

Intergovernmental Initiative Case Study

**New Mexico's Home and Community-Based Care Services Waiver:
The Disabled and Elderly Waiver Program**

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Introduction:

The United States has witnessed a steady, gradual increase of their senior citizen population; between 1990 and 2000, people aged sixty-five and older grew to 12% (U.S. Census, 2008). Due to this significant increase, senior citizens are seeking medical and custodial care at an alarming rate. Families and caregivers are also seeking resources to assist their elderly loved ones with the assistance that they will need as they age and continue to need specialized long term care. Unfortunately, many senior citizens and their families do not have adequate resources to cover long term care as their medical needs become more advanced. The issue of senior citizens increased need for custodial care coupled with their limited financial resources is compounded by the quandary that many of their families are unable to care for them due to their own financial responsibilities and busy schedules. Additionally, many senior citizens symbolically observe institutionalized long term care as an unfavorable option and often seek alternatives in order to prevent leaving their homes. Unfortunately, in-home care is not reimbursable through Medicare and senior citizens and their families usually have no other choice but to pay privately for long term care or home based care services or else consequentially risk being transferred to a long-term care setting. Fortunately, Home and Community Based waivers (HCBS) through Medicaid are available to ease the burden of providing in-home care to the elderly or disabled. Home and community based waivers ease the burden for elderly, medically fragile and disabled populations by providing in-home care and support, which would typically otherwise be sought from through a long-term care facility.

The Federal government officially recognized waiver programs in 1962, through section 1115(c) of the Social Security Act, which renders the secretary of Health and Human Services the ability to “authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute” (CMS, 2008). Waiver programs provide states

the flexibility to bypass federal requirements in order to develop and implement services for eligible recipients; those who typically are debilitated in some manner and qualify for Medicaid (Conlan & Posner, 2008). In 1981, the federal government gave states the flexibility to provide Home and Community Based care services for their elderly or disabled residents, thereby waiving Medicaid requirements (Weissert & Weissert, 2008). Since their federal inception, states have embraced the ability to utilize HCBS waivers as a service option for the disadvantaged and medically vulnerable and their acceptance has continued to spread. In 2005, all fifty states participated in Home and Community Based Care Services (HCBS) waivers and there are 287 active HCBS waiver programs in the country (CMS, 2008). Waiver programs are becoming a favorable option for states and their residents, in 2005 approximately 2.8 million people had utilized Medicaid HCBS services nationally and between 1995 and 2007, federal expenditures for HCBS programs rose from 19% to 21% (Ng, Harrington & O'Malley, 2008). Fundamentally, HCBS waiver programs serve a multitude of populations; these include but are not limited to developmentally disabled and mentally retarded clients, medically fragile children, AIDS patients and the elderly and disabled.

The federal government has given authority to the State of New Mexico to provide its residents with eleven separate waiver programs under the home and community based provision of Medicaid statute 1915(c). Four of these waiver programs in the State of New Mexico fall under the category of Medicaid Home and Community Based Care Services (HCBS). The state of New Mexico adopted the Medicaid waiver program formally entitled the Disabled and Elderly (D&E) waiver program in 1990 (CMS, 2008). The states adoption of the New Mexico Disabled and Elderly Program was especially favorable in the state, considering that between 1990 and 2000 the elderly population increased by 12% in New Mexico (U.S. Census, 2008). The (D&E) waiver program provides disabled and elderly individuals who are Medicaid eligible with in-

home assistance in order to avoid being admitted to a long term care facility, otherwise known as a “nursing home.”

The D&E waiver was enacted as a cost saving program for the state, and provides elderly and disabled residents the ability to stay in their home; providing that the costs of services they receive through the waiver does not exceed the annual costs of stay in a long term care facility (Conlan & Posner, 2008). In March of 2009, the average total cost for an individual receiving D&E services in the state of New Mexico was \$2,189 a month or \$26,268 per year (N.M. Aging and Long Term Services Department (ALTSD), 2009). Essentially, the goal of the initiative is to prevent clients from becoming residents in institutionalized care settings and allows them to remain in their home and maintain their independence for as long as possible. It should be noted that the program is not a twenty-four hour personal attendant service, and that clients and their families must be able to provide supplemental care when needed.

The D&E waiver provides Medicaid eligible elderly and disabled clients with a variety of services specific to their needs, this includes nursing, home health aides, physical, occupational and speech therapies, case management, respite care, assisted living, emergency response systems and environmental modifications for their homes. All service providers involved in the implementation of the D&E waiver services must be cleared by the national criminal data base to ensure the clients safety. In 2005 there were approximately 2,442 participating clients in the disabled and elderly waiver system in New Mexico (CMS, 2008) any individual is allowed to put themselves on the D&E waiver waiting list and as of March, 2009, there were 14,544 people on the central registry (ALTSD, 2009).

In order for the disabled and elderly waiver program to be implemented to potential clients, the New Mexico Medicaid waiver program allots program spaces for prospective clients both statewide and countywide. “Allocation to the D&E Waiver program begins when funding

becomes available to serve additional individuals on the waiver. A letter is sent from the state Aging and Long Term Services Department (ALTSD) resource center instructing the individual to complete and return the form entitled, Freedom of Choice Form” (ALTSD, 2006). By completing the freedom of choice form, the client is given several options to decide who they want to seek case management services from and then designates their chosen case management agency that is ultimately responsible for initiating and providing services. As of March, 2009, the average number of days it takes from the actual D&E waiver allocation to active service implementation is 97 days (ALTSD, 2009). As long as they qualify, D&E waiver clients can stay on services as long as they are eligible both financially and medically. The clients designated case management agency must resubmit a multitude of documents supporting the clients eligibility to the state of New Mexico’s Utilization Review Board, annually or quarterly if the client has experienced a change of condition or if an added service needs to be included on the clients annual D&E waiver budget. The New Mexico Utilization Review Board can and often does “buck back” a proposed service plan or budget to the contracting agency; this can be for a multitude of reasons including a request for additional information or denial for services because the client has reached their annual “cap” for services.

The case management agencies who implement the D&E waiver service are non-profit organizations that typically execute other waiver programs aside from the D&E waiver programs. The state of New Mexico provides a contractual relationship with clinical providers which can be either public or private that are then responsible for determining eligibility, assessment, and case managing the clients disabled and elderly waiver services. When the case management agency develops a caseload of HCBS D&E waiver recipients, the state of New Mexico reciprocates by providing funding, training and education to ensure that clients are safe and receiving the quality of services they deserve.

Weissert, Cready & Pawelak (2005) have extensively researched the effects of HCBS waiver programs, focusing specifically on the elderly population, and while they are generally in support of HCBS programs, they found that the cost savings for implementing these services are minimal and that clients of HCBS programs were more likely to be hospitalized, which raises questions regarding the true benefits of this intergovernmental cooperative effort.

Interdependencies between Government Agencies:

While the federal government provides ultimate authority to provide the state of New Mexico with the option of offering the D&E Medicaid Waiver program to its residents, all operational and administrative functions are implemented through state agencies. The major state agency players include the Human Services Department (HSD) the Medical Assistance Division for the State of New Mexico or state Medicaid agency (MAD) and the states Aging and Long Term Services Department (ALTSD). The MAD/HSD and ALTSD cooperate in the operation of the waiver under a joint powers agreement that “delineates each department’s responsibilities” (HSD: NM, 2008). The state HSD and ALTSD departments then allow for contractual relationships between clinical service providers who are considered non-profit entities. While the client’s chosen case management agency is responsible for program implementation and ensuring service delivery to clients; with the exception of case management services, they do not actually provide their clients with the actual services rendered (eg: nursing, respite, therapies, ect.) In this respect, local case management agencies and local clinical service providers must collaborate to ensure satisfactory implementation of services to D&E waiver clients. It should be noted that all service providers including the actual case management agency must be authorized by the state to carry out services for Medicaid Waiver recipients (eg: registered nurses, physical therapists, ect.) These local agencies can [and do] often call on the state agencies for counsel and advice concerning budgetary glitches, service delivery issues and ethical issues. Conversely, if

the state agency feels that the local agencies need additional training or decline approval of a service plan for a particular client, they will communicate with the local agencies with the goal of rectifying the situation.

Significant Models of Intergovernmental Management:

Ogden & Adams (2009) discuss the cooperation that state and federal governments have engaged in to provide “an intricate policy quadrille to help elders by fostering a market based solution to the demand of care” (p.3). In essence, this type of engagement that federal, state and local government participates in to provide D&E Medicaid waiver services can be considered as cooperative federalism. Although the federal government holds the ultimate authority to grant states such as New Mexico with the permission to implement HCBS waiver services, the state and local governments are provided with a great amount of flexibility to develop their programs specific to their residents needs. The federal government appears to trust the states enough to allow them to monitor and control the amount of clients served and put limits on overall expenditures in order to implement HCBS programs (Weissert & Weissert, 2008). States appear to covet the flexibility that they receive from the federal government in order to implement HCBS state waivers. Cooperative federalism allows for states to focus on developing relationships with the federal government and localities by utilizing an array of networks, exercising negotiations and docile authority (Conlan, 2008).

Intergovernmental Coordination Tools and Strategies:

One of the main tools that sub-national participants utilize to implement the D&E waiver is a 148 page application for a 1915(c) HCBS waiver that is required by the federal government once the waiver expires and needs to be reauthorized; this occurs every five years (Weissert & Weissert, 2008). The New Mexico Human Services Department and the state Medical Assistance Division must complete this comprehensive form that provides explanation to the federal

government in terms of how the waiver money intends to be spent, quality indicators that demonstrate the success of the program and assessments of the performance of contracted agencies responsible for service delivery and program implementation. The form also explains to the federal government the projected number of clients served during a five year period; when the waiver is in effect. The state also ensures the federal government that they are responsible for annual on-site audits and performance reviews for contracted non-profit agencies that provide D&E waiver services. This extensive form is considered a significant tool in the D&E waiver program because it addresses literally every single aspect of the waiver processes including, responsibilities, rules and regulations that the state enacts in order to ensure that clients are receiving quality care and fair treatment under state laws and regulations.

Contracted agencies that are responsible for implementing the D&E waiver services are reimbursed through the state of New Mexico for services rendered and utilize a budgeting tool to forecast each individual clients expected annual costs for D&E services. The budget tool must be submitted to the state for authorization and approval of services. Agencies must also utilize several tools that essentially create a picture of each client's individual needs and medical condition to the state. These tools include but are not limited to a comprehensive individualized assessment, an initial service plan, a history and physical form from their physician and a level of care form. Case managers must also mandatorily utilize federal tools to ensure the privacy of their clients such as the health information privacy protection act form (HIPPA) and the freedom of choice for case management provider's form. Once these forms are submitted to the states, the client (who is typically a Medicare recipient) can also qualify for Medicaid, so essentially the sub-national tools that are utilized to achieve the D&E waiver services reach beyond to the federal Medicaid level of assistance as well.

Overcoming Barriers for Successful Coordination:

The State of New Mexico is rather rural and is sparsely populated in many of its regions and counties. Many of its residents reside in small localities and may not be aware that public services such as the D&E waiver exist. To circumvent this barrier, the Aging and Long Term Services Division along with the Elderly and Disability Services Division have provided informational sessions and sought input through a series of presentations for home hospice agencies, conferences on aging, tribal governments and the Medicaid Advisory Committee (HSD: NM, 2008). The state is also home to several Navajo Indian reservations that exist in the rural outskirts of most towns. The Aging and Long Term Services Department has ensured that it has notified the all federally recognized tribal governments that the D&E waiver is available to residents of the reservation and has designated a location in which all waiver requests and renewals can be submitted. The designation of a waiver application “drop-off” location has assisted reservations with outreach and equal access to services and has assisted in circumventing the barriers towards D&E service delivery.

Evaluation of the Success of New Mexico’s D&E Waiver Program

New Mexico’s D&E waiver program proves to be quite successful with many clients utilizing the program. Medicaid programs such as the D&E waiver provide cost savings for Medicare because the program focuses primarily on clinical care that provides preventative and rehabilitative care to clients; thus keeping them out of institutional setting such as hospitals and long term care facilities (Grabowski, 2007). While many positive factors emerge from the HCBS cooperative intergovernmental scenario, some concerns remain. The D&E waiver is not considered a program that assists with chronic or acute illnesses and if clients do end up having these issues, they risk hospitalization or institutionalized care. When a HCBS recipient finds themselves admitted into a hospital or an skilled nursing facility, the HCBS case manager

typically does not follow the case due to the issue of duplication of services as far as Medicaid payments are concerned (Peters, 2005; Grabowski, 2007). HCBS case managers cannot bill Medicaid for waiver services if their clients are hospitalized or admitted into a long term care setting such as a skilled nursing facility, and they have little power to reintegrate their clients back into the community (Grabowski, 2007). If a client were able to have the option to continue case management services while hospitalized or while rehabilitating in a skilled nursing facility, at least for a window of time while Medicaid continued to reimburse both the waiver program and the clinical care setting, perhaps clients would have the ability to return back home to their waiver services. Additionally, if Medicaid would consider reimbursing HCBS waiver programs for specialized care that focused on acute and chronic needs, there is a possibility that these preventative, therapeutic measures could help patients avoid entering into clinical or skilled nursing settings.

Lessons Learned from this Case: After obtaining my degree in social work, I accepted a position as a Medicaid D&E waiver case manager for a non-profit agency in New Mexico. While I was aware of the important role that the state played in providing services and funds to my clients for services rendered, I was unaware that the waiver program was federally funded and that the federal government gave states the flexibility to provide waiver services to their residents. I also was unaware that the federal government gave all 50 states the flexibility to provide waiver services, and that all fifty states participate in this program. Prior to learning about the cooperative federalism component of HCBS waivers, I was under the impression that the D&E waiver was specific to the State of New Mexico. After learning about the federal government's role with by allowing states to use HCBS waivers, I am able to see the interdependencies between public, private and non-profit organizations in a clearer perspective.

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