agencies, that the recent proposed change to include substitute care costs in the ARA led to family living providers requesting an exchange of therapy funding for an increase in substitute care hours.

Comparisons between family and supported living reimbursement rates are difficult to compare. Both services are funded for a maximum of 340 days per year. Supported living receives a bundled rate which includes other services, such as nursing and nutritional counseling, which are separately funded in family living services. Family living, a 24 hour per day service, may be furnished by a companion, surrogate or family member in the client's or family living provider home. At a minimum, family living providers receive $2,150 per month for providing services to the client, with additional funding available for another family member, including a parent, to be paid for relief hours.

Reimbursement is not adjusted for family living providers when the primary care giver is away and substitute care is being delivered. In addition, reimbursement to the family or supported living provider is not decreased or suspended for the time a client spends in day habilitation or supported employment. The time spent in day habilitation is dependent upon what is approved in the individual service plan (ISP) and could be daily (Monday through Friday).

Supported living occurs in a provider-operated setting of four or fewer individuals, with 24 hour per day staffing. Additional costs are incurred in supported living when one individual is housed alone. As an example, Los Lunas Community Programs has five individuals living in homes alone, each of which would require a minimum of two staff persons 24 hours per day.

Table 8. Community Living Provider Reimbursements

Type	Rate Range	Average Annual	Unit of Billing	Allowable Billing
Supported Living	$118.56-$316.69	$51,680	Daily	340 days/year maximum
Independent Living	N/A	$22,404	Monthly	$1,867/mo with 12 mo/year maximum
Family Living	N/A	$34,085	Daily	340 days/year maximum

Source: MAD March 2009 Rate Supplement

Supported living and independent living are reimbursed based upon the LOC. Family living is a flat rate, without regard to the LOC.

Environmental modifications can be requested by a family, client or provider to enhance the individual's health, safety or function and is approved by the direct care provider. The amount for modifications cannot exceed $5 thousand every five years. Until this year, the allowable amount for modifications was $7 thousand every five years. Environmental modifications of provider-owned properties are done at the state's expense. During interviews, it was discovered some providers assume this as their business expense and do not request reimbursement. The DD waiver costs for environmental modifications were $551 thousand in FY07 and increased to $935 thousand in FY08.

Based on budget realities, certain support services need increased scrutiny to ensure relevance to individual service plans (ISPs) and functional needs. Goods and services provide opportunities for an individual to achieve desired goal outcomes. Examples of goods and services which could assist the individual in meeting goals are: fitness membership fees, tuition for classes, social membership, assistive technologies, instructional books and computers. Approval for a goods and services purchased is made by the direct care provider. Each individual on the DD waiver can spend up to $1 thousand per year for goods and services, which creates a potential yearly liability to the state of $3.8 million. This amount includes a 10 percent administrative fee for providers. The purchase must relate to the ISP and meet functional, medical or social needs. According to providers, recent requests have included wide-screen televisions and electronic games. In FY07, goods and service expenses were $34.9 thousand and increased to over $800 thousand dollars in FY08.

The state has not fully re-evaluated the DD waiver program benefit design to ensure it meets modern-day needs at an affordable cost. An opportunity and need exists to re-evaluate the purpose, benefit design, and price of the DD waiver program in light of reduced federal support and amount of unmet community need.

The opportunity for re-evaluation of the existing costly program design should be addressed within the state's waiver renewal process. The current waiver expires in June of 2011. The renewal application must be submitted to CMS by March 30, 2011. DDSD is in the process of preparing the application and has solicited input from stakeholders.

At the current time, DDSD is considering applying for a single waiver, as is presently in place. Many other states have opted for two or more waivers, dividing individuals by age or level of care required to meet needs. The New Mexico DD waiver benefit package has recently been described to the media by the DDSD Director "as a very generous waiver and offers a richer array of services than other states".

Therapist interviewees suggested that too much of the client's ARA therapy budget goes toward documentation. In addition to direct care services, therapists can receive reimbursement for plan development and progress reporting. They further stated the answer is not to eliminate this reimbursement, but to validate the necessity of all the required documentation and decrease the volume as appropriate. In addition to their routine documentation, therapists are required to develop or update an intervention plan and submit annual and semi-annual reports, even if no changes have occurred.

The complaint about onerous documentation was voiced by all interviewees. This problem is compounded by DDSD issuing new directives, standards, and memoranda without officially rescinding previous communications. Providers expressed frustration in seeking clarification.

Physical and occupational therapy assistants are infrequently used, but could reduce overall costs of therapy services. The DD waiver service array does allow for the use of such ancillary personnel. However, according to therapists, the rates for ancillary staff do not presently meet what would be required for the licensed therapist to deliver service and provide supervision. As an example, in physical therapy, assistants could be responsible for positioning, range of motion exercises and mobility, at a $45/hour rate versus the therapist's $97/ hour rate.

Family members and providers suggested that employment is not a viable option for certain clients and efforts to find employment for those clients should not be a priority. The client and family should have more choice in declining this option. Concern was also expressed that older clients, desiring retirement, are not assisted in developing other options for a meaningful day.

In FY08, supported employment, a priority of the department, served 1,287 at a cost of $6.3 thousand per individual. However, providers of supported employment expressed concern that reimbursement does not support the time and resources dedicated to the process. Prior to job placement, a provider agency must conduct vocational assessments, complete a career development plan, reach out to potential employers, assist in writing applications, solicit references, arrange appointments for job tours, interviews, and job trials. For this reason, some providers indicated they are not willing to provide this service. If an employed client is in need of day-to-day assistance with their job, the provider is also responsible for assigning a job coach who will accompany the client to their job. This assignment could be a daily requirement, with the coach providing assistance with the job duties. Many employers also expect the job coach to replace the client on absent days.

Descriptions of day habilitation by interviewees range from a "meaningful day" to "warehousing of clients". DDSD standards state adult habilitation is to consist of daily functional and purposeful activities, including choice-making and community membership. Continually engaging clients in group activities, without regard to individual goals, was the concern most often expressed. The Human Services Resource Institute, in its presentation to the 2009 Developmental Disabilities Directors meeting suggested that many states have a "reliance on legacy systems", systems which have continued to add but not change or delete ineffective services, creating "living museums". Based upon the information offered by interviewees, it appears as if there is wide variance in the quality of services rendered in day habilitation programs.

There is no verifiable evidence that Los Lunas Community Programs (LLCP) services clients who are not the same type, same diagnosis, or acuity or have better outcomes than those served by community providers. LLCP is a program administered by the Facilities Management Division of DOH, serves individuals with developmental disabilities and bills the DD waiver for waiver services. Services include crisis intervention, group homes, a 4-bed ICF/MR, day habilitation and supported employment. Services, except crisis support, could be provided by other community providers with DDSD oversight. The FY09 cost of operations was $21.1 million, 42 percent coming from the state general fund. This is an increase from 24 percent in FY08. In the same year, LLCP served approximately 300 individuals, employed 330 people and expended $2.48 million for staff overtime. An admission moratorium has been in place for some time. LLCP rents 29 homes in which to deliver services to clients at a monthly cost of $41.8 thousand. Five of the homes house one client. In addition, LLCP has an enhanced rate schedule from New Mexico's Medicaid program.

In almost all cases, unless services are discontinued because of death, a move out of state or transfer to another waiver, the client remains on the DD waiver for a lifetime. According to 7.26.3.8 NMAC, "Nothing in this regulation shall provide an entitlement to programs, supports, services or benefits that does not otherwise exist pursuant to other law or regulation."

Other states have implemented different system and benefit designs to ensure fair and cost-effective allocation of resources for services. Survey responses were requested from states that operate similar programs to New Mexico's DD waiver program, those managing home and community-based waivers and which have few or no large state-operated facilities for persons with developmental disabilities. Alaska, Nebraska, Virginia and Vermont responded to the survey.

Results of the survey are summarized below:

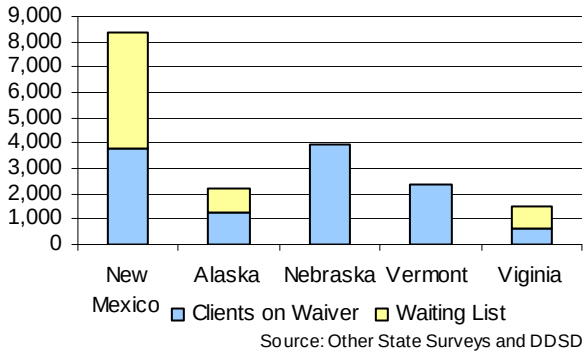
- Cost per client ranged from $30.2 thousand to $64 thousand,
- A standard assessment tool is used to determine need,
- A common theme was not identified for initial assessment administration,
- Three of the four responding states do not pay for family living services and
- Standards for case management require fewer visits.

Other states have implemented or proposed cost containment measures in an effort to hinder creeping program costs. Below are examples of actions or proposals from other states:

- Freezing additional waiver allocations,
- Using database management to reduce operating expenses,
- Refining service definitions,
- Proposing a five percent reduction in payment rates and
- Funding the most cost effective level of services, model of services or service type that meet the needs of clients rather than the desired service(s).

The graph below illustrates the current number of clients on the DD waiver and waiting list for each of the responding states. Alaska and Virginia currently have 981 and 881 waiting list clients, respectively.

Graph 20. Current Count by State DD Waiver and Waiting List Clients



Source: Other State Surveys and DDSD

RECOMMENDATIONS

The Legislature should consider appropriating the funding for the federal match directly to HSD, as occurs with other waiver programs, to avoid the need for inter-agency fund transfers.

HSD and DOH should:
Consider applying for two separate waivers, a supported and comprehensive waiver, to more appropriately meet the needs of clients.

Consider the most appropriate placement or structure of the DD waiver program in state government to improve issues of system fragmentation.

Update the existing inter-agency JPA to reflect current or more appropriate division of responsibilities.

HSD should:
Amend the contract with the utilization review agency directing the agency to perform utilization review on all requests for exceptions and outliers, and initial and annual assessments, using pre-established criteria.

DOH should:
Continue their plan to require "fade-out" strategies for all therapy service plans. Therapy assistant rates should be reviewed to ensure reimbursement promotes appropriate use of assistants. Consideration should be given to collapsing therapy rates into a single rate by averaging the integrated and clinic rates.

Review all provider documentation requirements to determine what is used by the department, and what can be eliminated or streamlined.

Implement an online comprehensive directory for current directives, standards, memoranda and any other compliance regulations which govern the DD waiver program, to include clear detail of retractions.

Evaluate practices in other states for biological family living which relate to: family living provider reimbursement structures, to determine how respite/substitute care is reimbursed and if the level of care is considered in the amount of funding.

Consider need in the requirement for case management visit standards.

Identify purchases which will qualify for goods and services or eliminate this benefit. Contractually obligate supported living providers to assume partial or complete financial responsibility for environmental modification costs.

Determine the outcome value of all services with a special focus on day habilitation to ensure services are operated in a way to address individual goals and promote independence.

Evaluate the mission of LLCP and consider contracting out services to community-based providers.

ENHANCED PERFORMANCE REPORTING TO THE LEGISLATURE AND PUBLIC COULD HELP BUILD ON POSITIVE BENEFITS INITIALLY PROVIDED THROUGH THE DD WAIVER PROGRAM AND FEDERAL CONSENT DECREES

DOH has a highly structured quality monitoring system and has received most favorable national rankings for outcome performance. Foremost, New Mexico has been a national leader in expansion of community-based services and reduced reliance on large institutions for people with developmental disabilities. New Mexico is only one of eight states which do not operate large state institutions for the care of individuals with developmental disabilities.

DOH collects, analyzes, and reacts to a large volume of quality monitoring data. Data is measured against New Mexico past years' performance and that of other states. New Mexico has received favorable national rankings. Unfortunately, policymakers have not been made routinely aware of these successes. DOH performance measures, in the departmental report card, are directed towards measuring numbers and not monitoring outcome-focused performance. Performance measures in the 2009 General Appropriation Act (GAA) were not continued in 2010 pending new measure development.

DOH participates in the National Core Indicators (NCI), which is a collaboration among 22 state directors for developmental disabilities and the Human Services Research Institute. The goal is to develop a systemic approach to performance and outcome measurement. The NCI participants monitor over 100 individual indicators from 20 states. In the 2007-2008 Consumer Outcome Survey, New Mexico was highly ranked among other participating states. Other quality monitoring scores are shared in Appendix C. The department also conducts annual surveys of families and providers beyond the requirements of NCI which are shared and discussed with quality committee members, including community membership.

Table 9. Consumer Survey Outcomes
National Core Indicators Report
2007-2008

Measurement	NM Ranking
Community Inclusion	#1
Aid and Ability to Make Life Decisions	#2
Proportion of people who visited more than one residential home prior to locating	#1
Proportion of people who looked at more than one job	#2
Proportion of people who had a routine dental exam in last 6 months	#8
Family guardian satisfaction survey	#3

Source: Human Services Research Institute

DOH's Division of Health Improvement (DHI) conducts scheduled surveys of all DD waiver providers. The surveys determine compliance with federal and state standards to assure the health, safety, and welfare of individuals receiving services through the DD waiver, and to identify opportunities for improvement. Results of the reviews are shared in an interagency committee, with members from DDSD, DHI and Medical Assistance Division (MAD). The committee determines the course of action necessary to correct deficiencies and how the action plans will be monitored. DHI does conduct follow up surveys to ensure compliance with corrective action plans.

The MAD Quality Division conducts desk audits of DD waiver providers. If it is determined that fraud or abuse could be an issue, MAD forwards the review to the Attorney General's Medicaid Fraud and Elderly Abuse Division. MAD does not receive feedback on the status of referred cases from the Attorney General's Office.

A review of DOH Internal Audit Office audits conducted since 2002 demonstrates common issues such as, simultaneous billings for same date of service, lack of supporting documentation for billing, lack of internal controls and inappropriate altering of original documents. Of the 10 audits, the evaluation team could only identify one instance where recoupment of funds from providers was recommended. All other recommendations focused on implementation of corrective action plans, but no follow up audits were performed to ensure practice change. No audits were completed to review conflicts of interest which might create unfair financial advantages within the system. No audits have been conducted since 2007. The Internal Audit Office states lack of staff prevents more oversight and auditing of the DD wavier program.

Federal requirements and the Jackson federal consent decree result in the state collecting massive amounts of information on service, compliance, spending, performance and quality information. The original intent of the Jackson lawsuit (JLS) and the state's efforts toward community-based as opposed to, institutional care has been accomplished. State efforts are now dedicated to refining the community-based service system and responding to the mandates of the Jackson Stipulation for Disengagement (JSD). Examples of JLS benefits are as follows:

- Except those individuals housed in ICF/MRs, all JLS members are receiving community-based services.
- A robust set of services is provided to meet the needs of the people with developmental disabilities.
- Regionalization of state services provide more convenient access for client and providers to training, technical assistance, waiver information, service resources, and trouble-shooting. Regionalized service allows DDSD staff to more closely monitor provider compliance with standards for service delivery.

The Office of Behavioral Services, created in response to JLS compliance, conducts a sexuality training program for people with developmental disabilities. A recent graduation demonstrated clients were able to express self-esteem, discuss their individual importance to their families and community, identify appropriate relationship behaviors, and how to protect themselves from unwanted advances and sexually transmitted diseases

According to providers and family members of people with developmental disabilities on the DD waiver, JLS corrective action plans have not all been positive. Providers and families indicate many action plans relating to JLS have been imposed by DDSD on all waiver clients. A large majority of providers and families interviewed describe the stipulations of the JLS as based upon a one-size-fits-all, medical model which is intrusive and violates the rights to independence and the dignity of risk for the entire DD waiver population. It is described as applying equity to mean everyone gets the same rather than everyone gets what they need. The same concerns were raised in DDSD's Adult Services Sub-committee meeting on June 30, 2009. In general, as a result of regulation, oversight, and JLS compliance plans in all service sites, including client homes, the system has been described as having created "mini-institutions".

The ability of the state to disengage from the lawsuit is complicated. The state must comply with the Jackson Plan of Action, with over 400 objectives and its Appendix A with over 100 additional required actions the 1998 Community Audit Recommendations, and Continuous Improvement Scores, as measured by the Community Practice Review. Each outcome within the Plan of Action and its Appendix A may require numerous actions to attain compliance. For instance, one requirement, "implement Dr Wilcox's mortality review recommendations" requires implementation of 65 separate actions.

The Plan of Action and its Appendix A identify obligations for all three state entities named in the lawsuit. DDSD is the lead entity for DOH's implementation, monitoring and compliance. To coordinate activities among agencies, there is a joint powers agreement between DVR and DOH, and a Jackson Coordinating Committee to address interagency class member issues between HSD and DOH.

When the state determines they have fulfilled the obligations of a section of one of the documents, a request for disengagement is submitted to the plaintiffs' attorneys. The plaintiff attorneys can either accept or contest the request from the state. If the plaintiffs contest, the state can continue the process for improvement for the section for which relief was requested or move forward with a request for disengagement to the court. A court-selected mediator is available to assist with reconciliation between the state and plaintiff attorneys. The mediator, who is a judge, is selected by the judge assigned to the lawsuit and is expensed to the New Mexico court system.

As of March 2010, DDSD claims that the department has complied with 73 percent of the JSD. The state has also provided documentation to the court and plaintiff attorneys to hopefully demonstrate compliance with five other action items.

Other circumstances impede the state's ability to gain full compliance with the court ordered action plans:

- State staff turnover disrupts the disengagement process. The plaintiff attorneys have remained fairly constant since the lawsuit was filed.
- Best practices of care, such as a focus on employment opportunities for the developmentally disabled population, have changed significantly since the onset of the lawsuit. This has required the state to implement practices which were non-existent when the suit was filed.
- New Mexico's health system has a shortage of primary care physicians and dentists, which impedes their ability to meet the medical and dental access goals. Existing practitioners may choose not to serve this population.

Ensuring quality services to JLS class members is shared by many entities. DDSD devotes significant resources to monitoring the progress and quality of the disengagement plan. Some examples are:

- Includes JLS members in the National Core Indicator surveys and monitoring.
- Monitors implementation of quality improvement plans developed as a result of mortality reviews.
- Maintains regional offices in five locations.
- Conducts annual Community Practice Reviews for each region, under the oversight of the Community Monitor.
- Uses 15 employee positions transferred in FY09 from the DHI to DDSD to ensure action on the JLS objectives One position serves as the Medical Director for DDSD and the remainder are divided into two groups:
    1. Community Practice Review Team conducts practice reviews, support DDSD and providers in understanding and addressing findings, work with providers on the review process and use results to improve services
    2. Continuous Improvement and Coordination Team identifies and addresses continuous improvement needs by region, identifies and help teams members

solve problems related to individual review recommendations that are not closed or are related to repeat findings, analyzes information from the review team and others sources to determine action needs and works on individual and systemic issues.

OTHER STATES

Other states have faced lawsuits similar to New Mexico. The table shows lawsuit file dates and status as of August 2009. Of the states identified, only two have litigation remaining open.

Table 10. Summary of Similar Lawsuits within Other states

State	Date Filed	Resolved
Alabama	1970	2003
California	1990	1994
Connecticut	1994	2008
Washington DC	1999	2001
Delaware	2002	2004
Florida	1992	2006
Georgia	1995	1995
Montana	1996	2004
North Carolina	1990	1993
Nebraska	1995	Open
New Hampshire	2002	2003
New Jersey	2005	Open
New Mexico	**1987**	**Open**
Oregon	2002	2002
West Virginia	1979	1981

Source: PAS – University of California

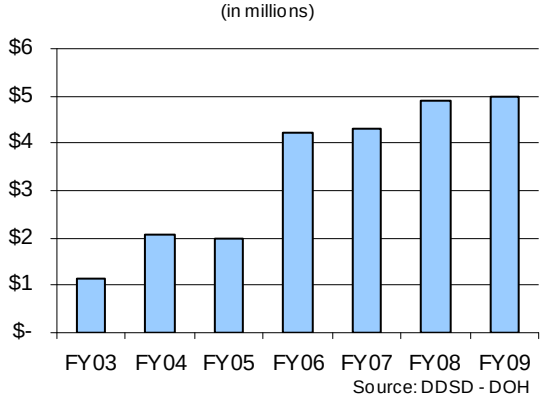
It should be noted that some states are also engaged in lawsuits for attempting to move clients from state institutions or ICF/MRs to community-based services.

The annual cost to support the Jackson lawsuit is $5 million of which only about eight percent pays for plaintiff legal fees. Although the state is responsible for both the plaintiff and defendant legal fees for the JLS, these are not the primary cost drivers of the lawsuit. In addition to the legal fees, administrative and compliance monitoring costs and state staff salaries add to the expense. Several consultants and monitors are contracted by the state. Some are engaged by the state to aid in compliance with the JLS, while others are court mandated. As most DDSD employees have responsibilities to JLS, in addition to their general duties, not all costs can be accurately allocated between JLS and other services for individuals on the DD waiver. For instance, DOH states a significant amount of employee time is dedicated to quarterly progress reporting to the court. Per DDSD, JLS costs from 2003 to 2009 amount to $23.6 million.

There has been growing concern from interim legislative committees regarding the JLS and its financial and operational impact on the state. As the appropriating body for the state, the Legislature is not receiving scheduled updates on the status of the disengagement process

If the lawsuit is settled, administrative costs associated with JLS could be dedicated to allocations for clients to move from the waiting list to the waiver.

Graph 21. Budgeted Contract Amount by Fiscal Year



Source: DDSD - DOH

DOH and HSD lack useful management reports that aggregate key information on the DD waiver program and appear overwhelmed by data collection activities. The evaluation team received no response for routine reports used to provide effective management of the DD waiver program.

DOH/DDSD does not have an integrated system by which to manage and monitor the program. DDSD's use of a paper system has built a reliance on ad hoc reporting from other departments and agencies, creating many opportunities for missing data, prevented real-time monitoring and problem solving, hindering the sharing of client status and progress reports among providers.

Products, which are commercially available, are successfully being used by other states for their waiver programs. Costs range from $500 thousand to $1 million

RECOMMENDATIONS

DOH should:
Submit semi-annual disengagement progress reports to the Legislative Finance and Health and Human Services Committees.

Urge the court to focus on goal outcomes and allow DOH to develop and implement plans to meet the outcome expectations, instead of issuing detailed action plans.

Expand disengagement plan to include unresolved issues, next needed action items and anticipated completion dates so progress is not interrupted by executive administration and departmental personnel changes.

NEW MEXICO DEPARTMENT OF HEALTH

Alfredo Vigil, MD
Secretary

Building a Healthy New Mexico!

Bill Richardson, Governor

Katrina Hotrum
Deputy Secretary

Jessica Sutin
Deputy Secretary

Michael Mulligan
Acting Deputy Secretary

Karen Armitage, MD
Chief Medical Officer

4 June 2010

Legislative Finance Committee,

The Department of Health, Developmental Disability Supports Division appreciates the efforts of the Legislative Finance Committee's goal to better understand the services and problems of service delivery for the DD Waiver. The LFC audit staff was quite interested and intent on obtaining the information to make a valued assessment of the program. As you are aware, the DD Waiver is a massive and complicated system, but with the added responsibilities of the Jackson Litigation it becomes more intricate.

The audit itself revealed some areas of concern that DDSD has been working toward effective solutions. Others are predicated on the need to submit a new waiver packet for renewal of the waiver. The opportunity before us is one of a lifetime. We have the opportunity to re-design the existing service package to better serve the needs of those on the waiver while cutting overall costs, thereby allowing us to provide services to more individuals.

To date the Federal government has not addressed the need to extend the enhanced FMAP for an additional six months. The original Jobs bill that included the extension was passed without the inclusion. The Department submits its response to findings and recommendations listed in the report as follows:

Spending Levels For the Existing DDW Program Enrollment Are Becoming Unsustainable. The Department agrees with this finding. The Department has hired Human Services Research Institute (HSRI) and National Association of State Directors of Developmental Disabilities Services (NASDDDS) to assist the Department in rate establishment and systems development. Last summer, the Department proposed to the provider and advocate communities cost containment measures which would be incorporated in the January 2011, waiver re-writes. The Department is currently working with key stakeholders in the DDW community to define services to incorporate in the re-write. In January, 2010 the Department was faced with the possibility of decreased Federal funding and proposed cost saving measures to ensure services for individuals did not laps. Fortunately the FMAP decrease has not yet materialized. The department is happy to partner with the legislature to make necessary to sustain fiscal responsibility.

DDW Programs Lacks A Needs-Based Assessment Tool And Utilization Review Process To Ensure Participants Receive The Right Care At The Right Time. The Department agrees with this finding. The Department is interested in utilizing the Supports Intensity Scale (SIS) assessment tool, developed by American Association of Intellectual/Developmental Disabilities Services (AAIDDS) The SIS is a comprehensive tool which requires the assessment to be administered by in independent party to eliminate bias. The Department worked with AAIDDS to develop a plan on how to assess all 4,000 individuals receiving DDW services across New Mexico however, at a cost of $850 per assessment, the implementation of this plan is cost prohibitive at this time.

The Waiting List Numbers Considerably Outpace Allocations To The DDW Causing Individuals With Unknown Needs To Wait 7 To 8 Years For Waiver Services. The Department agrees with this finding. The Department is currently developing a need-based survey for individuals on the waiting list to be completed and implemented by July 2010. The survey will be conducted annually thereafter to the first 500 individuals on the waiting list. The Department will utilize the results of the survey to project budgets, determine resources, and identify systems needs.

Increased Program Oversight, Improved Cost Management, And Benefit Redesign Will Be Necessary To Maintain Or Expand The DDW Program. The Department agrees with this finding. Currently, the Department has little control over the level of care and the system is lacking appropriate oversight and utilization review. Both HSD and DOH have identified the need of placing payment system edits in the Omnicaid system to prevent the over billing of consumer budgets. The Department will address this issue in the DDW re-write process.

In response to the finding that ***"There is no verifiable evidence that Los Lunas Community Programs (LLCP) services clients who are not the same type, same diagnosis, or acuity or have better outcomes than those served by community providers"*** The Department respectfully disagrees. LLCP is considered a safety net service and provides care for some of the most medically fragile and behaviorally challenged individuals in a community setting. LLCP is only one of five tier three crisis providers in the state and is the only provider that takes court referred and court committed cases.

In response to the recommendation that HSD and DOH ***"Should consider the most appropriate or structure of the DD waiver program in state government to improve issues of system fragmentation"*** the Department respectfully disagrees. The DD Waiver is appropriately placed within the Department of Health. Improved oversight over budgets, appropriate utilization review and ensuring care are direct service functions not provided by HSD.

Enhanced Performance Reporting To The Legislature And Public Could Help Build On Positive Benefits Initially Provided Through The DDW Program And Federal Consent Decrees. The Department partially agrees with this finding. As stated in the body of the LFC report, the Department has received favorable nationally rankings in several areas of the DDW system. The favorable rankings are partially attributed to the states obligation to comply with the Jackson Lawsuit (JLS). Although the JLS requirements contribute to the increase cost of the waiver, the Department disagrees that separate standards and regulations should be in place solely for Jackson Class Members. Many of the systems put in place are considered best practice and the Department believes that all DDW recipients should benefit.

With regard to the JLS, the Department does not agree that we should "expand disengagement to include unresolved issues, next needed action items and anticipated completion dates so progress is not interrupted by departmental personnel changes". The Department has aggressive outside council to assist in ending the JLS. Since 2008, the Department has disengaged from six Plan of Action items, two Appendix A items and notified the parties of seven pending disengagement motions. The Department and its council believe that expanding disengagement will further increase the Departments obligations and will only prolong the ending of the JLS.

With respect to the additional Legislative oversight to monitor operational performances and progress for disengagement from the JLS, the Department is willing to provide a copy of the JLS Report submitted quarterly to the court. Additionally, the department is willing to work with the LFC on performance measures to report, along with the Departments full report annually. Since HHS has an already established subcommittee to address DD issues, the Department questions the need for an additional committee for the sole purpose of oversight of the DDW.

Again, thank you for the analysis of our program. The department will take the necessary steps to continue to improve the DDW Program and work to implement some of your recommendations.

Sincerely,

Mikki Rogers
Director
Developmental Disabilities Supports Division

New Mexico Human Services Department

Medical Assistance Division
PO Box 2348
Santa Fe, NM 87504-2348
Phone: (505) 827-3103

Bill Richardson, Governor
Kathryn Falls, Secretary

June 4, 2010

David Abbey
Director
New Mexico Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, New Mexico 87501

Re: Human Service Department (HSD) Response to draft of Developmental Disabilities Waiver (DDW) Report

Dear Director Abbey:

Thank you for the opportunity to read and respond to your well-researched report about the DDW program. We would like to comment on a number of statements in the report and hope you will see fit to modify it as appropriate.

Executive Summary, page 2:

"DD Waiver Program Lacks A Needs-Based Assessment Tool And Utilization Review Process To Ensure Participants Receive The Right Care At The Right Time. *... The LOC, a key determinant used to set the annual resource allotment (ARA), is established by a case manager and not reviewed or approved by the department."*

This statement is not entirely accurate as the LOC is approved by the TPA Contractor on behalf of HSD. This process is in the DD waiver approved by CMS.

Executive Summary, page 2:

"The Number of Individuals Being Placed on the DD Waiver Considerably Outpace Allocations To The DD Waiver Causing Individuals With Unknown Needs To Wait Seven To Eight Years For Waiver Services. *Of the 4,555 individuals on the waiting list, 2,676 received services funded by the Medicaid program, either through managed care or fee-for–service plans. This information was generated by HSD from encounter data submitted by the managed care organizations. The evaluation team expresses*

concern about the validity of the encounter data. Managed care organizations' (MCOs) capitation payments, per member per month payment to MCOs by HSD, for individuals on the waiting list exceeded the MCO submitted encounter costs by $91.1 million from FY05 through FY09. Encounter costs are the reimbursements paid to providers by the MCOs for the delivery of services. If the information is not correct, the opportunity for DOH or HSD to assess the needs of waiting list individuals, identify those who have received services and forecasting future DD waiver costs is compromised. If the information is accurate, there would appear to be resources available to more quickly move individuals to waiver status."

HSD expressed to the LFC team that we had a low confidence in the encounter payment amounts and explained why, as acknowledged on page 16 of the report. HSD offered to have the MCOs generate reports on their spending for the individuals with developmental disabilities, but it was late in the research process at that time. HSD is still willing to obtain this data from the MCOs for the LFC. While we agree that improved encounter data would help in the administration of the DD waiver, we do not believe it is useful to suggest, on the basis of the data received, that that there could be additional resources to the tune of $91.1 million over four years. This is almost certainly not the case. Also, HSD has explained that it is difficult to determine the actual value of Medicaid services delivered to individuals enrolled in the SALUD! program and request that this be noted in the report.

Executive Summary, Page 3:

"Increased Program Oversight, Improved Cost Management, And Benefit Redesign Will Be Necessary To Maintain Or Expand The DD Waiver Program. *Multiple state agencies and contractors are responsible for oversight and management of the DD waiver program and services. Fragmented management of the system complicates effective oversight of program operations, results in overspending budgets, causes information gaps and inaccuracies and prevents expansion of services to people in need. Inadequate oversight of utilization review allows use of services, beyond the annual resource allocation (ARA), causing significant increases in program costs."*

The Joint Powers Agreements between HSD and DOH and ALTSD are currently being upgraded to better delineate the duties and responsibilities of the agencies. Also, the contract with the Third Party Assessor requires utilization review, including review of outliers, and is being amended to improve that function. Further, the last sentence of the above is correct to the extent that the Medicaid Management Information Systems (MMIS) does not prevent payment of services if the payment amount will cause the client to exceed their ARA. However, it is not clear that this causes a significant increase in program costs. Services and the amount of service units that are authorized are entered into the MMIS by the Utilization Review contractor in the form of a prior authorization. The MMIS will not issue payment for billed services if the number of units billed exceeds the number of units authorized, so payments are limited to the ARA indirectly. In addition, we ask that it be noted that HSD is currently working on changes to the

MMIS that will enable it to directly prevent the payment of services that are beyond the ARA.

Findings and Recommendations, Page 12:

"The level of care (LOC), a key determinant used to set the annual resource allotment (ARA), is established by a case manager and not reviewed or approved by the department. *... The present utilization review agency, as of January, had not issued any denials for services, accepting all case management approved LOC, ARA, and service authorizations."*

As stated above, this is not entirely accurate as the LOC is approved by the TPA Contractor on behalf of HSD. This process is in the DD waiver approved by CMS. Also, Molina does indeed report that there we no denials from August 2009 through April, 2010. However, it should also be noted that (1) There were very few if any new allocations to the waiver during this time and therefore, these were annual reviews for a population whose medical conditions remain fairly static, and (2) historical information from the previous utilization review agency shows few denials as well for this population. Molina further reports that there were denials in May, 2010.

Findings and Recommendations, Page 16:

"**Managed care organizations' (MCOs) capitation payments for individuals on the waiting list exceeded the MCO submitted encounter costs by $91.1 million from FY05 through FY09.** *For example, in 2009, HSD paid $32.8 million in MCO capitation payments for waiting list clients. Of this amount, the state received encounter data supporting only $7 million in services to waiting list individuals. Encounter costs are HSD expressed low confidence that the data submitted since 2008 by MCOs is accurate and complete. HSD stated certain factors make encounter reporting problematic: incomplete or non-submitted data, MCO sub-capitation rate agreements between the MCO and their providers (which are not required to have a payment attached), complete hospital stays and a month of home health visits may appear as single encounters. Accurate encounter data is important to monitor service delivery and quality, and set rates for MCOs. The graphs below illustrate the capitation and encounter cost submission data for waiting list individuals for fiscal years 2005 through 2009. However, Coordinated Long-Term Services(CoLTS) encounter costs, through which some encounters were paid, have not been reported to the state and not included in the reported costs. The total amount, from FY07 through FY09, of administrative costs paid to the behavioral health MCO was $149 thousand.*

The department stated 'capitation rates are actuarially sound, based on utilization and cost experience for individuals in specific categories of eligibility and age groups. The cost data used to develop rates is supplied by the MCOs, but not from the encounter data'. However, based on the data received, it is unclear how the state is assured that the capitation rates are sound. LFC has previously expressed concerns regarding the quality of encounter data, lack of auditing, and the access to full rate information within

LFC's Human Services Department – Program Evaluation of Medicaid Managed Care (Physical Health) report, issued January 14, 2009. Recently, HSD has agreed to move forward with a confidentiality agreement allowing HSD to share more MCO data with LFC staff."

HSD has concerns with some of the wording in the above paragraphs in that it omits key information:

1. *HSD expressed low confidence that the data submitted since 2008 by MCOs is accurate and complete.* HSD is indeed aware that payment data from the encounter submissions was incomplete. However, we are able to obtain payment information for other sources and can share that information with LFC. Also, it should be noted that, while HSD currently does require claim payment information on MCO encounter data submissions, it did not do so prior to late 2008. The MCOs did submit encounter data prior to 2008 but not claim payment information.

2. *"...complete hospital stays and a month of home health visits may appear as single encounters".* It should be noted that this has to do with the numbers of encounters and has no relevance to the costs. This sentence could be removed since it is unrelated to encounter payments and may confuse the issue.

3. "*... CoLTS encounter costs, through which some encounters were paid, have not been reported to the state."* This is not entirely accurate as AMERIGROUP is submitting encounter data. Evercare is starting to submit encounter data. HSD is closely monitoring this and has imposed an on-going sanction on Evercare for failure to report encounter data. HSD respectfully requests that wording be changed to indicate that the CoLTS encounter data is not complete, and to indicate that the CoLTS program was not fully implemented until April 2009.

4. "*The department stated 'capitation rates are actuarially sound, based on utilization and cost experience for individuals in specific categories of eligibility and age groups. The cost data used to develop rates is supplied by the MCOs, but not from the encounter data'. However, based on the data received, it is unclear how the state is assured that the capitation rates are sound."* HSD contracts with an actuarial company that certifies the capitation rates are sound. It is a federal requirement to have actuarially sound rates.

Findings and Recommendations, Page 18:

The scope of responsibilities of the utilization review agency is very limited per the contract with HSD. The contract states, "The individual service plans (ISPs) are approved by the recipient's case manager. There are only three instances in which the case manager's need to review for medical necessity. The contractor will enter the case manager approved plan as written into the MAD 046 directly into the Omnicaid system"

The TPA contract includes additional responsibilities regarding level of care and individual service plan reviews beyond what is cited in the report. As previously noted, the TPA contract is being amended to improve the utilization review function.

Sincerely,

Katie Falls
Cabinet Secretary

Cc: Lawrence Davis
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APPENDIX A: FY09 JACKSON LAWSUIT RELATED EXPENSES

Title	Services	Cost
Consultant	Technical assistance to state	$650,000
Consultant	Direct sign language services	$3,500
Therapist	Direct assistance to class members	$120,234
Consultant	Support completion of day services Activities	$96,957
Facilitator	Facilitate and support preliminary Risk screenings	$ 5,620
Court monitor	Advisor to judge. Provides her own analysis of system adequacy to the judge.	$362,484
Consultant	Consultation and direct support to class members re: sexuality	$ 67,678
Consultant	Consultation to state re: positive behavioral support and development of Office of Behavioral Services	$155,000
Consultant	Technical assistance to state on risk Management and assessment of people with inappropriate sexual behaviors	$54,000
Consultant	Seating expert	$53,600
Fiscal Agent	Assistive technology fund operation	$33,000
Fiscal Agent	Fiscal oversight for employment initiative	$150,000
Therapist	Direct assistance to class members	$124,605
Consultant	Support completion of day service Activities	$122,157
Consultant	Expert advisor for employment services	$120,000
Therapist	Consultation for seating clinic	$6,815
Therapist	Direct services to class members and consult to state	$120,234
Community Monitor	Conduct audits of system for court	$450,000
Consultant	Expert advisor for speech language Pathology	$30,000
Consultant	Medical technical assistance to providers and state	$1,065,961
Consultant	Case management redesign	$13,000
Consultant	Direct evaluation of class members with complex needs	$464,094
Therapist	Provides swallowing evaluations	$92,459
Plaintiff Attorneys	Legal services to class members	$400,000
Defendants Attorneys	Legal services for state	$144,119
Total		**$4,905,517**

Source: DDSD

APPENDIX B: INTERVIEWEES CONCERNS AND RECOMMENDATIONS

During evaluation field work, approximately 50 non-DDSD staff were interviewed.

Common Themes

- Improved assessment processes for clinical assessment and annual resource allocations.
- Eliminate or more closely monitor the use of the goods and services accounts.
- Reduce excessive DDSD documentation requirements.
- Determination of services should be based upon sound clinical and functional measurement criteria and not solely upon the request of providers, family members or guardians.
- Solicitation of clients within the system is prevalent.
- Complaints need to be investigated and follow-up provided to complainants.
- Communication among direct care providers needs to be strengthened.
- DD waiver is increasingly becoming a medical model in which the plan of care is very prescriptive and compromises self determination and independence.
- The DD waiver is viewed as an entitlement system instead of a mechanism for support that is based on need.
- Jackson lawsuit members should be placed within a separate waiver.
- The Jackson lawsuit has driven the DD waiver to something it was never intended to be.
    - Has created a medical model to the extent that individual's homes have become mini institutions.
    - What should the role of the waiver be?
    - Nursing home model, medical model, support model or a community model.
- State's attorneys have not been assertive enough in legal proceedings.
- The state should develop an integrated information system that allows electronic interaction among all appropriate stakeholders. This would eliminate a lot of unnecessary manual paper work.
- DDSD needs to address conflicts of interest between case management agencies and direct care providers.

Other Concerns

- Review family living providers who are receiving reimbursement for family living and substitute care while that are employed outside the home and family member is attending day habilitation.
- Aspiration protocol is onerous.
- Alignment between community access and day habilitation rates.
- Non-medical transportation should be eliminated.
- Saturation of provider in the metro area.
- Disparity in DDSD training requirements among providers.
- Disproportionate cut recently proposed (25 percent) for family providers but support an across the board cut.
- Therapy hours should be tiered based on level of care.
- High turnover rate within agencies hinder therapists abilities to implement ISP's.
- Willingness to implement therapist plans within agencies and family home settings is not ideal.
- Therapist plans have to be simple and elegant in order for success.

- Aspiration protocol like other initiatives relating to the Jackson lawsuit, are applied to the general DD population.
- Providers are cautious when recommending or denying services because individuals and families are being encouraged to sue whenever possible.
- DDSD has not properly outlined job descriptions or scopes of work for nurses.
- Waiver service outcomes rather than processes need to be reviewed.
- Therapies should be consultative in nature as directed by the DD waiver standards.

APPENDIX C: DOH QUALITY PERFORMANCE

New Mexico conducts and collects data relating to the operation of the system and satisfaction of clients served through the DDW program. Data is used to measure NM's progress across years and much is submitted to the National Core Indicators. The National Core Indicators is a collaboration among participating National Association of State Directors of Developmental Disability Services (NASDDDS) member state agencies and the Human Services Research Institute (HSRI), with the goal of developing a systematic approach to performance and outcome measurement. Outcomes for over 100 performance measures are monitored and comparisons are made among states. The few examples shown here are from both DOH and NCI's databases.

Percentage of Individuals with Positive Responses Perception of Independence

Year	NM Rate
2009	89.9%
2008	88.7%
2007	89.7%
2006	89.9%
2005	88.9%
2004	86.9%

Source: HSRI

National Core Indicator
Percent of Positive Responses Compared to Other States
2009

Performance Measure	New Mexico	Other States
Adequacy of Information and Planning	72.4%	67%
Access to and Delivery of Services and Supports	72,4%	67.7%
Community Connections	56.9%	41.4%
Outcomes and Satisfaction with Service and Supports	79.6%	71.5%

Source: HSRI

DDW Provider Turnover Rate

Year	NM Rate	US Rate
2009	43%	50%
2008	43%	50%
2007	45%	50%
2006	45%	50%
2005	41%	50%
2004	41%	50%

Source: HSRI

State Rankings 2007-2008

National Core Indicator	NM Ranking Compared to Other States
Treated with respect by provider	1
Personal Life Satisfaction	3

Source: HSRI