Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver’s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The State of New Mexico requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
   Mi Via - ICF/MR Renewal Waiver

C. Waiver Number: NM.0448
   Original Base Waiver Number: NM.0448.

D. Amendment Number: NM.0448.R01.01

E. Proposed Effective Date: (mm/dd/yy)
   03/01/13

   Approved Effective Date: 04/09/13
   Approved Effective Date of Waiver being Amended: 10/01/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
   1. Implementation of a debit card for payment of related goods,
   2. Revised Definition of Developmental Disability (DD),
   3. Removal of references to Administrative Services Organization (ASO).

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (check each that applies):

<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Application</td>
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<td>✔ Appendix A – Waiver Administration and Operation</td>
<td>A-2, 3, 5</td>
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<td>✔ Appendix B – Participant Access and Eligibility</td>
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<td>❌ Appendix C – Participant Services</td>
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<tr>
<td>❌ Appendix D – Participant Centered Service Planning and Delivery</td>
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</tbody>
</table>

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Component of the Approved Waiver | Subsection(s)
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☑ Appendix E – Participant Direction of Services | E-2
☐ Appendix F – Participant Rights
☐ Appendix G – Participant Safeguards
☐ Appendix H
☑ Appendix I – Financial Accountability | I-2
☐ Appendix J – Cost-Neutrality Demonstration

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):
☐ Modify target group(s)
☐ Modify Medicaid eligibility
☐ Add/delete services
☐ Revise service specifications
☐ Revise provider qualifications
☐ Increase/decrease number of participants
☐ Revise cost neutrality demonstration
☐ Add participant-direction of services
☑ Other

Specify:
Implementation of a debit card for payment of related goods.
Removal of references to Administrative Services Organization (ASO)

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of New Mexico requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):
Mi Via - ICF/MR Renewal Waiver

C. Type of Request: amendment

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

☐ 3 years ☐ 5 years

Original Base Waiver Number: NM.0448
Waiver Number: NM.0448.R01.01
Draft ID: NM.15.01.03

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/09
Approved Effective Date of Waiver being Amended: 10/01/09

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

☐ Hospital

Select applicable level of care

☐ Hospital as defined in 42 CFR §440.10
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

- Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

☐ Nursing Facility
Select applicable level of care

- Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

- Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

☑ Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

- Not applicable

☐ Applicable
Check the applicable authority or authorities:

☐ Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

☐ Waiver(s) authorized under §1915(b) of the Act.
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

☐ §1915(b)(1) (mandated enrollment to managed care)

☐ §1915(b)(2) (central broker)

☐ §1915(b)(3) (employ cost savings to furnish additional services)

☐ §1915(b)(4) (selective contracting/limit number of providers)

☐ A program operated under §1932(a) of the Act.
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ A program authorized under §1915(i) of the Act.

☐ A program authorized under §1915(j) of the Act.

☐ A program authorized under §1115 of the Act.
Specify the program:

H. Dual Eligibility for Medicaid and Medicare.
Check if applicable:
2. Brief Waiver Description

Brief Waiver Description. In one page or less, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

New Mexico's program called Mi Via, which means "my path", "my way", or "my road", is the State's Medicaid Self-Directed Home and Community-Based Services (HCBS) Waiver program. The goal of Mi Via is to provide a community-based alternative to institutional care that facilitates greater participant choice, direction and control over services and supports. When participants are minor children or have cognitive impairments, the term “participants” also includes families, e.g., any relative or other legally authorized decision-maker.

The program is administered through a partnership among the New Mexico Aging and Long-Term Services Department (ALTSID), Department of Health (DOH), and Human Services Department (HSD).

Mi Via is the implementation of the efforts of many individuals and groups statewide, starting in 2000, to realize inclusion of self-direction as an option in New Mexico's HCBS Waivers. Mi Via's Guiding Principles state that all participants have value and potential; shall be viewed in terms of their abilities; have the right to participate and be fully included in their communities; and have the right to live, work, learn, and receive all services and supports, appropriate to their individual needs, in the most integrated settings within their communities.

Participants' easy access to information about Mi Via is critical for a successful program. Participants are offered a multifaceted education program, including information, tools, training and support, in order to make informed choices and to plan, direct and manage their services and supports.

Mi Via recognizes the essential role of participants in planning and purchasing services and supports. Consultant agencies provide required consultant and support guide services. Consultants, who are well-versed in the philosophy and practice of self-direction, assist participants in understanding Mi Via and in developing and implementing the Service and Support Plan. Support guides are available to participants who need additional assistance with implementation of their plan. Mi Via's covered services include those necessary for participants to live at home and in the community as independently as possible. The array of Mi Via services and supports are structured around key life areas: living supports, community membership and health and wellness to allow participants to design their services and supports in a flexible and individualized fashion. Participants utilize qualified employees, traditional waiver service providers, and/or generic resources of their choice. Other participant-delegated supports are also available to enhance outcomes in the key areas to provide for development of a comprehensive person-centered plan.

The State determines the individual participants' allocated budgetary amount and authorizes the plan and budget. The State procures and contracts with a Financial Management Agent (FMA), which is well-versed in the philosophy and practice of self-direction. Based on the authorized budget, the FMA sets up individual participant accounts, makes expenditures that follow the approved budget, handles all payroll functions on behalf of participants who hire service providers and other support personnel, provides participants with a monthly report of expenditures and budget status, and provides the State with a quarterly and annual documentation of expenditures.

Quality improvement mechanisms are implemented that reflect the shared roles of the participant, State, consultant agencies, and FMA, but ultimately the State is accountable for assuring that participants' functional needs are satisfied, approved funds are used appropriately, and the quality of the Mi Via program is continually improving.

3. Components of the Waiver Request

The waiver application consists of the following components. Note: Item 3-E must be completed.

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (Select one):

- Yes. This waiver provides participant direction opportunities. Appendix E is required.
- No. This waiver does not provide participant direction opportunities. Appendix E is not required.

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (select one):

- Not Applicable
- No
- Yes

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (select one):

- No
- Yes

If yes, specify the waiver of statewideness that is requested (check each that applies):

- **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
  Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make participant-direction of services as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
  Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:
5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in Appendix C are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in Appendix C.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in Appendix I.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in Appendix B.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in Appendix B, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in Appendix J.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.146; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in Appendix D. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in Appendix I.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in Appendix C.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. Appendix F specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in Appendix H.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Extensive input was solicited and received from the public in anticipation of the Mi Via Waiver renewal. Beginning in September of 2008, the Self-Directed Waiver (SDW) Subcommittee, which is comprised of over 100 interested and committed stakeholders, including older persons, individuals with disabilities, their families, advocates, service providers, and others, began consideration of what was working in Mi Via and what needed improvement. Smaller representative working groups from the Subcommittee were formed to focus and provide input on specific Mi Via Waiver issues, including participant challenges assessment, resource facilitation, budgets and quality.

In addition, in July of 2008, the Human Services Department (HSD), Aging and Long-Term Services Department (ALTSD), and Department of Health (DOH) jointly requested nominations from the Mi Via public-at-large to fill 10 appointed positions on the Task Force on Mi Via Growth, Nurturing, and Sustainability, henceforth referred to as the Mi Via Task Force. In September of 2008, appointments were made to the Task Force, including participants from the various Mi Via populations, families, and one advocate. The role of the Mi Via Task Force is to identify ways to simplify the Mi Via processes; engage “on the ground floor” in providing input during policy considerations; assist the State with the on-going evaluation of Mi Via; and reinforce the Mi Via philosophy of self-direction. The Task Force has been instrumental in providing input during development of the Waiver renewal, including the structure, access and eligibility, service plans, health and safety, and financial accountability. In this regard, since November 2008, the Task Force has held eight meetings and has made recommendations for improvements, many of which the State has incorporated into the Waiver renewal application.

The public also has regular input regarding Mi Via through the Medicaid Advisory Committee, the ALTSD’s Long-Term Services Subcommittee, DOH’s Advisory Council on Quality Supports for Persons with Developmental Disabilities and Families (ACQ), and the Brain Injury Advisory Council.

J. **Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

# 7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Medrano</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Angela</td>
</tr>
<tr>
<td>Title:</td>
<td>Bureau Chief, Long-Term Services and Support</td>
</tr>
<tr>
<td>Agency:</td>
<td>Human Services Department</td>
</tr>
<tr>
<td>Address:</td>
<td>2025 S. Pacheco</td>
</tr>
<tr>
<td>Address 2:</td>
<td>P.O. Box 2348</td>
</tr>
<tr>
<td>City:</td>
<td>Santa Fe</td>
</tr>
<tr>
<td>State:</td>
<td>New Mexico</td>
</tr>
<tr>
<td>Zip:</td>
<td></td>
</tr>
</tbody>
</table>
Phone: 87504-2348

Fax: (505) 827-1348  Ext:  

E-mail: (505) 827-3185

Sarah.Barth@state.nm.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Stevenson

First Name: Cathy

Title: Director, Developmental Disabilities Support Division

Agency: Department of Health

Address: 810 San Mateo

Address 2: 

City: Santa Fe

State: New Mexico

Zip: 87504

Phone: (505) 476-8913  Ext:  

Fax: (505) 827-2595

E-mail: Cathy.Stevenson@state.nm.us

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.
Signature: Julie Weinberg

Submission Date: Mar 21, 2013

Attachment #1: Transition Plan

Last Name: Title: Agency:
Weinberg Julie

Address: Address 2:
Human Services Department 2025 S. Pacheco Street

City: State:
P. O. Box 2348 Santa Fe

Zip: Phone:
New Mexico 87504-2348

Fax:
(505) 827-3106 Ext: [ ] TTY

E-mail:
(505) 827-3185 julie.weinberg@state.nm.us

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (select one):

   ○ The waiver is operated by the State Medicaid agency.
Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (select one):

- The Medical Assistance Unit.
  Specify the unit name:

  (Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.
  Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Check item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.
  Specify the division/unit name:
  Department of Health, Developmental Disabilities Supports Division (DOH/DDSD)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

DOH/DDSD operates the ICF/MR Mi Via Waiver and HSD/MAD is responsible for the oversight of the waiver. DOH monitors program quality and compliance with program requirements, through participation on the Tri-Agency Quality Committee (TriAQ), as described in Appendix H of this application. As part of this process, DOH collects and aggregates data including: number of participants served; number of services and supports offered; number of consultants and providers participating; participant training and communication; calls to the ALTSD Resource Center that are routed to the DOH for resolution; number, types and resolutions of participant complaints and fair hearings; number, types and resolutions of critical incidents reported; financial data, including Financial Management Agent (FMA) quarterly and annual reports on expenditures; consultant, FMA, and provider training and communication; whether level of care (LOC) reviews have been conducted and approved as required; whether service and support plans and budgets are completed and authorized, as required; and whether Freedom of Choice (FOC) has been
provided, as requested.

HSD oversees DOH with respect to its operational responsibilities using multiple methods as described below:

- The Memorandum of Agreement (MOA) among HSD, DOH and ALTSD sets forth provisions for operating Mi Via, for which HSD holds DOH and ALTSD accountable for various responsibilities relative to this application. DOH is the state operating agency for this application. ALTSD is the operating agency for the Mi Via application that includes the Nursing Facility (NF) LOC application. HSD/MAD provides oversight to both agencies. HSD/MAD monitors DOH and ALTSD for compliance with the MOA, to ensure they have fulfilled their operational responsibilities, and performed the functions listed in the section A-7 chart. HSD/MAD monitors these activities, in part, through monthly meetings. HSD provides access to Medicaid data to the operating agency for their use as described above.

- As described in Appendix H, HSD/MAD also oversees DOH’s operational responsibilities and contract management responsibilities through the TriAQ which reviews the Mi Via Quality Improvement Strategy (QIS). The TriAQ meets quarterly to review trended data collected through a variety of means by DOH and ALTSD. The TriAQ identifies areas of program improvement and key action steps for the development and implementation of Action Plans to address the areas.

- Either as part of TriAQ meetings, or as a separate review, as needed, HSD/MAD annually reviews the following: aggregate operational data that must be tracked and reported by DOH and ALTSD; action plans developed by DOH, ALTSD and the TriAQ in order to address areas of improvement identified through the data review; and the effectiveness of the action plans to improve the program. Through its TriAQ participation and QIS review process, HSD/MAD provides oversight to DOH and ALTSD to ensure the MOA is implemented, operational responsibilities of DOH and ALTSD are met, and functions specified in the section A-7 chart are performed.

- HSD/MAD participates on the DOH/Developmental Disabilities Services Quality Improvement (DDSQI) Steering Committee through representatives from the HSD/MAD Quality Assurance Bureau (QAB) and the Long-Term Services and Support Bureau (LTSSB). The responsibilities of the DDSD/QMI Steering Committee include the review of the TriAQ reports, monitoring trends and other system-level data, and the design, implementation and evaluation of strategies for program improvement and CMS Quality Strategies specific to the DD and MF populations.

- HSD serves on the Advisory Council on Quality Supports for Persons with Developmental Disabilities and Families, mandated by statute to advise DOH on issues related to the developmentally disabled.

- HSD also serves with DOH and ALTSD on various waiver specific and cross-waiver workgroups related to development and implementation of policies and procedures related to Home and Community-Based Services (HCBS) waivers.

In all oversight activities, HSD collaborates with DOH to review and analyze findings, develop strategies for improvement, and make timely changes to the program, as indicated. If HSD/MAD identifies any issues that are inconsistent with Medicaid requirements at any time, HSD/MAD ensures that DOH corrects the problem.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (select one):

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. Complete Items A-5 and A-6.

Contracted entities referenced in Appendix A-7 refer to the Third-Party Assessor (TPA) Contractor, and the Financial Management Agent (FMA) Contractor. The State is utilizing three (3) contracted entities. The types and functions are described as follows:

- The TPA Contractor: reviews required Level of Care (LOC) assessments and determines medical eligibility for participants transferring from existing waivers and for individuals who are newly allocated to the waiver; and conducts utilization reviews (prior authorization of waiver services) and approvals for Service and Support
Plans (SSP) and budgets to ensure that waiver requirements are met.

- The FMA Contractor: disseminates budget and employer-related information; assists participants in becoming employers of record; provides forms, training, and interface with state and federal tax agencies; enrolls providers and vendors; verifies waiver provider qualifications; executes and holds Medicaid provider agreements on behalf of HSD/MAD; pays claims and handles all employer-related functions on behalf of Mi Via participants and verifies against the participants’ approved budgets and plans; verifies waiver expenditures against approved levels; and provides reports to participants and the State on participants’ budget expenditures.

All of the contracted entities have provisions in their contracts for quality assurance and quality improvement activities. The State provides oversight of the entities for these activities.

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (Select One):

- Not applicable
- Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

  - Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

    Specify the nature of these agencies and complete items A-5 and A-6:

- Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

    Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

- TPA Contractor: HSD/MAD contracts with the TPA Contractor and assesses this contractor’s performance in conducting its respective waiver operational and administrative functions based on the contract.

- FMA Contractor: DOH, ALTSD, and HSD/MAD contract with the FMA relative to the contractor’s scope of work. HSD/MAD and DOH assess the performance of this contractor in conducting the contractor’s operational and administrative functions according to the State agencies’ respective jurisdictions (see A-6 response).
Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

TPA Contractor: HSD/MAD conducts an annual on-site operational and performance review of the Contractor including a review of the Contractor’s quality management activity to assess compliance with the terms of the contract. In addition, HSD/MAD utilizes participant-satisfaction survey data, phone and complaint data, and Fair Hearing data to assess the Contractor’s performance. ALTSD and DOH provide HSD/MAD with any data, complaints or other information DOH or ALTSD have obtained from any source regarding the TPA Contractor’s performance as part of the review. If any problems are identified, HSD/MAD requires a corrective action plan from the Contractor and monitors its implementation. HSD/MAD reviews oversight findings with DOH and ALTSD.

FMA: HSD/MAD, DOH, and ALTSD share oversight of the Contractor, as follows:

• HSD/MAD, DOH, and ALTSD jointly conduct an annual on-site operational and performance review of the FMA Contractor to assess compliance with the terms of the contract. DOH and ALTSD also utilize participant satisfaction survey data, phone and complaint data, and Fair Hearing data to assess performance.

• HSD/MAD, DOH, and ALTSD perform on-going monitoring of the FMA Contractor’s claims payment accuracy and adherence to the terms of the provider agreement, and perform web-based and on-site reviews of the claims history, as needed.

• DOH provides HSD/MAD with any data, complaints or other information DOH has obtained from any source regarding the FMA’s performance.

• HSD/MAD, DOH, and ALTSD review oversight findings.

• HSD/MAD and ALTSD conduct an annual on-site operational and performance review of the HSD/MAD, DOH and ALTSD share oversight of the Contractor(s), as follows:

• As part of its oversight responsibilities, if HSD/MAD identifies any issues that are inconsistent with Medicaid requirements at any time, HSD/MAD ensures that DOH or ALTSD correct the problem.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (check each that applies):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

<table>
<thead>
<tr>
<th>Function</th>
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<th>Contracted Entity</th>
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<td>✔</td>
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<tr>
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<td>Waiver expenditures managed against approved levels</td>
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<td>✔</td>
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<tr>
<td>Level of care evaluation</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>Review of Participant service plans</td>
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<td>Prior authorization of waiver services</td>
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<tr>
<td>Utilization management</td>
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Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HSD/MAD measures DOH's percent of compliance with monitoring criteria specific to the Fiscal Management Agent (FMA). Numerator: The number of FMA specific criteria monitored. Denominator: The number of FMA specific criteria.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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Performance Measure:
DOH has the signed MOA on file.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The MOA

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<th>Sampling Approach (check each that applies)</th>
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Performance Measure:
The State has not contracted for ASO services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The State has not contracted for ASO services.
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**Performance Measure:**
HSD/MAD monitors the percent of compliance with the Department of Health's (DOH) implementation of the MOA to assure that provisions of the MOA are met. Numerator: The number of items that DOH is compliant with on an annual basis. Denominator: All items identified in the MOA as the responsibility of the Department of Health.

**Data Source (Select one):**
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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☐ Continuously and Ongoing

☐ Other
Specify:

Performance Measure:
HSD/MAD monitors the TPA contract to ensure all contractual requirements are met.
Numerator: The Number of items that the TPA is compliant with an annual basis.
Denominator: All items identified in the contract as the responsibility of the TPA.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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Data Aggregation and Analysis:

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- [ ] State Medicaid Agency
- [ ] Operating Agency
- [ ] Sub-State Entity
- [ ] Other
  - Specify:

**Frequency of data aggregation and analysis (check each that applies):**

- [ ] Weekly
- [ ] Monthly
- [ ] Quarterly
- [ ] Annually
- [ ] Continuously and Ongoing
- [ ] Other
  - Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

Performance Measure:
HSD/MAD reviews complaint trends to ensure that system wide issues are identified and addressed. Numerator: # of system wide issues identified Denominator: # of program improvements implemented

**Data Source (Select one):**
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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**Data Source (Select one):**
Trends, remediation actions proposed / taken
If 'Other' is selected, specify:

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☐ Other Specify:

### ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

As noted in Appendix A: 2.b., HSD/MAD monitors ALTSD and DOH for compliance with the Memorandum of Agreement (MOA) to ensure that the agencies have fulfilled their operational responsibilities, based on the MOA, and performed the functions listed in the section A-7 chart. HSD/MAD monitors these activities through monthly meetings, review of quarterly and annual reports, review of actions taken by the operating agency, and a separate annual formal MOA review. In addition, formal quality improvement processes are in place, as described in detail in the Tri-Agency Quality Committee (TriAQ) description and structure in Appendix H, in which HSD/MAD participates with the operating agencies.

### b. Methods for Remediation/Fixing Individual Problems
i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement related to HSD/MAD’s administrative authority are identified by HSD/MAD, processes are in place to ensure that appropriate and timely action is taken whether the situation is in regard to participants, providers and vendors of services and supports, contractors, or the State agencies’ systems. Methods for fixing identified problems include verbal direction, letters of direction, formal corrective action plans; documentation is kept on all actions taken. In some instances, policy and/or regulatory changes are required. In all cases, if HSD/MAD, DOH or ALTSD identifies any issues that are inconsistent with Medicaid requirements at any time, HSD/MAD ensures that DOH and/or ALTSD correct the problem and that compliance with the Assurance is met. Problems with functions performed by the TPA and/or the FMA as identified by various discovery methods will result in placing the TPA and/or the FMA on corrective action, and/or sanctions will be implemented, including possible contract termination.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ State Medicaid Agency</td>
<td>□ Weekly</td>
</tr>
<tr>
<td>☑ Operating Agency</td>
<td>□ Monthly</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
<td>☑ Quarterly</td>
</tr>
<tr>
<td>☑ Other</td>
<td>☑ Annually</td>
</tr>
<tr>
<td>Specify: TriAQ</td>
<td></td>
</tr>
<tr>
<td>☐ Continuously and Ongoing</td>
<td></td>
</tr>
<tr>
<td>☑ Other</td>
<td></td>
</tr>
<tr>
<td>Specify: Data aggregation and analysis will be done more frequently to address specific issues should they arise.</td>
<td></td>
</tr>
</tbody>
</table>

iii. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:
b. **Additional Criteria.** The State further specifies its target group(s) as follows:

In addition to the Mental Retardation or Developmental Disability target groups indicated in B-1.a above, the waiver will also include "Aged or Disabled, or Both - Specific Recognized Subgroups" as follows: Medically Fragile (minimum age 0; no maximum age limit).

Additional Criteria:
1. Criteria for All Participants Individuals who choose to self-direct their waiver services.

2. Developmentally Disabled – The individual must have a developmental disability and mental retardation or a specific related condition. Related conditions are limited to cerebral palsy, autism (including Asperger syndrome), seizure disorder, chromosomal disorders (e.g., Down's), syndrome disorders, inborn errors of metabolism, and developmental disorders of brain formation.

Developmental disabilities waiver services are intended for eligible recipients who have developmental disabilities limited to intellectual disability (ID) or a specific related condition as determined by the DOH/DDSDS. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated. The eligible recipient must also require the level of care provided in an intermediate care facility for individuals with developmental disabilities (ICF/IID), in accordance with 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements.

1) Intellectual disability: An individual is considered to have MR/ID if she/he has significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

2) Specific related condition: An individual is considered to have a specific related condition if she/he has a severe chronic disability, other than mental illness, that meets all of the following conditions:

   (a) is attributable to:

   (i) cerebral palsy or seizure disorder; or

   (ii) is attributable to autistic disorder (as described in the fourth edition of the diagnostic and statistical manual of mental disorders); or

   (iii) is attributable to chromosomal disorders (e.g. down's), syndrome disorders, inborn errors of metabolism, or developmental disorders of the brain formation limited to the list in Paragraph (3) below;

   (b) results in impairment of general intellectual functioning or adaptive behavior similar to that
of persons with intellectual disability and requires treatment or services similar to individuals with ID;
(c) is manifested before the person reaches age 22 years;
(d) is likely to continue indefinitely; and
(e) results in substantial functional limitations in three or more of the following areas of major
life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent
living and economic self-sufficiency.

(3) List of chromosomal disorders (e.g., down) syndrome disorders, inborn errors of metabolism or
developmental disorders of the bring formation.
(a) chromosomal disorders: autosomes: 4p-, trisomy 4p, trisomy 8, 5p-, 9p-, trisomy 9p, trisomy 9p mosaic, partial
trisomy 10q, 13q-, ring 13, trisomy 13 (Patau), 18p-, 18q, trisomy 18 (Edwards), trisomy 20p, G (21,22)
monosomy/deletion, trisomy 21 (down), translocation 21 (down), “cat-eye” syndrome; Prader-Willi syndrome (15);
(i) x-linked mental retardation: Allan syndrome; Atkin syndrome; Davis syndrome;
Fitzsimmons syndrome; fragile x syndrome; fragile x phenotype (no fragile site); Gireis syndrome; glycerol kinase
deficiency; Golabi syndrome; Hones syndrome; Jueberg syndrome; Lujan syndrome; Menken syndrome;
Schimke syndrome; Vasquez syndrome; nonspecific x-linked mental retardation;
(ii) other x chromosome disorders: xo syndrome (Turner); xxy syndrome; xxy syndrome
(Klinefelter); xxy syndrome; xxxxy syndrome; xxyxy syndrome; xxyxxx syndrome (penta-x);
(b) syndrome disorders:
(i) neurocutaneous disorders: ataxia-telangiectasia (Louis-Bar); basal cell nevus
syndrome; dyskeratosis congenital; ectodermal dysplasia (hypohidrotic type); ectromelia ichthyosis syndrome;
focal dermal hypoplasia (Goltz); ichthyosis-hypogonadism syndrome, incontinentia pigmenti (Bloch-Sulzberger);
Ito syndrome; Klippel-Trenauney syndrome; linear sebaceous nevus syndrome; multiple lentigines syndrome;
neurofibromatosis (Type 1); polikidroma (Rothmund-Thomsen); Pollitt syndrome; Sjogren-Larsen syndrome;
Sturge-Weber syndrome; tuberous sclerosis; xeroderma pigmentosum
(ii) muscular disorders: Becker muscular dystrophy; chondrodystrophic myotonia
(Schwartz-Jampel); congenital muscular dystrophy; Duchenne muscular dystrophy; myotonic muscular dystrophy;
(iii) ocular disorders: Aniridia-Wilm’s tumor syndrome; anophthalmia syndrome (xlinked);
Leber amaurosis syndrome; Lowe syndrome; microphthalmia-corneal opacity-spasticity syndrome; Norrie
syndrome; oculocerebral syndrome with hypopigmentation; retinal degeneration-trichogenega syndrome; septooptic
dysplasia;
(iv) craniofacial disorders: acrocephalo-etyl lip-radial aplasia syndrome; acrocephalosyndactyly; type 1 (Apert); type 2
(Apert); type 3 (Saethre-Chotzen); type 6 (Pfeiffer); Carpenter syndrome with absent digits and cranial defects;
Baller-Gerold syndrome; cephalopolysyndactyly (Greig) “cloverleaf-skull” syndrome; craniofacial dysostosis
(Crouzon); craniofetofacial dysplasia; multiple synostosis syndrome;
(v) skeletal disorders: acroodysostosis, CHILD syndrome; chondrodysplasia punctata (Conradi-Hunerman type);
chondroectodermal dysplasia; Dyggve-Melchior-Clausen syndrome; frontometaphyseal dysplasia; hereditary
osteodystrophy (Albright); hyperostosis (Lenz-Majewski); hypochondroplasia; Klippel-Feil syndrome; Nail-patella
syndrome; osteopetrosis (Albers-Schonberg); pyknodysostosis; radial aplasiathromboctytopenia syndrome; radial
hyoplasia pancytopenia syndrome (Fanconi); Roberts-SC phocomelia syndrome;
(c) inborn errors of metabolism:
(i) amino acid disorders: phenylketonuria: phenylalanine hydroxylase (classical, Type
1); dihydropteridine reductase (type 4); dihydrobipterin synthetase (type 5); histidinemia; gamma-glutamylcysteine
synthetase deficiency; hyperlysinemia; lysinuric protein intolerance; hyperprolinemia; hydroxyprolinemia; sulfite
oxidase deficiency; iminoglycinuria; branched-chain amino acid disorders: hypervitaminemia;
hyperuricosuriceliuscinemia;
maple-syrup urine disease; isovaleric academia, glutaric academia (type 2); 3-hydroxy-3-methylglutaryl CoA lyase
deficiency; 3-ketohiolase deficiency:, biotin-dependent disorders: holocarboxylase deficiency; biotinidase
deficiency; propionic academia: type A; Type BC, methylmalonic academia: mutase type (mut+); cofactor affinity
(type mut-); adenosylcobalamin synthetase type (cbl A); ATP: cobalamin adenosyltransferase type (cbl B), with
homocystinuria, type 1 (cbl C), with homocystinuria, type 2 (cbl D); folatedependent disorders: congenital defect of
folate absorption; dihydrofolate reductase deficiency; homocystinuria, type 1; homocystinuria, type 2
(folate D); folate-dependent disorders: congenital defect of folate absorption; dihydrofolate reductase deficiency;
methylene tetrahydrofolate reductase deficiency; homocystinuria; hyperkarotinemia; non-k toxic hyperglycinemia; hyper-betaalaninemia; carnosinase deficiency; homocarnosinase deficiency; Hartnup disease; methionine malabsorption (oasthouse urine disease);
(ii) carbohydrate disorders: glycogen storage disorders: type 1, with hypoglycemia (von Gierke); type 2 (Pompe);
galactosemia; fructose-1, 6-diphosphatase deficiency; pyruvic acid disorders: pyruvate dehydrogenase complex
(Leigh); pyruvate carboxylase deficiency; mannosidosis; fucosidosis; aspartylglucosaminuria;
(iii) mucopolysaccharide disorders: alpha-L-iduronidase deficiency: Hurler type;
Scheie type, Hurler-Scheie type; iduronate sulfatase deficiency (Hunter type); Heparan N-sulfatase deficiency
(Sanfilippo 3A type); N-acetyl-alpha-D-glucosaminidase deficiency (Sanfilippo 3B type); Acetyl CoA;
glucosaminide N-acetyltransferase deficiency (Sanfilippo 3C type); N-acetyl-alpha-D-glucosaminide 6-sulfatase
deficiency (Sanfilippo 3D type); beta-glucuronidase deficiency (Sly type);
(iv) mucolipid disorders: alpha-neuraminidase deficiency (type 1); N-acetylglucosaminidase deficiency; lysosomal storage disorders; mucolipidosis type 4;
(v) urea cycle disorders: carbamyl phosphate synthetase deficiency; ornithine transcarbamylase deficiency; argininosuccinic acid synthetase deficiency (citrullinemia); argininosuccinic acid (ASA) lyase deficiency; arginase deficiency (argininemia);
(vi) nucleic acid disorders: Lesch-Nyhan syndrome (HGPRTase deficiency); orotic aciduria; xeroderma pigmentosum (group A); De Sanctis-Cacchione syndrome;
(vii) copper metabolism disorders: Wilson disease; Menkes disease;
(viii) mitochondrial disorders: Kearns-Sayre syndrome; MELAS syndrome; MERRF syndrome; cytochrome c oxidase deficiency; other mitochondrial disorders;
(ix) peroxisomal disorders: Zellweger syndrome; adrenoleukodystrophy: neonatal (autosomal recessive); childhood (x-linked); infantile Refsum disease; hyperpipelicolic academia; chondrodysplasia punctata (rhizomelic type);
(d) developmental disorders of brain formation:
(i) neural tube closure defects: anencephaly; spina bifida; encephalocele;
(ii) brain formation defects: Dandy-Walker malformation; holoprosencephaly; hydrocephalus: aqueductal stenosis; congenital x-linked type; Lissencephaly; pachygyria; polymicrogyria; schizencephaly;
(iii) cellular migration defects: abnormal layering of cortex; colpocephaly; heterotopias of gray matter; cortical microdysgenesis
(iv) intraneuronal defects: dendritic spine abnormalities; microtubule abnormalities;
(v) acquired brain defects: hydranencephaly; porencephaly; and
(vi) primary (idiopathic) microcephaly.

3. Medically Fragile - This subgroup is further defined as follows: individuals who have been diagnosed with a medically fragile condition before reaching age 22; and individuals who have a development disability or developmental delay, or who are at risk for developmental delay; and a medically fragile condition defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following: a life-threatening condition, characterized by reasonably frequent periods of acute exacerbation, which require frequent medical supervision and/or physician consultation, and which, in the absence of such supervision or consultation, would require hospitalization; frequent, time-consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained. Examples include, but are not limited to, ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen.

The assessment instrument used for Medically Fragile participants is titled the Medically Fragile Long-Term Assessment Abstract -(DOH 378 Form) Developmental Disability Criteria. To be eligible for the Medically Fragile program, participants must meet both the ICF/MR LOC Criteria and the Medical Fragility Criteria. The nurse reviewer applies the information derived from the assessment instrument against the ICF/MR LOC Criteria to determine medical eligibility for the Waiver program. The nurse reviewer utilizes the Medical Fragility Criteria to determine the degree of nursing or home health services required by the participant.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (select one):

- ☐ Not applicable. There is no maximum age limit
- ☐ The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:
Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (select one) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

☐ No Cost Limit. The State does not apply an individual cost limit. Do not complete item B-2-b or item B-2-c.

☐ Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. Complete Items B-2-b and B-2-c.

The limit specified by the State is (select one):

☐ A level higher than 100% of the institutional average.

Specify the percentage: [Blank]

☐ Other

Specify:

[Blank]

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. Complete Items B-2-b and B-2-c.

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

[Blank]

The cost limit specified by the State is (select one):

☐ The following dollar amount:

Specify dollar amount: [Blank]

The dollar amount (select one)

☐ Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula: [Blank]

☐ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

☐ The following percentage that is less than 100% of the institutional average:
Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

...  

...  

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (check each that applies):

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual's needs may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

...  

...  

Other safeguard(s)

Specify:

...

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>225</td>
</tr>
<tr>
<td>Year 2</td>
<td>300</td>
</tr>
<tr>
<td>Year 3</td>
<td>400</td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
</tr>
</tbody>
</table>
b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (select one):

✔ The State does not limit the number of participants that it serves at any point in time during a waiver year.

☐ The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served At Any Point During the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td></td>
</tr>
</tbody>
</table>

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (select one):

✔ Not applicable. The state does not reserve capacity.

☐ The State reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (select one):

✔ The waiver is not subject to a phase-in or a phase-out schedule.

☐ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

✔ Waiver capacity is allocated/managed on a statewide basis.

☐ Waiver capacity is allocated to local/regional non-state entities.
Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Individuals are allocated to the waiver on a statewide basis in chronological order by date of waiver registration. In addition, individuals can be allocated as crisis placements if the DDSD Crisis Referral Review Team determines a crisis situation exists and the individual meets the criteria in the DDSD crisis policy. The DDSD crisis policy states that a person not receiving waiver services may be allocated immediately if s/he is in the following situations: released from incarceration, under court order or homeless. The individual, who meets eligibility criteria, and who is under court order to the Department of Health, Developmental Disabilities Supports Division, may be offered an expedited allocation or may be served using other funding resources. The individual has the choice to receive ICF/MR waiver or other available funding.

When funding becomes available based on appropriations from the New Mexico Legislature, a registrant receives an allocation letter. At that time, the individual selects either institutional care or Home and Community-Based Services (HCBS). After an individual selects HCBS, an individual is offered a choice of Mi Via or another HCBS waiver if they choose not to self-direct.

New Mexico will enroll individuals who have an allocation based upon the criteria specified, up to the approved unduplicated users and contingent upon appropriations from the Legislature to cover the costs of services.

If a participant finds that their needs cannot be met in the Mi Via Self-Directed Waiver, they may request to transition to the traditional Developmental Disabilities or Medically Fragile Waivers.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.  
1. State Classification. The State is a (select one):
   - ☐ §1634 State
   - ☐ SSI Criteria State
   - ☐ 209(b) State

2. Miller Trust State.
   Indicate whether the State is a Miller Trust State (select one):
   - ☐ No
   - ☐ Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. Check all that apply:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)
Low income families with children as provided in §1931 of the Act
☐ SSI recipients
☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
☐ Optional State supplement recipients
☐ Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

☐ 100% of the Federal poverty level (FPL)
☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act
☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
☐ Medically needy in 209(b) States (42 CFR §435.330)
☐ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
☐ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

---

**Special home and community-based waiver group under 42 CFR §435.217** Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

☐ No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
☐ Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

☐ All individuals in the special home and community-based waiver group under 42 CFR §435.217
☐ Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

☐ A special income level equal to:

Select one:

☐ 300% of the SSI Federal Benefit Rate (FBR)
☐ A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

☐ A dollar amount which is lower than 300%.
Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (select one):

- ☐ Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

  In the case of a participant with a community spouse, the State elects to (select one):

  - ☐ Use spousal post-eligibility rules under §1924 of the Act. (Complete Item B-5-b (SSI State) and Item B-5-d)
  - ☐ Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State) (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
  - ☐ Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver
services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. **Allowance for the needs of the waiver participant (select one):**

- The following standard included under the State plan
  
  **Select one:**
  
  - SSI standard
  - Optional State supplement standard
  - Medically needy income standard
  - The special income level for institutionalized persons
  
  *(select one):*
  
  - 300% of the SSI Federal Benefit Rate (FBR)
  - A percentage of the FBR, which is less than 300%

  Specify the percentage:
  
  - A dollar amount which is less than 300%

  Specify dollar amount:
  
  - A percentage of the Federal poverty level

  Specify percentage:
  
  - Other standard included under the State Plan

  Specify:

- The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post-eligibility process which includes income that is placed in a Miller trust.

ii. **Allowance for the spouse only (select one):**

- Not Applicable
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

  Specify:
Specify the amount of the allowance (select one):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The following dollar amount:
  
  Specify dollar amount:___ If this amount changes, this item will be revised.

- The amount is determined using the following formula:
  
  Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)
- AFDC need standard
- Medically needy income standard
- The following dollar amount:
  
  Specify dollar amount:___ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:
  
  Specify:

- Other
  
  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
- The State does not establish reasonable limits.
- The State establishes the following reasonable limits
  
  Specify:
Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons
- A percentage of the Federal poverty level

Specify percentage: 

- The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

The maintenance needs allowance is equal to the individual's total income as determined under the post-eligibility process which includes income that is placed in a Miller trust

- Other

Specify:

- 

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.725, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State’s Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
- The State does not establish reasonable limits.
- The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- The provision of waiver services at least monthly
- Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (select one):

- Directly by the Medicaid agency
- By the operating agency specified in Appendix A
- By an entity under contract with the Medicaid agency.

Specify the entity:

Page 37 of 190
Evaluations and Reevaluations are completed by the Third-Party Assessor (TPA) Contractor. HSD/MAD establishes or approves the TPA Contractor’s scope of work including forms, tools, processes, criteria, updates to criteria as appropriate and timeframes to be used. HSD/MAD provides oversight for the LOC process through a variety of contract management responsibilities.

**Other**

**Specify:**

**c. Qualifications of Individuals Performing Initial Evaluation**: Per 42 CFR §441.303(0)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The educational/professional qualifications of persons performing initial evaluations of level of care (LOC) for waiver participants include licensed physicians, licensed registered nurses, licensed independent social workers (LISW), licensed master’s level social workers and qualified mental health retardation professionals as defined in 42 CFR 483.430.

**d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Individuals must be diagnosed with a developmental disability to be eligible for the developmental disabilities category in Mi Via. Additionally, the individual has to meet the level of care required in an Intermediate Care Facility for Persons with Mental Retardation (ICFMR). The Long Term Care Abstract is used to determine if institutional level of care is needed for an individual to remain safe in the community.

The Long Term Care Abstract determines the level of care based on the amount of direct support or intervention the participant needs to be safe in the community.

The scoring for the Long Term Care Abstract is on a Richter scale for each question. Levels of care are determined by the totaling the scores. Three levels are determined by the total score: Level I, Level II and Level III.

After the level of care is determined with the Long Term Care Abstract, other documents are used to verify the level of care is accurate. The Client Individual Assessment (CIA) verifies the level of care in the following areas: self determination, factors affecting client care, medical history, use of durable medical equipment, communication, community living skills and affective development. The CIA further delineates if there are three or more substantial functional limitations in three or more areas of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self direction, capacity for independent living and economic self-sufficiency. The Adaptive Behavior Scale (ABS) or Vineland (ages 16 and under) and History and Physical are reviewed for any inaccuracies that may dispel the level of care determined in the Long Term Care Abstract.

For Developmentally Disabled participants, the TPA Contractor reviews the Intermediate Care Facility for the Mentally Retarded (ICF-MR) Long-Term Care Assessment Abstract (LTCAA), the Client Individual Assessment (CIA), a current history and physical, and a norm referenced, age-appropriate assessment, and other relevant medical information available. The actual level of care (LOC) criteria that are utilized for this waiver are the ICF/MR LOC criteria.

The HSD/MAD policy for LOC is 8.312.2-UR NMAC 8.302.5.

**e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (select one):

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.

- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.
f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

1. The initial LOC evaluation occurs after the participant has received an allocation letter for waiver services. The State assigns an eligibility assistant to assist the participant with the LOC process. Upon notification by the State, the eligibility assistant contacts the participant immediately and assists the participant in completing the LOC eligibility process.

2. The eligibility assistant, with the assistance of the participant, conducts the assessments (Client Individual Assessment [CIA] and norm referenced adaptive behavior scale) and submits the completed LOC form and history and physical information to the TPA Contractor to substantiate the LOC. Criteria that are used to evaluate the participant’s level of care address the following factors: medical; cognitive; nutritional; communication/hearing; mood and behavior patterns; psychosocial well-being; and physical, functional, and structural limitations.

3. The TPA Contractor reviews, evaluates and approves all initial LOC determinations.

4. All participants are re-evaluated on an annual basis. The TPA Contractor reviews, evaluates and approves all annual LOC redeterminations.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (select one):

- Every three months
- Every six months
- Every twelve months
- Other schedule

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (select one):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (specify):

The TPA Contractor uses a report tracking system to ensure that LOC reevaluations are completed on an annual basis and according to the timeliness requirements. Report tracking is done via a database system. The TPA enters all pertinent dates into the database and applies to any date specific requirement. This system triggers when notifications are to be sent out as well as the date the notification is sent out to ensure timely notifications. The TPA Contractor notifies the participant and consultant at ninety (90), sixty (60), and forty-five (45) days prior to the expiration of the current LOC that a new LOC is due.

As part of its TPA contract compliance review, HSD monitors LOC reevaluations and medical eligibility decisions for timeliness of LOC reviews via various compliance timeline reports.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

LOC evaluation and reevaluation records are maintained at the offices of the TPA Contractor.
Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances
   i. Sub-Assurances:

a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of new Mi Via waiver applicants with completed LOC evaluations. Numerator: Number of LOC evaluations performed. Denominator: Number of new waiver applicants.

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
TPA Contractor reports on LOC reviews.

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<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
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Specify:
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TriAQ

b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of waiver participants with at least 12 months of continuous enrollment who have received LOC reevaluations. Numerator: Number of annual LOC reevaluations performed. Denominator: Number of waiver participants with continuous enrollment of at least 12 months.

Data Source (Select one):
### Other
If 'Other' is selected, specify:

TPA Contractor reports on LOC reevaluation reviews.

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Other
Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

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c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of LOC determinations for waiver applicants that comply with the processes and/or use the instruments specified in the approved waiver.

Numerator: Number of compliant LOC determinations for new waiver applicants. Denominator: Total number of LOC determinations for new waiver applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC assessment documentation; HSD/MAD audits of TPA contractor; reports to DOH; TriAQ.

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| ✔ Other | |
| Specify:  
Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise. | |

**Performance Measure:**
The percentage of LOC reevaluations for waiver participants that comply with the processes and/or use the instruments specified in the approved waiver.

**Numerator:** Number of compliant LOC reevaluations for waiver participants.

**Denominator:** Total number of LOC reevaluations for waiver participants.

**Data Source (Select one):**

- **Other**
- If 'Other' is selected, specify:

  LOC assessment documentation; HSD/MAD audits of TPA contractor; reports to DOH; TriAQ.
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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. Formal quality improvement processes are in place, as described in detail in the TriAQ description and structure in Appendix H.

b. Methods for Remediation/Fixing Individual Problems
   i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement are identified by HSD/MAD related to Level of Care (LOC), processes are in place to ensure that appropriate and timely action is taken. In addition, the TriAQ routinely collects, aggregates, analyzes, and trends LOC data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

Methods for fixing identified problems include verbal direction, letters of direction, formal corrective action plans; documentation is kept on all actions taken. In some instances, policy and/or regulatory changes are required. In all cases, if DOH identifies at any time any issues that are inconsistent with Medicaid requirements related to LOC, HSD/MAD ensures that the problem is corrected and that compliance with the Assurance is met.

   ii. Remediation Data Aggregation
   Remediation-related Data Aggregation and Analysis (including trend identification)

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   c. Timelines
   When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

   ☐ No
   ☐ Yes
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

**Freedom of Choice.** As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

i. informed of any feasible alternatives under the waiver; and  
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals register for waiver services through their local HSD, Income Support Division (ISD) office, or their local DOH/Developmental Disabilities Supports Division Regional Office (DDSD). Individuals registering for a home and community-based waiver are given the choice of registering for any of the traditional waivers in New Mexico.

Individuals are allocated to the waiver from the DOH Central Registry. When the individual receives an offer for waiver services from DOH to begin the medical and financial eligibility processes, the individual is given information from DOH staff about the freedom to choose home and community-based waiver services or institutional services, informed about alternatives, risks and responsibilities associated with choosing self-direction through Mi Via, asked to select whether they want home and community-based services or institutional care, and assisted with implementation of their choice.

Upon receipt of the approved medical eligibility, the DOH/DDSD Intake and Eligibility Bureau sends out a Freedom of Choice form to select a consultant agency.

The State notifies the Consultant/Case Management Agency to initiate contact with the individual. Participants in Mi Via have a high degree of choice among qualified traditional and non-traditional providers, employees and generic vendors. Participants document their choices on the Service and Support Plan action plan and on the Employee or Agency/Vendor agreements they complete with the employees and/or vendors selected.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Freedom of Choice records are maintained at the DOH/DDSD Intake and Eligibility Bureau.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Informational materials are available in English and Spanish. Spanish-speaking individuals are available at the HSD/ISD offices and at HSD and ALTSD statewide toll-free numbers. Statewide disability resource agencies, such as the ALTSD Resource Center, Independent Living Resource Centers, Governor's Commission on Disabilities, and New Mexicans with Disabilities Information Center, have bi-lingual staff available. The Consultant Contractor(s) and the FMA Contractor are required to communicate in the language that is functionally required by the participant.
Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Service</td>
<td>Consultant/Support Guide</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Customized Community Supports</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Employment Supports</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Homemaker/Direct Support Services</td>
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<tr>
<td>Statutory Service</td>
<td>Respite</td>
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<tr>
<td>Extended State Plan Service</td>
<td>Home Health Aide Services</td>
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<tr>
<td>Extended State Plan Service</td>
<td>Skilled Therapy for Adults</td>
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<tr>
<td>Supports for Participant Direction</td>
<td>Personal Plan Facilitation</td>
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<tr>
<td>Other Service</td>
<td>Assisted Living</td>
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<td>Other Service</td>
<td>Behavior Support Consultation</td>
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<td>Customized In-Home Living Supports</td>
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<td>Environmental Modifications</td>
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<td>Specialized Therapies</td>
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<td>Other Service</td>
<td>Transportation</td>
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Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Consultant/Support Guide

HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:

Service Definition (Scope):
CONSULTANT AGENCY
The consultant agency provides consultant and support guide services to Mi Via participants that assist the participant (or the participant’s family or representative, as appropriate) in arranging for, directing, and managing Mi Via services and supports. The consultant agency is required to provide the level of support necessary for the participant to be successful in self-direction. The consultant agency must demonstrate knowledge about self-direction, have a local presence, and understand the resources available in the community to be served.

Consultant Services:
• Contact the participant upon his/her choosing Mi Via to provide information regarding Mi Via, including the range and scope of choices and options; rights, risks, and responsibilities associated with self-direction; and the opportunity to choose a Support Guide as an accommodation for successful self-direction;
• Assist with development of the Service and Support Plan (SSP) and budget;
• Assist with development of an emergency back-up plan;
• Assist with recognizing and reporting critical incidents;
• Consult with the participant on steps to implement the SSP and budget, including educating and assisting the participant regarding required employer and vendor functions, such as recruiting, hiring and supervising workers, completing forms, and faxing timesheets and payment request forms, and identifying and negotiating with vendors;
• Assist with evaluating participant employee training needs and, when the participant is unable to provide training him/herself, assist with identifying and accessing training for the employee;
• Assist the participant with implementing the SSP;
• Assist the participant with management of the budget, including reviewing the spending reports;
• Assist the participant with identifying and accessing local community resources, activities and services;
• Prepare and submit budget revisions;
• Assist with resolution of problems encountered in Mi Via by participants (with the State, FMA, eligibility issues, utilization review issues, crisis response);
• Participate in a conflict resolution process, when needed, on behalf of the participant;
• Work closely with the Support Guide, as he/she assists the participant;
• Be available to and serve as an advocate for the participant, as needed, to enhance his/her opportunity for success with self-direction;
• Contact the participant at least on a monthly basis for a “check-in” and meet face-to-face with the participant, at a minimum, on a quarterly basis;
• Support the participant to develop and implement his/her quality assurance plan; and
• Oversee quality assurance activities to ensure implementation of the SSP, utilization of the participant’s authorized budget, and timely revisions of the SSP and budget.

SUPPORT GUIDE SERVICES
Support Guide Services directly assist the participant in implementing the SSP to ensure access to Mi Via services and supports and to enhance success with self-direction. Support Guide Services provide additional assistance to the participant with employer/vendor functions or with other aspects of implementing his/her SSP.

A support guide can be identified for the participant by the consultant agency or identified and chosen by the participant, but the support guide must be trained by the consultant agency and employed by or under contract with the consultant agency prior to providing support services. A participant cannot hire or contract directly with a support guide.

The consultant is ultimately accountable for all information and support services, as listed under the consultant responsibilities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service Delivery Method *(check each that applies)*:

- [ ] Participant-directed as specified in Appendix E
- [x] Provider managed

Specify whether the service may be provided by *(check each that applies)*:

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Support Guide</td>
</tr>
<tr>
<td>Agency</td>
<td>Consultant Agency</td>
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</table>

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Statutory Service  
**Service Name:** Consultant/Support Guide

**Provider Category:**
- Individual

**Provider Type:**  
Support Guide

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**
Support Guide Required Qualifications:
1. Be at least 18 years of age;
2. Complete a required Mi Via Support Guide training course, approved by the State and conducted by the Consultant Agency upon employment, and demonstrate knowledge of and competence in Mi Via policies and procedures, including self-direction;
3. Participate in ongoing continuing education at a minimum of 10 hours per year, and
4. Pass a criminal background check and abuse registry screen.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
The Administrative Service Organization, which is under contract with HSD and acts as its designee, must assure the consultant agency meets the provider qualifications.

**Frequency of Verification:**
Initially and every 3 years

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Statutory Service  
**Service Name:** Consultant/Support Guide

**Provider Category:**
Agency:  
Provider Type: Consultant Agency
Provider Qualifications
License (specify):
Hold a current business license issued by the State, county, or city government.
Certificate (specify):

Other Standard (specify):
Consultant Required Qualifications:
1. Hold a Bachelor's degree in social work, human services, counseling, nursing, special education, or closely related field;
2. Have one year of supervised experience working with individuals with disabilities;
3. Demonstrated experience with the waiver's targeted populations;
4. Complete a training on self-direction; and
5. Pass a criminal background check and abuse registry screen.

Verification of Provider Qualifications
Entity Responsible for Verification:
The Administrative Service Organization, which is under contract with HSD and acts as its designee, must assure the consultant agency meets the provider qualifications.
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services
C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service
Service:
Habilitation
Alternate Service Title (if any):
Customized Community Supports

HCBS Taxonomy:

Category 1: Sub-Category 1:
Category 2: Sub-Category 2:
Category 3: Sub-Category 3:
Category 4: Sub-Category 4:
Service Definition (Scope):
(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)
Customized community supports are designed to offer the Mi Via participant flexible supports. These supports can include participation in congregate community day programs and centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Customized community supports may include Adult Day Habilitation, Adult Day Health and other day support models and does not duplicate waiver case management, community direct support services, employment supports or any other waiver service. Customized Community Supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings. These services are provided at least 4 or more hours per day one or more days per week as specified in the participant’s service plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):
✓ Participant-directed as specified in Appendix E
☐ Provider managed

Specify whether the service may be provided by (check each that applies):
☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

<table>
<thead>
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<th>Provider Category</th>
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</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Adult Habilitation Provider</td>
</tr>
<tr>
<td>Agency</td>
<td>Adult Day Health Provider</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Customized Community Supports

Provider Category:
Agency

Provider Type:
Adult Habilitation Provider

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
An Adult Habilitation Provider Agency must meet requirements including a business license, financial solvency training requirements, records management, quality assurance policy and processes. The Adult Habilitation Agency staff must meet the following requirements:
• Be 18 years of age or older;
• Demonstrate capacity to perform required tasks;
• Have at least one year of experience working with individuals with disabilities;
• Be able to communicate successfully with the participant; and
• Pass a criminal background check and abuse registry screen.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Customized Community Supports

Provider Category:
Agency

Provider Type:
Adult Day Health Provider

Provider Qualifications
License (specify):
NM Licensed adult day health facility
Certificate (specify):

Other Standard (specify):
An Adult Day Health Provider Agency must meet requirements including a business license, financial solvency training requirements, records management, quality assurance policy and processes.
The Adult Day Health Agency staff must meet the following requirements:
• Be 18 years of age or older;
• Have at least one year of experience working with individuals with disabilities;
• Be able to communicate successfully with the participant; and
• Pass a criminal background check and abuse registry screen.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):
Employment Supports

HCBS Taxonomy:
Category 1:  

Sub-Category 1:  

Category 2:  

Sub-Category 2:  

Category 3:  

Sub-Category 3:  

Category 4:  

Sub-Category 4:  

Service Definition (Scope):  
(As referred to in the overview of the new framework and approach for the MiVia program in the Renewal Section 1. Major Changes.)  
Employment Supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted. The job coach provides training, skill development, and employer consultation that an individual may require while learning to perform specific work tasks on the job; co-worker training; job site analysis; situational and/or vocational assessments and profiles; education of the participant and co-workers on rights and responsibilities; and benefits counseling.  
Job development is a service provided to participants by skilled staff. The service has five components:  
(1) job identification and development activities;  
(2) employer negotiations;  
(3) job restructuring;  
(4) job sampling; and  
(5) job placement.  
Employment Supports will be provided by staff at current or potential work sites. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.  
Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).  
Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:  
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;  
2. Payments that are passed through to users of supported employment programs; or  
3. Payments for training that is not directly related to an individual's supported employment program.  

FFP cannot be claimed to defray expenses associated with starting up or operating a business  
Specify applicable (if any) limits on the amount, frequency, or duration of this service:  

Service Delivery Method (check each that applies):  

☑ Participant-directed as specified in Appendix E  
☐ Provider managed  

Specify whether the service may be provided by (check each that applies):  

☑ Legally Responsible Person
Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Employment Supports

Provider Category:
Individual

Provider Type:
Job Coach

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):
Job Coach must:
- Be at least 18 years of age;
- Pass Criminal background check and abuse registry screen;
- Experience as a job coach for at least one year in the State of New Mexico;
- Experience for at least one year using job and task analyses;
- Training on American with Disabilities Act (ADA); and
- Trained on the purpose, function and general practices of the Department of Vocational Rehabilitation (DVR) office.

Additionally, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Employment Supports

Provider Category:
Agency

Provider Type:
Supported Employment Provider Agency

Provider Qualifications
Other Standard (specify):

Supported Employment Provider Agency must meet requirements including a current business license, financial solvency, training requirements, records management, quality assurance policy and processes. The agency must hire job developers and job coaches with the following requirements:

Job Developer must:
- Be at least 18 years of age;
- Pass Criminal background check and abuse registry screen;
- Experience as a job developer for at least one year in the State of New Mexico;
- Experience for at least one year developing and using job and task analyses;
- Trained on American with Disabilities Act (ADA);
- Experience for at least one year working with the Department of Vocational Rehabilitation (DVR) office; and
- Trained on the purposes, functions and general practices of entities such as:
  - Department of Labor Navigators
  - One-Stop Career Centers
  - Business Leadership Network
  - Chamber of Commerce
  - Job Accommodation Network
  - Small Business Development Centers
  - Retired Executives
  - New Mexico Employment Institute

Job Coach must:
- Be at least 18 years of age;
- Pass Criminal background check and abuse registry screen;
- Experience as a job coach for at least one year in the State of New Mexico;
- Experience for at least one year using job and task analyses;
- Trained on American with Disabilities Act (ADA); and
- Trained on the purpose, function and general practices of the Department of Vocational Rehabilitation (DVR) office.

Verification of Provider Qualifications

Entity Responsible for Verification:
- Financial Management Agent (FMA)

Frequency of Verification:
- Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Employment Supports

Provider Category:
- Individual

Provider Type:
- Job Developer

Provider Qualifications
License (specify):

Certificate (specify):
Other Standard (specify):
Job Developer must:
- Be at least 18 years of age;
- Pass Criminal background check and abuse registry screen;
- Experience as a job developer for at least one year in the State of New Mexico;
- Experience for at least one year developing and using job and task analyses;
- Trained on American with Disabilities Act (ADA);
- Experience for at least one year working with the Department of Vocational Rehabilitation (DVR) office; and
- Trained on the purposes, functions and general practices of entities such as:
  Department of Labor Navigators
  One-Stop Career Centers
  Business Leadership Network
  Chamber of Commerce
  Job Accommodation Network
  Small Business Development Centers
  Retired Executives
  New Mexico Employment Institute

Additionally, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services
C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Homemaker

Alternate Service Title (if any):
Homemaker/Direct Support Services

HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:

Category 3: Sub-Category 3:
Category 4: Sub-Category 4:

Service Definition (Scope):
(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)
Homemaker/Direct Support Services are provided on an episodic or continuing basis to assist the participant with activities of daily living, performance of general household tasks, provide companionship to acquire, maintain, or improve social interaction skills in the community, and enable the participant to accomplish tasks he/she would normally do for him/herself if he/she did not have a disability. Homemaker/Direct Support services are provided in the participant’s home and in the community, depending on the participant’s needs. The participant identifies the Homemaker/Direct Support Worker’s training needs, and, if the participant is unable to do the training himself, the participant arranges for the needed training. Services are not intended to replace supports available from a primary caregiver. Homemakers services are not duplicative of home health aide services. Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Homemakers do not have this ability to perform such tasks.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
- Two or more participants living in the same residence, who are receiving services and supports under Mi Via will be assessed both independently and jointly to determine coverage of services and supports that are shared. Services and supports will be approved based on the common needs and not on individual needs, unless it has been assessed by the TPA contractor that there is an individual need for the provision of the service(s) or supports.
- Personal Care Services are covered under the State Plan as expanded EPSDT benefits for Waiver participants under age 21.

Service Delivery Method (check each that applies):

☑ Participant-directed as specified in Appendix E
☐ Provider managed

Specify whether the service may be provided by (check each that applies):

☑ Legally Responsible Person
☑ Relative
☑ Legal Guardian

Provider Specifications:

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<tr>
<th>Provider Category</th>
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<td>Homemaker/Direct Support</td>
</tr>
<tr>
<td>Agency</td>
<td>Home Health Agency/Homemaker Agency</td>
</tr>
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</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

| Service Type: Statutory Service |
| Service Name: Homemaker/Direct Support Services |

Provider Category:
Individual

Provider Type:
Homemaker/Direct Support

Provider Qualifications
License (specify):

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Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker/Direct Support Services

Provider Category:
Agency

Provider Type:
Home Health Agency/Homemaker Agency

Provider Qualifications

License (specify):
Home Health Agency

Certificate (specify):
Homemaker agencies must be certified by HSD/MAD or its designee

Other Standard (specify):
Home Health Agency/Homemaker Agency must meet requirements including a current business license, financial solvency, training requirements, records management, quality assurance policy and processes.

The Homemaker/Direct Support Agency staff must meet the following requirements:
• Workers must be 18 years of age or older;
• Demonstrate capacity to perform required tasks;
• Be able to communicate successfully with the participant; and
• Pass a criminal background check and abuse registry screen.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Agent (FMA)

Frequency of Verification:
Initially and every 3 years
State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
- Statutory Service
- Service: Respite
- Alternate Service Title (if any):

**HCBS Taxonomy:**

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**Service Definition (Scope):**
(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)
Respite is a flexible family support service, the primary purpose of which is to provide support to the participant and give the primary caregiver time away from his/her duties. Respite Services include assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities; assisting the participant to enhance self-help skills, leisure time skills and community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the participant to make his/her own choices with regard to daily activities. Respite services are furnished on a short-term basis and can be provided in the participant's home, the provider's home, in a community setting of the family's choice (e.g., community center, swimming pool, and park) or at a center in which other individuals are provided care. Federal Financial Participation (FFP) is not claimed for the cost of room and board as part of respite services.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method (check each that applies):**
- [x] Participant-directed as specified in Appendix E
- [ ] Provider managed

**Specify whether the service may be provided by (check each that applies):**
- [x] Legally Responsible Person
- [ ] Relative
- [x] Legal Guardian

**Provider Specifications:**
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<td>Agency</td>
<td>Respite Provider</td>
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<td>Individual</td>
<td>Respite Provider</td>
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</tbody>
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**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

| Service Type: Statutory Service  
<table>
<thead>
<tr>
<th>Service Name: Respite</th>
</tr>
</thead>
</table>

**Provider Category:**
- Individual

**Provider Type:**
- RN/LPN

**Provider Qualifications**

- **License (specify):**
  Licensed by the NM State Board of Nursing as a RN or LPN

- **Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

- **Entity Responsible for Verification:**
  Financial Management Agent (FMA)
- **Frequency of Verification:**
  Initially and annually or up to every 3 years

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**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

| Service Type: Statutory Service  
<table>
<thead>
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<th>Service Name: Respite</th>
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**Provider Category:**
- Agency

**Provider Type:**
- Respite Provider

**Provider Qualifications**

- **License (specify):**

- **Certificate (specify):**

**Other Standard (specify):**

Respite Provider Agency must meet requirements including a current business license, financial solvency, training requirements, records management, quality assurance policy and processes.

The Respite provider staff must meet the following requirements:

- Be 18 years of age or older;
- Demonstrate capacity to perform required tasks;
• Be able to communicate successfully with the participant; and
• Pass a criminal background check and abuse registry screen.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Respite Provider

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
Worker must be:
• 18 years of age or older;
• Demonstrate capacity to perform required tasks;
• Be able to communicate successfully with the participant; and
• Pass a criminal background check and abuse registry screen.

Additionally, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Home Health Aide Services

HCBS Taxonomy:

Service Definition (Scope):
Category 1: 

Sub-Category 1: 

Category 2: 

Sub-Category 2: 

Category 3: 

Sub-Category 3: 

Category 4: 

Sub-Category 4: 

referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)

Home Health Aide Services provide total care or assist a participant in all activities of daily living. The Home Health Aide Services assist the participant in a manner that will promote an improved quality of life and a safe environment for the participant. Home Health Aide services can be provided outside the participant's home. State Plan home health aide services are intermittent and provided primarily on a short-term basis; whereas, in Mi Via, Home Health Aide services are hourly services, for participants who need this service on a more long-term basis. Home Health Aide services are not duplicative of homemaker services; Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Homemakers do not have this ability to perform such tasks.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Home Health Aide services are covered under the State Plan as expanded EDSDT benefits for Waiver participants under 21.

Service Delivery Method (check each that applies):

☑ Participant-directed as specified in Appendix E
☐ Provider managed

Specify whether the service may be provided by (check each that applies):

☑ Legally Responsible Person
☑ Relative
☑ Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Agency</td>
<td>Home Health Agency/Homemaker Agency</td>
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</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Home Health Aide Services

Provider Category:
Agency

Provider Type:
Home Health Agency/Homemaker Agency

Provider Qualifications
License (specify):
Home Health Agency, Rural Health Clinic or Federally Qualified Health Center

Certificate (specify):

Other Standard (specify):
A Home Health Agency must meet requirements including a current business license, financial solvency, training requirements, records management, quality assurance policy and processes.

Home Health Aides must have successfully completed a home health aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a home health aide training program described in the New Mexico Regulations Governing Home Health Agencies, 7.28.2.30 NMAC. Home health aides must also be supervised by a registered nurse and such supervision, which must occur at least once every sixty (60) days in the participant's home, shall be in accordance with the New Mexico Nurse Practice Act and be specific to the participant's Service and Support Plan.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services
C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Skilled Therapy for Adults

HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

Service Definition (Scope):
(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)
Extended State Plan Skilled Therapy for Adults services include Physical Therapy, Occupational Therapy or Speech Language Therapy. Services are provided when State Plan skilled therapy services are exhausted. Adults on the Mi Via Waiver access therapy services under the State Plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to adults under Mi Via focus on maintenance, community integration, socialization, and exercise, or enhance support and normalization of family relationships.

Physical Therapy is the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy activities do the following: 1) increase, maintain or reduce the loss of functional skills; 2) treat a specific condition clinically related to a participant’s developmental disability; 3) support the participant’s health and safety needs; and/or 4) identify, implement, and train on therapeutic strategies to support the participant and his/her family/support staff consistent with the participant’s Service and Support Plan (SSP) desired outcomes and goals.

Occupational Therapy is the diagnosis, assessment, and management of functional limitations intended to assist adults to regain, maintain, develop, and build skills that are important for independence, functioning, and health. Occupational Therapy services typically include: customized treatment programs to improve one’s ability to perform daily activities; comprehensive home and job site evaluations with adaptation recommendations; skills assessments and treatment; assistive technology recommendations and usage training; and guidance to family members and caregivers. Occupational Therapy services do the following: 1) increase, maintain, or reduce the loss of functional skills; 2) treat specific conditions clinically related to a participant’s developmental disability; 3) support the participant’s health and safety needs; and/or 4) identify, implement, and train therapeutic strategies to support the participant and his/her family/support staff consistent with the participant’s SSP desired outcomes and goals.

Speech and Language Pathology is the diagnosis, counseling and instruction related to the development and disorders of communication including speech fluency, voice, verbal, and written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal, and sensor motor competencies. Speech Language (SL) Pathology is also used when a participant requires the use of an augmentative communication device. Services are intended to improve or maintain the participant’s capacity for successful communication or to lessen the effects of the participant’s loss of communication skills and/or to improve or maintain the participant’s ability to eat foods, drink liquids, and manage oral secretions with minimal risk of aspiration or other potential injuries or illness related to swallowing disorders. Activities include identification, implementation and training of therapeutic strategies to support the participant and his/her family/support staff consistent with the participant’s SSP desired outcomes and goals. Based upon therapy goals, services may be delivered in integrated natural setting, clinical setting and/or in a group. Children on this waiver will receive Skilled Therapy services outside the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service: Children on this waiver receive skilled therapy services outside the waiver.

Service Delivery Method (check each that applies):

- [✓] Participant-directed as specified in Appendix E
- [ ] Provider managed

Specify whether the service may be provided by (check each that applies):

- [✓] Legally Responsible Person
- [✓] Relative
- [✓] Legal Guardian

Provider Specifications:

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<td>Individual</td>
<td>Physical Therapist</td>
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<td>Agency</td>
<td>Group Practice</td>
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<tr>
<td>Individual</td>
<td>Speech and Language Pathologist</td>
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</table>
Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Skilled Therapy for Adults

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications
License (specify):
Licensed as per NM Regulation and Licensing Dept; Occupational Therapy Act, NMSA 1978, Section 61-12A-1 et.seq.
Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and annually or up to every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Skilled Therapy for Adults

Provider Category:
Individual

Provider Type:
Physical Therapist

Provider Qualifications
License (specify):
Licensed as per NM Regulation and Licensing Dept; Physical Therapy Act, NMSA 1978, Section 61-12-1.1 et.seq
Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years
Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

| Service Type: Extended State Plan Service |
| Service Name: Skilled Therapy for Adults |

Provider Category:
- Agency

Provider Type:
- Group Practice

Provider Qualifications
- License (specify):
  - Physical Therapist: Licensed as per NM Regulation and Licensing Dept; Physical Therapy Act, NMSA 1978, Section 61-12-1.1 et.seq.
  - Occupational Therapist: Licensed as per NM Regulation and Licensing Dept; Occupational Therapy Act, NMSA 1978, Section 61-12A-1 et.seq.
  - Speech and Language Pathologist: Licensed as per NM Regulation and Licensing Dept; Speech and Language Pathology Act, NMSA 1978, Section 61-14B-1 et.seq.

Certificate (specify):
- 

Other Standard (specify):
- Group Practice Agency that employs licensed occupational therapists, physical therapists, or speech therapists in accordance with New Mexico Regulations & Licensing Department.

Verification of Provider Qualifications
- Entity Responsible for Verification:
  - Financial Management Agent (FMA)
- Frequency of Verification:
  - Initially and annually or up to every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

| Service Type: Extended State Plan Service |
| Service Name: Skilled Therapy for Adults |

Provider Category:
- Individual

Provider Type:
- Speech and Language Pathologist

Provider Qualifications
- License (specify):
  - Licensed as per NM Regulation and Licensing Dept; Speech and Language Pathology Act, NMSA 1978, Section 61-14B-1 et.seq.

Certificate (specify):
- 

Other Standard (specify):
- 

Verification of Provider Qualifications
- Entity Responsible for Verification:
  - Financial Management Agent (FMA)
- Frequency of Verification:
Initially and annually or up to every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Personal Plan Facilitation

HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

Service Definition (Scope):

Personal Plan Facilitation supports planning activity that results in a holistic person-centered plan that may be used by the participant to develop his/her Service and Support Plan (SSP) as well as identify other sources of support outside the SSP process. Essential lifestyle planning, Circles, MAPS, PATH, personal future planning, lifestyle style planning, and personal profile or other appropriate person-centered processes may be used by the facilitator to produce the plan. Personal Plan Facilitation is a product of the self-determination movement. Personal Plan Facilitation is a nationally recognized service that provides an opportunity for the individual to explore and articulate the vision a participant has for his/her life. This service is provided by trained staff using personal planning facilitation tools. This service is not duplicative of waiver case management because the provider skillfully discovers and documents an individual’s long range goals and desires that may only be addressed in the SSP by short range outcomes. This service is available to participants one time per budget year.

In the scope of Personal Planning Facilitation, the Personal Plan Facilitator will:

(1) Meet with the participant and his/her family (or guardian, as appropriate) prior to the personal planning session to discuss the process, to determine who the participant wishes to invite, and determine the most convenient date, time and location. This meeting preparation shall include an explanation of the techniques the facilitator is proposing to use or options if the facilitator is trained in multiple techniques. The preparation shall also include a discussion of the role the participant prefers to play at the planning session, which may include co
- facilitation of all or part of the session.
(2) Arrange for participation of invitees and location.
(3) Conduct the personal planning session.
(4) Document the results of the personal planning session and provide a copy to the participant, the Consultant and any other parties the participant would like to receive a copy. Elements of this report shall include:
(a) Strengths, gifts, talents, interests and preferences of the participant;
(b) Long term dream(s)/goal(s) the participant wishes to pursue;
(c) Challenges the participant faces (if any) in pursuing his or her dream(s)/goal(s);
(d) Potential resources, especially natural supports within the participant’s community that can potentially support the participant in pursuing his or her dream(s)/goal(s); and
(e) A list of any follow-up actions to take, including time lines.
(5) Provide session attendees, including the participant, with an opportunity to provide feedback regarding the effectiveness of the session.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limit one personal plan per year up to $650.00.

Service Delivery Method (check each that applies):

☑ Participant-directed as specified in Appendix E
☐ Provider managed

Specify whether the service may be provided by (check each that applies):

☑ Legally Responsible Person
☑ Relative
☑ Legal Guardian

Provider Specifications:

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<tr>
<td>Individual</td>
<td>Personal Plan Facilitator (Sole Proprietor)</td>
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Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Personal Plan Facilitation

Provider Category:
Agency

Provider Type:
Personal Plan Facilitator Agency

Provider Qualifications
License (specify):  * 
Certificate (specify):  *

Other Standard (specify):
A Personal Plan Facilitator Agency must meet requirements including a current business license, financial solvency, training requirements, records management, quality assurance policy and processes. The personal plan facilitation agency staff must:
- Be at least 18 years old;
- Have at least one experience working with persons with disabilities;
- Be trained and certified in the planning tool used;
- Be trained and certified in mediation; and
- Have at least one year experience in providing the personal plan facilitation service.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

 Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

| Service Type: Supports for Participant Direction |
| Service Name: Personal Plan Facilitation |

Provider Category:
Individual

Provider Type:
Personal Plan Facilitator (Sole Proprietor)

Provider Qualifications
License (specify):  
Certificate (specify):  

Other Standard (specify):
A Personal Plan Facilitator must:
- Be at least 18 years old;
- Have at least one year experience working with persons with disabilities;
- Be trained and certified in the planning tool used;
- Be trained and certified in mediation; and
- Have at least one year experience in providing the personal plan facilitation service.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services
C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Assisted Living

HCBS Taxonomy:

Service Definition (Scope):
As Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)

Assisted Living is a residential service that includes personal care and supportive services (homemaker, chore, attendant services, meal preparation), including companion services: medication oversight (to the extent permitted under State law); and 24-hour, on-site response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety, and security. Services also include social and recreational programming. Coverage does not include 24-hour skilled care or supervision or the cost of room or board. Nursing and skilled therapy services are incidental, rather than integral, to the provision of assisted living services. Services (other than those included in the bundle of "Assisted Living" services) provided by third parties must be coordinated with the assisted living provider.

Specify applicable (If any) limits on the amount, frequency, or duration of this service:

Participants who access this service cannot utilize Mi Via homemaker/direct support, environmental modifications, emergency response, customized community supports and customized in-home living supports services because these activities are already provided within Assisted Living services.

**Service Delivery Method (check each that applies):**

- [ ] Participant-directed as specified in Appendix E
- [x] Provider managed

**Specify whether the service may be provided by (check each that applies):**

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

**Provider Specifications:**

<table>
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<tr>
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<td>Assisted Living Provider</td>
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</table>

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type:** Other Service

**Service Name:** Assisted Living

**Provider Category:**

- **Agency**:
- **Provider Type:** Assisted Living Provider
Provider Qualifications
License (specify):
New Mexico Licensed Adult Residential Care Facility
Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and annually or up to every three years.

Appendix C: Participant Services
C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Behavior Support Consultation

HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

Service Definition (Scope):
(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)
Behavior Support Consultation services consist of functional support assessments, treatment plan development, and training and support coordination for a participant related to behaviors that compromise a participant's quality of life. Behavior Support Consultation: 1) informs and guides the participant's service and support employees/vendors toward understanding the contributing factors to the participant's behavior; 2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities,
adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s); 3) supports effective implementation based on a functional assessment and subsequent Service and Support Plan (SSP); 4) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues, and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the participant and his/her service and support providers. Based on the participant's SSP, services are delivered in an integrated/natural setting or in a clinical setting.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

☑ Participant-directed as specified in Appendix E
☐ Provider managed

Specify whether the service may be provided by (check each that applies):

☑ Legally Responsible Person
☑ Relative
☑ Legal Guardian

Provider Specifications:

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<td>Agency</td>
<td>Behavior Consultation Practice</td>
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</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Support Consultation

Provider Category:
Individual

Provider Type:
Behavior Support Consultant

Provider Qualifications
License (specify):
M.D., licensed clinical psychologist, licensed psychologist associate, licensed social worker,
licensed professional clinical counselor, licensed professional counselor, licensed psychiatric nurse,
NM licensed marriage and family therapist, NM licensed practicing art therapist

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and annually or up to every 3 years
Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

<table>
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<tbody>
<tr>
<td>Service Name: Behavior Support Consultation</td>
</tr>
</tbody>
</table>

Provider Category:
- Agency

Provider Type:
- Behavior Consultation Practice

Provider Qualifications

License (specify):
The agency will ensure each clinician is licensed as one of the following: M.D., licensed clinical psychologist, licensed psychologist associate, licensed social worker, licensed professional clinical counselor, licensed professional counselor, licensed psychiatric nurse, NM licensed marriage and family therapist, NM licensed practicing art therapist

Certificate (specify):

Other Standard (specify):
The Behavior Consultant provider agency shall have a current business license issued by the state, county or city government, if required by any of these government entities. The Behavior Consultant provider agency shall comply with all applicable federal, state, and Waiver regulations and policies and procedures regarding behavior consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:
- Financial Management Agent (FMA)

Frequency of Verification:
- Initially and annually or up to every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
- Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
- Community Direct Support

HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:
Category 3:  

Sub-Category 3:  

Category 4:  

Sub-Category 4:  

Service Definition (Scope):  
(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.) Community Direct Support delivers support to the participant to identify, develop, nurture and maintain community connections and to access social, educational, recreational and leisure options. The community direct support provider may be a skilled independent contractor or a hired employee depending on the level of support needed by the participant to access the community. The community direct support provider may instruct and model social behavior necessary to interact with community members or in groups, provide assistance in needed ancillary tasks related to community membership, provide attendant care and help the participant schedule, organize and meet expectations related to chosen community activities. Community Direct Support services provide assistance to the participant outside of the individual’s residence and segregated facilities. Community Direct Support services promote the development of valued social relationships and builds connections within local communities. This service supports the participant in having frequent opportunities to expand meaningful roles in the community to increase and enhance natural supports, networks, friendships and build a sense of belonging. This promotes self-determination, increases interdependence and enhances the individual’s ability to interact with and contribute to his or her community. Community Direct Support services also assist in the development of skills and behaviors that strengthen an individual’s connection with his or her community. The participant is supported to create such community connections individually, not as a part of a group of people with disabilities. The skills to assist someone in a community setting may be different than those for assisting a person at home. The provider will demonstrate knowledge of the local community and resources within that community that are identified by the participant on the service and support plan. The provider will also be aware of the participant’s barriers to communicating and maintaining health and safety while in the community setting. Community Direct Support does not duplicate Person-centered Plan facilitation as it does not result in the creation of a life plan. Community Direct Support does not duplicate waiver case management service as it is a care service provided only outside the participant’s residence.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:  

Service Delivery Method (check each that applies):  

☑ Participant-directed as specified in Appendix E  
☐ Provider managed

Specify whether the service may be provided by (check each that applies):  

☑ Legally Responsible Person  
☑ Relative  
☑ Legal Guardian

Provider Specifications:

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<td>Agency</td>
<td>Community Access Provider Agency</td>
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</table>

Appendix C: Participant Services  
C-1/C-3: Provider Specifications for Service  

Service Type: Other Service
Service Name: Community Direct Support

Provider Category:
Individual

Provider Type:
Community Direct Support

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
Worker must be:
• 18 years of age or older;
• Demonstrate capacity to perform required tasks;
• Be able to communicate successfully with the participant; and
• Pass a criminal background check and abuse registry screen

Additionally, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Direct Support

Provider Category:
Agency

Provider Type:
Community Access Provider Agency

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
A Community Access Provider Agency must meet requirements including a business license, financial solvency training requirements, records management, quality assurance policy and processes. The agency staff must meet the following qualifications:
• Be 18 years of age or older;
• Demonstrate capacity to perform required tasks;
• Be able to communicate successfully with the participant; and
• Pass a criminal background check and abuse registry screen.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services
C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Customized In-Home Living Supports

HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

Service Definition (Scope):
(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)
Customized In-Home Living Supports are individually designed services and/or supports that are related to the participant’s qualifying condition or disability which enables him/her to live his/her apartment or house that is owned or leased, not to include homes owned by providers, in the community of his/her choice, for the purpose of preventing institutionalization. These services and/or supports are provided in the participant’s home and are individually designed to instruct or enhance home living skills as well as address health and safety. Services and/or supports provided under Customized In-Home Living supports include assistance with activities of daily living and assistance with the acquisition, restoration, and/or retention of independent living skills. This service is provided on a regular basis (at least 4 or more hours per day one or more days per week or as specified in the service plan).

Participants receiving Customized In-Home Living Supports may not use Homemaker/Direct Support or Home Health Aide Services because they are already provided via Customized In-Home Living Supports. This service does not duplicate any other waiver service. Specifically, this does not duplicate Customized Community Supports since Customized Community Supports is provided in a different setting (non-institutional and non-residential settings).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service Delivery Method (check each that applies):

☑ Participant-directed as specified in Appendix E
☐ Provider managed

Specify whether the service may be provided by (check each that applies):

☑ Legally Responsible Person
☑ Relative
☑ Legal Guardian

Provider Specifications:

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<td>Customized Living Provider</td>
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Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Customized In-Home Living Supports

Provider Category:
Individual

Provider Type:
Customized Living Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):
Worker must be:
• 18 years of age or older;
• Have one year of experience working with people with disabilities;
• Demonstrate capacity to perform required tasks;
• Be able to communicate successfully with the participant; and
• Pass a criminal background check and abuse registry screen

Additionally, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Customized In-Home Living Supports
Provider Category:
Agency

Provider Type:
Customized Living Provider

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
A Customized Living Provider Agency must meet requirements including a business license, financial solvency training requirements, records management, quality assurance policy and processes.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)

Frequency of Verification:
Initially and annually or up to every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Emergency Response Services

HCBS Taxonomy:

Category 1:
Sub-Category 1:

Category 2:
Sub-Category 2:

Category 3:
Sub-Category 3:

Category 4:
Sub-Category 4:

Service Definition (Scope):
Emergency Response services provide an electronic device that enables a participant to secure help in an emergency at home and avoid institutionalization. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant’s phone and programmed to signal a response center when a "help" button is activated. The response center is staffed by trained professionals. Emergency response services include: installing, testing and maintaining equipment; training participants, caregivers and first responders on use of the equipment; twenty-four (24) hour monitoring for alarms; checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.; and, reporting participant emergencies and changes in the participant’s condition that may affect service delivery.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- [ ] Participant-directed as specified in Appendix E
- [ ] Provider managed

Specify whether the service may be provided by (check each that applies):

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

Provider Specifications:

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</table>

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Emergency Response Services

Provider Category:
Agency

Provider Type:
Emergency Response Provider

Provider Qualifications
License (specify):

Certificate (specify):

Other Standard (specify):
Approved Emergency Response Provider; must comply with all laws, rules and regulations from the Federal Trade Communication Commission for Telecommunications

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management: Agent (FMA)
Frequency of Verification:
Initially and every 3 years
Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Environmental Modifications

HCBS Taxonomy:

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Service Definition (Scope):
Environmental Modification services include the purchase and/or installation of equipment and/or making physical adaptations to a participant's residence that are necessary to ensure the health, welfare, and safety of the participant or enhance the participant's level of independence. Adaptations include the installation of ramps and grab-bars; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing); turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light-activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating/cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems and/or signaling devices.

All services shall be provided in accordance with applicable federal, state, and local building codes. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction/remodeling services, provide administrative and technical oversight of construction projects, provide consultation to family members, waiver providers and contractors concerning environmental modification projects to the participant's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

Environmental Modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Environmental Modification services are limited to seven thousand dollars ($7,000.00) every five (5) years. Additional services may be requested if a participant's health and safety needs exceed the specified limit.
Environmental modifications will not be paid for under Participant-Delegated services and supports.

Service Delivery Method (check each that applies):

- [ ] Participant-directed as specified in Appendix E
- [ ] Provider managed

Specify whether the service may be provided by (check each that applies):

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

Provider Specifications:

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Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual

Provider Type:
Individual or Company

Provider Qualifications
License (specify):
Appropriate plumbing, electrician, contractor license; appropriate technical certification to perform the modification
Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Upon initial employee or vendor/provider agreement and at annual Service and Support Plan and Budget Review.

Appendix C: Participant Services

C-1/C-3: Service Specification
State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Nutritional Counseling

**HCBS Taxonomy:**

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**Service Definition (Scope):**

(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)

Nutritional Counseling services include assessment of the participant’s nutritional needs, development and/or revision of the participant’s nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

**Service Delivery Method (check each that applies):**

- [✓] Participant-directed as specified in Appendix E
- [ ] Provider managed

Specify whether the service may be provided by (check each that applies):

- [✓] Legally Responsible Person
- [✓] Relative
- [✓] Legal Guardian

**Provider Specifications:**

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</table>
Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

| Service Type: Other Service          |
| Service Name: Nutritional Counseling |

Provider Category:
- Individual

Provider Type:
- Dietitian

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):
Must be registered as a Dietitian by the Commission on Dietetic Registration of the American Dietetic Association, Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A-1 et.seq.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Agent (FMA)

Frequency of Verification:
Initially and annually or up to every 3 years

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Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

| Service Type: Other Service          |
| Service Name: Nutritional Counseling |

Provider Category:
- Agency

Provider Type:
- Group Practice

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):
A Nutritional Counseling Provider Agency must meet requirements as outlined in a nutritional counseling provider agency application approved by HSD or its designee including a business license, financial solvency training requirements, records management, quality assurance policy and processes.

The worker must be registered as a Dietitian by the Commission on Dietetic Registration of the American Dietetic Association; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A-1 et.seq.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Agent (FMA)
Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
- Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Private Duty Nursing for Adults

HCBS Taxonomy:

Category 1:  Sub-Category 1:

Category 2:  Sub-Category 2:

Category 3:  Sub-Category 3:

Category 4:  Sub-Category 4:

Service Definition (Scope):
(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)
Private Duty Nursing for Adults includes activities, procedures, and treatment for a participant’s physical condition, physical illness or chronic disability. Services include medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Children on this waiver will receive private duty nursing services outside the waiver.

Service Delivery Method (check each that applies):

- [✓] Participant-directed as specified in Appendix E
- [ ] Provider managed

Specify whether the service may be provided by (check each that applies):
Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Duty Nursing for Adults

Provider Category:
Agency

Provider Type:
Home Health Agency/Rural Health Clinic/FQHC

Provider Qualifications

License (specify):
Agency licensed by the State of New Mexico; nurses licensed by the New Mexico State Board of Nursing as a RN or LPN.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Agent (FMA)

Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Duty Nursing for Adults

Provider Category:
Individual

Provider Type:
RN/LPN

Provider Qualifications

License (specify):
Licensed by the NM State Board of Nursing as a RN or LPN

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications
**Entity Responsible for Verification:**
Financial Management Agent (FMA)

**Frequency of Verification:**
Initially and every 3 years

---

**Appendix C: Participant Services**
**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Related Goods

HCBS Taxonomy:

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**Service Definition (Scope):**
(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)
Related goods are equipment, supplies or fees and memberships, not otherwise provided through this Waiver or through the Medicaid State Plan. Related goods must address a need identified in the participant’s Service and Support Plan (including improving and maintaining the participant’s opportunities for full membership in the community) and meet the following requirements: be responsive to the participant’s qualifying condition or disability; and/or accommodate the participant in managing his/her household; and/or facilitate activities of daily living; and/or promote personal safety and health; and afford the participant an accommodation for greater independence; and advance the desired outcomes in the participant’s Service and Support Plan (SSP); and decrease the need for other Medicaid services. Related goods must be documented in the SSP.
The participant receiving this service does not have the funds to purchase the related good(s) or the related good(s) is/are not available through another source. These items are purchased from the participant’s individual budget. Experimental or prohibited treatments and goods are excluded.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

---
**Service Delivery Method** *(check each that applies):*

- [✓] Participant-directed as specified in Appendix E
- [ ] Provider managed

**Specify whether the service may be provided by** *(check each that applies):*

- [✓] Legally Responsible Person
- [✓] Relative
- [✓] Legal Guardian

**Provider Specifications:**

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### Appendix C: Participant Services

**C-1/C-3: Provider Specifications for Service**

- **Service Type:** Other Service
- **Service Name:** Related Goods

**Provider Category:**
- [ ] Agency
- [ ] Provider Type:
- [ ] Vendor

**Provider Qualifications**
- **License (specify):**
- **Certificate (specify):**

**Other Standard (specify):**
Business license for the locale they are in and a tax ID for the state and federal government

**Verification of Provider Qualifications**
- **Entity Responsible for Verification:**
- **Financial Management Agent (FMA):**
- **Frequency of Verification:**
  Initially and every 3 years

### Appendix C: Participant Services

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- **Service Type:**
  - [ ] Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

- **Service Title:**
  - Specialized Therapies
HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

Service Definition (Scope):
(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)

Specialized Therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. A participant may include specialized therapies in his/her Mi Via Service and Support Plan (SSP) when the services enhance opportunities to achieve inclusion in community activities and avoid institutionalization. Services must be related to the participant's disability or condition, ensure the participant's health and welfare in the community, supplement rather than replace the participant's natural supports and other community services for which the participant may be eligible, and prevent the participant's admission to institutional services. Experimental or investigational procedures, technologies or therapies and those services covered as a Medicaid State Plan benefit are excluded.

Services in this category include:

Acupuncture
Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits.

Biofeedback
Biofeedback uses visual, auditory or other monitors to feed back to participants physiological information of which they are normally unaware. This technique enables a participant to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health and performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

Chiropractic
Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis, for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health.

Cognitive rehabilitation therapy
Cognitive rehabilitation therapy services are designed to improve cognitive functioning by reinforcing,
strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome specific cognitive problems.

Hippotherapy
Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for participants with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the participant use cognitive functioning, especially for sequencing and memory. Participants with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and for individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production.

Massage Therapy
Massage therapy is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a participant's ability to be more independent in the performance of activities of daily living; thereby, decreasing dependency upon others to perform or assist with basic daily activities.

Narapath
Narapath focuses on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, narapath uses manipulation of connective tissue to open these channels of body function.

Native American Healers
There are twenty-two sovereign Tribes, Nations, and Pueblos in New Mexico, as well as numerous Native American individuals who come from many other tribal backgrounds. Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support participants in their communities by addressing their physical, emotional and spiritual health. Treatments may include prayer, dance, ceremony and song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel and/or other sacred objects. This form of therapy may be provided by community-recognized medicine men and women and others as healers, mentors and advisors to participants, and provides opportunities for participants to remain connected with their communities. The communal and spiritual support provided by this type of healing can reduce pain and stress and improve quality of life. It is also important to note that some Tribes, Nations, and Pueblos prefer to keep these healing therapies and practices safeguarded due to the significance of their religious ties.

Play Therapy
Play therapy is a variety of play and creative arts techniques (the 'Play Therapy Tool-Kit') utilized to alleviate chronic, mild and moderate psychological and emotional conditions in children that are causing behavioral problems and/or are preventing children from realizing their potential. The Play Therapist works integratively using a wide range of play and creative arts techniques, mostly responding to the child's wishes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

✓ Participant-directed as specified in Appendix E
Specify whether the service may be provided by (check each that applies):

- ✓ Legally Responsible Person
- ✓ Relative
- ✓ Legal Guardian

Provider Specifications:

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Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

| Service Type: Other Service |
| Service Name: Specialized Therapies |

Provider Category:
- Individual

Provider Type:
- Specialized Therapist

Provider Qualifications

License (specify):
- A current NM State license as applicable
- Acupuncture and Oriental Medicine license
- Biofeedback – license in a health care profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision.
- Chiropractic Physician license
- Cognitive rehabilitation therapy – license in a health care profession whose scope of practice includes cognitive rehabilitation therapy, and appropriate specialized training and clinical experience and supervision.
- Hippotherapy – license in a health care profession whose scope of practice includes hippotherapy, and appropriate specialized training and experience.
- Massage Therapist license
- Naprapathic Physician license
- Play therapy – license in a mental health profession whose scope of practice includes play therapy, a master’s degree or higher mental health degree, and specialized play therapy training and clinical experience and supervision.

Certificate (specify):

Other Standard (specify):
- Native American Healers – individuals who are recognized as healers within their communities

Verification of Provider Qualifications

Entity Responsible for Verification:
- Financial Management Agent (FMA)

Frequency of Verification:
- Initially and every 3 years for all providers listed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

| Service Type: Other Service |
| Service Name: Specialized Therapies |
Provider Category:
Agency
Provider Type:
Group Practice/Vendor
Provider Qualifications
License (specify):
Group practice/vendor staff must hold current NM licensure and training in their respective
discipline as follows:
Acupuncture and Oriental Medicine license
Biofeedback – license in a health care profession whose scope of practice includes biofeedback, and
appropriate specialized training and clinical experience and supervision.
Chiropractic Physician license
Cognitive rehabilitation therapy – license in a health care profession whose scope of practice
includes cognitive rehabilitation therapy, and appropriate specialized training and clinical
experience and supervision.
Hippotherapy – license in a health care profession whose scope of practice includes hippotherapy,
and appropriate specialized training and experience.
Massage Therapist license
Naprapathic Physician license
Play therapy – license in a mental health profession whose scope of practice includes play therapy,
a master’s degree or higher mental health degree, and specialized play therapy training and clinical
experience and supervision.
Certificate (specify):

Other Standard (specify):
Native American Healers – individuals who are recognized as traditional healers within their
communities

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years for all providers listed

Appendix C: Participant Services
C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request
through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional
service not specified in statute.
Service Title:
Transportation

HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:
Category 3:  Sub-Category 3:

Category 4:  Sub-Category 4:

Service Definition (Scope):
(As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.)
Transportation services are offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. Transportation services under the waiver are offered in accordance with the participant’s service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a), and does not replace them. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the State plan are to transport participants to medically necessary physical and behavioral health services. Payment for Mi Via transportation services is made to the participant’s individual transportation employee or to a public or private transportation service vendor; payment cannot be directed to the individual participant. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- [✓] Participant-directed as specified in Appendix E
- [ ] Provider managed

Specify whether the service may be provided by (check each that applies):

- [✓] Legally Responsible Person
- [✓] Relative
- [✓] Legal Guardian

Provider Specifications:

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Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Transportation Vendor
Provider Qualifications
License (specify):
Valid NM drivers license
Certificate (specify):
Other Standard (specify):
Provider agencies will have a current business license and tax identification number. Each agency will ensure drivers meet the following qualifications:
1. Be at least 18 years old;
2. Possess a valid New Mexico driver’s license;
3. Be free of physical or mental impairment that would adversely affect driving performance;
4. No DWI convictions or chargeable (at fault) accidents within the previous two years;
5. Have current CPR/First Aid certification;
6. Be trained on DHI Critical Incident Reporting Procedures; and
7. Have a current insurance policy and registration.

Each agency will ensure vehicles have a current basic First Aid kit in the vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and every 3 years

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual

Provider Type:
Driver

Provider Qualifications
License (specify):
Valid NM drivers license
Certificate (specify):

Other Standard (specify):
The driver must meet the following qualifications:
1. Be at least 18 years old;
2. Possess a valid New Mexico driver’s license;
3. Be free of physical or mental impairment that would adversely affect driving performance;
4. No DWI convictions or chargeable (at fault) accidents within the previous two years;
5. Have current CPR/First Aid certification;
6. Be trained on DHI Critical Incident Reporting Procedures; and
7. Have a current insurance policy and registration.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Agent (FMA)
Frequency of Verification:
Initially and annually
Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (select one):

- Not applicable - Case management is not furnished as a distinct activity to waiver participants.
- Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.
- As an administrative activity. Complete item C-1-c.

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- No. Criminal history and/or background investigations are not required.
- Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The Department of Health (DOH) Caregivers Criminal History Screening (CCHS) Act requires that persons whose employment or contractual service includes direct care or routine and unsupervised physical or financial access to any care recipient served by that provider, must consent to a nationwide and statewide criminal history screening to ensure to the highest degree possible the prevention of abuse, neglect, or financial exploitation of individuals receiving services. This requirement does not pertain to independent health care professionals, licensed or Medicaid-certified in good standing, who are not otherwise associated with the care provider as an administrator, operator, or employee, and who are involved in the treatment or management of the medical care of a care recipient such as attending or treating physicians or other health care professionals providing consultation or ancillary services.

The Financial Management Agent (FMA) Contractor is responsible for conducting criminal history screenings for all applicable persons, as described above, employed or contracted to provide services to Mi Via waiver participants. The FMA Contractor must ensure that the person has submitted to a request for a nationwide criminal history screening within 30 days of the person beginning employment.

This screening collects information concerning a person's arrests, indictments, or other formal criminal charges, and any dispositions arising therefrom, including convictions, dismissals, acquittals, sentencing, and correctional supervision. If the person’s nationwide criminal history record reflects a disqualifying conviction and results in a final determination of disqualification, then this person cannot be hired or continue to be employed.
ALTSD and DOH are responsible for monitoring the FMA Contractor’s compliance with this provision of the contract. The process for monitoring is outlined in Appendices A-5 and A-6.

The Caregivers Criminal History Screening Act is available for review and can be found in NMSA 1978, Sections 29-17-2 through 29-17-5. Regulations are found at 7.1.9 NMAC.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Based on legislation passed during the New Mexico 2005 Legislature, the Employee Abuse Registry Act went into effect on January 1, 2006. This rule, which implements the Act, requires listing employees with substantiated registry-referred abuse, neglect, or exploitation on the registry, following an opportunity for a hearing. This rule also requires that providers check with the registry and avoid employing an individual on the registry (NMAC 7.1.12).

The Department of Health has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined to have engaged in a substantiated registry-referred incident of abuse, neglect, or exploitation of a person receiving care or services from a provider.

The FMA Contractor is responsible for ensuring that screening has been completed on applicable providers of services to Mi Via participants. The registry screening applies to persons employed by or on contract with a provider, either directly or through a third-party arrangement to provide direct care. An “employee” does not include a NM licensed health care professional practicing within the scope of the professional’s license or a certified nurse aide practicing as a certified nurse aide.

The FMA Contractor, prior to enrolling a provider who a Mi Via participant is employing or contracting with, shall inquire of the registry whether the individual under consideration for direct or contractual employment is listed on the registry. The Mi Via participant may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect, or exploitation of a person receiving care or services from that individual. The FMA Contractor shall maintain documentation in the employee’s personnel or employment records that evidences the fact that the Contractor made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the Contractor, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

ALTSD and DOH are responsible for monitoring the FMA Contractor’s compliance with this provision of the contract. The process for monitoring is outlined in Appendices A-5 and A-6.

The Employee Abuse Registry Act is available for review and can be found in NMSA 1978, Sections 27-7A-1 through 27-7A-8. Regulations are found at 7.1.12 NMAC and 8.11.6. NMAC.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. Select one:
No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

<table>
<thead>
<tr>
<th>Facility Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Residential Care Facilities</td>
</tr>
</tbody>
</table>

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Requirements for assisted living facilities are specified by Department of Health/Division of Health Improvement (DOH/DHI)/Health Facility Licensing and Certification (HFL&C) Bureau as an Adult Residential Care Facility pursuant to 7.8.2 NMAC.

In addition to the Assisted Living Facility meeting all requirements set forth by the HFL&C Bureau as an Adult Residential Care Facility, Assisted Living Services must provide a homelike environment. The Assisted Living provider is responsible for providing a home-like environment that must include the following:

- A minimum of 100 square feet of floor space in each single bedroom. Closet and locker areas shall not be counted as part of the available floor space. Each resident room shall be provided with a bedside table or desk, a chair, a reading lamp, a mirror, and window shades, drapes, curtains, or blinds, in good repair and of flame retardant materials;
- A minimum of 80 square feet of floor space per recipient in a semi-private bedroom. Sharing a bedroom is the recipient’s choice only. Closet and locker area shall not be counted as part of the available floor space. Each resident room shall be provided with a bedside table or desk, a chair, a reading lamp, a mirror, and window shades, drapes, curtains, or blinds, in good repair and of flame retardant materials;
- Recipients must have access to a separate common living area, kitchen, and bathroom that are all accessible for persons with a disability;
- A kitchen that must be furnished with a sink, a refrigerator, at least a two burner stove top or 1.5 cubic foot microwave oven;
- A dining area that shall be provided for meals. Each dining area shall be designated and have furnishings to meet the individual needs of the residents;
- Each unit must be equipped with an emergency response system; and
- Common living areas must be smoke free.

Each facility licensed pursuant to these regulations must either provide safe transportation or assist the resident in using public transportation. These facilities are required to provide the appropriate level of care for residents utilizing available supportive services in the community to meet the needs of residents. If possible, individuals have easy access to resources and activities in the community of their choosing at times convenient to the individual. However, New Mexico is a frontier state and as such, Assisted Living facilities may not always have the means for providing easy access to resources and activities in the community.

The facility must protect and assure the resident’s right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member, or other visitor; and privacy in the resident's own room. The facility must also assure the resident's right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and assure the resident's right to receive visits from family, friends, lawyers, ombudsmen, and community organizations. Individuals living in adult residential care facilities have easy access to visitors and phone use at all times convenient to the individual.
Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:
Adult Residential Care Facilities

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant/Support Guide</td>
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<tr>
<td>Environmental Modifications</td>
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<tr>
<td>Community Direct Support</td>
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<tr>
<td>Customized Community Supports</td>
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<tr>
<td>Emergency Response Services</td>
<td></td>
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<tr>
<td>Customized In-Home Living Supports</td>
<td></td>
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<tr>
<td>Transportation</td>
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<tr>
<td>Personal Plan Facilitation</td>
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<tr>
<td>Specialized Therapies</td>
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<tr>
<td>Assisted Living</td>
<td>✅</td>
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<tr>
<td>Behavior Support Consultation</td>
<td></td>
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<tr>
<td>Related Goods</td>
<td></td>
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<tr>
<td>Employment Supports</td>
<td></td>
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<tr>
<td>Home Health Aide Services</td>
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<tr>
<td>Nutritional Counseling</td>
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<tr>
<td>Private Duty Nursing for Adults</td>
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<tr>
<td>Homemaker/Direct Support Services</td>
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<tr>
<td>Respite</td>
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<tr>
<td>Skilled Therapy for Adults</td>
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</tbody>
</table>

Facility Capacity Limit:

Two (2) unrelated individuals is the lower capacity limit. The upper limit is the capacity number the owner indicates on the license application that is accepted by the regulatory agency.

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (check each that applies):

<table>
<thead>
<tr>
<th>Scope of State Facility Standards</th>
<th>Topic Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td></td>
</tr>
<tr>
<td>Admission policies</td>
<td>✅</td>
</tr>
<tr>
<td>Physical environment</td>
<td>✅</td>
</tr>
<tr>
<td>Sanitation</td>
<td>✅</td>
</tr>
<tr>
<td>Safety</td>
<td>✅</td>
</tr>
<tr>
<td>Standard</td>
<td>Topic Addressed</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Staff : resident ratios</td>
<td>✓</td>
</tr>
<tr>
<td>Staff training and qualifications</td>
<td>✓</td>
</tr>
<tr>
<td>Staff supervision</td>
<td>✓</td>
</tr>
<tr>
<td>Resident rights</td>
<td>✓</td>
</tr>
<tr>
<td>Medication administration</td>
<td>✓</td>
</tr>
<tr>
<td>Use of restrictive interventions</td>
<td>✓</td>
</tr>
<tr>
<td>Incident reporting</td>
<td>✓</td>
</tr>
<tr>
<td>Provision of or arrangement for necessary health services</td>
<td>✓</td>
</tr>
</tbody>
</table>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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**Appendix C: Participant Services**

**C-2: General Service Specifications (3 of 3)**

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
- ☐ Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

Legally responsible individuals may be paid for waiver services under extraordinary circumstances in order to assure the health and welfare of the participant and avoid institutionalization, and provided that the State is eligible to receive federal financial participation. Extraordinary circumstances include the inability of the legally responsible individual to find other qualified, suitable caregivers when the legally responsible individual would otherwise be absent from the home and, thus, must stay at home to ensure the participant’s health and safety. Legally responsible individuals may not be paid for any services that he/she would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness.

Legally responsible individuals who may receive payment for the provision of services through Mi Via include biological or adoptive parents of recipients under eighteen (18) and spouses of adult participants. Legally responsible individuals may be paid to provide all Mi Via Waiver services, except for consultant/support guide; assisted living; customized community supports; and related goods.

The service must:
Meet the definition of a service or support, as outlined in Appendix C and as approved by CMS;

- Be necessary to avoid institutionalization;
- Be specified in the participant’s SSP and budget;
- Be provided by a parent or spouse who meets the provider qualifications and training standards specified in the waiver for that service;
- Be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and approved by the TPA Contractor;
- Not be services that the legally responsible individual would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness.

The legally responsible individual who is a service provider must be approved by the Department of Health (DOH) prior to submission of the SSP and budget to the TPA Contractor and must comply with the following:

- A parent, parents in combination, or a spouse may not provide more than forty (40) hours of services in a seven (7)-day period. For parents, forty (40) hours is the total amount of service regardless of the number of children who receive services under the waiver;
- Planned work schedules must be identified in the approved SSP and budget, and variations to the schedule must be reported to the participant’s consultant and noted and supplied to the FMA when billing;
- Time sheets and other required documentation must be maintained and submitted to the FMA for hours paid;
- Married individuals must be offered a choice of providers. If they choose a spouse as their service provider, it must be documented in the SSP.

New Mexico’s monitoring requirements include:

- The participant’s Consultant monitors implementation and management of the SSP and budget, as described in Appendix D-1.a. This includes the Consultant’s quality assurance activities, e.g., ensuring that all applicable procedures related to plan and budget development occur, including the procedures for payment of legally responsible individuals; monitoring implementation of the approved plan; communicating with the FMA to monitor appropriate use of the authorized budget, according to the SSP; supporting the participant in developing and implementing his/her individual quality assurance plan; and supporting the participant in revising the SSP and budget, as indicated, to meet the participant’s changing circumstances and needs.
- The Consultant is required to contact the individual participant at least on a monthly basis and meet face-to-face with the participant at a minimum on a quarterly basis;
- The FMA monitors, on a monthly basis, hours billed for services provided by the legally responsible family member and the total amounts billed for all goods and services during the month.
- If the Consultant and FMA have any concerns that the best interests of the participant are at risk or that the approved SSP and budget are not being followed, these concerns must be brought to the attention of the Consultant Agency, FMA and to the State for investigation and follow-up.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. Select one:

- The State does not make payment to relatives/legal guardians for furnishing waiver services.
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed
to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.

Relative/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Any type of relative or legal guardian, except legally responsible individuals (i.e., spouses and parents of minor children), may provide any waiver service, except consultant/support guide; assisted living; customized community supports; and related goods. Payment is made to participant’s relatives, legal guardian or attorney-in-fact for services when the relative/legal guardian is qualified to provide the service and clears a criminal background check. The services must be identified in the SSP, and the participant or his/her representative is responsible for verifying that services have been rendered by completing, signing and submitting documentation, including the timesheet, to the FMA. There are no specific limits on the amount of services furnished by a relative or legal guardian.

The consultant assists the participant in developing and implementing his/her SSP and budget, and is required to monitor the participant’s progress and the implementation of the SSP. If the consultant has any concerns that the best interests of the participant are at risk, these concerns must be brought to the attention of the Consultant Agency and to the State for investigation and follow-up.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

In their Service and Support Plan, participants will identify needed services and the appropriate providers from which to purchase those services. Mi Via participants may choose to hire any and all willing and qualified providers. Regional lists of providers are maintained and available to participants and consultants. Providers of goods and services that are not currently enrolled as Medicaid-participating providers and want to participate in Mi Via may request information from the FMA and are then enrolled by the FMA.

Information on becoming a provider is readily accessible on the ALTSD, DOH and HSD/MAD websites. Information on applications for becoming a consultant provider is also available on the FMA website.

All willing and qualified providers are eligible to serve Mi Via participants, but must be enrolled as a Medicaid provider. Provider eligibility requirements are specified in Appendix C-3 of the application. The ASO Contract specifies provider enrollment for consultant agencies and timelines and verifies provider qualifications. The FMA contract specifies provider enrollment procedures and timelines and verifies waiver provider qualifications for all other Mi Via providers.

All applicants will be reviewed at a regularly scheduled meeting with the tri-agencies (ALTSD, DOH, and HSD/MAD). The tri-agencies will approve a provider within four weeks of the application submission date. If approved by the tri-agencies, the provider enrollment unit at HSD/MAD will then provide final review of the consultant provider applications before providing a Medicaid number. HSD/MAD will enroll and provide Medicaid numbers within six weeks of their review for qualified applicants.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.
### a. Methods for Discovery: Qualified Providers

#### i. Sub-Assurances:

**a. Sub-Assurance:** The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

The percentage of enrolled licensed/certified providers who are in compliance with all survey/visit, licensure/certification, and training requirements.

**Numerator:** Number of compliant enrolled licensed/certified providers.

**Denominator:** Total number of enrolled licensed/certified providers.

**Data Source (Select one):**

- Other

If 'Other' is selected, specify:

**Record reviews submitted by the Consultant Agency contractor (ASO):**

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ State Medicaid Agency</td>
<td>☐ Weekly</td>
<td>☐ 100% Review</td>
</tr>
<tr>
<td>✔ Operating Agency</td>
<td>☐ Monthly</td>
<td>✔ Less than 100% Review</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
<td>☐ Quarterly</td>
<td>✔ Representative Sample</td>
</tr>
<tr>
<td>✔ Other Specify: DOH/DDSD ASO Contractor</td>
<td>☑ Annually</td>
<td>☐ Stratified Describe Group:</td>
</tr>
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<td></td>
<td>☐ Continuously and Ongoing</td>
<td>☐ Other Specify:</td>
</tr>
<tr>
<td>Responsible Party for data collection/generation (check each that applies):</td>
<td>Frequency of data collection/generation (check each that applies):</td>
<td>Sampling Approach (check each that applies):</td>
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<td>✓ State Medicaid Agency</td>
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<tr>
<td>✓ Operating Agency</td>
<td>✓ Monthly</td>
<td>✓ Less than 100% Review</td>
</tr>
<tr>
<td></td>
<td>✓ Quarterly</td>
<td>✓ Representative Sample</td>
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<td></td>
<td></td>
<td>Confidence Interval = +/- 5% margin of error and a 95% confidence level</td>
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<tr>
<td>✓ Other</td>
<td>✓ Annually</td>
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<tr>
<td>Specify: DOH/DDSD FMA Contractor</td>
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<td>Specify: Semi-annually in years 1 and 2; annually in years 3, 4, and 5. Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.</td>
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Performance Measure:
The percentage of enrolled licensed/certified providers who are qualified to provide services prior to delivering services. Numerator: Number of qualified enrolled providers. Denominator: Total number of enrolled providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.
### Performance Measure:
The percentage of enrolled non-licensed/non-certified providers who are in compliance with all state requirements. Numerator: Number of compliant enrolled non-licensed/non-certified providers. Denominator: Total number of enrolled non-licensed/non-certified providers.

### Data Source (Select one):
Other  
If 'Other' is selected, specify:  

#### Record reviews submitted by the Consultant Agency (ASO)

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Confidence Interval = +/- 5% margin of error and a 95% confidence level |
| ☑ Other  
Specify: DOH/DDSD ASO Contractor | ☑ Annually | ☐ Stratified  
Describe Group: |
| ☐ Continuously and Ongoing | | ☐ Other  
Specify: |
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#### Data Source (Select one):
Other  
If 'Other' is selected, specify:  
Provider reports compiled by the Financial Management Agency (FMA) contractor.
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c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of employee-providers who are in compliance with training requirements as specified in the Mi Via Waiver and Service Standards.
Numerator: Number of compliant employee-providers. Denominator: Total number of employee-providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:

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<td>Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.</td>
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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Formal quality improvement processes are in place, as described in detail in the TriAQ description and structure in Appendix H.

b. Methods for Remediation/Fixing Individual Problems
i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement are identified by the State related to qualified providers, processes are in place to ensure that appropriate and timely action is taken. In addition, the TriAQ routinely collects, aggregates, analyzes, and trends provider qualification data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

Methods for fixing identified problems include verbal direction, letters of direction, formal corrective action plans; documentation is kept on all actions taken. In some instances, policy and/or regulatory changes are required. In all cases, if ALTSD or DOH identifies at any time any issues that are inconsistent with Medicaid requirements related to provider qualifications, HSD/MAD ensures that the problem is corrected and that compliance with the Assurance is met.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)
c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

omaly No
omaly Yes
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (select one).

omaly Not applicable- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

omaly Applicable - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (check each that applies)
Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

The State gives the participant an individual budgetary amount, the methodology for which is described in Appendix E.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Participant Service and Support Plan (SSP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (select each that applies):

- Registered nurse, licensed to practice in the State
- Licensed practical or vocational nurse, acting within the scope of practice under State law
- Licensed physician (M.D. or D.O)
- Case Manager (qualifications specified in Appendix C-1/C-3)
- Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker.

Specify qualifications:

Other

Specify the individuals and their qualifications:

Consultant – Bachelors Degree and at least one year’s experience in working with people with disabilities.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Select one:
Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify:

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**Appendix D: Participant-Centered Planning and Service Delivery**

**D-1: Service Plan Development (3 of 8)**

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Consultant provides support to the participant prior to the Service and Support Plan (SSP) meeting and assists him/her with SSP planning through three (3) distinct activities: orientation to Mi Via, including information about available services (enrollment meeting); the opportunity to choose personal plan facilitation (PPF); and the completion of the Participant/Employer Self Assessment Tool by the participant.

**New Allocations and Transfers:**

During the enrollment meeting, the Consultant informs the participant of the services available in Mi Via as part of an orientation to the Mi Via Program and reviews the service definitions and the scope of services. The Consultant also informs the participant of the option to receive the PPF service. The Consultant/Support Guide is available to assist the participant with contacting a Personal Plan Facilitator who is chosen by the participant. Additionally, at the enrollment meeting, the Consultant explains the Participant/Employer Self Assessment and its importance in assisting the participant with SSP development. The Consultant ensures the participant receives copies of the Participant/Employer Self Assessment, Participant Guidebook, and the local resource manual. The Consultant informs the participant that anyone in his/her circle of support may be invited to the SSP development meeting. The participant is also given additional program information literature such as: policies and procedures of the Consultant Agency, rights and responsibilities, incident reporting guidelines and training, Fair Hearing rights, and other documents.

**Current Participants:**

The Consultant supports the participant with pre-planning activities for the next SSP development during the third quarter of the current plan. During the face-to-face quarterly meeting, the Consultant re-informs the participant about the services available in Mi Via. The Consultant also informs the participant about the option to receive the PPF services. The Consultant reviews the current Participant/Employer Assessment with the participant. The participant receives a new copy of the Participant/Employer Self Assessment to complete prior to the SSP meeting. The Consultant also provides copies of the Participant/Employer Self Assessment, Participant Guidebook and any updated local resource manuals at the third quarterly visit with the participant. The Consultant/Support Guide are available to assist the participant in contacting chosen Personal Plan Facilitators. The Consultant informs the participant that anyone in his/her circle of support may be invited to the SSP development meeting.

A Personal Plan Facilitator is an additional support that the participant may purchase to assist in the planning and development of the SSP. The Personal Plan Facilitator utilizes personal planning tools to assist the participant in life planning. The Personal Plan Facilitator provides the completed report/tool to the participant prior to the SSP meeting in compliance with the Mi Via Waiver Service Standards. The participant may also request the presence of his/her Personal Plan Facilitator at the SSP meeting.

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**Appendix D: Participant-Centered Planning and Service Delivery**

**D-1: Service Plan Development (4 of 8)**

d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including
securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant’s needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

For development of the participant-centered service plan, the planning meetings are scheduled at times and locations convenient to the participant. The State obtains information about participant strengths, capacities, preferences, desired outcomes and risk factors in a number of the following ways: through the Level of Care (LOC) assessment; through the participant's completion of his/her Participant/Employer Self-Assessment tool; and through the person-centered planning process that is undertaken between the consultant and participant to develop the participant’s Service and Support Plan (SSP). If the participant chooses to purchase personal plan facilitation services, that assessment information would also be used in developing the SSP.

Assessments

Assessment activities that occur prior to the SSP meeting assist in the development of an accurate and functional plan. The functional assessments conducted during the LOC determination process address the following needs of a person: medical, adaptive behavior skills, nutritional, functional, community/social and employment. Assessments occur on an annual basis or during significant changes in circumstance. After the assessments are completed, the results are made available to the participant and his/her Consultant by the Third-Party Assessor (TPA) for use in planning. The participant and the consultant will assure that the SSP addresses the information and/or concerns identified through the assessment process.

Participant/Employer Self Assessments are completed prior to SSP meetings (Participant/Employer Self Assessments may be revised during the year to address any life changes). Specifically, this tool addresses the following: activities of daily living assistance needs; health care needs; employee training on assistance with individual specific needs; environmental modifications; equipment needs; relationships in the home and community; personal safety and employer responsibilities. The SSP must address areas of need, as recognized in the Participant/Employer Self Assessment.

Pre-Planning

The Consultant contacts the participant upon his/her choosing Mi Via to provide information regarding Mi Via including: the range and scope of choices and options, rights, risks, and responsibilities associated with self-direction. The Consultant provides the participant with the Mi Via Participant Guidebook which is the preparation to developing the SSP. The Guidebook includes exercises on how to interview and hire employees, what kinds of services and supports the participant needs, and other information that prepares the participant to develop his/her budget. The Consultant assists with the Participant/Employer Self Assessment and discusses areas of need to address on the participant’s SSP. The Consultant provides support during the annual redetermination process to assist with completing medical and financial eligibility in a timely manner.

Personal Plan Facilitators are optional supports. To assist in pre-planning, the participant is also able to access an approved provider to develop a personal plan. During the SSP meeting, the participant who opts to work with a Personal Plan Facilitator utilizes during the SSP meeting the written report or other documentation of the outcomes of the planning process. The participant may choose to invite the Personal Plan Facilitator to attend and participate in the SSP meeting.

Services and Support Plan Meeting

The participant receives a Mi Via Guidebook, Participant/Employer Self Assessment, LOC assessment and local resource manual prior to the SSP meeting. Prior to the SSP meeting, the participant may begin planning and drafting the SSP utilizing those tools alone or with his/her circle of support.

During the SSP meeting, the Consultant assists the participant in ensuring that the SSP addresses the participant's goals, health, safety and risks. The participant and the Consultant will assure that the SSP addresses the information and/or concerns identified through the assessment process. The Consultant assists the participant in planning and documenting how the concerns will be addressed through natural or paid supports. The completed personal planning tool/report and the local resource manual may be referenced to assist with SSP development.

The Consultant ensures for each participant that:
• The planning process addresses the participant's needs and personal goals in at least the following areas: supports needed at home; community membership (including employment); and health and wellness;
• Services selected address the participant's needs as identified during the assessment process. Needs not addressed in the SSP will be addressed outside the Mi Via Program;
• The outcome of the assessment process for assuring health and safety are considered in the plan;
• Services do not duplicate or supplant those available to the participant through the Medicaid State Plan or other public programs;
• Services are not duplicated in more than one service code;
• Job descriptions are complete for each provider and employee in the plan. Job descriptions will include frequency, intensity and expected outcomes for the service;
• The Quality Assurance section of the SSP is complete and specifies the roles of the participant, Consultant and any other listed in this section;
• The responsibilities are assigned for implementing the plan;
• The Back-up plans are complete; and
• The SSP is submitted to the Third-Party Assessor (TPA) after the SSP meeting, in compliance with Mi Via Waiver Service Standards.

The SSP is updated if personal goals, needs and/or life circumstances change that may or may not result in a change of the LOC. Revisions may be requested by the participant. The Consultant may also confer with the participant to initiate revisions. The participant is contacted by the Consultant to schedule the SSP meeting in compliance with the Mi Via Waiver Service Standards. Consultants submit all SSPs.

Monitoring
The Consultant is responsible for assisting the participant in directing the SSP pre-planning and development process. The detailed job descriptions and accompanying quality plans allow the Consultant and participant to monitor paid services in Mi Via with more ease. SSPs are monitored on a monthly basis via phone by the Consultant and quarterly in person.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Mi Via philosophy of self-direction reflects a strong commitment throughout the planning process to being sensitive to the person’s preferences, including responsibilities and measures for reducing risks. However, the State must assure the participant’s safety, and the consultant is required to work with the participant in developing a plan that addresses risks that have been identified during the participant’s LOC assessment, the Participant/Employer Self-Assessment, and the SSP development process.

The LOC packet (Long-Term Care Assessment Abtract [LTCAA], other assessments such as the Adaptive Behavior Scale [ABS] and Client Individual Assessment [CIA]) addresses the following needs of a person: medical, adaptive behavior skills, nutritional, functional, community/social, and employment. Copies of the assessment and recommendations are provided to the participant and Consultant by the Third-Party Assessor (TPA). Assessments will occur on an annual basis. Assessments may occur earlier if there is a significant change in life circumstances or the LOC.

The Participant/Employer Self Assessment aids the participant in being pro-active in identifying potential risk areas to be addressed in the SSP and considered in developing the back-up plan. The back-up plan is incorporated into the SSP. The Participant/Employer Self-Assessment tool is completed by the participant, in collaboration with the consultant, and the consultant uses the participant's responses to the tool in assisting the participant during development of the participant's SSP and back-up plan.

Back-up plans are required for all natural or paid supports that address critical areas of concern outlined in the LOC assessment/recommendation(s). All other paid services are required to have a back-up plan. The Participant/Employer Self-Assessment tool is completed by the participant, in collaboration with the Consultant, and the Consultant uses the participant's responses to the tool in assisting the participant during development of the participant's SSP and back-up plan. The back-up plan is incorporated into the SSP. Consultants monitor the use and
effectiveness of back-up plans during monthly contacts and quarterly visits to mitigate any future health and safety risks. Specifically this tool addresses the following: employee training on individual specific needs, environmental modifications, equipment needs, relationships in the home and community, personal safety, and employer responsibilities.

An expedited SSP review process addresses risks identified in the Participant/Employer Self Assessment. Consultants can request an expedited process to address concerns for new enrollees or emergent concerns for current participants. This process is in accordance with the Mi Via Waiver Service Standards.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the enrollment meeting, the participant is informed about every type of service offered in the Mi Via program. The participant has access to a list of State approved Medicaid consultant agency providers for Mi Via. Every Consultant Agency is required to maintain a resource listing. Each Consultant Agency can obtain provider information from the FMA and incorporate new local providers into the agency provider listing ongoing. The provider list is shared with participants during initial SSP development, SSP revisions and at any other time as requested by the participant. The resource list is required to be updated on a periodic basis. Resource lists are reviewed as part of the Quality Assurance review of each Consultant Agency to ensure that information is current. As for other providers and vendors, The Consultant assists the participant, as requested, in identifying qualified providers and vendors, including making available a list of providers and vendors in his/her area that are enrolled with the Medicaid agency through the FMA, as well as information about other provider options. The self-directed philosophy in Mi Via encourages participants to identify their own providers. The provider list is shared with participants during initial SSP development, SSP revisions and at any other time as requested by the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Consultants submit SSPs and budgets to the TPA Contractor for approval. (See Appendix H for oversight activities.)

On behalf of HSD/MAD, the TPA Contractor approves each participant’s SSP annually or more often if there is a change in the participant’s needs or circumstances. The TPA Contractor is required to monitor reviewers’ approval accuracy and compliance with criteria during its monthly quality assurance activities and report findings to HSD/MAD quarterly. HSD/MAD reviews the TPA Contractor’s approvals during the annual contract compliance review. If HSD/MAD identifies any issues that are inconsistent with Medicaid requirements at any time, HSD/MAD ensures that the TPA Contractor corrects the problem. The Quality Assurance (QA) Bureau of the Medicaid Assistance Division (MAD) conducts an annual systematic random sample audit for monitoring purposes. The MAD/QA Bureau uses a random sampling of at least 10% of the population served.

Internal auditors use a Stratified Random Sample methodology defined as:
Determining the size of the smallest subgroup in the population (claims or providers); and
Calculating the number required to achieve the desired error level and level of confidence for this subgroup using internet and/or EFADS software.

A larger group means a smaller percentage is required to get the same level of accuracy. Therefore, the 10% random sample pertains to 10% of a particular service or a particular provider type and is specific to this population or service. 10% represents a nationally accepted random sample size methodology and allows for a 95% confidence level. Therefore, based on this population, we anticipate using a 10% random sample size when monitoring, auditing and/or reviewing this waiver population.
Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (check each that applies):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Consultant Agency

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Implementation
The Consultant assists the participant with implementing his/her SSP and budget. As part of the Consultant’s services, if the participant needs more focused support to implement the SSP, the services of a Support Guide are available.

Monitoring
Mi Via supports the participant in monitoring the services provided in accordance with his/her SSP. The SSP includes a quality assurance section that is developed by the participant to evaluate if services are addressing his/her needs and preferences.

The Consultant monitors the progress of the SSP to ensure that it is implemented as approved by the TPA Contractor. The Consultant supervises the Support Guide. The consultant agency trains the Support Guide on the policies and procedures of the consultant agency, reporting changes in participant status, reporting critical incidents and abuse, neglect, and exploitation. As part of the Consultant’s services, if the participant is receiving Support Guide services, the Consultant works closely with and monitors the activities of the Support Guide.

The Consultant monitors the progress of the plan at least every month by contacting the participant. During the monthly contact, the Consultant:

- Reviews the participant’s access to services and whether they were furnished, per the approved plan
- Reviews the participant’s exercise of free choice of provider
- Reviews whether services received are meeting the participant’s needs
- Reviews whether the participant is receiving access to non-waiver services identified in the approved plan
- Reviews activities conducted by the Support Guide
• Follow-up on complaints against service providers
• Documents changes in status
• Monitors the use and effectiveness of the back-up plan
• Documents and follows-up (if needed) if challenging events occurred
• Determines if abuse, neglect or exploitation occurred; if not reported, takes remedial action to ensure correct reporting
• Documents progress of time-sensitive activities outlined in the SSP including employee trainings and eligibility activities
• Determines if health and safety issues are being addressed appropriately
• Discusses budget utilization concerns

At least quarterly, during face-to-face visits, the Consultant ensures purchased goods are present and operational. The Consultant also reviews the quality assurance section of the SSP with the participant. The Consultant completes a quarterly review that addresses health and safety, employee issues, navigation of Mi Via services, eligibility process, complaints, and SSP implementation issues. As indicated, the consultant takes prompt remedial action on all identified problems. Methods for remedial action range from working directly with the participant to resolve the problems that are identified, and, if indicated, reporting the problems to the Consultant Agency leadership, the Administrative Services Organization contractor, and the State for follow-up and remedial action. Monitoring results are documented in the participant’s record and reported to State program managers, as part of the Quality Improvement Strategy. Data collected from reports and on-site record reviews are aggregated and analyzed by the State, and remedial action is taken, as outlined in the Appendix D Quality Improvement: Service Plan.

b. Monitoring Safeguards. Select one:

○ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

○ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:

Appendix D: Participant-Centered Planning and Service Delivery
Quality Improvement: Service Plan

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances
   i. Sub-Assurances:

   a. Sub-assurance: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

   Performance Measures

   For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

   For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

   Performance Measure:
   Percentage of service plans (new and annual recertifications) that adequately address needs identified through participants’ self-assessment and LOC.
assessments. Numerator: Number of service plans determined to adequately address needs identified through participants' self-assessment and LOC assessment. Denominator: Total number of service plans developed.

Data Source (Select one):
- Other
  If 'Other' is selected, specify:
  Third Party Assessor (TPA) reports; participant Service and Support Plans (SSPs)

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  Specify: TPA Contractor (100% review) Consultant Agency (CA) |
  Continuous and Ongoing |
| ✔ Other | ✔ Other |
  Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise. |

Data Aggregation and Analysis:
b. **Sub-assurance:** The State monitors service plan development in accordance with its policies and procedures.

**Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**
Percentage of new service plans that meet Mi Via Waiver Service Standards service plan policies. Numerator: Number of new service plans meeting Mi Via Waiver Service Standards service plan policies. Denominator: Total number of new service plans developed.

**Data Source (Select one):**
Other
If ‘Other’ is selected, specify:
Third Party Assessor (TFA) reports; participant Service and Support Plans (SSPs)

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c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measures

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For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of service plans that have been reviewed/updated for Mi Via participants with continuous enrollment of 12 months and/or a change in status. Numerator: Number of service plans reviewed/updated for participants with continuous enrollment of 12 months and/or a change in status. Denominator: Total number of participants with continuous enrollment of 12 months and/or a change in status.

Data Source (Select one):
- Other
  - If 'Other' is selected, specify:
    - Third Party Assessor (TPA) reports; participant Service and Support Plans (SSPs)

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d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.
For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of Mi Via participants receiving services consistent with their service plan of record, as measured by type, scope, amount, duration, and frequency of service. Numerator: Number of Mi Via participants receiving services consistent with their service plan of record. Denominator: Total number of Mi Via participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Service and Support Plans (SSPs)

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Page 124 of 190
Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Participant Satisfaction Surveys

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  TriAQ
- Quarterly
- Annually
- Continuously and Ongoing

Frequency of data aggregation and analysis (check each that applies):

- Quarterly
- Annually
- Continuously and Ongoing

Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of new waiver participants who sign the Primary Freedom of Choice (PFOC) documents. Numerator: Number of new waiver participants who signed the Primary Freedom of Choice (PFOC) documents. Denominator: Total number of new waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reviews of PFOC documents; participant Service and Support Plans (SSPs); Fiscal Management Agent (FMA) records.

Responsible Party for data collection/generation (check each that applies):
- State Medicaid Agency
- Operating Agency
- Sub-State Entity

Frequency of data collection/generation (check each that applies):
- Weekly
- Monthly
- Quarterly

Sampling Approach (check each that applies):
- 100% Review
- Less than 100% Review
- Representative Sample
Confidence Interval =

Stratified
Describe Group:

Continuously and Ongoing

Other
Specify:
A systematic random sample audit of participant SSPs and FMA records conducted by HSD/MAD and DOH/DDSD for monitoring purposes.

Other
Specify:
Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.

Data Aggregation and Analysis:

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### Performance Measure:


### Data Source (Select one):

Other

If 'Other' is selected, specify:

Reviews of PFOC documents; participant Service and Support Plans (SSPs); Fiscal Management Agent (FMA) records.

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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. Formal quality improvement processes are in place, as described in detail in the TriAQ description and structure in Appendix H.

b. Methods for Remediation/Fixing Individual Problems
   i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement are identified by the State related to service plans, processes are in place to ensure that appropriate and timely action is taken. In addition, the TriAQ routinely collects, aggregates, analyzes, and trends service plan data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

Methods for fixing identified problems include verbal direction, letters of direction, formal corrective action plans; documentation is kept on all actions taken. In some instances, policy and/or regulatory changes are required. In all cases, if ALTSD or DOH identifies at any time any issues that are inconsistent with Medicaid
requirements related to service plans, HSD/MAD ensures that the problem is corrected and that compliance with the assurance is met.

**ii. Remediation Data Aggregation**

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ State Medicaid Agency</td>
<td>☑ Weekly</td>
</tr>
<tr>
<td>☑ Operating Agency</td>
<td>☑ Monthly</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
<td>☑ Quarterly</td>
</tr>
<tr>
<td>☑ Other Specify: DOH/DDSD TriAQ</td>
<td>☑ Annually</td>
</tr>
<tr>
<td>☐ Continuously and Ongoing</td>
<td></td>
</tr>
<tr>
<td>☑ Other Specify:</td>
<td>Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.</td>
</tr>
</tbody>
</table>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ☑ No
- ☐ Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

---

**Appendix E: Participant Direction of Services**

**Applicability** (from Application Section 3, Components of the Waiver Request):

- ☑ Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
- ☐ No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

**Indicate whether Independence Plus designation is requested (select one):**

- ☑ Yes. The State requests that this waiver be considered for Independence Plus designation.
- ☐ No. Independence Plus designation is not requested.
Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver’s approach to participant direction.

Mi Via recognizes the essential direct role of participants in planning and purchasing of services and supports. To assume this leadership role and be successful in self-direction, the participant must have the requisite on-going education, training, information, tools, and support related to Mi Via, which includes but is not limited to information about: basic core values and philosophy of self-direction; Mi Via guiding principles and processes; rights, risks, and responsibilities; independent living; disability rights; range of services and supports; finding, training and managing providers; complaint process and incident reporting; individual budgeting and paying for services and supports; working with the consultant and financial management agent (FMA); and quality monitoring.

The participant develops his/her individualized service and support plan (SSP), within the State-assigned budgetary allotment, and directs all services and supports identified in his/her plan. These services and supports must address the participant’s qualifying condition or disability and assist the individual to live at home, go to school, work, and integrate into the community as independently as possible. The breadth of services and supports should reflect all aspects of a participant’s life, including but not limited to home, community, school, work, and productive activity. Using the person-centered approach, the SSP revolves around the individual participant and reflects his or her chosen lifestyle and culture. Planning should occur where, when and with whom the participant chooses. The participant directs development of the Plan, which serves as the foundation for participation in Mi Via.

The Consultant and the FMA support the participant in self-direction. As is discussed in Appendix D, consultants, who have strong interpersonal skills, know how to communicate with people who may have limited language skills and know how to generate trust, assist participants in understanding Mi Via and developing their person-centered plans. The participant identifies the individuals he/she wants to be involved in the development of his/her plan, and the Consultant helps the participant explore options and make informed choices, based on his/her individual needs. The Consultant also helps the participant to negotiate with family members, providers, and others and build consensus.

The Consultant is trained in and must demonstrate understanding of all aspects of the Mi Via program, such as the guiding principles for self-direction, role of the participant in the person-centered planning process, available service and support options, locating and securing services and supports, and development and management of the individual budget. The Consultant must have knowledge about community resources and how to seek out resources. The Support Guide is also available as an aspect of consultant services for an individual who may need more frequent and intensive hands-on support to direct and implement his/her SSP.

The FMA is independent of the entities/persons delivering services or supports to avoid conflicts of interest. The FMA is trained in and must demonstrate understanding of all aspects of Mi Via as it relates to the planning process and development and managing the individual budget. Based on the participant’s individual Service and Support Plan and budget, the FMA sets up an individual account, makes expenditures that follow the authorized budget, handles all payroll functions on behalf of the participant who hires service providers and other support personnel, provides the participant with a monthly report of expenditures and budget status, answers inquiries, solves related problems, and provides the State with quarterly documentation of expenditures.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.

Select one:

○ Participant: Employer Authority. As specified in Appendix E-2, Item a, the participant (or the participant’s representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
Participant: Budget Authority. As specified in Appendix E-2, Item b, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in Appendix E-2. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. Check each that applies:

☑ Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☑ Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☑ The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Assisted Living

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (select one):

☑ Waiver is designed to support only individuals who want to direct their services.
☑ The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
☑ The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria:

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Prior to enrolling in Mi Via, the participant (or the participant’s representative) must have ready access to on-going education, training, information, tools, and support related to all aspects of Mi Via so that the participant, or participant’s representative, can make informed decisions regarding self-direction. A multifaceted approach is utilized to communicate Mi Via information, such as easy-to-understand written materials that address cultural diversity, video presentations, website information, alternative formats, and community education forums for participants, families, providers, and other interested parties. Materials and activities are developed in collaboration with and through contribution from participants, advocates, and families so that information is as clear as possible.

Learning objectives are focused on what the participant needs to learn in order to be successful, such as what Mi Via is, e.g., its goals, basic core values, guiding principles, who is eligible to participate, what self-direction and self-
determination mean, and what services, supports, and goods are covered; as well as planning and budgeting; service and support plan and budget implementation; health; safety; and quality assurance. The training includes multiple topics to support the learning objectives.

ALTSD and DOH work together in regard to on-going education, training, and information-sharing. State staff as well as advocacy organization and peer trainers in local communities conduct initial and on-going training as well as information-sharing programs. The State also uses State websites and existing information-sharing and training networks, as appropriate, to disseminate information.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative (select one):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (check each that applies):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

<table>
<thead>
<tr>
<th>Participant-Directed waiver Service</th>
<th>Employer Authority</th>
<th>Budget Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Modifications</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Community Direct Support</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Customized Community Supports</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Emergency Response Services</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Customized In-Home Living Supports</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Personal Plan Facilitation</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Specialized Therapies</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Behavior Support Consultation</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Related Goods</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Employment Supports</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Home Health Aide Services</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. Select one:

- Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. Check each that applies:

- Governmental entities
- Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. Select one:

- FMS are covered as the waiver service specified in Appendix C1/C3

  The waiver service entitled:

- FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

  The FMA is procured according to New Mexico Procurement Code, a contract is signed, and individual participants are supported at the local level.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

  Payment will be negotiated during the contracting process. The FMA Contractor will be compensated by monthly fee per participant, as negotiated with the FMA Contractor.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (check each that applies):

  Supports furnished when the participant is the employer of direct support workers:

  - Assists participant in verifying support worker citizenship status
iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and (c) how frequently performance is assessed.

The Tri-Agencies (ALTSD, DOH, and HSD) hold the FMA contract. All agencies, primarily HSD/MAD, are parties to this contract. HSD, DOH and ALTSD conduct quarterly audits of the FMA to ensure compliance with the FMA's contract with the State. The audit monitors that: all services paid on behalf of the participant are included in the participant's approved SSP and budget; all services paid on behalf of the participant are accurately processed by the FMA; and all claims are submitted to the MMIS appropriately. The State implements corrective actions against the FMA as necessary.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (check each that applies):
Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Waiver Service Coverage. Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

<table>
<thead>
<tr>
<th>Participant-Directed Waiver Service Coverage</th>
<th>Information and Assistance Provided through this Waiver Service Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant/Support Guide</td>
<td>☑</td>
</tr>
<tr>
<td>Environmental Modifications</td>
<td></td>
</tr>
<tr>
<td>Community Direct Support</td>
<td></td>
</tr>
<tr>
<td>Customized Community Supports</td>
<td></td>
</tr>
<tr>
<td>Emergency Response Services</td>
<td></td>
</tr>
<tr>
<td>Customized In-Home Living Supports</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
</tr>
<tr>
<td>Personal Plan Facilitation</td>
<td>☑</td>
</tr>
<tr>
<td>Specialized Therapies</td>
<td></td>
</tr>
<tr>
<td>Assisted Living</td>
<td></td>
</tr>
<tr>
<td>Behavior Support Consultation</td>
<td></td>
</tr>
<tr>
<td>Related Goods</td>
<td></td>
</tr>
<tr>
<td>Employment Supports</td>
<td></td>
</tr>
<tr>
<td>Home Health Aide Services</td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing for Adults</td>
<td></td>
</tr>
<tr>
<td>Homemaker/Direct Support Services</td>
<td></td>
</tr>
<tr>
<td>Respite</td>
<td></td>
</tr>
<tr>
<td>Skilled Therapy for Adults</td>
<td></td>
</tr>
</tbody>
</table>

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).
Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A Mi Via participant, who transitions from the DD or MF Waiver and decides to discontinue self-directing his/her services may transition to the traditional DD or MF Waivers. When the participant transitions to the traditional waiver program, he/she takes his/her funding with him/her. The participant is assisted with the transition process and accessing services by the Consultant in Mi Via and the Case Manager in the traditional waiver who coordinate Mi Via and traditional waiver services, plans and budgets to ensure that there is timely revision of the SSP, that there is no duplication of services and that there is no break in delivery of services needed.

A new Mi Via participant, who decides to discontinue self-directing his/her services, may transfer to the appropriate traditional waiver. When a participant transfers to the traditional waiver, he/she takes his/her funding with him/her. An individual that desires to transition out of Mi Via and into another waiver program will continue to receive the services and supports from the Mi Via Waiver until the day before the new waiver services start. This will ensure that no break in service occurs. The Consultant and the Service Coordinator in the new waiver will work closely with the participant and each other to ensure that the participant’s health and safety is maintained. The ASO will also monitor the transition process.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Criteria for Involuntary Termination from Self-Direction Waiver Services (Mi Via)

A participant may be terminated involuntarily and offered services through another waiver or through the Medicaid State Plan under the following circumstances:

1. The participant refuses to follow Mi Via program rules and regulations after repeated and focused technical assistance and support from the program staff, consultant, and/or FMA.

2. The participant is at immediate health and safety risk associated with self-direction, e.g., imminent risk of death or risk of irreversible or serious bodily injury related to participation in the waiver. Examples include but are not limited to:
   - The participant refuses to include and maintain services on his/her Service and Support Plan (SSP) and budget that would address health and safety challenges identified in his/her medical assessment and/or the challenges assessment after repeated and focused technical assistance and support from the program staff, Consultant, and/or FMA.
   - The participant is experiencing significant health or safety needs, and, after having been referred to the State/Contractor Team for level of risk determination and assistance, refuses to incorporate the Team’s recommendations, including resources referred to, into his/her SSP and budget (as applicable).
   - The participant puts others in danger.
3. The participant misuses Mi Via funds following repeated and focused technical assistance and support from the consultant and/or FMA.

4. The participant commits Medicaid fraud.

An individual that is involuntarily terminated from the Mi Via Waiver program will be offered a non self-directed waiver alternative. The participant will continue to receive the services and supports from the Mi Via Waiver until the day before the new waiver services starts. This will ensure that no break in service occurs. The Consultant and the Service Coordinator in the new waiver will work closely with the participant and each other to ensure that the participant’s health and safety is maintained. The ASO will also monitor the transition process. The Fair Hearing notice and process apply.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Employer Authority Only</th>
<th>Budget Authority Only or Budget Authority in Combination with Employer Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Participants</td>
<td>Number of Participants</td>
</tr>
<tr>
<td>Year 1</td>
<td></td>
<td>225</td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
<td>300</td>
</tr>
<tr>
<td>Year 3</td>
<td></td>
<td>400</td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
<td>500</td>
</tr>
<tr>
<td>Year 5</td>
<td></td>
<td>600</td>
</tr>
</tbody>
</table>

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority. Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. Select one or both:

[ ] Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

[ ] Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. Select one or more decision making authorities that participants exercise:

- [x] Recruit staff
- [ ] Refer staff to agency for hiring (co-employer)
- [x] Select staff from worker registry
- [ ] Hire staff common law employer
- [ ] Verify staff qualifications
- [ ] Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

- [x] Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.
- [x] Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- [x] Determine staff wages and benefits subject to State limits
- [x] Schedule staff
- [x] Orient and instruct staff in duties
- [x] Supervise staff
- [x] Evaluate staff performance
- [x] Verify time worked by staff and approve time sheets
- [x] Discharge staff (common law employer)
- [ ] Discharge staff from providing services (co-employer)
- [ ] Other

Specify:

### Appendix E: Participant Direction of Services

#### E-2: Opportunities for Participant-Direction (2 of 6)

b. **Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Select one or more:

- [x] Reallocation funds among services included in the budget
- [x] Determine the amount paid for services within the State's established limits
- [x] Substitute service providers
- [ ] Schedule the provision of services
- [x] Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- [x] Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- [x] Identify service providers and refer for provider enrollment
- [x] Authorize payment for waiver goods and services
- [x] Review and approve provider invoices for services rendered
Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Participants in Mi Via have authority to expend waiver funds for services through an approved annual budgetary amount that is to be expended on a monthly basis. Each participant’s annual individual budget is based on the traditional Developmental Disabilities Waiver (DDW) Annual Resource Allocations (ARA) method. The DDW ARAs are determined by an analysis of expenditure and utilization data over a five-year period based on level of care and age of the individuals. The ARAs allow the individual to utilize a flexible combination of services that are identified in the traditional DDW Individual Service Plan (ISP) up to the maximum available amount.

Adult Budget Methodology
The adult (21 and over) Mi Via non-residential budgets are developed using the ARAs for non-residential services, deducting the cost for case management services and the State applied a 10 percent (10%) discount to the net remaining amount. The ten percent (10%) discount, which reflects administrative/overhead agency costs that are not provided by and included in the reimbursement to self-directed providers, is used to fund the fiscal management role under the self-directed waiver. The State performed this calculation for the remaining adult level of care ARAs. The State then calculated a weighted budget using the new amounts multiplied by the number of participants at the time of calculation in each corresponding level of care category to get a total cost divided by the total number of participants.

For adults that need to receive a Community Living service or enhanced supports similar to those residential options, the State then applied the same methodology to adult residential ARAs. The weighted residential ARA developed is added to the annual cost of the most flexible and community oriented Community Living Service in the traditional DDW, Family Living, to derive the Adult Enhanced Supports Budget allotment for Mi Via.

Children’s (0 – 20 years) Budget Methodology
The same methodology utilizing the DDW ARAs for children was applied. Generally, in New Mexico, children under 18 have residential options available through the Children, Youth and Families Department rather than through Waiver services. However, under the DDW, young adults ages 18-20 are eligible for Community Living Services. Should a young adult require residential or similar supports, a budgetary amount equal to Intensive Independent Living (IIL) under the DDW would be made available. The Intensive Independent Living rate was chosen as it provides assistance to an individual living at home or in his/her own home for 100 to 300 hours per month. This is equivalent to 8-10 hours per day and should provide sufficient support as these individuals are still receiving school services during the day.

The assigned budgets change as the person ages, at the time of the change or at recertification.

Medically Fragile
The State applies the same methodology to persons on the Medically Fragile Waiver (MFW) that transition to Mi Via, as they also would benefit from services available to other persons with developmental disabilities. The annual Mi Via budget for medically fragile children is calculated by removing case management and the ten percent (10%) discount (as with other Mi Via budget methodologies). The resulting budget, when included in the weighted calculations, is consistent with the weighted average of budgets for other children with developmental disabilities. For medically fragile individuals 21 years and over, the rates developed for
Adults with Developmental Disabilities will apply including the opportunity to access community living services or enhanced supports.

Availability to the Public
The budget methodology for Mi Via is made available to the public. The application is posted to the HSD/MAD and DDS/M website. The budget methodology is listed in the application. It is provided to the public upon request.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant's Consultant has information regarding the budget and informs the participant of his/her individual annual budgetary allotment as the budget is being developed. The participant is also made aware of the total proposed SSP and budget amount once the budget development process is complete. The amount of the annual budget cannot exceed the participant's individual annual budgetary allotment. The rare exception would be a participant whose assessed or documented needs, based on his/her qualifying condition, cannot be met within the annual budgetary allotment, in which case the participant would initiate a request for an adjustment through his/her consultant. The participant tracks budget usage over the course of the year through the monthly spending reports provided by the FMA.

The participant’s budget is sent by the Consultant to the Third-Party Assessor (TPA) for review. The TPA will either approve or deny the budget. The budget is then sent to the participant with a letter of approval or denial of services. If any action is taken resulting in a reduction, termination, modification, suspension or denial of services, the Participant is notified in writing by the TPA of that action and his/her right to request a fair hearing with the State Medicaid agency.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. Select one:

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority
v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMA and Consultant work with the participant to ensure that the budget is utilized according to the Service and Support Plan. When problems are identified, the Consultant and FMA work together with the participant to find solutions and make changes, as indicated. In addition, the FMA sets up an individual account, based on the participant’s approved individual Service and Support Plan and budget, makes expenditures that follow the authorized budget, provides the participant with a monthly report of expenditures and budget status, and provides the State with a quarterly documentation of expenditures. The FMA sends a budget Utilization Report to the Consultant Agency and the participant. This report includes each service category, total approved dollars in the budget, total spent to date, and unused dollars.

Receipt audits will occur on a monthly basis. The FMA will focus on three (3) areas with respect to audits:

1. The FMA will receive a monthly report that identifies: the date of the purchase, the merchant, and the amount of the purchase. The auditor will review this report for anything that looks unusual and request receipts.

2. The State believes there should be an emphasis on auditing purchases made at retail stores such as Wal-Mart and Walgreens to ensure that only authorized purchases were made.

3. The FMA will utilize a monthly purchase report to randomly select up to 10 percent of the purchases to audit. Participant information will be redacted to ensure there is no bias.

The State will have online access to the reports that are generated on a monthly basis. FMA will retain the reports for six (6) years. Reports on billing and spending patterns will not include actual items purchased but will document date of purchase, amount, and merchant. Safeguards will be in place to prevent the card from being used based on a specific type of merchant. For example, merchants classified as hotels, casinos, liquor stores, etc., would be excluded. Please keep in mind that today a check can be presented at Wal-Mart in the amount of $100 and there is no way to prevent the participant from buying unauthorized purchases with the check.

If it is determined that a participant is using the debit card incorrectly, the State will provide targeted training up to involuntary termination.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The participant is given information by the Consultant Agency (CA) during the initial training on Mi Via about his/her right and how to request a Fair Hearing, as set forth in the Medical Assistance Division (MAD) Regulations 8.352.2 NMAC Recipient Hearing Policies. When services, the budget, LOC, and other waiver decisions result in a reduction, termination, modification, suspension, or denial of services, the participant is notified in writing about the right to a Fair Hearing. Consultants are trained in this process and available to assist participants in understanding how to request a Fair Hearing.

Information on how to request a Fair Hearing is included in participant training and in the Participant Guidebook, and provided when any action is taken regarding services, the budget, LOC, and other waiver decisions that result in a reduction, termination, modification, suspension or denial. The State, the CA, the Third-Party Assessor (TPA), and the Financial Management Agent (FMA) can provide information on how to request the Fair Hearing.
Various agencies are responsible for notifying the waiver participant of his/her right to a Fair Hearing as defined by 8.352.2 NMAC. A participant may request a Fair Hearing when he/she believes that Medicaid has taken an action erroneously. The participant is informed by the TPA and the Human Services Department (HSD), in writing, of the opportunity to request a Fair Hearing when Medicaid services are terminated, modified, reduced, suspended or denied. The denial letter sent by the TPA explains the participant’s right to continue to receive services during the Hearing process and the time frame to request continued services. The agencies responsible for notification of Fair Hearings are responsible for maintaining documentation of the notification.

1. The TPA Contractor provides notice to the Department of Health (DOH), HSD, and the individual when an individual does not meet level of care criteria.
2. The TPA Contractor provides notice when services are denied.
3. The DOH/Developmental Disabilities Supports Division (DDSD) provides notice when DOH/DDSD determines that an individual does not meet the definition of developmental disabilities.
4. The HSD/Income Support Division (ISD) office provides notice when an individual does not meet financial and non-financial criteria.
5. The DOH/DDSD provides notice when an individual is not given a choice between home and community-based services as an alternative to institutional care.
6. The DOH/DDSD provides notice when an individual is not provided the opportunity to select the providers of his/her choice.

Notices of adverse actions and the opportunity to request a Fair Hearing are maintained at the HSD, DOH and TPA Contractor offices.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. Select one:

- No. This Appendix does not apply
- Yes. The State operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Individual Assistance and Advocacy (IAA) Unit within DOH/DDSD has an available statewide due process (Team Facilitation Process) for all recipients of services within the DDSD, which includes the Mi Via Medicaid Waiver. The Manager of the IAA Unit informs the participant that the Team Facilitation Process is not a prerequisite or substitute for a Fair Hearing when the participant is informed that the dispute has been accepted and a mediator has been assigned.

The Team Facilitation Process was established to allow all participants to have a voluntary means to present and address their concerns or issues in the presence of a neutral third party (trained mediator). Issues or conflicts that can be disputed apply to the participant’s Service and Support Plan (SSP) when the participant’s SSP is not being implemented appropriately. Conflict resolution consensus is developed with the participant and other relevant parties. This process is offered in addition to the Medicaid Fair Hearing process.

The process includes the following:
1. The requestor contacts the Manager of the IAA Unit either by telephone, in writing, by fax, or in person to request team facilitation.
2. The IAA Manager reviews and determines to accept or deny the request per criteria (has five work days to review).
3. If not accepted, a letter is sent to the requestor, stating the reason for denial, within ten (10) workdays.
4. If accepted, the case is assigned to a trained mediator who has thirty (30) days to complete the team facilitation.

The mediator:
  a. Speaks to the requestor and other pertinent parties;
b. Collects necessary documents;
c. Schedules a meeting;
d. Facilitates the meeting and has participants sign agreement to mediate;
e. Documents in writing, at the meeting, the resolution(s) on an agreement sheet that is signed by all participants; and
f. Hands out the agreement sheet(s) to all participants (agreements amend the service plans, and therefore, are binding).

The role of the mediator is to provide strategies to facilitate communication, act as a resource, and provide technical assistance to the team.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. Select one:

☐ No. This Appendix does not apply
☒ Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

DOH/DDSD, ALTSD/EDSD, and HSD/MAD are responsible for the operation of the grievance/complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or operating agency (if applicable).

Participants may register a complaint or grievance about any issue they are dissatisfied with as it relates to the Mi Via Waiver. Participants may register complaints with DOH/DDSD via email, mail, or by phone. The DOH/DDSD utilizes a standardized complaint form and has established a dedicated email address to register complaints. Participants can also register complaints with the ALTSD/EDSD, and HSD/MAD. When this occurs, the complaint is referred to DOH/DDSD. The participant is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing.

The complaint/grievance is required to be resolved within fourteen (14) days from the date the complaint/grievance was filed by the participant.

Upon receipt of the complaint/grievance, the complaint is entered into the complaint tracker by DOH/DDSD and the appropriate contractor/provider is emailed the nature of the complaint/grievance to begin the resolution process.

The participant is contacted within one (1) business day from the date the complaint/grievance is received by DOH/DDSD to acknowledge receipt of the complaint/grievance.

At day five (5) and ten (10) the DOH/DDSD follows up with the contractor/provider on progress being made to resolve the complaint/grievance. Based on the conversation, the DOH/DDSD enters all pertinent information into the complaint tracker.

On day fourteen (14) or prior to the fourteenth day, the contractor/provider is required to email the resolution to the DOH/DDSD. The date the email is sent to DOH/DDSD is the date the complaint/grievance is resolved. Once received, the DOH/DDSD enters the resolution into the complaint tracker and calls the participant to verify the resolution occurred. The conversation with the participant is documented into the complaint tracker.

Contractors/providers may request extensions to resolve issues at least three (3) days prior to the fourteen (14) day deadline. Extensions to resolve complaints must occur via email to DOH/DDSD. DOH/DDSD will grant or deny extensions within one business day. If approved by DOH/DDSD, extensions will be granted for an additional fourteen (14) days.
Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. Select one:

- Yes. The State operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)
- No. This Appendix does not apply (do not complete Items b through e)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DOH/Division of Health Improvement (DHI)/ Incident Management Bureau (IMB) receives, triages, and investigates all reports of alleged abuse, neglect, exploitation, and other reportable incidents for Mi Via Services provided by community-based waiver service agencies, and expected and unexpected deaths. The reporting of incidents is mandated pursuant to 7.1.13. NMAC. Per the regulation, any suspected abuse, neglect, or exploitation must be reported to the Children Youth and Families Department (CYFD)/Child Protective Services (CPS) for individuals under the age of 18 or to the Aging & Long-Term Services Department (ALTSD)/Adult Protective Services (APS) for individuals age 18 or older by reporting or faxing an incident report (IR). Additionally, the IR form must be faxed to DOH/DHI within 24-hours of knowledge of an incident or the following business day in the event of a weekend or holiday. Anyone may report an incident; however, the person with the most direct knowledge of the incident is the individual who is required to report the incident.

When an incident is reported late, and the Mi Via service is provided by a community-based waiver service agency, a letter is sent to the provider stating that an incident report was received beyond the required 24-hour timeline for reporting. The letter further reiterates the requirement to report incidents within 24 hours. The consequences of non-compliance may result in sanctions, as set forth in NMAC 7.1.13.12.

With respect to waiver services provided by any employee, contractor or vendor other than a community-based waiver service agency, any suspected abuse, neglect, or exploitation must be reported to the CYFD/CPS for individuals under the age of 18 or to the ALTSD/APS for individuals age 18 or older by reporting or faxing an incident report. Regulations are found in NMSA 1978, Sections 27-7-14 through 27-7-31 (Adult Protective Services Act) and in NMSA 1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect Act).

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Training and information on reporting critical incidents is provided several ways: training and information, including incident reporting forms and phone numbers, is provided to participants and/or family members or legal representatives at the initial enrollment meetings; during the annual plan renewal meetings; and in printed materials such as the Participant Guidebook. As noted in Appendix E-1e., the basic Mi Via training includes a section on self-protection, how to recognize abuse, neglect and exploitation, and where to go for help. Consultants and support guides are trained annually on incident reporting, abuse, neglect and exploitation. Consultants and support guides are resources to provide direction to participants, staff and circles of support. Consultants will ensure staff are trained on incident reporting, abuse, neglect and exploitation.

This information is reinforced by the consultants, who work with participants during the planning and monitoring...
process. DOH/DHI presents an abuse, neglect and exploitation workshop to identify the indications of abuse, neglect and exploitation as well as identify risk factors and risk reduction.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

With respect to services provided by community-based waiver service agencies, the DOH/DHI/IMB receives reports and investigates incidents of abuse, neglect and exploitation. The entire intake process must be completed by close of business the day following the date of receipt.

Upon receipt of the Incident Report, DOH intake staff:

I. Search for and print a history from the database of prior reported incidents (past 12 months) on the individual consumer

II. Verify or attain the funding source

III. Triage/Intake Investigation is the decision process utilized by Intake staff to determine priority, severity and assignment of the case. Intake staff will triage the case within one working day of receipt.

A. Reportable Incidents
A decision is made regarding whether the reported incident meets the definition of at least one of the eight categories of reportable incidents listed below. Categories include:
Abuse
Neglect
Misappropriation, e.g., exploitation
Unexpected death
Natural/expected death
Environmental hazard
Law enforcement intervention
Emergency services
If the incident meets the definition of what is reportable, the following steps are taken:

1. Review Consumer History
Identify possible trends

2. Determine Severity and Priority
Medical Triggers that receive priority: Aspiration, fractures, dehydration, and a history of multiple emergency room (ER) visits (in a short period of time).
Priority is described as:
   Emergent: investigator must initiate response no later than the following working day from the investigator’s assignment
   Urgent: investigator must initiate response no later than five working days from the investigator’s assignment
   Routine: investigator must initiate response no later than 10 working days from the investigator’s assignment
   Unknown: responsibility of the intake staff to make an assignment within one working day.

   Severity is described as:
   Severity 3 (S3): harm or potential for harm that is life threatening or could result in long-term disability, or an unexpected death
   Severity 2 (S2): harm or potential for harm that is moderate to serious but not life-threatening
   Severity 1 (S1): expected death, minimal harm, or low potential for harm

3. Assign Investigator
Region of the incident occurrence: DHI/IMB has divided the state into five regions (consistent with DOH/Developmental Disabilities Support Division (DDSD) Regional designations). DHI investigators are located in each region.
Consumer specific: Investigator with an existing case involving the consumer or with the most knowledge of the consumer. Cultural or language needs of the consumer are also given consideration.
Provider specific: Investigator with an existing case involving the responsible provider.
Caseload based: Cases will be assigned with a caseload maximum. Level of urgency: Cases may be assigned based on the most available investigator.
Gender based
Deaths: All deaths are assigned to the DHI Clinical Team for investigation.

4. Determine ALTSD/APS or CYFD Status: Reconciling Cases with ALTSD Adult Protective Services (APS), and Children, Youth and Families Department (CYFD) Child Protective Services (CPS)
   Was the case received from ALTSD or CYFD Statewide Central Intake (SCI)? If yes and ALTSD or CYFD (APS, CPS) has accepted the case for investigation, and DOH has jurisdiction then the case will be assigned a DHI investigator and will be a collaborative investigation process.
   If no, and the case involves an allegation of abuse, neglect, or exploitation, it will be referred to APS or CPS after the Triage process.

5. The intake staff will then document the Triage decisions

6. Database Entries will be made as appropriate. See also Appendix F: Incident Management Database Users Manual.

7. Notifications will be made to the following entities, as appropriate:
   Office of General Counsel (OGC), DOH
   DOH/DDSD
   ALTSD (APS)
   ALTSD (EDSD)
   CYFD (CPS)
   DOH DHI and DDSD Director’s Office
   Law Enforcement
   Human Services Department (HSD) Medical Assistance Division (MAD), Medicaid Fraud Control Unit, NM Attorney General’s Office
   Office of Internal Audit (OIA), DOH
   Responsible Provider in cases of late reporting or failure to report

8. After Data entry, the IR and attachments are given to the support staff for faxing to the assigned investigator and notifications to the appropriate entities within 24 hours.

9. Once all faxing has been completed, the support staff will file the entire packet in the appropriate file and make a file folder for cases closed during the Intake process. Closure notifications will be sent at this time for each case completed during Intake to case managers, guardians and the provider.

B. Non-Reportable Incidents and Non-Jurisdictional Incidents (NRI/NJ)
1. Data Entry of information into the separate NRI/NJ Database.

2. As appropriate Notifications should be made to the following entities:
   Office of the General Counsel (OGC), DOH
   DOH/DDSD
   ALTSD (APS)
   ALTSD (EDSD)
   CYFD (CPS)
   DOH/DHI and DDSD Director’s Office
   Law Enforcement
   HSD/MAD
   Medicaid Fraud Control Unit, NM Attorney General’s Office
   OIA, DOH

Referral of Law Enforcement
A. All cases involving the use of law enforcement initiated by a community-based waiver service agency in the course of services to a Mi Via Participant will be reported automatically to DOH/DHI.
B. Notification of the use of law enforcement will also be faxed to the DOH/DDSD/Office of Behavioral Supports.
C. Investigations must be initiated within the assigned priority. The investigations must be completed within a 45 day timeline. If problems were identified and not corrected within the course of the investigation, the follow-up process will begin to assure the health and safety of the consumer and the correction of the identified issues. Case closure letters are sent to the participant, and/or his/her guardian, Consultant and, if appropriate, the provider.

Reports and Trends
Numerous reports are generated and trends are addressed, including:
A. Multiple allegations for participants in one quarter are discussed by the ALTSD/APS or DOH (DDSD/DHI) and APS staff and appropriate interventions are taken as needed.
B. Multiple incidents for a participant are discussed by the ALTSD/APS or DOH (DDSD/DHI) and APS staff and appropriate interventions are taken as needed.
C. DHI conducts quarterly meetings in each region with DDSD and APS staff.
D. The DOH/HSD Developmental Disabilities Quality Improvement Steering Committee (DDSQI) meets regularly throughout the year and will receive standard reports on the waiver assurances and other information as requested about the Mi Via Program. DDSQI will make recommendations to DOH/ALSTD regarding systemic actions needed in response to their analysis/review.

With respect to waiver services provided by any employee, contractor or vendor other than a community-based waiver service provider, incidents are reported to ALTSD/APS or CYFD/CPS for review, investigation, and response. The Adult Protective Services Division provides services mandated by state law on behalf of persons age 18 years of age or older. Services include investigation of reports of abuse, neglect and/or exploitation; protective placement; caregiver services; and legal services, such as filing for guardianship/conservatorship. The Division’s efforts are targeted toward preventing and/or alleviating conditions that result in abuse, neglect and/or exploitation; preserving families; and maintaining individuals in their homes and communities. When a case is accepted, Adult Protective Services Division also has the following services available to vulnerable populations, including Mi Via participants: case management, home care, adult day care, and attendant care services. Training on reporting procedures and on the operations of APS is available to Mi Via Program staff, other state employees, and contractors and may be offered to groups of participants if requested.

When a report of abuse or neglect of a child (person under age 18) is being made, the call comes into the toll-free number. The SCI worker asks a series of questions (demographics of each participant) and records the issues and concerns of abuse or neglect. The SCI worker then enters the information into the FACTS system. A Structured Decision Making Tool in the FACTS system is done on each report. This assists the worker to determine a priority status for each report ranging from an emergency (1 to 3 hour response time for face-to-face contact), P-1 (face to face contact within 24 hours), P-2 (1-5 calendar days to respond with face-to-face contact) or Screen-Out (no investigation).
- Emergency (1-3 hour response time) requires face-to-face contact and is staffed with a Supervisor who has the discretion of lowering or raising the status on any report. The report is generated electronically and submitted to the Supervisor for review to insure all the information is correct and the allegations match the narrative. The Supervisor then processes and assigns the report to the county where the family resides. The report is called out telephonically and an electronic report is created in the FACTS system, accessible by the particular county.
  - P-1 (face-to-face contact within 24 hours) requires face-to-face contact and is staffed with a Supervisor who has the discretion of lowering or raising the status on any report. The report is generated electronically and submitted to the Supervisor for review to insure all the information is correct and the allegations match the narrative. The Supervisor then processes and assigns the report to the county where the family resides. The report is called out telephonically and an electronic report is created in the FACTS system, accessible by the particular county.
  - P-2 (1-5 calendar days to respond with face-to-face) - The report IS NOT called out but is sent to the county as soon as it is processed.
  - Screen-Out which requires no investigation – These reports are faxed to law enforcement and the New Mexico Regulation & Licensing Department (as needed). Hard copies are kept at SCI for 18 months and then archived.

All reports generated at SCI whether investigated by CYFD or not are cross reported to local law enforcement agency. CYFD’s Investigations Unit in each County then takes over the case.

Notification to the Participant:
In each situation that critical incident investigations are completed by ALTSD/APS, CYFD/CPS, or DOH/DHI, the Mi Via participant or the participant's guardian receives a letter stating the results of the investigation.

Regulations are found in NMSA 1978, Sections 27-7-14 through 27-7-31 (Adult Protective Services Act) and in NMSA 1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect Act).

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

ALTSD/EDSD, DOH/DDSD and DOH/DHI are jointly responsible for trending, remediation and oversight of critical incidents and management in collaboration with HSD/MAD. Oversight of critical incidents and events is part
of the Quality Improvement Strategy. As with all components of the Quality Improvement Strategy, ALTSD/EDSD, DOH/DDSD and DOH/DHI work together to analyze aggregated data and identify trends. Quality assurance and quality improvement action plans are developed as needed, based on identified trends and other identified issues in order to prevent re-occurrence. ALTSD and DOH are responsible for designing, implementing and evaluating the effectiveness of quality assurance and quality improvement plans for each respective waiver. Meetings with ALTSD/EDSD, DOH/DHI and HSD/MAD about the Quality Improvement Strategy occur quarterly, or more often if necessary, to communicate information and findings. The aggregated data and identified trends are then reported to the Tri-Agency Quality Committee (TriAQ) for review. Trending and analysis of the data are used to prioritize improvements of the quality management system.

Technical Assistance for individual specific critical incident follow ups and/or identification and remediation of health and safety challenges is available through the Department of Health as requested by the Consultant. Issues brought to the Department of Health Mi Via Program Manager or Regional Offices by concerned consultants will be addressed in terms of options or resources for the participant to pursue in mitigating their risks. The Department of Health may consult with knowledgeable professionals within other state departments or other relevant community resources to explore potential options.

The State has a system to monitor, track and investigate critical incidents for Mi Via waiver participants. DOH/DHI investigates and follows up regarding traditional waiver providers and critical incidents. ALTSD/APS and CYFD/CPS have systems to monitor, track and investigate critical incidents for Mi Via participants using nontraditional vendors or employees.

**Appendix G: Participant Safeguards**

**Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)**

a. **Use of Restraints. (Select one):**

- ☐ The State does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

As with any event or incident that occurs during service delivery, there is a system in place for reporting and follow-up. The participant or any one with knowledge of the event can contact law enforcement, 911, the State via the complaint tracker, his/her Consultant or Adult Protective Services to report his/her concerns. During orientation, participants are provided with contact information for Adult Protective Services, Child Protective Services and the Division of Health Improvement. The Consultant through the monthly contact will inquire if there are any issues or concerns regarding service delivery. The Quarterly Review tool utilized by consultants supports this type of information sharing. Mi Via does not authorize the use of restraints or seclusion.

For participants with behavioral support needs seeking support through Mi Via, planning should include strategies for positive behavioral support and effective intervention that reduce risk resulting from the behavior.

- ☐ The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

   [Blank]

   [Blank]

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

   [Blank]

   [Blank]
Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions
(2 of 3)

b. Use of Restrictive Interventions. (Select one):

- The State does not permit or prohibits the use of restrictive interventions
  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

  As with any event or incident that occurs during service delivery, there is a system in place for reporting and follow-up. The participant or any one with knowledge of the event can contact law enforcement, 911, the State via the complaint tracker, his/her Consultant or Adult Protective Services to report his/her concerns. During orientation, participants are provided with contact information for Adult Protective Services, Child Protective Services and the Division of Health Improvement. The Consultant through the monthly contact will inquire if there are any issues or concerns regarding service delivery. The Quarterly Review tool utilized by consultants supports this type of information sharing. MiVia does not authorize the use of restraints or seclusion.

  For participants with behavioral support needs seeking support through MiVia, planning should include strategies for positive behavioral support and effective intervention that reduce risk resulting from the behavior.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services
  Complete Items G-2-b-i and G-2-b-ii.

  i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions
(3 of 3)

c. Use of Seclusion. (Select one):

- The State does not permit or prohibits the use of seclusion
  Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

- The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

  i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- No. This Appendix is not applicable (do not complete the remaining items)
- Yes. This Appendix applies (complete the remaining items)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Mi Via medication management is addressed in the assessments conducted by the Third-Party Assessor (TPA). If the participant’s medical regime requires medication and the participant needs assistance with administration of medication, the participant, with the assistance from the Consultant will select the service that provides this support. The participant’s SSP will define how the service will be provided and will describe the degree of recipient support that is required. The Consultant will assist the participant with hiring appropriate staff to assist with the administration of medication. When the provider is a community-based waiver service agency, assistance with medications must comply with the DOH/DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.

Quality monitoring will be performed by DOH as part of routine Mi Via Consultant Agency provider surveys/monitoring. The Consultant’s quality oversight responsibilities will include: the Consultant monitors implementation of the SSP during quarterly reviews and reports any concerns regarding medication management to the Consultant Agency and DOH. DOH investigates the matter and takes action appropriately. If the participant selects to purchase the services of licensed professionals or licensed facilities to manage medications, requirements specific to the professional’s and/or facility’s license apply. For example, licensed nurses and provider agencies are required to comply with the Board of Nursing and the Board of Pharmacy regulations regarding medication administration and management of adverse events.

Registered Nurses or Licensed Practical Nurses may administer medications as part of waiver services. For Mi Via Waiver participants who reside outside an Assisted Living facility, non-licensed personnel are limited to assisting waiver participants who self-administer medication by prompting and reminding only. Non-licensed facility staff are limited to assisting waiver participants who self-administer medication by prompting and reminding only. Ongoing Medication Management and follow-up are provided through the Assisted Living provider by a licensed health care professional. Additionally, for participants who purchase Assisted Living services, the Assisted Living provider must ensure that a consulting pharmacist reviews the participant’s medication regime quarterly, or as needed (7.8.2 NMAC et seq.). According to 7.8.2.36 NMAC, all Assisted Living facility staff assisting with medications must have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. The Pharmacy Board licenses all facilities in which medication administration occurs including Assisted Living facilities. The DOH, Division of Health Improvement (DHI), licenses Assisted Living facilities annually (See: NMAC 7.9.2.9). State law requires oversight by a pharmacist and periodic reviews
by DOH/DHI facility surveyors during the facility’s annual certification process.

State law requires the facilities to have a consultant pharmacist available to the facility to periodically review all patient medication administration and regimens. The pharmacist’s medication regimen review determines that all medication records are accurate and current. The pharmacist is required to establish procedures and protocols for maintaining medications, reporting adverse reactions and events, and controlling distribution. All irregularities must be reported to the Director of the facility and the irregularities must be acted upon. The pharmacist has the responsibility of continuing to report an unresolved issue regarding any medication.

DOH/DHI monitoring surveys of Assisted Living facilities are reviewed with ALTSD/EDSD staff and monitored as part of the Quality Management Strategy (QMS), as are all provider-monitoring surveys.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The Pharmacy Board licenses all facilities in which medication administration can occur, including Assisted Living facilities. The DOH, Division of Health Improvement (DHI), Licensing and Certification Unit also licenses Assisted Living facilities annually. State law requires oversight by a pharmacist and periodic reviews by DOH/DHI facility surveyors during the facility’s annual certification process. State law requires the facilities to have a consultant pharmacist available to the facility to periodically review all patient medication administration and regimens. The pharmacist’s medication regimen review determines that all medication records are accurate and current. The pharmacist is also required to establish procedures and protocols for maintaining medications, reporting adverse reactions and events, and distribution controls. All irregularities must be reported to the Director of the facility and the irregularities must be acted upon. The pharmacist has the responsibility of continuing to report an unresolved issue regarding any medication.

The facility is monitored annually by the DOH, Division of Health Improvement through a Memorandum of Understanding (MOU) with HSD. Medication management is reviewed as part of the annual survey. The survey includes: 1) a file review; 2) attendance and observation during a medication pass; 3) a medication log review; 4) an interview with the prescribing physicians; and 5) any other medication management issue (included in the annual survey is review of the chemical restraint provisions, including pertinent nurse aid training and competency evaluations). The facility surveyors have the responsibility to assure all the procedures are followed including that the irregularities reported are acted upon. Whenever surveyors find deficiencies, notice is given to the facility and follow-up visits are scheduled to note improvement or lack of improvement. If a facility is unable to correct their procedures, the license and certification is revoked.

The DOH/DHI monitoring surveys of Assisted Living facilities are reviewed with ALTSD/EDSD staff and monitored as part of the QMS, as are all provider-monitoring surveys.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. Select one:

- Not applicable. (do not complete the remaining items)
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (complete the remaining items)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
When a recipient’s medication is dispensed by the pharmacist, state law requires the pharmacist to provide necessary consultation services with regard to the use of the medication and to address any questions the recipient or the agent of the recipient may have. The pharmacist is responsible for detecting over or under utilization and potential drug interactions according to the records the pharmacy maintains. Additional information is supplied to the pharmacist when the claim is in the process of being dispensed through the Medicaid real-time Point-of-Sale Drug Program. The technology in place includes edits informing the provider of over-utilization, duplicative utilization, drug interactions and the severity of the interaction. A registered commercial pharmacist will note excessively high doses and/or any related issues or discrepancies and report to the individual’s provider. This prospective drug utilization review capability (pro-DUR) is performed and is effective even if the drug items are dispensed by more than one pharmacy and are in addition to any internal system maintained by an individual pharmacy. Depending on the severity of the issue, the pharmacist may just receive notice in order to be more informed and to react as appropriate; the medication may be approved until the pharmacist speaks to a help desk; or the medication may not be approved until the prescriber speaks to the help desk. The help desk is available 24 hours each day, 7 days per week. There is also the capability of a retrospective drug utilization review (DUR).

It is also the responsibility of any licensed practitioner seeing the recipient to report any noticed non-compliance or adverse reactions related to medications.

For Mi Via Waiver participants who reside outside an Assisted Living facility and receive services from an entity other than a community-based waiver services agency, non-licensed staff (employees or vendors) are limited to assisting waiver participants who self-administer medication by prompting and reminding only. Non-licensed staff may get a glass of water or juice as requested if recipient is not able to do that for himself/herself or hand the recipient a daily medication box or medication bottle.

According to 7.8.2.36 NMAC, all Assisted Living facility staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications.

iii. Medication Error Reporting. Select one of the following:

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  [ ]

  (b) Specify the types of medication errors that providers are required to record:

  [ ]

  (c) Specify the types of medication errors that providers must report to the State:

  [ ]

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

Mi Via providers (employees, contractors, vendors) that administer medications are required to record medication errors including administering medication to the wrong person, at the wrong time, administering the wrong medication, the wrong dose, wrong route, missed doses, and inaccurate documentation. The provider must make information about medication errors available to the participant and when requested by the State. The respective State agency investigates the issue and takes appropriate action to address the problem.
iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

State law requires oversight by a pharmacist including periodic reviews by a pharmacist and periodic reviews by facility surveyors during the facility annual certification process. The facility surveyors have the responsibility to assure all the procedures are followed including that medication error is documented, reported, and acted upon. Other administrative and enforcement agencies include the Pharmacy Board that separately licenses the facility and determines that medication error reporting procedures are followed.

The Pharmacy Board licenses all facilities in which medication errors can occur, including nursing facilities, hospitals, clinics and Assisted Living facilities. State law requires the facilities to have a consultant pharmacist available to the facility. The consultant pharmacist is required by state law to establish procedures and protocols for reporting adverse reactions and medication error events, including use the Pharmacy Board’s “Significant Adverse Drug Event Reporting” system.

The HSD/MAD uses a signed MOA with the DOH/DHI to specifically look at medication management during the provider (community-based waiver service agency) survey. This survey occurs once every three years for routine audits, or if circumstances trigger a focused review, this may occur as often as needed. The survey includes a review of documentation, agency reporting, tracking and trending as well as action taken to reduce medication errors. When deficiencies are identified the facility is notified, technical assistance is provided if needed, the corrective action process is completed and follow up visits are scheduled to assess for improvement or the lack of improvement. If a community-based waiver service agency or an Assisted Living facility is unable to correct deficiencies, the provider agreement, license and certification may be revoked. If there is a medication error, or pattern of errors, that result in alleged medical neglect, the incident management system is activated and all corresponding regulations apply.

Licensing bodies for each type of provider, such as the Board of Pharmacy, the Board of Nursing, the Medical Board the Department of Health/Division of Health Improvement/Health Facilities Licensing and Certification as well as state statutes and regulations apply in regard to medication administration requirements and medication error reporting.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.


The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percentage of approved Mi Via consultant agencies with systems in place to identify, report, and address incidents of participant abuse, neglect, and exploitation.
Numerator: Number of approved consultant agencies with systems in place to identify,
report, and address incidents of participant abuse, neglect, and exploitation.
Denominator: Total number of approved consultant agencies.

**Data Source (Select one):**
Other
If 'Other' is selected, specify:
Consultant Agency (CA) reports; reviews of participant Service and Support Plans (SSPs)

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<th>Frequency of data collection/generation (check each that applies)</th>
<th>Sampling Approach (check each that applies)</th>
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### Performance Measure:
Percentage of Mi Via participants who received training on how to detect signs of abuse, neglect, and exploitation and know how and where to report it and/or get help.

**Numerator:** Number of Mi Via participants who received training on how to detect signs of abuse, neglect, and exploitation and know how and where to report it and/or get help.

**Denominator:** Total number of Mi Via participants.

### Data Source (Select one):
Other
If 'Other' is selected, specify:

**Consultant Agency (CA) reports; participant Service and Support Plans (SSPs)**

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Performance Measure:
Percentage of employees/independent contractors provided with information on how to report incidents of participant abuse/neglect/exploitation. Numerator: Number of employees/independent contractors provided with information on how to report incidents of participant abuse/neglect/exploitation. Denominator: Total number of employees/independent contractors employed by Mi Via participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Consultant Agency (CA) reports: participant Service and Support Plans (SSPs)

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Specify:
Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Formal quality improvement processes are in place, as described in detail in the TriAQ description and structure in Appendix H.

---

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement are identified by the State related to health and welfare, processes are in place to ensure that appropriate and timely action is taken. In addition, the TriAQ routinely collects, aggregates, analyzes, and trends health and welfare data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

Methods for fixing identified problems include verbal direction, letters of direction, formal corrective action plans; documentation is kept on all actions taken. In some instances, policy and/or regulatory changes are required. In all cases, if ALTSD or DOH identifies at any time any issues that are inconsistent with Medicaid requirements related to health and welfare, HSD/MAD ensures that the problem is corrected and that compliance with the Assurance is met.

---

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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Specify:
TriAQ

| □ Continuously and Ongoing                    |
| □ ✔ Other                                    |

Specify:
Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise.

---

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent roles/responsibilities of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously assess the effectiveness of the QMS and revise it as necessary and appropriate.

If the State’s Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.
Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The primary goals for Mi Via’s Quality Improvement Strategy (QIS) are to administer and measure a quality improvement system that:

- Supports participants in exercising greater choice and control over the types of services and supports that are purchased within a State assigned budgetary amount;
- Serves the most people possible within available resources;
- Identifies opportunities for improvement and ensures action, when indicated; and
- Ensures that the State meets each of its statutorily required assurances to CMS.

The State uses the following measures and processes to determine that it is meeting its QIS goals:

- Measures: The primary measures are specific to each of the Waiver assurances. Within the assurances, measures are identified that provide evidence of compliance with the assurance. These are described as Performance Measures in Appendices A, B, C, D, G, and I. These performance measures are utilized by the Tri-Agency Quality Committee (TriAQ) to measure success of the assurance strategies and to develop remediation strategies, as necessary.
- Processes: Multiple discovery processes/activities, both prospective and retrospective, are utilized to evaluate the program at the individual and systemic levels, to determine if the strategies are successful to continually identify areas for improvement. These activities occur through the quality committee structure, including the Assurances Workgroups and Mi Via Task Force, which feed into the TriAQ.

The State’s Mi Via Quality Improvement Strategy is employed to determine on a continual basis: 1) whether the State is operating the Mi Via Waiver in accordance with the approved design of the Waiver as described in the Waiver application; and 2) is achieving the desired goals, as listed above.

The TriAQ is composed of at least one representative of each of the three Mi Via agencies (Human Services Department [HSD], Aging and Long-Term Services Department [ALTSD], and Department of Health [DOH]), with HSD, as the Medicaid agency, as the lead. These individuals are Mi Via Program Managers or their designees. They meet quarterly and review the information derived from discovery and remediation activities (described in other appendices) provided by the Assurances Workgroups and the Mi Via Task Force. Trending and analysis of the data are used to prioritize improvements of the quality management system. The reviews and analyses are documented in the meeting notes and distributed to the Assurance Workgroups and senior management. Based on the findings, the TriAQ implements changes, as indicated, within the Assurances Workgroup strategies and within the TriAQ strategies to continually improve the data accuracy, strategy effectiveness, effectiveness of the improvement initiatives, and the quality of services. The mission of the TriAQ is to ensure that the strategies being managed are successful. The fourth quarterly meeting of the TriAQ is an annual meeting, and the tasks of this annual meeting are described in H.1.b.i and ii.

The three Assurance Workgroups, e.g., LOC/eligibility; Service Plans, Qualified Providers and Health and Welfare; and Administrative and Financial Accountability Workgroups, respectively, are each composed of at least one representative from each State agency. The Assurances Workgroups meet monthly to review the quality improvement activities that are underway in their respective assurance areas and to determine whether the State is meeting the CMS Mi Via Waiver requirements. Data collected from those activities and any additional concerns or issues are reported each month to the TriAQ, which reviews and provides feedback at the quarterly TriAQ meeting. This data is also submitted to the DOH Developmental Disabilities Services Quality Improvement Steering Committee, for the ICF/MR MI Via Waiver for trending and remediation.

The Mi Via Task Force is comprised of ten (10) appointed individuals, who are participants, family members and an advocate organization, which meet quarterly or more often, as indicated. The role of the Task Force is to engage “on the ground floor” in providing input and to assist the State with the on-going evaluation of Mi Via. The Task Force forwards participant feedback and recommendations to the TriAQ and is a key source of individual and system-level information for appraising the State’s performance.
Recommendations made by the TriAQ for system design changes are forwarded to senior management of HSD, ALTSD and DOH for consideration and implementation.

When a system design change is to be implemented, the TriAQ informs the Assurances Workgroups. Those workgroups adapt the data collection and strategies to reflect the change. The TriAQ also incorporates any necessary system design changes into the review and analysis processes that are utilized for reports sent by the Assurances Workgroups. The system design changes are also incorporated into the annual report by the TriAQ. HSD, ALTSD and DOH senior management informs the Mi Via Program staff and Contract Managers, who, in turn, inform the Contractors through letters of direction, as indicated, the Mi Via Task Force, and other identified stakeholders of any changes that are directed or implied with the new system design. This information is shared at the time the decision is made and again when the change is implemented. The format for the information is determined by the change and its perceived impact on participants and stakeholders. Information-sharing formats may include letters, announcements at scheduled meetings, website updates and state-wide meetings to share the information. If the Mi Via Service Standards or State regulation changes are needed, the State will follow applicable State rules.

This quality structure implements the Mi Via Quality Improvement Strategy (as described throughout this Waiver application), but it is reproducible and may eventually be adapted for all of the other HCBS waiver programs including:

-The AIDS Waiver #WA-NM 0161.90.R2, operated by DOH/PHD;
-The Developmental Disabilities (DD) Waiver #NM 0173.90.R3 operated by DOH/DDSD;
-The CoLTS “c” Waiver #NM 0479.R00.00, operated by ALTSD/EDSD; and
-The Medically Fragile Waiver #NM 0223.90.R2, administered by DOH/DDSD.

### ii. System Improvement Activities

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<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of Monitoring and Analysis (check each that applies):</th>
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<tr>
<td>Specify:</td>
<td>Specify: Additional monitoring/analysis will be done, as</td>
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<tr>
<td>TriAQ</td>
<td>necessary, to address unusual/urgent issues.</td>
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<td>Mi Via Task Force</td>
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<td>FMA and TPA Contractor</td>
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### b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State’s targeted standards for systems improvement.

The Assurances Workgroups, Mi Via Task Force, and TriAQ all participate in monitoring and analyzing the effectiveness of system design changes by utilizing the ongoing processes described in H.1.a.i. The Assurances Workgroups utilize the data collection and strategies; the TriAQ utilize the review and analysis processes and reports that are sent by the Assurances Workgroups and the Mi Via Task Force. As part of its annual review, the TriAQ considers the findings related to system design changes and incorporates them into the year-end report. Information-sharing formats may include letters, announcements at scheduled meetings, website updates and state-wide meetings to share the information. If the Mi Via Service Standards or State regulation changes are needed, the State will follow applicable State rules.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.
The Annual Meeting of the TriAQ has an extended scope of work. It includes an evaluation of the effectiveness of both the assurance workgroup strategies in improving the functions of the Waiver and an evaluation of the effectiveness of the TriAQ oversight of the strategies. The final report of this assessment is distributed to senior management, the Assurances Workgroups, Mi Via Task Force, and identified stakeholders. This report also includes information about current remediation activities and projections of future quality management plans—all related to how well the functions of the Waiver are operating and to ensure that the Mi Via Waiver QIS supports participants in self-direction of services, identifies opportunities for improvement and an enhanced quality of life for participants, and ensures that the State meets each of the required assurances to the Centers for Medicare and Medicaid Services (CMS).

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Human Services Department (HSD)/Medical Assistance Division (MAD), Aging and Long-Term Services Department (ALTSD) and Department of Health (DOH) contract with the FMA, which is responsible for determining that providers of services and goods meet required qualifications. ALTSD and DOH share FMA contract oversight responsibilities with HSD. The FMA reviews claims submitted for payment by the participant’s provider and/or vendor to determine if the claims are consistent with the participant’s approved Service and Support Plan and participant’s budget. Based on this review, the FMA pays, suspends or denies payment. The FMA, in turn, bills HSD for claims paid retrospectively; HSD pays the FMA if claims are coded correctly and in accordance with the participant’s authorized individualized annual budget. The FMA is required to conduct a 100 percent review of all paid claims to ensure all claims are correctly coded and paid in accordance with specific waiver requirements. HSD, ALTSD, and DOH conduct an annual audit of the FMA to determine compliance with the contract, including oversight of provider qualifications and claims payment. An annual post-payment audit is conducted via a systematic random sample of the FMA records for monitoring purposes.

The State Auditor of New Mexico also contracts with an independent auditor to conduct an annual audit of the Human Services Department’s (HSD’s) Medicaid program that includes a financial audit as well as an audit of the program’s allowable costs.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.


State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The percentage of claims coded correctly in accordance with waiver coding requirements. Numerator: The number of claims coded correctly in accordance with waiver coding requirements. Denominator: Total number of claims submitted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Fiscal Management Agent (FMA) web-based reviews; MMIS exception analysis reports

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<th>Frequency of data collection/generation (check each that applies):</th>
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<td>✓ Other Specify: A systematic random sample audit of the FMA records conducted by HSD/MAD and DOH/DDSD for monitoring purposes.</td>
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Data Aggregation and Analysis:
### Performance Measure:
The percentage of claims paid in accordance with waiver claims payment requirements.
Numerator: The number of claims paid in accordance with waiver claims payment requirements. Denominator: Total number of claims paid.

### Data Source (Select one):
Other
If 'Other' is selected, specify:
Fiscal Management Agent (FMA) web-based reviews; MMIS exception analysis reports

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A systematic random sample audit of the FMA records by HSD/MAD and DOH/DDSD for monitoring purposes.

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Data Aggregation and Analysis:

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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Formal quality improvement processes are in place, as described in detail in the TriAQ description and structure in Appendix H.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement are identified by the State related to financial accountability, processes are in place to ensure that appropriate and timely action is taken. In addition, the TriAQ routinely collects, aggregates, analyzes, and trends financial data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.
Methods for fixing identified problems include verbal direction, letters of direction, formal corrective action plans; documentation is kept on all actions taken. In some instances, policy and/or regulatory changes are required. In all cases, if ALTSD or DOH identifies at any time any issues that are inconsistent with Medicaid requirements related to financial accountability, HSD/MAD ensures that the problem is corrected and that compliance with the Assurance is met.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

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c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☐ No
☐ Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Mi Via participants have their individual budgetary allotments and a range of rates for services, based on Medicaid waiver rates, to utilize in developing their Service and Support Plans and budgets, determining payment rates and negotiating with providers. Participants are informed of the waiver payment range of rates, which are based on what Medicaid currently pays for traditional waiver services, during the Service and Support Planning process. Payment rates for participant-delegated community membership supports, living supports, health and wellness supports, Personal Plan Facilitation, and other supports available through Mi Via will be negotiated by participants in the same way any individual in the community would in making a similar purchase. In the self-directed model, participants are given some flexibility in deciding how much to pay for services and goods; however, both the Service and Support Plan and budget, including payment rates, are authorized by the State, as discussed in Appendix E. The State establishes "set" rates for the traditional waiver services, such as therapies; however, for Mi Via, the
State utilizes a rate range wherein each participant can establish his/her own rate with a particular provider of the service. This rate range is within the parameters the State uses for the traditional waiver service.

Payment, along with other key components of Mi Via, is continuously discussed with participants and stakeholders during the many Mi Via workgroups and task forces. HSD, ALTSF, and DOH work collaboratively to determine rates and obtain stakeholder input.

Two or more participants living in the same residence, who are receiving services and supports under Mi Via will be assessed both independently and jointly to determine coverage of services and supports that are shared. Services and supports will be approved and paid based on the common needs and not on individual needs, unless it has been assessed by the TPA contractor that there is an individual need for the provision of the service(s) or supports. Additional criteria for coverage of services in shared households are set forth in the Mi Via Service Standards. Traditional waiver rates and all Medicaid rates are established by HSD/MAD. Information is obtained from the Medicaid Advisory Committee, which solicits public comments during meetings, advocacy organizations, and the New Mexico Legislature.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State’s claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

HSD budgets an annual amount for each individual participant. The Mi Via participant uses the annual amount in developing his/her Service and Support Plan and individual budget. The FMA pays the participant’s providers of services and goods, based on the authorized Plan and budget, and, retrospectively, bills the State for those claims that are paid.

HSD provides Mi Via Participants the opportunity to purchase approved Goods through the use of a debit card. The Participant first obtains a price quote of an approved Good and submits to the FMA for review. Once approved, the FMA will load the approved amount onto the Participant’s debit card and the Participant makes the purchase as authorized.

Provider billings are routed through the FMA for payment. The provider or vendor delivers the service or goods and bills the FMA. The FMA, under its provider agreement with HSD, bills the HSD/MAD Medicaid Management Information System (MMIS) for the services or goods and pays the participant’s service provider or vendor based on the authorized SSP and budget.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

☐ No. State or local government agencies do not certify expenditures for waiver services.

☐ Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

☐ Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

☐ Certified Public Expenditures (CPE) of Local Government Agencies.
Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4.b.)*

### Appendix I: Financial Accountability

#### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The FMA verifies the participant's eligibility, the providers' and vendors' qualifications, and compares all claims submitted against the authorized Service and Support Plan (SSP) and individual budget. The services and goods must be identified in the Service and Support Plan, and the participant or his/her representative is responsible for verifying that services have been rendered by completing, signing and submitting documentation, including the timesheet, as applicable, to the FMA.

The HSD/MAD MMIS pays the FMA after validating that the participant has waiver eligibility on the date of service and that the amount is within the participant's authorized SSP and budget.

Post-payment audits are conducted by the HSD/MAD to determine whether the services, supports and goods for paid claims were included in the SSP and budget and were rendered in accordance with Medicaid and the FMA contract requirements. Any paid claims that cannot be validated through the post-payment audit, are recouped and removed from the claim for FFP.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

### Appendix I: Financial Accountability

#### I-3: Payment (1 of 7)

**a. Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
- Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The FMA is independent of the entities/persons delivering services or goods to avoid conflicts of interest. Based on the participant's authorized individual Service and Support Plan and budget, the FMA sets up an individual account, makes expenditures that follow the authorized budget, handles all payroll functions on behalf of the participant who hires service providers, other support personnel, and vendors, provides the participant with a monthly report of expenditures and budget status, answers inquiries, solves related problems, and provides the State with a quarterly documentation of expenditures.

The FMA submits paid claims to HSD for retrospective payment. HSD monitors those claims and the expenditures against the participant's authorized individualized budget. HSD conducts annual audits of the FMA to determine compliance with all provisions of the contract and adherence to Mi Via policies and procedures and to ensure financial integrity and accountability. Where deficiencies are identified, corrective action will be required, according to the terms of the contract.

In addition, post-payment audits are conducted by HSD to determine if the services for paid claims were included in the SSP and budget and were rendered as specified.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for
expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- No. The State does not make supplemental or enhanced payments for waiver services.
- Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability
I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. Specify whether State or local government providers receive payment for the provision of waiver services.

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: Complete item I-3-e.

Los Lunas Community Programs, run by DOH/DDSD, provides homemaker/companion, community living, adult day habilitation, supported employment, respite, environmental modification, emergency response, community access, participant delegated goods and services, and private duty nursing services. The amount of payment to public providers does not differ from the amount paid to private providers of the same services in that private providers and Los Lunas Community Programs may both negotiate their payment rate with the Mi Via participant. The TPA Contractor approves the budget including the payment amount for both the private provider and the Los Lunas Community Programs in the same way. In Mi Via, all payment rates are negotiable within established parameters. However, the aggregate amount of payment to Los Lunas Community Programs for Mi Via services does not exceed the cost of providing those services.

Appendix I: Financial Accountability
I-3: Payment (5 of 7)
e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments
(including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used.
iii. Contracts with MCOs, PIHPs or PAHPs. Select one:

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. Select at least one:

- Appropriation of State Tax Revenues to the State Medicaid agency
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c;

- Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c;

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

- Not Applicable. There are no local government level sources of funds utilized as the non-federal share.
Applicable

Check each that applies:

☐ Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

☐ None of the specified sources of funds contribute to the non-federal share of computable waiver costs

☐ The following source(s) are used

Check each that applies:

☐ Health care-related taxes or fees
☐ Provider-related donations
☐ Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

☐ No services under this waiver are furnished in residential settings other than the private residence of the individual.

☐ As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Rates for room and board are excluded from the cost of services and are either billed separately by the provider or an itemized statement is developed that separates the costs of waiver services from the costs of room and board.
Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

☐ No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

☐ Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver’s home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

☐ No. The State does not impose a co-payment or similar charge upon participants for waiver services.

☐ Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

☐ Nominal deductible
☐ Coinsurance
☐ Co-Payment
☐ Other charge

Specify:


Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.
ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

○ No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

○ Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/IID
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Total Number Unduplicated Participants (from Item B-3-a)</th>
<th>Level of Care:</th>
</tr>
</thead>
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<tr>
<td></td>
<td></td>
<td>ICF/IID</td>
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<tr>
<td>Year 1</td>
<td>225</td>
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<tr>
<td>Year 2</td>
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<tr>
<td>Year 5</td>
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<td>600</td>
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</tbody>
</table>

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay was estimated from historic attrition rates from federal FY 2008 and first half federal FY2009 data and the anticipated growth rates in the waiver. Persons disenrolling were regarded as having a half month of enrollment during the month they disenrolled. Persons enrolling were regarded as having a half month of enrollment during the month they enrolled.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimate of Factor D is based on actual expenditures for waiver services provided to 106 Mi Via waiver participants who were in the waiver in federal FY 2008. The number of users for each service is projected based on the 2008 actual percentage of unduplicated participants using each service and the anticipated growth in total users. The units per user are anticipated to remain about the same as they were in 2008, and the 2008 actual unit costs are trended forward at the Medicare PPS MarketBasket Index of 3.8%.
Adjustments were made to projected “Number of Users” for shared services in shared households (i.e., two or more Mi Via participants living in the same residence) consistent with Mi Via service standards.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimate of Factor D' is based on actual expenditures for all Medicaid services which were not included in Factor D provided to the same 106 waiver participants as in J-2.c.i who were in the waiver in 2008 (fee-for-service payments for inpatient, outpatient, physician and clinical, laboratory, pharmacy, and DME; and capitation payments to MCOs for provision of the same set of services). The 2008 PMPY expenditures are trended forward in the same manner as described in J-2.c.i for Factor D expenditures.

As stated above, the estimate of Factor D' is based on actual 2008 PMPY waiver expenditures trended forward. The State did not use pre-Medicare Part D expenditure data in its estimate of Factor D' (Medicare Part D was implemented in January 2006), so it is not necessary to adjust for this.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimate of Factor G is based on actual expenditures for ICF/MR services provided to 269 individuals in 2008. The 2008 PMPY expenditures are trended forward in the same manner as described in J-2.c.i for Factor D expenditures.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimate of Factor G' is based on actual expenditures for all Medicaid services which were not included in Factor G provided to the same 269 individuals as in J-2.c.iii in 2008 (fee-for-service payments for inpatient, outpatient, physician and clinical, laboratory, pharmacy, and DME; and capitation payments to MCOs for provision of the same set of services). The 2008 PMPY expenditures are trended forward in the same manner as described in J-2.c.i for Factor D expenditures.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-.Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

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<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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Page 179 of 190
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GRAND TOTAL: 7388921.30
Total Estimated Unduplicated Participants: 325
Factor D (Divide total by number of participants): 338838.19
Average Length of Stay on Waiver: 315
### Appendix J: Cost Neutrality Demonstration

#### J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

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**GRAND TOTAL:**

Total Estimated Unduplicated Participants: 300  
Factor D (Divide total by number of participants): 33081.65  
Average Length of Stay on the Waiver: 314  

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**GRAND TOTAL:**

Total Estimated Unduplicated Participants:

Factor: Divide total by number of participants:

Average Length of Stay on the Waiver: 314
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

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GRAND TOTAL:
14107249.58
Total Estimated Unduplicated Participants: 400
Factor D (Divide total by number of participants): 353868.10
Average Length of Stay on the Waiver: 314
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**GRAND TOTAL:**

- Total Estimated Unduplicated Participants: 340
- Factor B (Divide total by number of participants): 38068.10
- Average Length of Stay on the Waiver: 314
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-.Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

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GRAND TOTAL: 18257995.63

Total Estimated Unduplicated Participants: 300
Factor D (Divide total be number of participants): 3606.00

Average Length of Stay on the Waiver: 323
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**GRAND TOTAL:** 18297998.63
**Total Estimated Unduplicated Participants:** 500
**Factor D (Divide total by number of participants):** 36596.00
**Average Length of Stay on the Waiver:** 323
### Appendix J: Cost Neutrality Demonstration

**J-2: Derivation of Estimates (9 of 9)**

**d. Estimate of Factor D.**

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

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**GRAND TOTAL:**

| Total Estimated Unduplicated Participants: | 5946 |
| Average Length of Stay on the Waiver:    | 319  |

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Page 188 of 190
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**GRAND TOTAL:**

Total Estimated Enrollees: 32788443.96
Factor D (Divide total by number of participants): 600
Average Length of Stay on the Waiver: 309
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GRAND TOTAL: 23798442.96
Total Estimated Unduplicated Participants: 600
Factor B (Divide total by number of participants): 37980.74
Average Length of Stay on the Waiver: 309