

# 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 waivers 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.

## 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*):

Supports Waiver

- C. **Type of Request:** new

**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

**New to replace waiver**

Replacing Waiver Number:

[Redacted]

**Base Waiver Number:**

[Redacted]

**Amendment Number**

(if applicable):

[Redacted]

**Effective Date:** (mm/dd/yy)

[Redacted]

**Draft ID:**            **NM.025.00.00**

- D. **Type of Waiver** (*select only one*):

Regular Waiver

- E. **Proposed Effective Date:** (mm/dd/yy)

07/01/20

### 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)**

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**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:

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**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:*

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#### **H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

**This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## **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 Supports Waiver (SW) is designed to provide an option for support to individuals on the Department of Health Developmental Disabilities (DD) waiver Wait List; providing support services to participants and their families, to enable participants to work toward self-determination, independence, productivity, integration, and inclusion in all facets of home and community life across their lifespan. The services provided are intended to build on each participant's current natural and generic community support structures. The program is operated by the New Mexico (NM) Department of Health, Developmental Disabilities Supports Division (DOH/DDSD) with oversight by the NM Human Services Department (HSD).

Services are delivered under either a Participant-Directed or Traditional Service Delivery model provided by qualified providers throughout the State. Services are provided based on each waiver participant's Person-Centered Plan, developed through the assistance of a Community Supports Coordinator (CSC) to enhance the participant's life as identified by the participant and his/her family through the person-centered planning process.

## **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

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**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. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

**No**

**Yes**

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

**Geographic Limitation.** A waiver of statewide requirements 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 statewide requirements 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

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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 §440.140; 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

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*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 inpatients 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:

**DEVELOPMENT OF THE WAIVER:**

The Department of Health (DOH), Developmental Disabilities Supports Division (DDSD) identified the Supports Waiver (SW) as an option to address the state's Wait List in strategic planning over the past 5 years. The DDSD Intake and Eligibility Unit gathered input about services needed from individuals on the Wait List through a "Keeping in Touch" letter in 2016.

The DDSD also partnered with the Developmental Disabilities Planning Council to conduct statewide townhalls in 2017 and 2018 under an initiative called "Know your Rights / Advocate Rights and Responsibilities." These townhalls resulted feedback from individuals receiving services and on the Wait List about the nature, extent, and quality of supports needed to live the lives they want in the community.

In addition, the DDSD surveyed a representative sample in March-April 2019 of individuals on the Central Registry/Wait List. The survey questions gathered data on current Medicaid and employment services utilized and which services they felt they needed to live successfully in their community. Data from the survey was used as a starting point in the development of the service array in the SW.

In March 2019, the Human Services Department (HSD)/Medical Assistance Division(MAD) met with the Secretary of the Indian Affairs Department (IAD) to provide information about New Mexico's Medicaid home and community-based waiver system and discussed how to best engage Tribal leaders and communities. In partnership with the IAD, on October 28, 2019, DOH and HSD facilitated a tribal consultation meeting with Tribal leadership and representatives. The audience also included Tribal healthcare and social services professionals, advocates, and community members. The purpose of the meeting was to share information on the SW and to get feedback on the needs of Native American individuals with developmental/intellectual disabilities. The meeting was held in Albuquerque.

In October 2019, DDSD with assistance from MAD, conducted twelve (12) statewide townhall meetings in key areas throughout the state involving individuals with disabilities, their families, advocates, service providers, and others to discuss what was working in our current waiver programs, areas of needed improvement, and to gather input on development of the SW. Meetings were held in: Roswell, Las Cruces, Santa Fe, Albuquerque, Farmington, and Gallup.

Feedback on the waiver also included the input received by DOH/DDSD and HSD/MAD through the Advisory Council on Quality Supports for Persons with Developmental Disabilities and their Families (ACQ), the Developmental Disabilities Planning Council (DDPC), and advocacy groups such as Disabilities Rights New Mexico (DRNM).

**FORMAL PUBLIC COMMENT:**

On January 10, 2020 HSD sent out notice to inform tribal leaders and tribal healthcare providers through letters and an HSD website posting regarding the proposed submission of the SW waiver application. A contact name, number and email was provided on the public notice for individuals who had questions or needed more information. HSD invited the public to send comments by close of business on March 13, 2020. HSD and DOH held a public hearing session on March 13, 2020 in Santa Fe.

On February 12, 2020, a public notice was sent to all interested parties summarizing the proposed waiver application and notification of the public hearing. Interested parties include but are not limited to, persons on the waiver central registry, advocacy groups, professional associations, and individual waiver providers. The notice provided the web link to the full waiver application website posting on the HSD webpage. A contact name, number and email was provided on the public notice for individuals who had questions or needed more information. Notices for Public Comment were published in the Las Cruces Sun and Albuquerque Journal on February 12, 2020. The Albuquerque Journal is distributed statewide.

<TO BE ENTERED UPON COMPLETION OF PUBLIC COMMENT>: Public hearings for the waiver application was held on held on March 13, 2020.

**Summary of Public Comments:**

<List/Note comments>

<XXX> changes to the waiver application were made as a result of public comments/The following changes were made:

Public comments and the State’s responses were published and made available to the public.

**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:

**Last Name:**

Roanhorse-Aguilar

**First Name:**

Sharilyn

**Title:**

Bureau Chief, Exempt Services and Programs Bureau

**Agency:**

Human Services Department, Medical Assistance Division

**Address:**

1 Plaza La Preza

**Address 2:**

**City:**

Santa Fe

**State:**

New Mexico

**Zip:**

87507

**Phone:**

(505) 827-1307

Ext:

TTY

**Fax:**

(505) 827-3138

**E-mail:**

sharilyn.roanhorse@state.nm.us

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

**Last Name:**

<b>First Name:</b>	Cornwell		
<b>Title:</b>	Jason		
<b>Agency:</b>	Director, Developmental Disabilities Supports Division		
<b>Address:</b>	Department of Health		
<b>Address 2:</b>	5301 Central North East		
<b>City:</b>	Albuquerque		
<b>State:</b>	New Mexico		
<b>Zip:</b>	87108		
<b>Phone:</b>	(505) 660-3453	Ext:	TTT
<b>Fax:</b>	(505) 841-5554		
<b>E-mail:</b>	jason.cornwell@state.nm.us		

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **New Mexico**

**Zip:**

**Phone:**  **Ext:**  **TTY**

**Fax:**

**E-mail:**

**Attachments**

**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.**
- Combining waivers.**
- Splitting one waiver into two waivers.**
- Eliminating a service.**
- Adding or decreasing an individual cost limit pertaining to eligibility.**
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- Reducing the unduplicated count of participants (Factor C).**
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver*

complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCBS Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver application will be subject and in compliance to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan.

## 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.

(Complete 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 Supports Waiver (SW). HSD is responsible for the oversight of the waiver and provides ongoing monitoring through a Joint Powers Agreement that specifies the roles and responsibilities of each department and under which HSD holds DOH/DDSD accountable.

DOH/DDSD participates and assists in the following operational and administrative functions: participant waiver enrollment; waiver enrollment and expenditures managed against approved limits and levels; qualified provider enrollment; execution of Medicaid provider agreements; establishment of a statewide rate development methodology; rules, policies, procedures and information development governing the waiver program; and quality assurance and quality improvement activities. DOH/DDSD also works with providers and families to obtain stakeholder input and to assist the State with the on-going evaluation of the waiver program through the Advisory Council on Quality Supports for Individuals with Developmental Disabilities (ACQ). The ACQ is a statutorily required committee that advises DOH on policy related to programs and supports that assist people with Intellectual/Developmental Disabilities (IDD).

In addition, DOH monitors program quality and compliance with program requirements, through participation on the Developmental Disabilities Services Quality Improvement Steering Committee (DDSQI), as described in Appendix H of this application. HSD participates on the DDSQI Steering Committee.

HSD monitors DOH for compliance of operational responsibilities through a variety of formal and informal oversight activities. These methods include:

- Collaborating with DOH/DDSD to review and analyze program findings, develop strategies for improvement, and make timely changes to the waiver program as determined necessary;
- Monthly meetings with DOH/DDSD to monitor the progress and to oversee the operations of the waiver program and to ensure compliance with Medicaid and CMS requirements; exchange information about the JPA; discuss department roles and responsibilities; identify and resolve program issues; identify and resolve client specific issues, complaints and concerns; identify needed changes; problem-solve; track and monitor progress on assignments and projects related to the operation of the waiver through work plans; and provide technical assistance;
- The DDSQI Steering Committee, as described in Appendix H of this application, follows a quality improvement strategy (QIS) which addresses compliance with waiver assurances among other quality improvement strategies and key performance indicators designed to help the waiver service system achieve better outcomes for consumers, their communities, and the New Mexico public at large; and
- Ad hoc and regular waiver specific and cross-agency workgroups related to the promulgation of state regulations and the development and implementation of standards, policies and procedures in alignment with all state and federal authorities related to home and community-based services (HCBS) waivers.

### 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.:*

The State utilizes two contracted entities referenced in Appendix A-7: Third-Party Assessor (TPA) Contractor; the Financial Management Agent (FMA) Contractor.

TPA Contractor: reviews required assessments and determines ICF-IID Level of Care (LOC) 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. Any third-party contractor that conducts level of care and assessments and determines medical eligibility for the waiver cannot be enrolled as a waiver provider.

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 self-directed Supports Waiver (SW) 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.

The contracted entities have provisions in their contracts for quality assurance and quality improvement activities. HSD 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

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- 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 relative to the contractor's scope of work. HSD/MAD assesses this contractor's performance in conducting its respective waiver operational and administrative functions based on the contract.

FMA CONTRACTOR: HSD/MAD contracts with the FMA relative to the contractor's scope of work. HSD/MAD assesses the performance of this contractor in conducting the contractor's operational and administrative functions according to the State agencies' respective jurisdictions.

## Appendix A: Waiver Administration and Operation

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- 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:**

The TPA is responsible for the following waiver operational and administrative functions: LOC evaluation; review of participant service plans; prior authorization of waiver services; and utilization management, quality assurance and quality improvement activities.

HSD/MAD utilizes monthly TPA reports to ensure the Contractor is compliant with the terms of the contract for the performance and operation of LOC and SSP/budget reviews, and specific monthly audits to monitor LOC performance. The Contractor is also required to attend monthly meetings with HSD/MAD's TPA contract manager whereby any waiver-related contract compliance issues may be identified and monitored to resolution. On an annual basis, HSD/MAD reviews and approves the Contractor's quality improvement/quality management work plan, evaluation and results to ensure compliance with quality management activities related to the waiver. In addition, HSD/MAD utilizes customer service and complaint data, Fair Hearings data, and the ACQ meetings to assess the Contractor's performance. HSD/MAD issues Letters of Direction (LODs) as necessary to the TPA to provide clarification, guidance and instructions required to be implemented.

DOH provides HSD/MAD with any data, complaints or other information DOH has obtained from any source regarding the TPA Contractor's performance.

If any problems are identified, HSD/MAD may require a state-directed corrective action plan from the TPA and monitor its implementation. The TPA may also impose its own internal corrective action plan (CAP), or performance improvement plan, prior to a state-directed CAP being placed. HSD/MAD shares oversight findings with DOH.

**FMA CONTRACTOR:**

The FMA is responsible for the following waiver operational and administrative functions: qualified provider enrollment and background checks; execution of provider agreements; complete payroll functions on behalf of the participant; and process and pay invoices for good and services.

HSD/MAD utilizes weekly and monthly FMA reports to assess compliance with the terms of the contract, processing of payments to providers; and quality assurance and quality improvement activities.

HSD/MAD performs on-going monitoring of the FMA Contractor's claims payment accuracy and adherence to the terms of the provider agreement and performs 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, reviews oversight findings with DOH.

If any problems are identified, HSD/MAD may require a state-directed CAP from the FMA and monitor its implementation. The FMA may also impose its own internal corrective action plan, or performance improvement plan, prior to a state-directed CAP being placed. HSD/MAD shares oversight findings with DOH.

**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.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment			

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Waiver enrollment managed against approved limits			
Waiver expenditures managed against approved levels			
Level of care evaluation			
Review of Participant service plans			
Prior authorization of waiver services			
Utilization management			
Qualified provider enrollment			
Execution of Medicaid provider agreements			
Establishment of a statewide rate methodology			
Rules, policies, procedures and information development governing the waiver program			
Quality assurance and quality improvement activities			

**Appendix A: Waiver Administration and Operation**

**Quality Improvement: Administrative Authority of the Single State Medicaid Agency**

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

*Where possible, include numerator/denominator.*

*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 delegated functions/deliverables specified in the Joint Powers of Agreement (JPA) with which DOH is compliant. Numerator: Number of JPA delegated functions/deliverables that DOH is complaint with on an annual basis. Denominator: Total number of JPA delegated functions/deliverables identified by HSD/MAD.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.                 </div>

**Performance Measure:**

**Percentage of waiver data reports specified in the Third Party Assessor (TPA) contract with the Medicaid Agency (HSD) agency that were submitted on time and in the correct format. Numerator: Number of data reports submitted on time and in correct format. Denominator: Total of TPA reports required to be submitted.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 2px; width: fit-content;">                         Third Party Assessor                     </div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/> Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

**Performance Measure:**

**Percentage of waiver data reports specified in the Fiscal Management Agent (FMA) contract with the Medicaid Agency that were submitted on time and in the correct format.**

**Numerator: Number of data reports submitted on time and in the correct format.**

**Denominator: Total number of FMA reports required be submitted.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="FMA"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	Additional data collection, analysis and aggregation will be done, as necessary to address unusual issues that may arise.

**Performance Measure:**

**Percentage of Community Supports Coordinators (CSC) Agency provider agreements that adhered to the State's uniform agreement requirements. Numerator: Number of CSC agency provider surveys found in compliance. Denominator: Total number of consultant agency provider surveys required by DOH.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">                         Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.                     </div>

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 DOH for compliance with the JPA to ensure that the agency has fulfilled its operational responsibilities, based on the JPA, 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, and review of actions taken by the operating agency.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States 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 addressing identified problems include verbal direction, letters of direction, and 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 identifies any issues that are inconsistent with Medicaid requirements at any time, HSD/MAD ensures that DOH corrects the problem and that compliance with the Assurance is met through regularly scheduled joint meetings.

Problems with functions performed by the TPA and FMA as identified by various discovery methods will result in state providing technical assistance. If the contractor fails to improve performance after receiving technical assistance from the state, a corrective action plan (CAP) may be required, and/or sanctions will be implemented, including possible contract termination. The contractor is required to submit a corrective action plan to the state within 30 days of the request from the state. Based on state approval of the corrective action plan, the contractor is required to remediate the identified performance issues.

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text" value="Data aggregation and analysis will be done more frequently to address specific issues should they 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 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:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<b>Aged or Disabled, or Both - General</b>					
		Aged	<input type="checkbox"/>	<input type="checkbox"/>	
		Disabled (Physical)	<input type="checkbox"/>	<input type="checkbox"/>	
		Disabled (Other)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
<b>Intellectual Disability or Developmental Disability, or Both</b>					
		Autism	0		
		Developmental Disability	0		
		Intellectual Disability	0		
<b>Mental Illness</b>					
		Mental Illness			
		Serious Emotional Disturbance			

**b. Additional Criteria.** The state further specifies its target group(s) as follows:

The State developmental disabilities waiver services are intended for eligible recipients who have developmental disabilities limited to intellectual disability (ID) or a related condition as determined by DOH/DDSD. 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 intellectual disabilities (ICF/IID), in accordance with 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements.

An individual is considered to have an intellectual disability if she/he has significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

- a. General intellectual functioning is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.
- b. Significantly sub-average is defined as approximately IQ of 70 or below.
- c. Adaptive behavior is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group. Deficits in Adaptive Behavior is defined as two standard deviations below mean ( $\leq 70$ ).
- d. The developmental period is defined as the period of time between birth and the 18th birthday.

#### Related Condition

An individual is considered to have a related condition if she/he has a severe, chronic disability that meets all of the following:

- a. Is attributable to a condition, other than mental illness, found to be closely related to ID because this condition results in limitations in general intellectual functioning or adaptive behavior similar to that of persons with ID and requires similar treatment or services
- b. Is manifested before the person reaches age twenty-two (22) years
- c. Likely to continue indefinitely
- d. Results in Substantial Functional Limitations (Adaptive Behavior scores  $\leq 70$ ) in 3 or more of the following areas:
  - i. Self-care
  - ii. Receptive and expressive language
  - iii. Learning
  - iv. Mobility
  - v. Self-direction
  - vi. Capacity for independent living
  - vii. Economic self-determination

- 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:

**Other**

*Specify:*

**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.*

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

**The following dollar amount:**

Specify dollar amount:

**The dollar amount (*select one*)**

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

Specify the formula:

**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:**

Specify percent:

**Other:**

*Specify:*

**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 cost limit 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: B-3-a**

Waiver Year	Unduplicated Number of Participants
<b>Year 1</b>	

Waiver Year	Unduplicated Number of Participants
	5000
Year 2	5000
Year 3	5000

**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: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	

**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:

When funding becomes available based on appropriations from the New Mexico Legislature, a registrant receives a letter of interest. At that time, the individual selects either institutional care or the Supports Waiver (SW). After an individual selects the SW, an individual is offered a choice between the participant-directed or traditional service delivery model. Acceptance or refusal of the SW does not change or negatively impact the individual's placement or position on the DOH Wait List; individuals who accept or refuse the SW are not removed from the DOH Wait List rather maintain their placement and position on the Wait List until offered an allocation to NM.0173 Developmental Disabilities waiver or the NM.0488 Mi Via waiver.

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.

## 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%.**

Specify dollar amount:

**Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

**Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42**

**CFR §435.320, §435.322 and §435.324)**

**Medically needy without spend down in 209(b) States (42 CFR §435.330)**

**Aged and disabled individuals who have income at:**

Select one:

**100% of FPL**

**% of FPL, which is lower than 100%.**

Specify percentage amount:

**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:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

*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. 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:

*Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

**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 uses spousal post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

*Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**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.

**Other**

*Specify:*

**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 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**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.**

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## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**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 §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

**Allowance is the same**

**Allowance is different.**

*Explanation of difference:*

**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-5: Post-Eligibility Treatment of Income (5 of 7)**

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

**Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (6 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

#### f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

**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 (7 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

#### g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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. 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).

**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

## 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:

**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 a government agency under contract with the Medicaid agency.**

*Specify the entity:*

Evaluations and reevaluations are performed by the 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 Level of Care (LOC) process through a variety of contract management responsibilities.

**Other**

*Specify:*

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(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.

The individual must meet the level of care required in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The State’s Long Term Care Assessment Abstract (LTCAA) is used to determine ICF/IID level of care. To be eligible for the Supports Waiver program, participants must meet both the ICF/IID LOC criteria and developmental disabilities criteria.

After the level of care is determined with the Long Term Care Assessment Abstract, other documents are used to further substantiate the level of care. Supporting documents include the Health and Physical completed by the applicant’s/participant’s primary care provider.

The rule criteria for LOC are set forth at 8.314.3 and 8.314.5 NMAC.

**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:

Level of Care evaluations/reevaluations are completed by the contracted Third Party Assessor.

1. The initial LOC evaluation occurs after the participant has received an allocation letter for waiver services. The Community Supports Coordinator assists the participant with the LOC process. Upon notification by the State, the selected Community Supports Coordinator contacts the participant and provides information and assistance to the participant in completing the LOC eligibility process.
2. The participant, Community Supports Coordinator (CSC) or participant's physician submits the State's LTCAA and the current History and Physical to the TPA with the assistance of the participant, to substantiate the LOC. Criteria that are used to evaluate the participant's level of care with the following factors: medical; cognitive; nutritional; communication/hearing; mood and behavior patterns; psychosocial well-being; and physical, functional, and structural limitations.
3. The TPA reviews, evaluates, and approves all initial LOC determinations.
4. All participants are re-evaluated on an annual basis. The TPA 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 uses a report tracking system to ensure that LOC reevaluations are completed on an annual or other 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 the Community Supports Coordinator (CSC) at ninety (90) days with reminders at 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/MAD 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

*The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.*

**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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 applicants, with whom there is reasonable indication that services may be needed in the future, with an initial completed LOC evaluation.**

**Numerator: Number of initial waiver LOC evaluations performed. Denominator:**

**Total number of new waiver applicants.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**TPA Contractor reports on LOC reviews.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		<input type="text"/>
<b>Other</b> Specify:  <input type="text" value="TPA"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify:  <input type="text" value="TPA"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text" value="Additional data collection, analysis, and aggregation, will be done if necessary to address unusual issues that may arise."/>

**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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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.*

- 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 initial LOC evaluations for waiver participants that comply with the processes and instruments specified in the approved waiver. Numerator: Number of compliant initial LOC evaluations for participant. Denominator: Total number of initial LOC evaluations for waiver participants**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**LOC assessment documentation; HSD/MAD audits of TPA contractor**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		=/- 5% margin or error and 95% confidence level
<b>Other</b> Specify:  <input type="text" value="TPA"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text" value="TPA contractor"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text" value="Additional data collection, analysis, and aggregation will be done, as necessary to address unusual issues that may arise."/>

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 DDSQI Steering Committee description and structure in Appendix H.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States 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. This applies to both current and new waiver applicants with a reasonable indication that services may be needed.

Methods for addressing and correcting 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.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**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 DOH/Developmental Disabilities Supports Division Regional Office (DDSD). Individuals are allocated to the waiver from the DOH Wait List.

When funding becomes available based on appropriations from the New Mexico Legislature, a registrant receives a letter of interest. At that time, the individual selects either institutional care or the Supports Waiver (SW). After an individual selects the SW, an individual is offered a choice between the participant-directed or traditional service delivery model. Acceptance or refusal of the SW does not change or negatively impact the individual's placement or position on the DOH Wait List; individuals who accept or refuse the SW are not removed from the DOH Wait List rather maintain their placement and position on the Wait List until offered an allocation to NM.0173 Developmental Disabilities waiver or the NM.0488 Mi Via waiver. The State notifies the Community Support Coordinator to initiate contact with the individual for assistance with the medical and financial eligibility requirements and to start the development of the Individual Service Plan.

**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 DOH statewide toll-free numbers. Statewide disability resource agencies, such as the New Mexico Aging and Long-Term Services Department (ALTSD) Resource Center, Independent Living Resource Centers and the Governor's Commission on Disabilities have bi-lingual staff available. The Department of Health, Developmental Disabilities Supports Division can arrange for a variety of translators for planning meetings upon participant request. Translated documents can also be arranged for through the DOH/DDSD upon participant request.

The Community Supports Coordinator(s), FMA, and TPA are required to communicate in the language that is functionally required by the participant and have "language lines" available for participants who speak a language other than Spanish or English.

## 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:

Service Type	Service		
Statutory Service	Community Supports Coordinator		
Statutory Service	Customized Community Supports - Individual		
Statutory Service	Customized Community Supports -Group		
Statutory Service	Employment Supports		
Statutory Service	Homemaker/Personal Care		
Other Service	Assistive Technology		
Other Service	Behavior Support Consultation		
Other Service	Environmental Modifications		
Other Service	Non-medical Transportation		
Other Service	Respite		
Other Service	Vehicle Modifications		

### 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):**

Community Supports Coordinator

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Community Support Coordination services are intended to educate, guide, monitor, and assist the participant to make informed planning decisions about services and supports, and monitor those services and supports. Specific waiver function(s) that CSC providers have are:

- Monitor service delivery and conduct face to face visits including home visits at least quarterly.
- Complete process to evaluate /re-evaluate Level of Care (medical eligibility).
- Educate, train and assist participant (and guardian, employer of record) about self-direction or agency/traditional-based models (includes adherence to standards, review of rights, recognizing and reporting critical incidents)
- Provide support and assistance during the Medicaid financial eligibility process;
- Develop the person- centered plan with the participant; to include revising e the plan as needed.
- Serve as an advocate for the participant to enhance his/her opportunity to be successful with self-direction or traditional-based program

**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:**

Provider Category	Provider Type Title
Agency	Community Supports Coordinator Agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Community Supports Coordinator**

**Provider Category:**

Agency

**Provider Type:**

Community Supports Coordinator Agency

**Provider Qualifications**

**License** (*specify*):

Hold a current business license issued by the State, county or city government.

**Certificate** (*specify*):

CARF International, Aging Service

The Council on Quality and Leadership, Quality Assurances Accreditation

**Other Standard** (*specify*):

Provider Qualifications:

- Be at least 21 years of age;
- Possess a Bachelor’s Degree in social work, psychology, human services, counseling, nursing, special education or a related field; or have a minimum of six years direct experience related to the delivery of social services to people with disabilities;
- Have at least one year’s experience in working with people with disabilities or I/DD;
- Complete all trainings as required by DOH/DDSD;
- Verification of Provider Qualifications;
- Pass a national care giver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. 7.19 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DOH assures that the community supports coordinator agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**Frequency of Verification:**

Initially and 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:**

Statutory Service

**Service:**

Habilitation

**Alternate Service Title (if any):**

Customized Community Supports - Individual

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition** (*Scope*):

**Category 4:**

**Sub-Category 4:**



Customized Community Supports consist of individualized services and support that enable an individual to acquire, maintain, and improve opportunities for independence, community membership, and inclusion. The support provider may be a skilled independent contractor or a hired employee depending on the level of support needed by the eligible recipient to access the community. Customized Community Supports services are designed around the preferences and choices of each individual and offers skill training and supports to include: adaptive skill development, adult educational supports, citizenship skills, communication, social skills, socially appropriate behaviors, self-advocacy, informed choice, community inclusion, arrangement of transportation, and relationship building. Provide help to the individual to schedule, organize and meet expectations related to chosen community activities. All services are provided in a community setting with the focus on community exploration and true community inclusion.

**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:**

Provider Category	Provider Type Title
Individual	Customized Community Support -Individual Provider

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Customized Community Supports - Individual**

**Provider Category:**

**Provider Type:**

**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;
- Must complete all training requirements as required DOH/DDSD; and
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC

In addition, for participant-directed services, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

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)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**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:**

Day Habilitation

**Alternate Service Title (if any):**

Customized Community Supports -Group

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Customized community 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 for an eligible recipient. Customized community supports may include adult day habilitation, adult day health and other day support models. Customized community supports are provided in community day program facilities and centers and can take place in 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:**

Provider Category	Provider Type Title
Agency	Customized Community Supports Group (Day Habilitation) Provider

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Customized Community Supports -Group**

**Provider Category:**

Agency

**Provider Type:**

Customized Community Supports Group (Day Habilitation) Provider

**Provider Qualifications**

**License (specify):**

Hold a current business license issued by the State, county or city government.

**Certificate (specify):**

CARF International, Employment and Community Services  
 The Council on Quality and Leadership, Quality Assurances Accreditation

**Other Standard** (*specify*):

Customized Community Group Support Provider Agency must meet requirements including a business license, financial solvency, training requirements, records management, quality assurance policy and processes.

The Customized Community Group Support Agency staff must meet the following requirements:

- i. Be at least 18 years of age;
- ii. Have at least one year of experience working with people with disabilities;
- iii. Be qualified to perform the service and demonstrate capacity to perform required tasks;
- iv. Be able to communicate successfully with the participant;
- v. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
- vi. Must complete all training requirements as required DOH/DDSD;
- vii. Complete participant specific training; the evaluation of training needs is determined by the participant or his/her legal representative; participant is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Mi Via participant’s Authorized Annual Budget (AAB); and
- viii. Meet any other service qualifications, as specified in the regulations.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Financial Management Agent (FMA)

DOH assures the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**Frequency of Verification:**

Initially and 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:**

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:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Employment Supports consists of intensive, ongoing services that support individuals to achieve competitive employment or business ownership who, because of their disabilities, might otherwise not be able to succeed without supports to perform in a competitive work setting or own a business. Community Integrated Employment activities are designed to increase or maintain the individual’s skill and independence, and may include: career exploration; career enhancement; job development; job placement; on-the-job training and support; business ownership; job coaching; job site analysis; skills training ; benefits counseling; employer negotiations; co-worker training; vocational assessment; arrangement of transportation; assistance with medication administration ; and nursing support while at the work place; integration of therapy plans; assistance with the use of assistive devices and medical equipment; personal care activities.

Employment Supports offers one-to-one support to individuals placed in jobs or business ownership in the community and support is provided at the work-site as needed for the individual to learn and perform the job. The provider agency is encouraged to develop natural supports in the workplace to decrease the reliance of paid supports. Individuals must have the opportunity for inclusion in non-disability specific work settings.

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

FFP services cannot be used to defray expenses associated with starting up or operating a business.

**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:**

Provider Category	Provider Type Title
Individual	Job Coach
Agency	Supported Employment Provider Agency

**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;
- Must have the high school diploma or GED;
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
- Complete all trainings as required by DOH/DDSD;
- Be qualified to perform the service; experience with providing employment supports, and training methods;
- Knowledgeable about business and employment resources;
- Be able to successfully communicate with the participant and with the employer and the participant's coworkers develop/ encourage natural supports on the job;
- Must complete all training requirements as required DOH/DDSD

In addition for participant-directed services, 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)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**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**

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**Provider Category:**

Agency

**Provider Type:**

Supported Employment Provider Agency

**Provider Qualifications**

**License** (*specify*):

Hold a current business license issued by the State, county or city government.

**Certificate** (*specify*):

CARF International, Aging Service

The Council on Quality and Leadership, Employment and Community Services

**Other Standard** (*specify*):

Employment Support 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:

- o Be at least 21 years of age;
- o Must have the high school diploma or GED;;
- o Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
- o Must complete all training requirements as required DOH/DDSD;
- o Experience in developing and using job and task analyses;
- o Knowledge of American with Disabilities Act (ADA);
- o Knowledge and experience working with the Department of Vocational Rehabilitation (DVR)office; and
- o Experiences with or Knowledge of 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  
 Local Businesses  
 Community Agencies  
 DDSD Resources

Job Coach must:

- Be at least 18 years of age;
- Have a high school diploma or GED
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
- Be qualified to perform the service; experience with providing employment supports, and training methods;
- Knowledgeable about business and employment resources;
- Be able to successfully communicate with the participant and with the employer and the participant's coworkers develop/ encourage natural supports on the job;

In addition for participant-directed services, 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)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**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/Personal Care

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Homemaker/Personal Care Services are provided on an intermittent basis to assist the eligible recipient with a range of activities of daily living, performance of general household tasks, and enable the eligible recipient to accomplish tasks he or she would normally do for himself or herself if he or she did not have a disability. Services are provided in the eligible recipient's home.

The eligible recipient identifies the personal care/ homemaker/chore service worker's training needs, and, if the eligible recipient is unable to do the training him or herself, the eligible recipient arranges for the needed training. Supports shall not replace natural supports such as the member's family, friends, and individuals in the community, clubs, and organizations that are able and consistently available to provide support and service to the member.

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

Waiver participants in all living arrangements are assessed individually and service plan development is individualized. The TPA will assess the service plans of participants living in the same residence to determine whether or not there are homemaker services that are common to more than one participant living in the same household in order to determine whether one or more employees may be needed to ensure that individual different cognitive, clinical, and habilitative needs are met. This waiver service is only provided to individuals age 21 and over. All medically necessary homemaker services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

**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:**

Provider Category	Provider Type Title
Individual	Homemaker/Personal care provider
Agency	Homemaker/Personal Care Agency

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Homemaker/Personal Care**

**Provider Category:**

Individual

**Provider Type:**

Homemaker/Personal care provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Homemaker/Direct Support  
 Worker must be:

- 18 years of age or older;
- Demonstrate capacity to perform required tasks;
- Be able to communicate successfully with the participant;
- Must complete all training requirements as required DOH/DDSD; and
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

In addition, for participant-directed services, 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)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**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: Homemaker/Personal Care**

**Provider Category:**

Agency

**Provider Type:**

Homemaker/Personal Care Agency

**Provider Qualifications**

**License** (*specify*):

Hold a current business license issued by the State, county or city government; home health agency

**Certificate** (*specify*):

**Other Standard** (*specify*):

Homemaker/Personal Care Agency must meet requirements including a current business license, financial solvency, training requirements, records management, quality assurance policy and processes.

The Homemaker/Personal Care 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;
- Must complete all training requirements as required DOH/DDSD; and
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

In addition, for participant-directed services, 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)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**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:**

Assistive Technology

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Assistive Technology (AT) service is intended to increase the individual’s physical and communicative participation in functional activities at home and in the community. Items purchased through the AT service assist the individual to meet outcomes outlined in the ISP, increase functional participation in employment, community activities, activities of daily living, personal interactions, and/ or leisure activities, or increase the individual’s safety during participation of the functional activity. Assistive Technology services allow individuals to purchase needed items to develop low-tech augmentative communication, environmental access, mobility systems and other functional AT, not covered through the individual’s State plan benefits.

Assistive Technology includes Remote Personal Support Technology. Remote Personal Support Technology is an electronic device or monitoring system that supports individuals to be independent in their home or community. This service may provides up to twenty-four (24) hour alert, monitoring or personal emergency response capability, prompting or in home reminders, or monitoring for environmental controls for independence through the use of technologies. The service is intended to promote independence and quality of life, to offer opportunity to live safely and as independently as possible in one’s home, and to ensure the health and safety of the individual in services. This service is not intended to provide for paid, in-person on-site response. On-site response must be planned through back up plans that are developed using natural and/or other paid supports.

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

Limitations: \$5000, once every three (3) years

**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:**

Provider Category	Provider Type Title
Individual	Individual or Company

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Assistive Technology**

**Provider Category:**

Individual

**Provider Type:**

Individual or Company

**Provider Qualifications**

**License** (specify):

Hold a current business license issued by the State, county or city government.

**Certificate** (specify):

**Other Standard** (specify):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Financial Management Agent (FMA)  
 DOH assures that the community supports coordinator agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**Frequency of Verification:**

Upon initial employee or vendor/provider agreement.

## 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:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Behavior support consultation services consist of functional support assessments, treatment plan development, and training and support coordination for the eligible recipient’s related to behaviors that compromise the eligible recipient’s quality of life. Based on the eligible recipient’s ISP, 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:**

Provider Category	Provider Type Title
Agency	Behavior Support Consultation Provider
Individual	Behavior Support Consultation Provider

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Behavior Support Consultation**

**Provider Category:**

Agency

**Provider Type:**

Behavior Support Consultation Provider

**Provider Qualifications**

**License** (*specify*):

A mental health professional that wants to provide BSC services must possess one of the following licenses approved by a New Mexico licensing board:

Psychiatrist; Clinical Psychologist; Independent Social Worker (LISW); Professional Clinical Mental Health Counselor (LPCC); Professional Art Therapist (LPAT); Marriage and Family Therapist (LMFT); Mental Health Counselor (LMHC); Professional Mental Health Counselor (LPC) (Until December 31, 2012); Master Social Worker (LMSW); Psychiatric Nurse; or Psychologist Associate (PA).

**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.

Provider must complete all training requirements as required DOH/DDSD.

In addition, for participant-directed services, 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)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**Frequency of Verification:**

The State of NM verifies the qualifications of all licensed providers annually.

**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 Consultation Provider

**Provider Qualifications**

**License** (*specify*):

A mental health professional that wants to provide BSC services must possess one of the following licenses approved by a New Mexico licensing board: Psychiatrist; Clinical Psychologist; Independent Social Worker (LISW); Professional Clinical Mental Health Counselor (LPCC); Professional Art Therapist (LPAT); Marriage and Family Therapist (LMFT); Mental Health Counselor (LMHC); Professional Mental Health Counselor (LPC) (Until December 31, 2012); Master Social Worker (LMSW); Psychiatric Nurse; or Psychologist Associate (PA).

**Certificate** (*specify*):

**Other Standard** (*specify*):

Provider must complete all training requirements as required DOH/DDSD.

In addition, for participant-directed services, 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)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**Frequency of Verification:**

The State of NM verifies the qualifications of all licensed providers annually.

**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:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Environmental Modifications Services include the purchase and/or installation of equipment and/or making physical adaptations to an individual’s residence that are necessary to ensure the health, welfare and safety of the individual or enhance the individual’s level of independence. Adaptations include: 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.

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

Limitations: \$5000, once every three years

**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:**

Provider Category	Provider Type Title
Individual	Individual or Company

**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; Hold a current business license issued by the State, county or city government.

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Financial Management Agent (FMA)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**Frequency of Verification:**

Upon initial employee or vendor/provider agreement.

**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:**

Non-medical Transportation

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Transportation services are offered to enable eligible recipients to gain access to services, activities, and resources, as specified by the SSP. Transportation services under the waiver are offered in accordance with the eligible recipient’s ISP. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the Medicaid state plan are to transport eligible recipients to medically necessary physical and behavioral health services. Payment for SW transportation services is made to the eligible recipient’s individual transportation employee or to a public or private transportation service vendor. Payment cannot be made to the member. Non-medical transportation services for minors is not a covered service as these are services that a LRI would ordinarily provide for household members of the same age who do not have a disability or chronic illness. Payment cannot be made to the eligible recipient. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge shall be identified in the ISP and 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:**

Provider Category	Provider Type Title
Agency	Transportation Vendor
Individual	Driver

**Appendix C: Participant Services**

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

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**Service Type: Other Service**

**Service Name: Non-medical Transportation**

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**Provider Category:**

Agency

**Provider Type:**

Transportation Vendor

**Provider Qualifications**

**License (specify):**

Valid NM drivers license; Hold a current business license issued by the State, county or city government.

**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 drivers license;
3. Have a current insurance policy and registration;
4. Must complete all training requirements as required DOH/DDSD.

In addition, for participant-directed services, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

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)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**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: Non-medical 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 drivers license;
3. Have a current insurance policy and registration;
4. Must complete all training requirements as required DOH/DDSD.

In addition, for participant-directed services, 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)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**Frequency of Verification:**

Initially and annually

**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:**

Respite

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Respite is a family support service, the primary purpose of which is to give the primary, unpaid caregiver time away from his or her duties. Respite services include assisting the eligible recipient 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 eligible recipient 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 eligible recipient to make his or her own choices with regard to daily activities. Respite services are furnished on a short-term basis and can be provided in the eligible recipient’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. 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):**

**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:**

Provider Category	Provider Type Title
Individual	Respite Provider
Agency	Respite Provider

## Appendix C: Participant Services

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

**Service Type: Other 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;
- Must complete all training requirements as required DOH/DDSD; and
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

In addition, for participant-directed services, 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)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**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: Respite**

**Provider Category:**

Agency

**Provider Type:**

Respite Provider

**Provider Qualifications**

**License** (*specify*):

Hold a current business license issued by the State, county or city government.

**Certificate** (*specify*):

CARF International, Employment and Community Services  
 The Council on Quality and Leadership, Quality Assurances Accreditation

**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;
- Must complete all training requirements as required DOH/DDSD;and
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

In addition, for participant-directed services, 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)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**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:**

Vehicle Modifications

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Adaptations or alterations to an automobile or van that is the waiver participant’s primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
2. Purchase or lease of a vehicle; and
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of services.

Vehicle accessibility adaptations consist of installation, repair, maintenance, training on use of the modifications and extended warranties for the modifications.

Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services.

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

Limitations: \$5000, once every three years

**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:**

Provider Category	Provider Type Title
Individual	Individual or company

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Vehicle Modifications**

**Provider Category:**

Individual

**Provider Type:**

Individual or company

**Provider Qualifications**

**License (specify):**

Appropriate mechanic or body work license; appropriate technical certification to perform the modification; Hold a current business license issued by the State, county or city government.

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Financial Management Agent (FMA)

DOH assures that the agency/provider meets the provider qualifications prior to the approval of the initial agreement and every 3 years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

**Frequency of Verification:**

Upon initial employee or vendor/provider agreement.

**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.

**As a primary care case management system service under a concurrent managed care authority.** 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

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### 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 Caregivers Criminal History Screening (CCHS) Requirements (7.1.9 NMAC) applies to caregivers whose employment or contractual service includes direct care or routine unsupervised physical or financial access to any care recipient served by the DD Waiver.

All covered care providers must undergo a nationwide criminal history background investigation through the use of fingerprints reviewed by the Department of Public Safety and also submitted to the Federal Bureau of Investigation to ensure to the highest degree possible the prevention of abuse, neglect, or financial exploitation of individuals receiving care. The direct care provider agency must initiate and perform the necessary nationwide criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-5 of the Caregivers Criminal History Screening Act. The direct care provider agency must ensure that the individual has submitted to a request for a nationwide criminal history screening within twenty (20) calendar days of first day of employment or effective date of a contractual relationship with the care provider.

The employee may only work under direct supervision until he/she clears the criminal history and background screen; the employee may not provide services alone during the screen.

DOH/Division of Health Improvement (DHI) monitors provider compliance with regulations governing criminal background screening of agency personnel. DOH/DHI reviews providers at a minimum of every three (3) years through on-site record reviews. The documentation required to be kept in the provider file is the CCHS letter or the agency must have proof of request of clearance for each employee within twenty (20) days of the date of hire. If DOH/DHI determines that a provider is out of compliance, a verification review may be conducted following the provider's completion of a Plan of Correction (POC). A verification review is a desk or on-site review of evidence from the agency that the POC has been implemented and that the agency is now in compliance.

Under the self-direction, 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 Supports Waiver participants. The FMA Contractor must ensure that the person has submitted to 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 there from, 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.

The FMA submits a monthly report to HSD of mandatory investigations that have been conducted. HSD is 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.

**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):

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

The Department of Health has established and maintains an electronic Employee Abuse Registry in accordance with NMAC 7.1.12 and NMSA Sections 27-7a-1 through 27-7a-8 of the Employee Abuse Registry Act. The Registry lists all unlicensed direct care providers who, while employed by a provider, have been determined to have engaged in a substantiated incident of abuse, neglect, or exploitation of a person receiving services and who have met the Registry's severity standard. Direct care providers include employees or contractors that provide face-to-face services or have routine unsupervised physical or financial access to a recipient of care or services. Health care providers are required to check this registry prior to hiring an unlicensed care provider, and to maintain documentation in that person's personnel file to reflect that this inquiry has taken place.

By statute, New Mexico providers must conduct screenings and document that screening has occurred. Documentation is required to be maintained in the employee's personnel record. It is a responsibility of the direct care provider to ensure that such screening has been conducted and properly documented.

DOH/Division of Health Improvement (DHI) monitors provider compliance with regulations governing the Employee Abuse Registry to ensure that screening has been conducted and properly documented. DOH/DHI reviews providers at a minimum of every three (3) years. If DOH/DHI determines that a provider is out of compliance, a verification review may be conducted following the provider's completion of a plan of correction.

Corrective action plans require that any identified risk of harm be corrected immediately, including immediate termination of an employee found to be on the abuse registry. The provider is required to submit a plan of correction within 10 business days from the receipt of the letter from DOH/DHI. The corrective action plan is required to be implemented within 45 from the approval date by DOH/DHI. A provider can dispute the findings within 10 business days of receipt of the letter.

Under the self-direction, the FMA Contractor is responsible for ensuring that screening has been completed on applicable providers of services to Supports Waiver 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 Supports Waiver 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 Supports Waiver 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.

The state receives monthly reports of all new employees and providers that have been screened through the nationwide caregiver criminal history screening and employee abuse registry. The FMA also notifies the state when a current employee has been involved in a disqualifying event.

HSD is 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.

## 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).**

**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.*

**Self-directed**

**Agency-operated**

**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.*

Relatives and legal guardians 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/legal guardian to find other qualified, suitable caregivers when the legally responsible individual/legal guardian would otherwise be absent from the home and, thus, must stay at home to ensure the participant's health and safety. A relative or legal guardian may not be paid for the following services: transportation of a minor, a Community Supports Coordinator, and customized group supports services, environmental or vehicle modifications, and assistive technology. A spouse may not be paid to provide transportation services for adult participants. A relative/legal guardian may not provide 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.

**Relatives/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.

**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:

Provider enrollment is a continuous, open enrollment. To assure that all willing and qualified providers have the opportunity to enroll as waiver service providers, the enrollment requirements, procedures, established timeframes for qualifying and enrolling in the program, and applications for enrollment are available on the DOH/DDSD website. Interested providers may also request information and a provider enrollment application at any time by calling the DOH/DDSD Provider Enrollment Unit. DOH/DDSD staff are available to meet with interested providers to provide technical assistance on the application process, review criteria or to obtain further information, as needed. In addition, DOH/DDSD issues a formal call for providers when provider capacity does not meet the demands of the waiver.

Once the provider enrollment application is approved by DOH/DDSD, it is forwarded to HSD/MAD for final approval, including approval of the administrative section of the application. All initial provider applications must be approved by HSD/MAD prior to the provision of waiver services.

Under the self-direction, in their Individual Service Plan (ISP), participants will identify needed services and the appropriate providers from which to purchase those services. Supports Waiver 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 the Supports waiver may request information from the Financial Management Agent (FMA) and are then enrolled by the FMA.

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

The DOH specifies provider enrollment for Community Service Coordinator agencies 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 by DOH. If approved by DOH, 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

#### **a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*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 licensed/certified providers who meet required licensure and/or certification standards prior to furnishing waiver services. Numerator: Number of newly enrolled licensed/certified providers who meet licensure/certification standards. Denominator: Total number of newly enrolled licensed/certified providers.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider reports compiled by FMA contractor. DOH/DDSD provider enrollment.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<b>Representative Sample</b> Confidence Interval = <input data-bbox="1078 1061 1264 1144" type="text"/>
<b>Other</b> Specify: <input data-bbox="408 1285 647 1368" type="text" value="FMA"/>	Annually	<b>Stratified</b> Describe Group: <input data-bbox="1078 1285 1264 1368" type="text"/>
	Continuously and Ongoing	<b>Other</b> Specify: <input data-bbox="1078 1509 1264 1592" type="text"/>
	<b>Other</b> Specify: <input data-bbox="718 1733 954 1816" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:  <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:  <input type="text" value="Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that arise."/>

**Performance Measure:**

The percentage of enrolled licensed/certified providers who continually meet required licensure/certification standards. Numerator: Number of enrolled licensed/certified providers who meet required licensure/certification standards. Denominator: Total number of enrolled licensed/certified providers.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider reports compiled by the Financial Management Agency (FMA) contractor. DOH record review.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		<input type="text"/>
<b>Other</b> Specify:  <input type="text" value="FMA"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text" value="Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that arise."/>

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

**requirements.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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 required background checks. 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:

**Provider reports and record reviews.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify:  <input type="text" value="FMA"/>	Annually	Stratified Describe Group:  <input type="text"/>
	Continuously and Ongoing	Other Specify:  <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 30px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">                         Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that arise.                     </div>

**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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*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 agency staff who are in compliance with training requirements as specified in the Waiver and Service Standards. Numerator: Number of compliant agency staff. Denominator: Total number of agency staff.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider agreements; DOH training database**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="FMA"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text" value="Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise."/>

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.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States 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.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

**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.

**No**

**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)*.

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

**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 C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

The state assures that the settings transition plan included in this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The state will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

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

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

**State Participant-Centered Service Plan Title:**

Individual Service Plan

**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:*

Community Supports Coordinator - Bachelors Degree in related field such as social work, psychology, social sciences and at least one year's experience in working with people with Intellectual/Developmental Disability (I/DD) or a minimum of 3 years experience related to the delivery of social services to people living with I/DD.

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

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**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:*

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

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**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.

**INFORMATION PROVIDED**

The Supports Waiver (SW) affords the opportunity to individuals to self-direct their services or access services through a traditional service model. The participant develops his or her Individual Service Plan (ISP) within the State's individual budgetary allotment and can direct services and supports identified in his or her ISP. The Community Supports Coordinator (CSC) provides the participant and his or her family members and authorized representative with written and oral information about the SW services and the process for developing an ISP including information about the participant's rights to determine his or her person-centered planning.

**PARTICIPANT AUTHORITY TO DETERMINE WHO IS INCLUDED IN THE PROCESS:**

The participant, or his or her authorized representative acting on the participant's behalf may invite family members, friends, advocacy specialists, coworkers, professionals, and anyone else he or she may desire to be part of the meetings or his or her circle of support. However, the participant, or his authorized representative, retains the authority to exclude any individual from development of his or her ISP with the CSC.

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

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### 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):

#### TIMING OF PLAN

For development of the ISP, 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 any risk factors in a number of the following ways including but not limited to: through the Level of Care (LOC) assessment process; and through the person-centered planning process that is undertaken between the Community Supports Coordinator (CSC) and participant to develop the participant's ISP.

#### ASSESSMENTS

Assessment activities that occur prior to the ISP meeting assist in the development of a person-centered plan that is an accurate and functional plan for the participant. 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. The participant and the CSC will assure that the ISP addresses the information and/or concerns identified through the assessment process.

#### PROVISION OF INFORMATION REGARDING AVAILABLE WAIVER SERVICES

The CSC contacts the participant upon his/her choosing the Supports Waiver (SW) program to provide information regarding SW including: the range and scope of service choices and options, rights, risks, and responsibilities associated with self-direction or traditional service delivery model. In addition, the CSC provides the participant with a copy of the SW service standards. The CSC also share information with the individual and his or her authorized representatives and family about qualified providers (example: individuals, community-based service agencies, vendors, and entities).

#### PLAN DEVELOPMENT ENSURES PLAN ADDRESSES THE PARTICIPANT'S GOALS, NEEDS AND PREFERENCES

The State requires each CSC use an individual-directed, person-centered planning approach which identifies the participant's strengths, needs, preferences, goals, access to paid and non-paid supports, health status, risk factors, and other information for the ISP. Based on a person centered planning approach an ISP is developed that identifies the supports and services to meet the individual's needs, goals, and preference in order for the participant to live in his or her home or community and whether those supports and services will be provided by natural or information supports, other local, State and federal programs, or through this waiver.

The CSC 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); health and wellness; safety, behavioral, and other support, including Environmental Modifications and technology.
- Services selected address the participant's needs as identified during the assessment process and ISP.
- Services do not duplicate or supplant those available to the participant through the Medicaid State Plan or other public programs;
- The responsibilities are assigned for implementing the plan;
- The Back-up plans and acknowledgement form are complete and on file.

#### HOW WAIVER SERVICES WILL BE COORDINATED

Waiver, community resources, natural support and other services available through other programs are coordinated through ongoing communication between the CSC, and the individual and/or family or legal representative as appropriate. The ISP is the focal point for coordinating services available under other programs, including this waiver, which meets the participant's needs, goals, and preferences as identified in the ISP.

#### HOW THE DEVELOPMENT PROCESS PROVIDES FOR ASSIGNMENT OF REPONSIBILTIES TO IMPLEMENT AND MONITOR THE PLAN

The ISP delineates the roles and responsibilities of natural supports, providers or employers, related to the implementation of the plan. Pursuant to the waiver service standards, the CSC is responsible for monitoring implementation of the plan on a monthly or quarterly basis, or more frequently as needed.

**HOWE THE PLAN IS UPDATED**

The ISP is updated annually, when requested by the individual, or when the participant experiences a change in needs, health status, outcomes or natural supports.

**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 State must assure the participant's safety. In order to adequately assess and mitigate risks, the Community Supports Coordinator (CSC) is required to work with the participant and persons chosen by the participant in the ISP development process, such as family or legal representative, to develop a plan that addresses risks that may have been identified during the participant's LOC assessment and the ISP development process.

**RISK MITIGATION STRATEGIES**

Once identified, the CSC discusses potential risk mitigation strategies with the participant and his or her family and must ensure health and safety while affording a participant dignity of risk. Risk mitigation strategies include:

1. **Implementation of Back up Plans.** Back-up plans are required for natural or paid supports that address critical areas of concern outlined in the LOC assessment/recommendation. The Back Up Plan is developed as part of the Individual-centered Plan and addresses paid services as well as outlines relatives, natural supports and CSC services that can be called upon to assist; list who the participant will contact if scheduled employees/providers are unable to report to work; calling 911 as necessary. The CSC monitors the use and effectiveness of back-up plans during monthly contacts and quarterly visits to mitigate any future health and safety risks.
2. **Hiring for adequate staffing to meet assessed needs.** Participants address the hours per week of services they require and plan accordingly as part of mitigating risks.

**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.

The Community Supports Coordinator (CSC) provides information to each participant, his or her authorized representative, his or her family members, and other identified planning team members regarding available waiver services, service delivery models (Participant-Directed and Traditional Service Delivery Model). The participant has access to a list of State approved, qualified, Medicaid providers for the Supports Waiver (SW) and is provided during initial ISP development, ISP revisions and at any other time as requested by the participant.

The SW allows for participant-direction of services. For participants choosing the participant-directed delivery model, participants are encouraged to identify their own providers. The CSC will provide the participant with information of his or her options under the employer authority to identify and select their staff and service providers.

The participant is encouraged to learn about multiple providers, including meeting and interviewing staff regarding services, prior to selecting their provider agency or hiring their employees.

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

**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):

Community Supports Coordinators (CSC) submit Individual Service Plans (ISP) and budgets to the TPA Contractor for approval.

On behalf of HSD/MAD, the TPA Contractor approves each participant's ISP 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. 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. Corrective measures may begin with detailed letters of direction (LODs) and can escalate, if necessary, to corrective action plans and contract sanctions.

## 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:*

## 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.

**MONITORING**

The Community Supports Coordinator (CSC) assists the participant with implementing his/her Individual Service Plan (ISP) and budget.

**IMPLEMENTATION AND FREQUENCY**

The CSC monitors the progress of the plan at least every month by contacting the participant. During the monthly contact, the CSC:

- 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
- Follows-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
- Assesses for suspected abuse, neglect or exploitation and report accordingly; if not reported, the CSC takes remedial action to ensure correct reporting
- Documents progress of time-sensitive activities outlined in the ISP including employee trainings and eligibility activities
- Determines if health and safety issues are being addressed appropriately
- Discusses budget utilization concerns

**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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

**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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 re-certifications) that adequately address needs identified through Level of Care (LOC) assessment and the Individual Service Plan (ISP). Numerator: Number of new and annual service plans determined to adequately address needs identified through LOC assessment and ICP.**

**Denominator: Total number of new and annual service plans submitted.**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="TPA"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text" value="TPA"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>

**b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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.*

**c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 were revised, as warranted by changes in participants’ needs, for participants with continuous enrollment of 12 months.**

**Numerator: Number of service plans revised for participants with enrollment of 12 months. Denominator: total number of service plans submitted for revision.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="TPA"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 2px; width: fit-content;">TPA</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**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.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 participants receiving services consistent with their service plan in type, scope, amount, duration and frequency of services. Numerator: Number of waiver individuals receiving services with their individual centered plan as measured by using 70% or more of their approved budget. Denominator: Total number of participants reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Medicaid Management Information System/Data Warehouse**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):

<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.                 </div>

**e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 waiver participants whose state records documented an opportunity was provided for choice of waiver services and providers. Numerator: Number of waiver participants whose state records documented an opportunity was provided for choice of waiver services and providers. Denominator: Total number of state records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Report from DDS Intake and Eligibility and FMA online portal.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		<input type="text"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/> Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.

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 DDSQI Steering Committee description and structure in Appendix H.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States 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, DDSQI routinely reviews, analyzes, and trends 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 service plans, 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)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**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.

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## Appendix E: Participant Direction of Services

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**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

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### 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.

Services and supports are based on assessed needs identified in the Individual Service Plan (ISP) that the participant feels can be addressed by waiver services. Participant-direction under the Supports Waiver (SW) 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 the self-direction under the Supports Waiver, which includes but is not limited to information about: basic core values and philosophy of self-direction; 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.

Participant-direction under the SW affords opportunities to individuals to self-direct their services. The participant develops his/her ISP within the State's individual 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 ISP 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 ISP, which serves as the foundation for participation in participant-direction under the Supports Waiver.

The Community Supports Coordinator (CSC), the Employer of Record (EOR), if applicable, and the FMA support the participant in self-direction. As is discussed in Appendix D, CSCs, 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 self-direction under the Supports Waiver and developing their ISP. The participant identifies the individuals he/she wants to be involved in the development of his/her ISP, and the CSC helps the participant explore options and make informed choices, based on his/her individual needs. The CSC also helps the participant to negotiate services and supports with family members, providers, and others and build consensus.

The CSC is trained in and must demonstrate:

1. understanding of all aspects of self-directed under the Supports Waiver, such as the guiding principles for self-direction;
2. role of the participant in the person-centered planning process;
3. available service and support options;
4. locating and securing services and support
5. development and management of the individual budget;
6. have knowledge about community resources and how to seek out resources; and
7. be able to provide the participant with a listing of community resources.

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 self-direction under the Supports Waiver as it relates to the planning process and development and managing the individual budget. Based on the participant's individual ISP 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:

## Appendix E: Participant Direction of Services

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### 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 participant's 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

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### 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 participant-direction under the Supports Waiver, the participant (or the participant's representative) must have ready access to on-going education, training, information, tools, and support related to key aspects of self-direction so that the participant, or participant's representative, can make informed decisions regarding self-direction. A multifaceted approach is utilized to communicate information, such as easy-to-understand written materials, website information, alternative formats, and community meetings for participants, families, providers, and other interested parties. Materials are developed in collaboration with and through contribution from participants, advocates, and families so that information is as clear as possible. A participant who is participant-directing their services can choose to move to the traditional-based service delivery model, and vice versa. The participant is assisted with the transition process and accessing services by their Community Services Coordinator so that there is no break in delivery of services needed. The DOH will also monitor the transition process as necessary.

Participants, and their representatives (legal guardian, EOR, etc.), enrolled in participant-direction under the Supports Waiver complete trainings that are focused on what the participant needs to learn in order to be successful, basic core values, guiding principles, 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.

State staff as well as advocacy organizations and constituents 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. As well, Community Supports Coordinators (CSC) are responsible for providing information regarding program rules including the Supports Waiver Standards. CSCs must provide participants with a hardcopy of the Supports Waiver Standards or information regarding how to access the Service Standards electronically. These Standards outline participant rights, responsibilities and the philosophy of the program highlighting choice, greater control and freedom regarding the services and supports they choose. These Standards also include information regarding the conditions for involuntary termination from the Supports Waiver if there is a failure to comply with program rules under participant-direction. During the enrollment meeting all participant-direction and waiver processes are reviewed with the participant to assure their understanding that failure to follow those processes could affect their Supports Waiver services.

## 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.

Waiver Service	Employer Authority	Budget Authority
Environmental Modifications		
Vehicle Modifications		
Assistive Technology		
Non-medical Transportation		
Homemaker/Personal Care		
Respite		
Customized Community Supports - Individual		
Customized Community Supports -Group		
Employment Supports		
Behavior Support Consultation		

## 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 C-1/C-3**

**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:

**Assist participant in verifying support worker citizenship status**

**Collect and process timesheets of support workers**

**Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

**Other**

*Specify:*

[Empty text box for specifying other supports]

Supports furnished when the participant exercises budget authority:

**Maintain a separate account for each participant's participant-directed budget**

**Track and report participant funds, disbursements and the balance of participant funds**

**Process and pay invoices for goods and services approved in the service plan**

**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

**Other services and supports**

*Specify:*

[Empty text box for specifying other budget authority supports]

Additional functions/activities:

**Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

**Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

**Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

**Other**

*Specify:*

[Empty text box for specifying additional functions/activities]

- 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.

HSD/MAD contracts with the FMA and monitors reports submitted by the FMA to ensure contract compliance. Monthly reports are monitored to ensure all services paid on behalf of the participant are included in the participant's approved ISP 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 with 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):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental Modifications	
Vehicle Modifications	
Assistive Technology	
Non-medical Transportation	
Homemaker/Personal Care	
Respite	
Community Supports Coordinator	
Customized Community Supports - Individual	
Customized Community Supports -Group	
Employment Supports	
Behavior Support	

<b>Participant-Directed Waiver Service</b>	<b>Information and Assistance Provided through this Waiver Service Coverage</b>
Consultation	

**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).*

**No. Arrangements have not been made for independent advocacy.**

**Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

While under appeal, participant's services will continue. In order to continue with current benefits during a fair hearing, "continuation of benefits" may be provided to eligible recipients. With a "continuation of benefits", the participant's current budget and SSP may not be revised until the conclusion of the administrative hearing process. The option to request a Continuation of benefits is provided through a denial letter from the TPA.

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**i. 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:

When participants are allocated to the Supports Waiver, they are allocated to one waiver slot. A participant who is participant-directing their services can choose to move to the traditional-based service delivery model, and vice versa. The participant is assisted with the transition process and accessing services by their Community Services Coordinator so that there is no break in delivery of services needed. The DOH will also monitor the transition process as necessary.

## 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 provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Individual preferences and dignity are taken into consideration but the state also has an obligation to maintain health and safety in the circumstances of imminent risk of death or risk of irreversible or serious bodily injury, or putting others in imminent danger despite focused technical assistance. In the event of involuntary transition or termination from self-direction, individual preferences and dignity will be taken into consideration during any focused technical assistance attempts to identify alternatives for support. The state will maintain the obligation to involuntarily transition or terminate those who are at immediate health and safety risk associated with self-direction (e.g. imminent risk of death or risk of irreversible or serious bodily injury or putting others in imminent danger) despite focused technical assistance.

A participant may be transitioned involuntarily by DOH to the traditional-model of service delivery under the following circumstances:

1. The participant refuses to follow Support Waiver program rules and regulations after repeated and focused technical assistance and support from the program staff, Community Supports Coordinator, 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 Individual Support Plan (ISP) 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, Community Support Coordinator, 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 ISP and budget (as applicable).
  - The participant puts others in danger.
3. The participant misuses Supports Waiver funds following repeated and focused technical assistance and support from the consultant and/or FMA.
4. The participant commits Medicaid fraud.
5. When DOH is notified the participant continues to utilize employees/vendors who have consistently been substantiated against for abuse, neglect, exploitation while providing waiver services after notification of this on multiple occasions by DOH.

The client Fair Hearings processes will apply, as described in Appendix F.

## 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 E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="5000"/>
Year 2	<input type="text"/>	<input type="text" value="5000"/>
Year 3	<input type="text"/>	<input type="text" value="5000"/>

## 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:*

**Recruit staff**

**Refer staff to agency for hiring (co-employer)**

**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:

**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.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

**Determine staff wages and benefits subject to state limits**

**Schedule staff**

**Orient and instruct staff in duties**

**Supervise staff**

**Evaluate staff performance**

**Verify time worked by staff and approve time sheets**

**Discharge staff (common law employer)**

**Discharge staff from providing services (co-employer)**

**Other**

Specify:

**Appendix E: Participant Direction of Services**

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**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:*

**Reallocate funds among services included in the budget**

**Determine the amount paid for services within the state's established limits**

**Substitute service providers**

**Schedule the provision of services**

**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

**Identify service providers and refer for provider enrollment**

**Authorize payment for waiver goods and services**

**Review and approve provider invoices for services rendered**

**Other**

Specify:

**Appendix E: Participant Direction of Services**

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**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 the participant-directed Supports Waiver have authority to expend waiver funds for services through an approved annual budgetary amount not to exceed the waiver's individual budgetary allotment.

Individual budgetary allotment is \$10,000. The budget limit is based on the amount of legislative appropriation at the time of the creation of the waiver. In addition, the State considered the availability of other services and supports (eg. family caregivers, natural supports, Medicaid State Plan services, public education) for the Supports Waiver's targeted population and information on the utilization of these other services and supports.

The limit does not include the cost of Community Supports Coordinator as provided in Appendix C, Fiscal Management Services as provided in Appendix E, and Medicaid State Plan services.

## 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 Community Supports Coordinator (CSC) 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 ISP and budget amount once the budget development process is complete. The amount of the annual budget cannot exceed the waiver's individual annual budgetary allotment. 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 CSC 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

## 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 Community Supports Coordinator (CSC) work with the participant to ensure that the budget is utilized according to the Individual Service Plan (ISP). The State and the FMA have established two safeguards for the timely prevention of premature depletion or underutilization of the participant-directed budget:

1. The FMA sets up an individual account, based on the participant's approved ISP and budget. Expenditures are made against the account that follows the participant's authorized budget and service plan. The FMA generates a monthly report that is provided to the participant. The reports are a means for timely prevention of the premature depletion of the participant-directed budget. The reports include each service category, total approved dollars in the budget, total spent to date, and unused dollars.
2. The monthly report is provided to the participant to allow them to review for accuracy of expenditures, identify any inaccuracies, and for monitoring of budget balance. When problems are identified, the CSC, FMA, and participant work together to find solutions and make changes as indicated. The reports can also be used to track budget underutilization. Real time reports are available at any time to the participant, consultants and state program manager through the FMA's online portal.
3. In addition to real-time and monthly reporting, the participant, CSC, Employer of Record (EOR) and the State have online access to the participants budgetary and service plans via the FMA's online portal, F. Participants and EOR's receive training on the access and use of the online portal prior to receiving services. At any time, the approved budget, per service, charges and expenditures, timesheets, payments, balances can be viewed for review. When problems are identified, the CSC, FMA and participant work together to make changes as indicated.

## 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.

In order to ensure that a participant is fully informed of rights to a Fair Hearing, DOH/DDSD provides general information about an individual's right to a Fair Hearing in various formats during the waiver entrance process and post enrollment activities, including:

1. The participant is given information by the Community Supports Coordinator (CSC) during the initial training on Supports Waiver about his/her rights 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. CSC are trained in this process and available to assist participants in understanding how to request a Fair Hearing.
2. 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, or 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, also called an adverse action. The adverse action letter 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.
  - a. 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.
  - b. The TPA Contractor provides notice when services are denied, reduced, terminated, modified, or suspended.
  - c. The DOH/Developmental Disabilities Supports Division (DDSD) provides notice when DOH/DDSD determines that an individual does not meet the definition of developmental disabilities.
  - d. The HSD/Income Support Division (ISD) office provides notice when an individual does not meet financial and/or medical Medicaid eligibility criteria.
  - e. The DOH/DDSD provides notice when an individual is involuntarily terminated from the SW program.
3. Website postings (see current information here: <http://actnewmexico.org/fair-hearing-rights.html>)
4. Hard copy informational documents distributed by DOH/DDSD and Office of Constituent Affairs at regular stakeholder meetings and public forums.
5. Written notice of rights accompany the SW application provided to the applicant, guardian and authorized representative at the start of the application process.
6. Verbal explanation provided by DDSD regional Offices as requested.

Eligible recipients are also offered the opportunity to participate in an agency review conference (ARC) to allow the agency or its designee, and the eligible recipient to meet and discuss the fair hearing issues to attempt clarification and possible resolution. Participation in the ARC is not mandatory and does not affect or delay the fair hearing process and is described in more detail in Appendix F-2b.

## 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.

**STATE AGENCY THAT OPERATES THE PROCESS**

HSD operates the additional dispute resolutions process known as an Agency Review Conference.

**NATURE OF PROCESS**

The written notice provided by the TPA Contractor when a service is denied, reduced, terminated, modified, or suspended also includes information on how to request a reconsideration if the individual is dissatisfied with the LOC or service/budget decision as set forth in the Medical Assistance Division Rule 8.350.2 NMAC Reconsideration of Utilization Review Decisions. The notice includes information on reconsiderations and fair hearing rights. Within the notice, the participant and/or guardian is informed that the dispute resolution mechanism is not pre-requisite or substitute for a Fair Hearing.

A reconsideration request must be received by the TPA Contractor within 30 calendar days of the decision notice. The TPA Contractor furnishes the reconsideration decision within 10 business days of receipt of the reconsideration request. If the reconsideration decision is adverse to the individual, the TPA Contractor issues a notice that includes a statement advising the individual that he/she can request a fair hearing.

Eligible recipients are also offered the opportunity to participate in an Agency Review Conference (ARC) to allow the eligible recipient to meet and discuss the fair hearing issues to attempt clarification and possible resolution before the Fair Hearing.

**HOW THE RIGHT TO A MEDICAID FAIR HEARING IS PRESERVED**

The right to a Medicaid Fair hearing is preserved in Supports Waiver New Mexico Administrative Code (NMAC) and NMAC 8.352.2 Claimant Hearings, NMAC 8.350.2 Reconsideration of Utilization Review Decisions, and NMAC 7.26.4 Client Complaint Procedures

Participant fair hearing rights are also outlined in the Supports Waiver Service Standards.

**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:**

Both HSD/MAD and DOH/DDSD is 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 the operating agency (if applicable).**

#### TYPES OF GRIEVANCES/COMPLAINTS THAT PARTICIPANTS MAY REGISTER

Participants may register a complaint or grievance about any issue they are dissatisfied with as it relates to the Supports Waiver (SW). Participants may register complaints with DOH/DDSD via email, mail, or by phone. The participant is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing.

#### THE PROCESS AND TIMELINES FOR ADDRESSING GRIEVANCES/COMPLAINTS

The DOH/DDSD follow up within two (2) business days from the date the complaint/grievance is received and informs the individual that the process is not a prerequisite or substitute for a fair hearing. Complaints may be resolved using state policies and procedures or other mechanisms as appropriate to the program.

#### THE MECHANISMS THAT ARE USED TO RESOLVE GRIEVANCES/COMPLAINTS

When a complaint is received regarding a Community Supports Coordinator (CSC) Agency, the participant is encouraged to follow the CSC Agency grievance/complaint procedures they are required to have per the SW Standards (NMAC 7.26.4 Client Complaint Procedures). If the complaint is not resolved after the utilization of the SW Agency procedures, the Participant may file a complaint/grievance in writing or orally with the DDSD/DOH SW Program Manager who will adhere to the NMAC Regulation 7.26.4 regarding Client Complaint Procedures. If received in writing, the complaint/grievance will be acknowledged when received by the Program Manager with the Participant. Upon receipt, the complaint/grievance will be tracked by the DOH/DDSD.

The NMAC Regulation 7.26.4 requires the review of the complaint and notification to the CSC Agency within 5 days of receipt of the complaint to obtain their response to the complaint if it has already been registered with them. DOH/DDSD will determine if a full investigation is required to address the complaint and if so, will initiate an investigation into the complaint and will complete a report within 45 days of receipt of the complaint. If the DOH/DDSD determines a full investigation is not necessary, the DOH/DDSD will issue a report within 15 days of the receipt of the complaint. The Division Director will review the report and issue a written decision within 10 days of the receipt of the written report unless further investigation is warranted and at that time which should be completed in 14 days unless extension is granted by the Division Director. An Administrative Appeal can be initiated by the Participant if the complaint/grievance is not addressed satisfactorily at that time. Corrective action plans, sanctions or other relief or a complaint may occur as a result of this process.

When a participant's complaint is received by the DOH/DDSD regarding issues related to the TPA or FMA, the DOH/DDSD will notify HSD of the complaint for their review and follow up. Complaints not related to the TPA or FMA will be handled by DOH to establish a plan of collaboration to address the complaint as well as establish a plan to make contact with the participant regarding the complaint and the outcome of steps taken to address the complaint as appropriate.

The FMA tracks complaints and applies an internal standard for complaint resolution: urgent inquiries are reported to HSD within four (4) hours of reporting and must be resolved by close of business; resolution for high, medium, and low priority inquiries are completed in twenty-four (24), forty-eight (48) and seventy-two (72) business hours respectively.

Oral or written complaints and grievances from a participant to the TPA are resolved within thirty (30) calendar days of the date of the event causing dissatisfaction. Within five (5) business days of receipt of a complaint, the TPA provides a written acknowledgement that the complaint has been received and what the expected resolution date. The TPA has thirty (30) calendar days of the date of the receipt of the complaint to investigate and render a final resolution. Informal grievances are documented and reported to the TPA Quality Improvement (QI) Department.

## 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 operates a reporting system for critical events or incidents involving individuals receiving Supports waiver services: the Division of Health Improvement (DHI)/Incident Management Bureau (IMB) protocols for incidents of abuse, neglect, exploitation, suspicious injury, environmental hazard and deaths.

**DOH/DHI/IMB REPORTING PROTOCOLS:**

The DOH/DHI/IMB operates a joint protocol with the NM's Children Youth and Families Department (CYFD)-Child Protective Services (CPS) and Aging and Long-Term Services Division (ALTSD)- Adult Protective Services (APS) for reports of:

Abuse  
Neglect  
Exploitation  
Suspicious Injury  
Environmental hazard  
Death

The DOH/DHI/IMB receives, triages, and investigates reports of alleged abuse, neglect, exploitation, any death, suspicious injury and environmentally hazardous conditions which create an immediate threat to health or safety of the individual receiving Supports waiver services. The reporting of incidents is mandated pursuant to 7.1.14 of the New Mexico Administrative Code (NMAC). Any suspected abuse, neglect, or exploitation must be reported to the CYFD/CPS for individuals under the age of 18 or to the DOH/DHI/IMB for those over the age of 18. Additionally, per the NMAC 7.1.14, those providing Supports Waiver services are directed to immediately report abuse, neglect, exploitation, suspicious injuries, any death and also environmentally hazardous conditions which create an immediate threat to life or health to the DHI hotline. Per NMAC 7.1.14 anyone may contact this hotline to report abuse, neglect, and/or exploitation. 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. An Immediate Action and Safety Plan is developed at the time of intake to ensure health and safety for the individual.

**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 HOW TO REPORT INCIDENTS

1. 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 and during the annual plan renewal meetings.

Training includes a section on self-protection, how to recognize abuse, neglect and exploitation, and where to go for help.

2. Community Support Coordinators (CSC) are trained annually on incident reporting, abuse, neglect and exploitation. Critical incident reporting is reinforced by the CSC who work with the participants during the planning and monitoring process.

For participants in self-direction, the CSC will work with participants to assure staff are trained on incident reporting, abuse, neglect and exploitation. Information regarding abuse, neglect and/or exploitation as well as state reporting requirements for this will be distributed through employee and vendor packets. Prior to working with the participant, CSC must take the initial face-to-face training from DDS on incident reporting, abuse, neglect and exploitation. The online refresher training is required annually after the initial face to face training for all CSCs. Each CSC Agency is required to have someone from that agency be trained as a train the trainer.

CSCs are required to train the participant and have the availability to offer face to face trainings, if requested.

CSCs are resources to provide direction to participants, staff and circles of support. CSCs will work with participants to assure staff are trained on incident reporting, abuse, neglect and exploitation. Online training is required for all participant employees and employer of records (EOR.)

In addition, information regarding abuse, neglect and/or exploitation as well as state reporting requirements for this will be distributed through employee and vendor packets. This information is reinforced by the CSCs, who work with participants during the planning and monitoring process. DOH/DHI presents an abuse, neglect and exploitation training to identify the indications of abuse, neglect and exploitation as well as identify risk factors and risk reduction. DOH/DHI is also responsible in disseminating information about training and education to participants, families, and/or legal representatives.

3. DOH/DHI posts online and presents an abuse, neglect and exploitation training to identify the indications of abuse, neglect and exploitation as well as identify risk factors and risk reduction. DOH/DHI presents an abuse, neglect and exploitation training to identify the indications of abuse, neglect and exploitation as well as identify risk factors and risk reduction. DOH/DHI is also responsible in disseminating information about training and education to participants, families, and/or legal representatives.

**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.

The DOH/DHI/IMB receives reports and investigates incidents of abuse, neglect, exploitation and death. The entire intake process must be completed within three (3) days following the date of receipt. The IMB does have an extended intake process that can be requested by the intake specialist in order to receive appropriate documentation.

Upon receipt of the Incident Report, DOH intake staff:

- I. Search 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 in order to determine if they have the proper jurisdiction or if the incident should be transferred to another jurisdiction. Once DOH/DHI has determined jurisdiction, they assign severity and priority.
- 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; the IMB does have an extended intake process that can be requested by the intake specialist in order to receive appropriate documentation.

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; Exploitation; Death; Environmental hazard; and Suspicious Injury. If the incident meets the definition of 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). Emergency Case are defined as: Harm or potential for harm that is life threatening or could result in long term disability, or an unexpected death.

Allegations that the consumer is in a state of serious harm or potential for harm that is life threatening or could result in long term disability or unexpected death. Due to the severity of the case the investigator will respond within three (3) hours.

Emergency Allegations include but are not limited to:

- Serious injuries – fractures, head injuries, lacerations requiring sutures, serious burns, internal injuries
- Lack of life sustaining medications
- Sexual abuse where there is danger of repeated abuse
- Severe lack of basic physical necessities that could result in dehydration or starvation
- Need for immediate medical attention to treat conditions that could result in irreversible physical harm – severe respiratory distress, unconsciousness, gangrene, advanced bedsores
- No caregiver is available and the consumer is unable to perform critical personal care activities

#### 3. Assign Investigator

Assignment of an investigator is based on the following:

- i. 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.
- ii. 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.
- iii. Provider specific: Investigator with an existing case involving the responsible provider.
- iv. Caseload based: Cases will be assigned with a caseload maximum. Level of urgency: Cases may be assigned based on the most available investigator.
- v. Gender Based
- vi. Deaths: All deaths are assigned to the DHI Clinical Team for investigation.

1. Determine Children Youth and Families Status: Reconciling Cases Children, Youth and Families Department (CYFD) Child Protective Services (CPS).

If CYFD (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 the DOH does not have jurisdiction, and the case involves an allegation of abuse, neglect, or exploitation, it will be referred to CPS after the Triage process.

5. Notifications will be made to the following entities, as appropriate:

Office of General Counsel (OGC), DOH,DOH/DDSD, ALTSD (APS), CYFD (CPS), Law Enforcement, Human Services Department (HSD) Medical Assistance Division (MAD), Medicaid Fraud Control Unit, NM Attorney General's Office, Office of Internal Audit (OIA), and DOH Responsible Provider in cases of late reporting or failure to report

With respect to waiver services provided by any employee, contractor or vendor other than a community-based waiver service provider, incidents are reported to DOH/DHI/IMB for individuals over age 18 and/or CYFD/CPS for individuals under age 18 for review, investigation, and response. 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.

If a report of abuse or neglect of a child (person under age 18) is being made to CYFD/CPS, 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.

Notification to the Participant:

In each situation that critical incident investigations are completed by APS, CYFD/CPS, or DOH/DHI, the Supports Waiver participant or the participant's guardian receives a letter stating the results of the investigation.

Regulations are found in NMSA 1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect Act).

The Department of Health, Division of Health Improvement (DOH/DHI) has forty-five (45) days to complete an investigation. Once completed, the investigator has ten (10) ten days to complete a report. This report is submitted to a supervisor who has seven (7) days to review and approve the closure of the investigation. If there is no further action needed at that time, a letter of findings is sent to the Community Supports Coordinator, Participant/Guardian.

**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.

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, DOH/DDSD and DOH/DHI work together to analyze aggregated data and identify trends. Quality assurance and quality improvement action plans can be developed as needed, based on identified trends and other identified issues in order to prevent re-occurrence. The aggregated data and identified trends are then reported to the (DDSQI) for review. Trending and analysis of the data are used to prioritize improvements of the quality management system.

The operating agency, DOH, reviews incidents monthly through the “Regional Quality Management Meetings” that DDSD and DHI attend to identify/review trends and any areas of necessary remediation. The Mortality Review Committee also meets monthly. It is facilitated through the DOH/DDSD/Litigation Management Bureau and includes HSD. If the Bureau has issues/concerns they follow up with the Supports Waiver Unit to address any issues/concerns who then follows up with the Community Supports Coordinator Agency and informs HSD.

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 Community Supports Coordinator. Issues brought to the Department of Health Supports Waiver Unit staff, Community Programs Bureau, or Regional Offices by concerned Community Supports Coordinator 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 Supports waiver participants. DOH/DHI investigates and follows up regarding providers and critical incidents.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

**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:

**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).

- 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:

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## 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:

DOH monitors safeguards against the use of restraints/restrictive interventions/seclusion through the Quarterly Update Form that is completed during the face-to-face Community Supports Coordinator participant meetings.
--

**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.

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- 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:

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## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

##### **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:

DOH monitors safeguards against the use of restraints/restrictive interventions/seclusion through the Quarterly Update Form that is completed during the face-to-face Community Supports Coordinator participant meetings.
--

**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.

**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.

**Appendix G: Participant Safeguards**

**Appendix G-3: Medication Management and Administration (2 of 2)**

**c. Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

**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).

**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:

**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.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

**a. Methods for Discovery: Health and Welfare**

*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 substantiated abuse, neglect and exploitation (ANE) investigations resulting in a corrective action plan (CAP) initiated by the Division of Health Improvement. Numerator: Number of CAPs developed as a result of substantiated ANE incidents. Denominator: Number of substantiated ANE incidents involving waiver participants.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHI Tracking Reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		<input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/> Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.

**b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively*

*resolves those incidents and prevents further similar incidents to the extent possible.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 waiver participants' critical incidents that were reported, initiated, reviewed and completed within required time frames as specified in the approved waiver. Numerator: Number of accepted participant critical incidents that were completed within required time frames. Denominator: Number of accepted and reported participant incidents.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHI tracking reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:  <input type="text" value="DHI"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>

	<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input style="width: 100%; height: 40px;" type="text"/> Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.

**c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 waiver participants without confirmed reports of restrictive interventions (including restraints and seclusion). Numerator: Number of Supports Waiver participants without confirmed reports or restrictive interventions.**

**Denominator: Total number of Supports Waiver participants.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DHI tracking reports**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="DHI"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text" value="Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise."/>

**d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*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 waiver participants who received physical exams in accordance with state waiver policies. Numerator: Number of waiver participants with a completed history and physical. Denominator: Total number of waiver participants with a completed LOC.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**LOC assessment documentation; HSD/MAD audits of TPA contractor**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     +/- 5% margin of error and 95% confidence interval                 </div>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                     TPA                 </div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100px; height: 30px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 30px;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 30px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 30px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">                     Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.                 </div>

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 DDSQI description and structure in Appendix H.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States 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, DDSQI 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 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)**

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b>

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>

**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 3)**

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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 QIS 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; and
- 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 OIS* 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 QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## **Appendix H: Quality Improvement Strategy (2 of 3)**

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### **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 the waiver’s Quality Improvement Strategy (QIS) are to administer and evaluate 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 Developmental Disabilities Services Quality Improvement (DDSQI) Executive Committee (comprised of HSD/MAD, DOH/DDSD, and DOH/DHI) utilizes the following measures and processes to ensure that the Supports Waiver program is meeting its QIS goals:

- **Performance Measures:** Performance measures are specific to each of the Waiver assurances and are described in Appendices A, B, C, D, G, and I. The Waiver assurance workgroup reports to the DDSQI Steering Committee where data are reviewed and actions are discussed and reported back to the program for implementation and remediation as required by CMS. Action plans must include an evaluative component to determine the effectiveness of actions once implemented.
- **Processes:** The role of the DDSQI Committee is to ensure continuous quality improvement. The DDSQI Steering Committee is responsible for making systemic improvements to the Supports Waiver based on compliance monitoring. This committee has regularly scheduled meetings and an annual schedule by which it reviews data collected from various waiver programs, develops and implements quality improvement strategies which are reported back to the DDSQI Committee.

Performance data is reviewed through the DDSQI.

Recommendations made by the DDSQI for system design changes are forwarded to senior management of HSD and DOH for consideration and implementation. When a system design change is approved by HSD and DOH senior management and implemented, the DDSQI is informed. Supports Waiver program staff, at both DOH and HSD, work together to inform families and providers (through various means) of changes due to new system design. The format/route for the information is dependent upon the impact of the change on the participants and stakeholders. Information regarding system design changes is always communicated to key stakeholders prior to implementation. Information-sharing may include letters, announcements at scheduled meetings, website updates and state-wide meetings. If Supports Waiver Service Standards or State regulation changes are needed, the State follows applicable State rules.

The DDSQI continuously assesses its own effectiveness, through regularly scheduled meetings to evaluate: the effectiveness of both the assurance workgroup strategies in improving the functions of the Waiver; the effectiveness of the DDSQI oversight of the strategies; and the established priorities for the coming year.

The Advisory Council on Quality Supports for Individuals with Developmental Disabilities and their Families (ACQ) is also statutorily required to advise the DOH on policy related to the programs administered by DOH. The ACQ meets regularly and is comprised of waiver stakeholders, which can include individual participants and their families.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b>	<b>Other</b>

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
Specify:  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         DOH/DDSQI                          FMA and TPA Contractors                     </div>	Specify:  <div style="border: 1px solid black; padding: 5px; width: fit-content;">                         Additional monitoring/analysis will be done, as necessary, to address unusual or urgent issues.                     </div>

**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 DDSQI has regularly scheduled meetings to review the performance data collected. The DDSQI meet to develop and implement quality improvement strategies related to the performance data collected. As part of its ongoing review of data collected, the DDSQI considers the findings related to system design changes and incorporates them into the DOH/DDSQI program planning process.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The DDSQI has an extended scope of work which includes an ongoing 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 DDSQI oversight of the strategies. The DDSQI continuously reviews 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 QIS supports participants in self-direction of services, identifies opportunities for improvement, and ensures that the State meets each of the required assurances to the Centers for Medicare and Medicaid Services (CMS). The DOH/DDSQI and DOH/DHI Senior Management receives regularly scheduled updates when trends and/or issues are identified as requiring higher level Departmental intervention.

**Appendix H: Quality Improvement Strategy (3 of 3)**

**H-2: Use of a Patient Experience of Care/Quality of Life Survey**

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

**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).

**INDEPENDENT AUDIT OF PROVIDER AGENCIES AND INTEGRITY:**

*Providers are required to have an annual financial statement audit. Providers delivering services through the agency-based model under the Supports Waiver sign a Provider Agreement at the time of entry and renewal periods in which they agree that if they receive State or Federal funds from the Department of Health (DOH), they shall comply, if applicable, with auditing requirements under the Single Audit Act (31 U.S.C. §7501, et seq.) and the New Mexico State Auditor's rules and regulations. If the Provider is determined to be a sub recipient and not a vendor under the Federal Single Audit Act, the provider shall comply with the audit requirements of the Single Audit Act. If the provider receives more than \$250,000 under this agreement or more than \$250,000 in any single fiscal year, from the Human Services Department (Medicaid), the provider shall prepare annual financial statements and obtain an audit of, or an opinion on, the financial statements from an external Certified Public Accountant.*

*Under participant direction, the Human Services Department (HSD)/Medical Assistance Division (MAD) and Department of Health (DOH) contract with the Financial Management Agency (FMA), which is responsible for reviewing and processing claims from providers serving participants under self-direction. HSD has oversight responsibility of the FMA. 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 Individual Service Plan (ISP) and participant's approved 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. The FMA submits a report monthly to HSD which details the number of paid claims per each participant. HSD 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.*

**AGENCY RESPONSIBLE FOR FINANCIAL AUDIT**

*The DOH Quality Management (QMB) conducts post-payment reviews of the waiver provider billing to verify whether services are being rendered according to the state's rules and regulations. Post-payment review methods are discussed below. The DOH/QMB creates an annual review schedule that is based on the contract terms of provider agreements. 100 % of Supports Waiver providers scheduled for annual review, who received payment for claims in the above services during the previous quarter, three months of paid claims, are reviewed. Claims data is taken from the MMIS system. Within that provider sample, 100% of paid claims for each provider are reviewed and validated for: 1) correct service codes; 2) correct billed units; 3) supporting documentation for services rendered. All reviews are conducted on-site. The agency is required to correct all deficiencies cited during the Plan of Correction Process and the Plan of Correction process is not closed until all deficiencies have been corrected. All QMB reports are shared with the Human Services Department and the Department of Health Office of Internal Audit who can make the determination whether or not to complete a more comprehensive financial review.*

*When deficiencies are found in billing, the agency is afforded the opportunity to submit a void/adjust claim to the Medicaid agency and no additional plan of correction is required.*

*In addition, the HSD, Medicaid Management Information System (MMIS) generates monthly client Explanation of Medical Benefits (EOMB) letters. The EOMB is a quality control tool that is used to verify that clients received the services billed by providers. A designated percentage of clients receive these letters. That percentage is determined from the HSD EOMB Report Selection Percentage parameter. The first client selected is based on a random selection process. The clients' reported claims are selected by claims payment date. The EOMB Month End Date parameter is used to determine the month of paid claims used for reporting.*

*The State Auditor of New Mexico also contracts with an independent auditor to conduct an annual audit of the Human Services Department's (HSD) Medicaid program that includes a financial audit as well as an audit of the program's allowable costs. In addition, the HSD or DOH may refer providers for audit to the Medicaid Fraud Control Unit of the State Attorney General's Office.*

*HSD's Administrative Services Division, Financial Accounting Bureau, receives and reviews the audits. The annual audits are submitted to DOH for further review.*

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

**a. Methods for Discovery: Financial Accountability Assurance:**

**The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.** (For waiver actions submitted before June 1, 2014, this assurance read "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. Sub-Assurances:**

**a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 traditional-based model claims coded in accordance with the reimbursement codes and rates approved by Medicaid. Numerator: Number of claims coded in accordance with the reimbursement codes and rates approved by Medicaid. Denominator: Total number of claims coded.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**FMA MMIS**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>

<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <p>FMA MMIS</p> </div>	<p><b>Annually</b></p>	<p><b>Stratified</b> Describe Group:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>
	<p><b>Continuously and Ongoing</b></p>	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; width: 100%; height: 30px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.</p> </div>

**Performance Measure:**

**Percentage of traditional-based model 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:

**FMA audit reports**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <input type="text"/>
<i>Other</i> <i>Specify:</i> <input type="text"/>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i> <input type="text"/>
	<i>Other</i> <i>Specify:</i> <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i>	<i>Annually</i>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">                     Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.                 </div>

**Performance Measure:**

**Percentage of participant-directed timesheets coded correctly in accordance with waiver coding requirements. Numerator: The number of timesheets coded correctly in accordance with waiver coding requirements. Denominator: Total number of timesheets submitted.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**FMA audit reports**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">                         FMA                          MMIS                     </div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<p><b>Other</b> Specify:</p> <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<p><b>Other</b> Specify:</p> <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<p><b>Other</b> Specify:</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">                     Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.                 </div>

**Performance Measure:**

**Percentage of participant-directed 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:

**FMA reports**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid</b>	<b>Weekly</b>	<b>100% Review</b>

<i>Agency</i>		
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <input type="text"/>
<i>Other Specify:</i> <input type="text" value="FMA"/>	<i>Annually</i>	<i>Stratified Describe Group:</i> <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <input type="text"/>
	<i>Other Specify:</i> <input type="text"/>	

**Data Aggregation and Analysis:**

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i> <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other Specify:</i>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
	<div style="border: 1px solid black; padding: 5px; margin: 5px;">                 Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.             </div>

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 rates that remain consistent with the approved rate methodology throughout the five year waiver cycle. Numerator: Number of rates that remained consistent with the rate methodology. Denominator: Total number of rates.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Supports Waiver Rate Schedule**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<b>Other Specify:</b>	<b>Annually</b>	<b>Stratified Describe Group:</b>

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"><i>Additional data collection, analysis and aggregation will be done, as necessary, to address unusual issues that may arise.</i></div>

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 DDSQI description and structure in Appendix H.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States 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 DDSQI 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.*

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i>  <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i>  <input type="text"/>

**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).*

*Rate determination and oversight is a joint responsibility between the Department of Health's Developmental Disabilities Supports Division (DDSD) and the Human Services Department (HSD). The State can increase rates based on Legislative appropriation, however, HSD must approve all rates and any changes to these rates. Most waiver services are reimbursed on a prospective, fee-for-service basis, with the exceptions noted below for items that are reimbursed based on cost. Rates do not vary by provider type.*

*The Supports Waiver rates are based on current NM.0448 Mi Via and NM.0173 Developmental Disabilities Medicaid waiver rates developed from what Medicaid currently pays for traditional waiver services. Waiver rates models take into account numerous factors:*

- direct support professionals' wages, benefits, and productivity (to account for non-billable responsibilities)*
- Other direct care costs, such as transportation and program supplies*
- Indirect costs such as program support and administration*

*In addition to cost assumptions, the rate models incorporate programmatic assumptions, such as staffing ratios. The individual assumptions within the rate models are not prescriptive to service providers; for example, providers are not required to pay the wages assumed in the rate models. Rather, providers have the flexibility within the total rate to design programs that meet members' needs, consistent with service requirements and members' individual service plans.*

*The Support Waiver rates uses the top dollar amount in the range of rates under the Mi Via Waiver rate schedule*

*In 2019 the State conducted a comprehensive rate study for all its 1915(c) HCBS waivers including the Traditional Development Disabilities Waiver (DDW), Medically Fragile Waiver (MFW) and two services under Mi Via. The rate study is intended to assure that rates continually afford participants' access to services and are consistent with efficiency, economy, and quality of care. Rate implementation and rate increases are contingent upon legislative appropriation.*

*Rates for waiver services are as follows:*

*Community Supports Coordinator \$231.13/month*  
*Customized Community Supports-Individual \$7.18/15 minutes*  
*Customized Community Supports-Group \$2.68/minutes*  
*Employment Supports \$6.93/15 minutes*  
*Homemaker/Personal Care Services \$14.60/hour*  
*Assistive Technology \$5000 once every 3 years*  
*Behavior Support Consultation \$20.65/15 minutes*  
*Environmental Modifications \$5000/each once every 3 years*  
*Respite Standard \$3.38/15 minutes*  
*Transportation \$0.41/mile; passes: amount based on approved estimate*  
*Vehicle Modifications \$5000/each once every 3 years*

- 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:*

*Under the traditional-based model providers bill to Medicaid directly via the MMIS or through a clearinghouse. The New Mexico MMIS claims processing system processes all waiver claims. Claims are processed for payment by the MMIS and paid by the HSD fiscal agent.*

*Under the participant-direction providers 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 contract 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**

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**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 New Mexico MMIS Claims Processing System processes all waiver claims. As claims enter the system they are subject to a complete series of edits and audits to ensure that only valid claims for eligible clients and covered services are reimbursed to enrolled providers. The Claims Pricing and Adjudication function edits, prices, audits, and processes claims to final disposition according to the policies and procedures established by MAD. A complete range of data validity, client, provider, reference, prior authorization, and third-party liability (TPL) edits are applied to each claim. In addition, the system performs comprehensive duplicate checking and utilization criteria auditing. The system determines the proper disposition of each claim using the Reference subsystem exception control database. The exception control database allows authorized staff to associate a claim disposition with each exception code (i.e. Edit or Audit) based on the claim input medium, claim document type, client major program, and claim type. Modifications to the claims exception control database are applied online.*

*Waiver Service Plan information is loaded to the MMIS system's prior authorization system. Each claim is then validated against the client's eligibility on date of service, allowed services, dates, and number of units contained in this prior authorization system. Any claim that contains services that are not contained in the waiver prior authorization or where the number of units has already been used for the authorization is denied.*

*Validation that services have been provided as billed on the claims is a function of quality assurance and audit functions performed by DOH and HSD/MAD. Retrospective audits include verification that the services were provided as billed.*

*Under self-direction, 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 ISP 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***

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### ***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:*

***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***

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### ***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:

Los Lunas Community Programs, operated by DOH/DDSD, may be selected by a participant to provide services as a vendor. The Los Lunas Community Program could provide any waiver service if they meet the credentialing requirements, as outlined in the waiver, for that service. This would be determined through Financial Management Agency (FMA) review of the Vendor Agreement. If the program/agency did not meet the credentialing requirements for a particular service, they would not be able to provide that service.

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 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. All payment rates are negotiable within established parameters. However, the aggregate amount of payment to Los Lunas Community Programs for Mservices 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**

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**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**

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**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.**

***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.***

***This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

***not selected***

*In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.*

**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:

**Do not complete this item.**

**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**

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**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):

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*Nominal deductible*

*Coinsurance*

*Co-Payment*

*Other charge*

Specify:

**Appendix I: Financial Accountability**

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**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.**

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**Appendix I: Financial Accountability**

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**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.**

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**Appendix I: Financial Accountability**

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**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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: ICF/IID**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	13373.65	8718.02	22091.67	138082.28	2029.83	140112.11	118020.44
2	6398.65	8970.84	15369.49	142086.66	2149.26	144235.92	128866.43
3	6398.22	9230.99	15629.21	146207.18	2211.59	148418.77	132789.56

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 7)**

**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: J-2-a: Unduplicated Participants*

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	5000		5000
Year 2	5000		5000
Year 3	5000		5000

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (2 of 7)**

**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.

Average length of stay (ALOS) estimates is based on experience in another waiver New Mexico operates that serves the same target population as the Supports Waiver. NM.0448 Mi Via Waiver services persons with developmental disabilities with an intermediate care facility level of care. The Mi Via waiver program, as in the Supports Waiver, offers service delivery under a self-directed model. ALOS is estimated to be held at 331 days, the level reported on the NM.0448 Mi Via waiver federal fiscal year (FFY) 2017 CMS 372.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (3 of 7)**

**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 and methodology for these estimates is as follows:

*For this new waiver the methodology used to estimate Factor D and the basis for the state's cost estimate is based on experience of utilization of similar services in New Mexico's NM.0448 Mi Via Waiver. NM.0448 Mi Via Waiver services persons with developmental disabilities with an Intermediate Care Facility (ICF) level of care. The Mi Via waiver program, as in the Supports Waiver, offers service delivery under a self-directed model. Utilization data for waiver services provided to Mi Via participant who were in the waiver FFY 2017 was used as reported on the NM.0448 Mi Via waiver federal fiscal year (FFY) 2017 CMS 372. Where noted, the Market Basket Index (MBI) growth rate is based on forecasted FY2020 Q4 Skilled Nursing Facility (2.9%).*

*NUMBER OF USERS: The number of users was calculated from actual number of waiver participants who used similar services reported on NM.0448 Mi Via waiver FFY2017 CMS372. The percentage of users for each similar service under NM.0448 was applied to the unduplicated recipient count for WY1-3 to estimate the number of Supports Waiver participants who would use the similar service. Environmental modifications, Vehicle modifications and Assistive Technology are estimated to be used at 50% of the UDR in the WY1 as this service is not readily available in the community and the state estimates higher utilization than seen in other New Mexico 1915 c waiver programs. In WY2-3, the number of users is estimated to be 50% of new allocants.*

*AVERAGE UNITS PER USERS: Average units per users was derived from data reported on NM.0448 Mi Via waiver FFY2017 CMS372. The Supports Waiver has a cost limit of ten thousand dollars (\$10,000) per participant per year which is 17% of Factor D reported on NM.0448 Mi Via waiver FFY2017 CMS372. New Mexico assumes that participants on the Supports Waiver will utilize 17% of units used under the NM.0448 Mi Via waiver, as their budget dictates for similar services. Community Supports Coordinator service is estimated to be used at the same units per user as the NM.0448 and NM.0173 waivers. The average units per uses was held constant through WY 1-3.*

*AVERAGE COST PER UNIT: The Supports Waiver rates are used as the average cost per unit. The Supports Waiver rates do not change from waiver year to waiver year; the average cost per unit is held constant through WY1-3.*

- 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:*

*Factor D' is the estimated annual average per capita Medicaid costs for all services that are furnished in addition to waiver services while the individual is in the waiver. Factor D' estimates account for managed care capitations and all fee for service claims and acute expenditures that are not waiver services. The State did not use pre-Medicare Part D expenditure data in its estimate for Factor D', so it was not necessary to adjust for this factor. In the case of this new waiver, the methodology used to estimate Factor D' is based on experience of utilization in NM.0448 Mi Via waiver FFY2017 CMS372. NM.0448 Mi Via Waiver services persons with developmental disabilities with an intermediate care facility level of care. Factor D' is based on the actual Factor D' reported in the NM.0448 Mi Via waiver FFY2017 CMS372 trended forward at the Medicare PPS (MBI) of 2.9% (FY2020 Q4 Skilled Nursing Facility).*

- 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:*

*Factor G is based on actual costs of institutional services for all individuals at the Intermediate Care Facility (ICF) level of care as reported in NM.0448 Mi Via waiver FFY2017 CMS372 trended forward at the Medicare PPS (MBI) of 2.9% (FY2020 Q4 Skilled Nursing Facility).*

- 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:*

*Projected first year G' did not deviate from previous year trends seen in other New Mexico waivers serving persons with intellectual and developmental disabilities with an Intermediate Care Facility (ICF) level of care. Factor G' is based on the actual Factor G' reported in NM.0448 Mi Via waiver FFY2017 CMS372 trended forward at the Medicare PPS Market Basket Index of 2.9% (FY2020 Q4 Skilled Nursing Facility).*

**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.

<b>Waiver Services</b>	
Community Supports Coordinator	
Customized Community Supports - Individual	
Customized Community Supports -Group	
Employment Supports	
Homemaker/Personal Care	
Assistive Technology	
Behavior Support Consultation	
Environmental Modifications	
Non-medical Transportation	
Respite	
Vehicle Modifications	

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 7)**

**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**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Supports Coordinator Total:</b>						11452491.50
Community Supports Coordinator	Month	4955	10.00	231.13	11452491.50	
<b>Customized Community Supports - Individual Total:</b>						5981248.74
Customized Community Supports - Individual	15 minutes	3911	213.00	7.18	5981248.74	
<b>Customized Community Supports -Group Total:</b>						417139.32
Customized Community Supports -Group	15 minutes	921	169.00	2.68	417139.32	
<b>Employment Supports Total:</b>						231247.17
Employment Supports	15 minutes	227	147.00	6.93	231247.17	
<b>GRAND TOTAL:</b>						66868273.51
Total Estimated Unduplicated Participants:						5000
Factor D (Divide total by number of participants):						13373.65
Average Length of Stay on the Waiver:						331

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Homemaker/Personal Care Total:</b>						10744140.00
Homemaker/Personal Care	hour	1650	446.00	14.60	10744140.00	
<b>Assistive Technology Total:</b>						12500000.00
Assistive Technology	each	2500	1.00	5000.00	12500000.00	
<b>Behavior Support Consultation Total:</b>						133812.00
Behavior Support Consultation	15 minutes	324	20.00	20.65	133812.00	
<b>Environmental Modifications Total:</b>						12500000.00
Environmental Modifications	each	2500	1.00	5000.00	12500000.00	
<b>Non-medical Transportation Total:</b>						334206.58
Non-medical Transportation	mile	722	1129.00	0.41	334206.58	
<b>Respite Total:</b>						73988.20
Respite	15 minutes	199	110.00	3.38	73988.20	
<b>Vehicle Modifications Total:</b>						12500000.00
Vehicle Modifications	each	2500	1.00	5000.00	12500000.00	
<b>GRAND TOTAL:</b>						66868273.51
Total Estimated Unduplicated Participants:						5000
Factor D (Divide total by number of participants):						13373.65
Average Length of Stay on the Waiver:						331

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (6 of 7)**

**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 2**

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Supports Coordinator Total:</b>						11452491.50
Community Supports					11452491.50	
<b>GRAND TOTAL:</b>						31993273.51
Total Estimated Unduplicated Participants:						5000
Factor D (Divide total by number of participants):						6398.65
Average Length of Stay on the Waiver:						331

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordinator	Month	4955	10.00	231.13		
<b>Customized Community Supports - Individual Total:</b>						5981248.74
Customized Community Supports - Individual	15 minutes	3911	213.00	7.18	5981248.74	
<b>Customized Community Supports -Group Total:</b>						417139.32
Customized Community Supports -Group	15 minutes	921	169.00	2.68	417139.32	
<b>Employment Supports Total:</b>						231247.17
Employment Supports	15 minutes	227	147.00	6.93	231247.17	
<b>Homemaker/Personal Care Total:</b>						10744140.00
Homemaker/Personal Care	hour	1650	446.00	14.60	10744140.00	
<b>Assistive Technology Total:</b>						875000.00
Assistive Technology	each	175	1.00	5000.00	875000.00	
<b>Behavior Support Consultation Total:</b>						133812.00
Behavior Support Consultation	15 minutes	324	20.00	20.65	133812.00	
<b>Environmental Modifications Total:</b>						875000.00
Environmental Modifications	each	175	1.00	5000.00	875000.00	
<b>Non-medical Transportation Total:</b>						334206.58
Non-medical Transportation	mile	722	1129.00	0.41	334206.58	
<b>Respite Total:</b>						73988.20
Respite	15 minutes	199	110.00	3.38	73988.20	
<b>Vehicle Modifications Total:</b>						875000.00
Vehicle Modifications	each	175	1.00	5000.00	875000.00	
<b>GRAND TOTAL:</b>						31993273.51
Total Estimated Unduplicated Participants:						5000
Factor D (Divide total by number of participants):						6398.65
Average Length of Stay on the Waiver:						331

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 7)**

**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 3**

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Supports Coordinator Total:</b>						11452491.50
Community Supports Coordinator	Month	4955	10.00	231.13	11452491.50	
<b>Customized Community Supports - Individual Total:</b>						5981248.74
Customized Community Supports - Individual	15 minutes	3911	213.00	7.18	5981248.74	
<b>Customized Community Supports -Group Total:</b>						417139.32
Customized Community Supports -Group	15 minutes	921	169.00	2.68	417139.32	
<b>Employment Supports Total:</b>						231247.17
Employment Supports	15 minutes	227	147.00	6.93	231247.17	
<b>Homemaker/Personal Care Total:</b>						10744140.00
Homemaker/Personal Care	hour	1650	446.00	14.60	10744140.00	
<b>Assistive Technology Total:</b>						875000.00
Assistive Technology	each	175	1.00	5000.00	875000.00	
<b>Behavior Support Consultation Total:</b>						133812.00
Behavior Support Consultation	15 minutes	324	20.00	20.65	133812.00	
<b>Environmental Modifications Total:</b>						875000.00
Environmental Modifications	each	175	1.00	5000.00	875000.00	
<b>Non-medical Transportation Total:</b>						334206.58
Non-medical Transportation	mile	722	1129.00	0.41	334206.58	
<b>Respite Total:</b>						71799.20
Respite	15 minutes	199	110.00	3.28	71799.20	
<b>Vehicle Modifications Total:</b>						875000.00
<b>GRAND TOTAL:</b>						31991084.51
Total Estimated Unduplicated Participants:						5000
Factor D (Divide total by number of participants):						6398.22
Average Length of Stay on the Waiver:						331

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications	each	175	1.00	5000.00	875000.00	
<p style="text-align: right;"><b>GRAND TOTAL:</b></p> <p style="text-align: right;"><i>Total Estimated Unduplicated Participants:</i></p> <p style="text-align: right;"><i>Factor D (Divide total by number of participants):</i></p> <p style="text-align: right;"><i>Average Length of Stay on the Waiver:</i></p>						<p>31991084.51</p> <p>5000</p> <p>6398.22</p> <p>331</p>