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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Request Information

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

B. **Program Title:**
**Developmental Disabilities Waiver Program**

C. **Waiver Number:NM.0173**
**Original Base Waiver Number: NM.0173.**

D. **Amendment Number:**

E. **Proposed Effective Date:** *(mm/dd/yy)*
04/01/15

**Approved Effective Date of Waiver being Amended: 07/01/11**

### 2. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:
1. Increase UDRs for waiver years 4 & 5
2. Increase Rates for Supported Employment, Customized In-Home Supports, Living Supports, and Customized Community Supports
3. Change Incident Management Bureau Language
4. Change Fair Hearing Language
5. Add Transition Plan Language

### 3. Nature of the Amendment

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

| Component of the Approved Waiver | Subsection(s) |
|---|---|
| ☑ **Waiver Application** | 7.A, 7.B, 8 attachmer |
| ☐ **Appendix A – Waiver Administration and Operation** | |
| ☑ **Appendix B – Participant Access and Eligibility** | B.3 |

| Component of the Approved Waiver | Subsection(s) |
|---|---|
| ☑ Appendix C – Participant Services | C.5 |
| ☐ Appendix D – Participant Centered Service Planning and Delivery | |
| ☐ Appendix E – Participant Direction of Services | |
| ☑ Appendix F – Participant Rights | F.1 |
| ☑ Appendix G – Participant Safeguards | G.1.b, G.1.c, G.1.d.B |
| ☐ Appendix H | |
| ☐ Appendix I – Financial Accountability | |
| ☑ Appendix J – Cost-Neutrality Demonstration | J.2.a, J.2.d- WYs 4 & |

**B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☑ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

  Specify:
  Increased Rates for Customized Community Supports, Customized In Home Supports, Living Supports, and Supported Employment

# 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*):
**Developmental Disabilities Waiver Program**

**C. Type of Request: amendment**

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

○ **3 years** ◉ **5 years**

**Original Base Waiver Number: NM.0173**
**Draft ID: NM.019.05.12**

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

**E. Proposed Effective Date of Waiver being Amended: 07/01/11**
**Approved Effective Date of Waiver being Amended: 07/01/11**

## 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 in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

- **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
- **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

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

Select one:

- **Not applicable**
- **Applicable**

Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

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

☐ **§1915(b)(2) (central broker)**

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

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

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligiblity 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.
The Developmental Disabilities Home and Community-Based Services Waiver serves individuals with mental retardation or specific related conditions and developmental disability that occur before the age of 22. New Mexico provides community-based services designed to increase independence and achieve personal goals while providing care and support to enable individuals to live as active members of the community while ensuring health and safety. The purpose of the program is to provide assistance to individuals who require long-term supports and services so that they may remain in the family residence, in their own home or small community living residences. The program serves as an alternative to an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The waiver sets specific dollar limits of services and supports that can be offered based on an individual's assessed level of support need.

The State has designed and defined a broad range of flexible community-based services that will support individuals. 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 natural supports that families and communities provide. Through the provision of services and supports identified through the Individual Service Plan and the operation of a quality assurance and improvement program, the State ensures the health and welfare of the individuals in the program. In addition, the program provides assurances of fiscal integrity and includes participant protections that will be effective and family-friendly.

The Department of Health (DOH) is responsible for the day-to-day operations of the Developmental Disabilities Waiver. The Human Services Department/Medical Assistance Division (HSD/MAD), as the Single State Medicaid Agency, oversees the DOH's operation of the waiver. The departments cooperate in the operation of the waiver under a Joint Powers Agreement (JPA) that delineates each department's responsibilities

## 3. Components of the Waiver Request

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

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

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

**C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery.Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

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

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

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

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

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

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

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

## 4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

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

*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; 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

***Note: Item 6-I must be completed.***

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

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

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

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

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

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

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

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
The Department of Health/Developmental Disabilities Supports Division (DDSD) worked with the Medical Assistance Division (MAD) of the Human Services Department (HSD) for over a year on the waiver renewal process. During this process, DDSD partnered with communities across the state, the Advisory Council on Quality Supports for Individuals with Developmental Disabilities and Their Families (ACQ) and the Developmental Disabilities Waiver (DDW) Renewal Task Force to receive input and feedback on restructuring the waiver

system. DDSD conducted eight (8) meetings with the DDW Renewal Task Force and received final recommendations on September 10, 2010.

In late October and early November of 2010, DDSD conducted ten (10) statewide public meetings to obtain feedback on the redesign of the waiver. Approximately 300 persons including: individuals with developmental disabilities, families, providers, advocates and the general public attended the public meetings.

An overview of the changes to the waiver was sent out to providers and families and included information on how to provide feedback to the DDSD regarding the waiver redesign.

Additionally, DDSD established a web page on the DDSD website: (http://www.health.state.nm.us/ddsd/resourcesupportbureaupublications/DDW/DDWaiverRenewalUpdate.htm) dedicated to the renewal process to inform the public and provide a mechanism to solicit feedback on the proposed changes.

A letter to tribal leaders in New Mexico was sent by the MAD in October 2010 to notify them of its intent to renew the waiver. Included in the letter was a copy of the overview and the link to the DDW renewal website. In February 2011, DDSD met with a State Tribal workgroup to gather additional feedback on the waiver renewal application. As a result, meetings with tribal leaders were held to obtain feedback on the waiver renewal.

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:** Medrano

**First Name:** Angela

**Title:** Bureau Chief, Excempt Services and Programs Bureau

**Agency:** Human Services Department

**Address:** 2025 S. Pacheco

**Address 2:** P.O. Box 2348

**City:** Santa Fe

**State:** New Mexico

**Zip:** 87504-2348

**Phone:**
(505) 827-1348 **Ext:** ☐ **TTY**

**Fax:**
(505) 827-3138

**E-mail:**
Angela. Medrano@state.nm.us

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

**Last Name:**
Stevenson

**First Name:**
Cathy

**Title:**
Director, Developmental Disabilities Supports Division

**Agency:**
Department of Health

**Address:**
810 San Mateo

**Address 2:**

**City:**
Santa Fe

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

**Zip:**
87502-6110

**Phone:**
(505) 827-2574 **Ext:** ☐ **TTY**

**Fax:**
(505) 827-2595

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

## 8. Authorizing Signature

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

**Signature:**

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**

Specify the transition plan for the waiver:

As part of the waiver renewal process, the DOH/Developmental Disabilities Supports Division (DDSD) solicited and received extensive feedback from stakeholders and the general public over the past year regarding the service and support needs of individuals with developmental disabilities in New Mexico. As a result of the feedback obtained, DOH/DDSD developed new service definitions in collaboration with the Developmental Disabilities Waiver (DDW) Renewal Task Force for the purpose of this waiver renewal.

The waiver renewal includes definitions for new services: Independent Living Transition; Shared Living; Intense Medical Living Supports; Preliminary Risk Screening and Consultation Related to Inappropriate Sexual Behavior; Socialization and Sexuality Education; and Personal Technology/On-Site Response; Customized Community Supports; and Customized In-Home Supports.

Independent Living Transition Services are intended to support individuals that transition from a congregate or family setting into their own home or apartment. Independent Living Transition Services will pay for expenses related to start-up

cost such as security deposits.

Intense Medical Living Supports are intended for individuals assessed with medical needs at a high acuity level and require intensive nursing care, clinical oversight and health management.

Intense Behavioral Supports offers enhanced staffing for individuals that are assessed with intense behavior needs. Services will be provided when the amount, frequency, duration and intensity of other waiver services, Medicaid State Plan, or generic supports are not sufficient to ensure the health and safety of the individual or the public.

Preliminary Risk Screening and Consultation Related to Inappropriate Sexual Behavior is provided by a qualified trained professional to screen individuals with potentially sexually inappropriate or offensive behaviors.

Socialization and Sexuality Education is provided by a qualified trained professional and self-advocates who will teach a curriculum approved by DOH/DDSD to individuals choosing this service.

Personal Technology/On-Site Response is an electronic device or monitoring system that supports individuals to be independent in the community or in their place of residence.

Customized Community Supports combines elements of the current adult habilitation and community access services. This service consists of individualized services and support that enable an individual to acquire, maintain, and improve opportunities for independence, community integration, and employment.

Customized In-Home Supports replaces the current Independent Living services. The difference is that Customized In-Home Supports is not a residential habilitation service.

Goods and Services in the current waiver is being removed as an available service in the waiver renewal.

Durable medical equipment based on medical necessity remains available under the Medicaid State Plan. Items related to assistive technology needs may be accessed under Assistive Technology services being requested through this waiver renewal.

Other changes to existing services in the waiver renewal include removing nursing as a component of residential habilitation services and adding a limitation on the amount of services available under the waiver.

The waiver renewal includes the use of the Supports Intensity Scale (SIS) and other assessment tools for person-centered planning and to develop resource allocations based on the support needs of the individual.

Between July 1, 2011 and December 31, 2011, the State anticipates that approximately 1,600 SIS assessments will be completed by the independent contractor that administers the Supports Intensity Scale (SIS)assessment (SIS Contractor) and other individuals trained and certified by the SIS Contractor in New Mexico. The results of the SIS assessments will be used by HSRI and Peter Burns and Associates to develop the resource allocation methodology and resource allocation levels.

Concurrently, the State projects to complete the work necessary through its contractors to develop the resource allocation methodology. Information about the resource allocation methodology and resource allocation levels will be presented to the individuals on the waiver, providers, and other stakeholders for public comment. Additionally, in collaboration with the contractors, the State will develop a strategy to consistently implement the resource allocation levels.

As part of this process, the state will revise policies and regulations supporting the implementation of the SIS and the resource allocation levels. In addition, the state will develop a policy to address the appeal process when an individual does not agree with their SIS score.

For the first year of the waiver renewal, DOH/DDSD will operate a dual system until all individuals on the waiver transition into new services, are assessed with the SIS for person-centered planning, and transition into nursing services that are unbundled from Community Living Support services. These changes will take place on the date of the individual's annual Individual Service Plan (ISP).

The transition to eliminate Goods and Services will also be addressed at the annual ISP.

Limitations on the amount of services available through the waiver renewal will be effective July 1, 2011. Case managers will meet with individuals on their caseload to review current budgets and to make adjustments based on the new changes. If the current level of services is reduced, individuals will receive timely notice of their right to a fair hearing. Individuals will receive notice in writing from the Medicaid Third-Party Assessor (TPA Contractor).

To ensure the health and safety of individuals on the waiver, DOH/DDSD will implement a prior authorization process based on justification and the identified need of individuals to obtain additional units of services not to exceed the amounts specified in Appendix C-3: waiver service specifications.

Prior to implementing the changes to the waiver, training and information on the transition process will be provided to individuals on the waiver, families, guardians, providers and other stakeholders.

During year two of the waiver renewal, DOH/DDSD will implement a resource allocation prototype using information from the SIS. Individuals will move into the new resource allocation prototype based on the date of their annual ISP. All individuals on the waiver will be using the resource allocation prototype by the end of the second waiver year. If the SIS determines a level of support that results in a reduction in services the individuals currently receives, the individual will receive a timely notice of their right to a fair hearing. Individuals will receive notice in writing from the Medicaid Third-Party Assessor (TPA Contractor).

**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 HCB 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.*

RESIDENTIAL SETTINGS:
The Department of Health (DOH) along with Human Services Department/Medical Assistance Division (HSD/MAD) completed an initial assessment of the extent to which its standards, rules, and other requirements comply with the HCBS residential setting requirements. The state's 1915(c) Home and Community-Based Services Waiver, the Developmental Disabilities Waiver (DDW) Service Standards, and the New Mexico Administrative Code (NMAC) Rules were analyzed against the HCBS setting requirements. Based on the attached assessment (Attachment #1-CMS Final Rule Crosswalk), the state determined its standards, rules, and other requirements comply with the CMS Final Rule, with the exception of three areas:
1. The individual has a lease or other legally enforceable agreement providing similar protections
Each individual has privacy in their sleeping or living unit. Units have lockable entrance doors, with the individuals and appropriate staff having keys to doors as needed
2. The individual access to food at any time. Modifications to the standards will include information necessary for Human Rights Committee review when food has the potential to be a danger to the individual.
3. Individual can have visitors at any time

NON-RESIDENTIAL:
The State will conduct an assessment once CMS provides additional guidance.

PROVIDER ASSESSMENT:
Currently, there are 77 Living Providers (Family, Intensive and Supported), 79 Customized Community Supports Providers, and 43 Community Integrated Employment Providers Statewide that provide residential, day, and employment services under the Developmental Disabilities Medicaid Waiver. The Department of Health (DOH) in collaboration with the Human

Services Department/Medical Assistance Division (HSD/MAD) will send a survey to all residential, day, and employment provider agencies which will inform the state if providers are in compliance with the CMS Final Rule through a self-assessment. The assessment will provide the state with the number of settings that;
1. Fully align with the federal requirements
2. Do not comply with the federal requirements and will require modifications

The survey will be developed by 5/1/2015 and will be emailed to residential, day and employment providers by 5/1/2015. The survey will also be available to providers, individuals receiving services, and representatives of consumer advocacy entities through the ACT NM website http://actnewmexico.org/ or by calling the New Mexico DOH at 505-476-8973.

REMEDIATION

STATE:

1. The DOH/DDSD will address the three areas stated above in the DD Waiver Service Standards that are currently being updated. It will be a requirement in the standards that providers comply with the three (3) requirements listed above in addition to all requirements outlined in the CMS Final Rule. The revised standards will be completed by July 1, 2015.
2. After the provider self-assessment is completed, the DOH/DDSD will conduct training for providers related to the new requirements outlined in the CMS Final Rule. The training documents will be disseminated to DDW providers by 2/1/2016. The training of providers will begin on 3/1/2016 and will be completed by 7/1/2016.
3. The DOH/DDSD regional offices will then perform a validity check on a statistically valid sample of provider agency responses to the self-assessment survey. This audit will begin on 7/1/2016 and end on 12/1/2016.
4. In collaboration with the DOH/Division of Health Improvement (DHI), the two departments will develop a tool incorporating requirements from the CMS Final Rule. This tool will be created by 12/1/2016 and DOH/DHI will implement the tool during routine surveys of the provider agencies beginning in 2017 to ensure compliance with the new CMS final rule and program requirements. DHI conducts surveys of provider agencies once every three years or sooner as determined necessary.

PROVIDER:

The DOH will analyze data collected from the provider surveys and based on findings will require corrective action plans from providers with timelines to ensure compliance with the final rule and program requirements. The DOH will do follow up surveys to ensure on-going compliance and will continuously monitor systemic compliance through our Developmental Disabilities Services Quality Improvement (DDS/QI) Steering Committee and CMS Waiver Assurances; and through on-going quality activities through the DOH.

If there are providers that are unable to comply with the new regulations, the DOH along with the HSD will relocate individuals to settings that are compliant with the regulations. When relocation of individuals is necessary the state will provide reasonable notice of due process to these individuals. The process will ensure individuals, through the person-centered planning process, are given the opportunity, the information and the support to make an informed choice of an alternate setting that aligns, or will align with the regulation and that critical services/supports are in place in advance of the individual's transition. The DOH will ensure that appropriate planning takes place to facilitate a smooth transition of eligible individuals to alternative environments. Individual choices will be given every consideration possible. Unless precluded by circumstances posing a danger to the health, safety or welfare of the individuals and/or others prior to relocation. The Interdisciplinary Team will convene at least thirty (30) calendar days prior to the proposed action to allow adequate time to develop a transition plan and properly execute the transition plan. Providers will not be allowed to discharge a individual until all policies are followed and all avenues pursued to keep the person in a setting that meets his/her choice and needs for services. In no instance may a individual be discharged from a program until alternative arrangements are made to meet the immediate needs of the person.

TIME FRAME AND MILESTONES:

7/1/2014 Project Start
7/21/2014 Cross Walk Completed
10/31/2014 Transition Plan sent for Tribal Notification
10/31/2014 Public Hearing Announcement Published
12/15/2014 Public Hearing
01/01/2015 Submit Transition Plan to CMS
5/1/2015 Provider Self-Assessment Survey Developed and Distributed
6/1/2015 Provider Self-Assessment Survey Completed by Providers
7/1/2015 Standards Effective and Distributed
1/1/2016 New Rule Training Documents Developed for Providers
2/1/2016 New Rule Training Documents Disseminated to Providers

3/1/2016 Statewide Provider Training Begins
6/1/2016 State Regional Onsite Validity Tool Completed
7/1/2016 State Regional Onsite Validity Audit Starts
12/1/2016 State Regional Onsite Validity Audit ends
12/1/2016 Develop ongoing DHI auditors Tool
1/1/2017 DHI Auditors Begin Using Tool to Monitor DH, Residential and SE
1/1/2018 Project End - Full Compliance/Ongoing Monitoring
3/1/2019 All Corrective Action Plans or Client Relocations Have Been Completed

## 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:
The DOH/DDSD operates the DD Waiver and the HSD/MAD 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/MAD holds DOH/DDSD accountable. The DOH and HSD entered into a Joint Powers Agreement (JPA) that specifies the roles and responsibilities of each department and under which the HSD/MAD holds DOH/DDSD accountable. Strong on-going collaboration and cooperation exist between the agencies to achieve desired outcomes. A variety of formal and informal oversight activities of DOH/DDSD occur to ensure effective administration of the waiver by HSD/MAD. 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; and
• Meetings with DOH/DDSD on a monthly basis to monitor the progress of the work plan collaboratively developed between the two agencies to oversee the operations of the waiver program and to ensure compliance with Medicaid and CMS requirements.

• HSD/MAD particpating and oversees the DOH/DDSD operational activities through the DOH Developmental Disabilities Services Quality Improvement (DDSQI) Steering Committee as described in Appendix H of this application. DDSQI follows a comprehensive quality improvement strategy. As part of this process, DOH collects and aggregates data including: number of individuals served; number of services and supports offered; number of participating providers; provider issues; types and resolution of individual complaints and fair hearings; number, types and resolutions of incidents reported; whether level of care (LOC) reviews have been conducted and approved as required; whether individual service plans and budgets are completed and authorized in required timelines; training compliance; and whether Freedom of Choice (FOC) has been provided, as required.

• As explained in Appendix H, HSD/MAD also oversees DOH's operational responsibilities through the DDSQI Steering Committee which reviews the DD Waiver Quality Improvement Strategy (QIS). The DDSQI Steering Committee meets every other month to review trended data collected through a variety of means by HSD and DOH. The DDSQI Steering Committee identifies areas of program improvement and key steps for the development and implementation of action plans to address the areas. The DDSQI Steering Committee reports back the results of program improvement and action plan activities to HSD at least quarterly. In addition, the DDSQI Steering Committee has workgroups for each of the waiver assurances that meet every other month to monitor compliance with each assurance based on review of data. HSD receives and reviews the reports, and ensures program improvement and action plan activities are completed. Additionally, HSD/MAD evaluates all quality assurance workgroups.

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

• HSD also serves with DOH on various waiver specific and cross-waiver workgroups related to development

and implementation of policies and procedures related to home and community-based services (HCBS) waivers.

In all oversight activities, HSD collaborates with DOH to review and analyze findings, develop strategies for improvement, and make timely changes to the DD Waiver program, as indicated. If HSD/MAD identifies any issues that are inconsistent with Medicaid requirements at any time, HSD/MAD ensures that DOH corrects the problem through program improvement activities such as verbal direction, letters of direction, and implementation of formal corrective action plans.

On a monthly basis, or more frequently if needed, HSD/MAD meets informally with DOH/DDSD staff to: 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; review and update the work plan developed to track and monitor progress on assignments and projects related to the operation of the waiver; and provide technical assistance. Examples of issues that would trigger a meeting prior to a regular monthly meeting include, but are not limited to special requests from policy makers; needed regulatory changes; provider issues; and constituent complaints.

## 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 contracted entities referenced in A-7 refer to the Third-Party Assessor (TPA) contractor and the independent contractor that administers the Supports Intensity Scale (SIS)assessment (SIS Contractor).

The TPA Contractor reviews required level of care (LOC) assessments and determines medical eligibility for individuals who are newly allocated to the waiver and for level of care redeterminations. In addition, the TPA Contractor conducts utilization reviews (prior authorization of waiver services) and approvals for Individual Service Plans (ISPs) and budgets to ensure that waiver requirements are met.

Initially the SIS will be administered by the SIS Contractor and New Mexico assessors endorsed by the SIS Contractor. Subsequently the SIS will be administered by a NM Medicaid provider as an administrative function. The Medicaid provider and its assessors are trained and endorsed by the SIS Contractor. Information obtained from the SIS will be used as part of the person-centered planning process to develop the ISP and for resource allocation.

The state conducts quarterly performance review of the SIS Contractor to assess compliance with the terms of the contract. The state's oversight includes monitoring of SIS Contractor's contracted delegated functions to conduct SIS assessments in accordance with the waiver requirements through a monthly review of deliverables and prior to approving payment for services rendered.

The State only uses SIS assessors that have been trained and certified by AAIDD to conduct SIS assessments in NM. The Sis Contractor conducts Inter-rater Reliability and Qualification Reviews to ensure consistent application of the SIS assessments by interviewers. The reviews are conducted by AAIDD SIS trainers. The State only uses SIS assessors that have been trained and certified by AAIDD to conduct SIS assessments in NM. The SIS Contractor conducts inter-rater reliability and qualification reviews to ensure consistent application of the SIS assessments by interviewers. The reviews are conducted by AAIDD SIS trainers.

Additionally, an analysis was conducted by the Human Services Research Institute (HSRI) to determine whether scoring was consistent among twenty-three (23) AAIDD trained SIS assessors in New Mexico. Based on HSRI's analysis, interviewers average scores are stable across 1,992 completed SIS assessments.

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

## Appendix A: Waiver Administration and Operation

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

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

## Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
   HSD/MAD contracts with the TPA Contractor and is responsible for assessing the Contractor's performance and compliance in conducting its respective waiver operational and administrative functions based on the terms of its contract.

   The DOH/DDSD is responsible for assessing the performance and compliance of the SIS Contractor conducting its respective waiver operational and administrative functions based on the terms of its contract.

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
   HSD/MAD conducts an annual on-site operational and performance review of the Third-Party Assessor (TPA) Contractor including a review of the TPA Contractor's quality management activity to assess compliance with the terms of the contract. HSD/MAD's oversight includes monitoring of the TPA Contractor's delegated functions which are: level of care evaluation, review of individual service plans, prior authorization of waiver services, utilization management, and quality assurance and quality improvement activities. In addition, HSD/MAD utilizes participant-satisfaction survey data, phone and complaint data, and Fair Hearing data to assess the TPA Contractor's performance. DOH provides HSD/MAD with any data, complaints or other information DOH has obtained from any source regarding the TPA Contractor's performance as part of the review. If any problems are identified, HSD/MAD requires a corrective action plan from the TPA Contractor and monitors its implementation. HSD/MAD

reviews oversight findings with DOH.

DOH/DDSD conducts a quarterly performance review of the SIS Contractor to assess compliance with the terms of the contract. DOH/DDSD's oversight includes monitoring of the SIS Contractor's contracted delegated functions to conduct SIS assessments in accordance with waiver requirements through monthly review of deliverables and prior to approving payment for services rendered.

HSD/MAD reviews the findings of the quarterly performance review conducted by DOH/DDSD to ensure that the SIS Contractor complies with the contracted delegated functions.

## 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 | ☑ | ☑ | ☐ |
| 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

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

i. **Performance Measures**

***For each performance measure 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:**
**Number and percent of provider agreements for newly enrolled providers that adhered to the State's uniform agreement requirements (specific to provider type). Numerator: Number of provider agreements in compliance. Denominator: Total number of new provider agreements.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of service plans for new DD Waiver enrollees that are completed in the timeframe specified by the state. Numerator: Number of new service plans completed within the required timeline. Denominator: Total number of new services plans completed.**

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

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

| | | |
|---|---|---|
| | ☐ **Other**<br>Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of DD Waiver data reports specified in the TPA 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 TPA reports required to be submitted.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**TPA Contractor Reports**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>TPA Contractor | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | | |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of LOC determinations completed within timelines as specified in the TPA contract with the Medicaid agency. Numerator: Number of LOC determinations completed within the required timelines. Denominator: Total number of LOC determinations completed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**TPA Contractor Reports**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = |
| ☑ **Other** Specify: TPA Contractor | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of new and revised policies and rules governing the operation of the waiver approved by the Medicaid agency. Numerator: Number of waiver policies and rules approved by the Medicaid Agency. Denominator: Total number of new waiver policies and rules implemented.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Project Approval Form Tracking Spreadsheet**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of prior authorization approvals and denials conducted in accordance with State procedures. Numerator: Number of prior authorization approvals and denials complying with the Medicaid requirements. Denominator: Total number of prior authorization approvals and denials.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**TPA Contractor Reports**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: TPA Contractor | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|

**Performance Measure:**
**Number and percent of new waiver openings that have been allocated according to State policies and procedures. Numerator: Number of compliant new waiver allocations. Denominator: Total number allocated to the waiver.**

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

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

**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):* |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☑ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☐ Quarterly |
| ☐ Other<br>Specify: | ☑ Annually |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**The number and percent of SIS assessments that are performed consistently across all certified SIS assessors. Numerator= SIS assessments conducted consistently Demoninator= total number of SIS assessments**

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

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

**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)*: |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

As noted in Appendix A: 2.b., HSD/MAD monitors 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. Formal quality improvement processes are in place, as described in detail in the Developmental Disabilities Services Quality Improvement (DDSQI) Steering Committee description and structure in Appendix H, in which HSD/MAD participates with the operating agency. Additionally, HSD/MAD conducts an annual on-site operational and performance review of the Third-Party Assessor (TPA) Contractor including a review of the TPA Contractor's quality management activity to assess compliance with the terms of the contract.

DOH/DDSD conducts a quarterly performance review of the the independent contractor that administers the Supports Intensity Scale (SIS)assessment (SIS Contractor)to assess compliance with the terms of the contract. DOH/DDSD's oversight includes monitoring of the SIS Contractor's contracted delegated functions to conduct Supports Intensity Scale (SIS) assessments in accordance with waiver requirements through monthly review of deliverables and prior to approving payment for services rendered. The contracted entities referenced in A-7 refer to the Third-Party Assessor (TPA) Contractor and the SIS Contractor.

The TPA Contractor reviews required level of care (LOC) assessments and determines medical eligibility for individuals who are newly allocated to the waiver and for level of care redeterminations. In addition, the TPA Contractor conducts utilization reviews (prior authorization of waiver services) and approvals for Individual Service Plans (ISPs) and budgets to ensure that waiver requirements are met.

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

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement related to HSD/MAD's administrative authority are identified by HSD/MAD, processes are in place to ensure that appropriate and timely action is taken whether the situation is in regard to individuals, providers and vendors of services and supports, contractors, or the State's systems. Methods for fixing identified problems with functions performed by DOH 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 may be required. In all cases, if HSD/MAD or DOH identifies any issues that are inconsistent with Medicaid requirements at any time, HSD/MAD ensures that DOH corrects the identified problems or issues and that compliance with the Assurance is met.

Problems with functions performed by the TPA Contractor as identified by various discovery methods will

result in placing the TPA Contractor on corrective action, and/or sanctions will be implemented, including possible contract termination.

If the contractor fails to improve performance after receiving technical assistance from the State, a corrective action plan (CAP) is required. 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 from the state, the contractor is required to remediate the identified performance issues.

When performance issues are identified with waiver functions performed by the SIS Contractor, DOH/DDSD provides technical assistance, documents and tracks the issues. If the issues are not resolved after receiving technical assistance and guidance by DOH/DDSD, the Contractor will be placed on corrective action, and/or sanctions will be implemented, including possible contract termination.

**ii. Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>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 |
| ☐ Aged or Disabled, or Both - General | | | | | |
| | ☐ | Aged | | | ☐ |
| | ☐ | Disabled (Physical) | | | |
| | ☐ | Disabled (Other) | | | |
| ☐ Aged or Disabled, or Both - Specific Recognized Subgroups | | | | | |
| | ☐ | Brain Injury | | | ☐ |
| | ☐ | HIV/AIDS | | | ☐ |
| | ☐ | Medically Fragile | | | ☐ |
| | ☐ | Technology Dependent | | | ☐ |
| ☑ Intellectual Disability or Developmental Disability, or Both | | | | | |
| | ☑ | Autism | 0 | | ☑ |
| | ☑ | Developmental Disability | 0 | | ☑ |
| | ☑ | Intellectual Disability | 0 | | ☑ |
| ☐ Mental Illness | | | | | |
| | ☐ | Mental Illness | | | |
| | ☐ | Serious Emotional Disturbance | | | |

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

Developmental Disabilities Waiver Services are intended for individuals who have developmental disabilities limited to Mental Retardation (MR) or a Specific Related Condition as determined by the Department of Health/Developmental Disabilities Supports Division. 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 individual must also require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), in accordance with 8.313.2 NMAC.

1. The definition for Mental Retardation is as follows:

Mental Retardation refers to 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.
d. The developmental period is defined as the period of time between birth and the 18th birthday.

2. The definition for Specific Related Condition is as follows:

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

a. Is attributable to Cerebral Palsy, Seizure Disorder, Autistic Disorder (as described in the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders), Chromosomal Disorders (e.g. Down's), Syndrome Disorders, Inborn Errors of Metabolism, or Developmental Disorders of the Brain Formation;
b. Results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with

mental retardation and requires treatment or services similar to people with mental retardation;
c. Is manifested before the person reaches age twenty-two (22) years;
d. Is likely to continue indefinitely; and
e. Results in substantial functional limitations in three (3) or more of the following areas of major life activity:

i. Self-care;
ii. Receptive and expressive language;
iii. Learning;
iv. Mobility;
v. Self-direction;
vi. Capacity for independent living; and
vii. Economic self-sufficiency.

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 |
|---|---|
| Year 1 | 3737 |
| Year 2 | 3692 |
| Year 3 | 3648 |
| Year 4 | 4229 |
| Year 5 | 4356 |

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 | 0 |
| Year 2 | 0 |
| Year 3 | 0 |
| Year 4 | 0 |
| Year 5 | 0 |

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|

## Appendix B: Participant Access and Eligibility

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

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

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

## Appendix B: Participant Access and Eligibility

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

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

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

*Select one*:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Individuals are allocated to the waiver on a statewide basis in chronological order by the date of waiver registration. In addition, individuals can receive an expedited allocation if the DDSD Expedited Referral Review Team determines a crisis situation exists, and the individual meets the criteria for expedited allocation in the Expedited Allocation to the Developmental Disability Waiver Program Policy 6-18-07.

## 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**
- [x] **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 spenddown 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 4)

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

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

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

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
*(Complete Item B-5-b (SSI State) and Item B-5-d)*

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

○ **The following standard included under the State plan**

*Select one*:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the State Plan**

*Specify:*

○ **The following dollar amount**

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

◉ **The following formula is used to determine the needs allowance:**

*Specify:*

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

○ **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 4)

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

i. **Allowance for the personal needs of the waiver participant**

(*select one*):

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

Specify percentage:

- ( ) **The following dollar amount:**

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

◉ **The following formula is used to determine the needs allowance:**

*Specify formula:*

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

○ **Other**

*Specify:*

**ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, 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-6: Evaluation/Reevaluation of Level of Care

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

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

i. **Minimum number of services.**

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

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

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

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

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

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

*Specify the entity:*

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 for waiver individuals include: a physician, a registered nurse licensed in New Mexico, or a qualified mental retardation professional as defined in 42 CFR 483.430. The TPA Contractor makes the level of care determination.
The TPA contractor must be a designated Quality Improvement Organization (QIO) or QIO-like entity as described in CFR 475. The current TPA contractor received CMS certification as a QIO-like entity effective September 4, 2012 through September 10, 2015. CMS indicated that certification is based on the TPA contractor meeting requirements to be a QIO-like entity, namely for being "a physician-access organization and able to perform limited medical and quality review functions."

The TPA contractor UR/UM clinical staff are comprised of registered professional nurses, licensed practical nurses, other licensed clinicians, paraprofessionals, and physicians. These professionals have a minimum of 3-5 years of clinical and utilization review experience. In addition, the TPA contractor employs master level, licensed social workers who have medical case management experience for all clinical functions and paraprofessionals educated in areas relating to special needs populations.

The process involved in making the LOC determination is as follows: DD waiver case manager will initiate the LOC review by submitting the State's ICF/MR long term care assessment abstract form along with supporting documentation (i.e. client individual assessment, history and physical, standardized norm referenced, age-appropriate assessment of adaptive behavior) to the TPA contractor. A TPA UR/UM reviewer will assess for medical necessity by comparing medical/clinical material contained in the history and physical and assessment information and other supporting documentation to the ICF/MR LOC criteria. In the event that the UR/UM reviewer determines that LOC was not met, a second review is conducted by the TPA Medical Director for a final determination.

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

Individuals must be diagnosed with a developmental disability and meet the level of care required in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The ICF/MR Long-Term Care Assessment Abstract (LTCAA-MAD 378) is used to determine if institutional level of care is needed for an individual to remain safe in the community.

The ICF/MR Level of Care Criteria includes the following:

A. Physical Development and Health

1. Health and Supervision: is applied to individuals who require supervision specific to their health needs.
2. Medication Assessment: is applied to individuals who require the effectiveness of their medications to be monitored by a licensed personnel.
3. Medication Administration: an individual's ability to self-administer medication.

B. Nutritional Status

1. Eating Skills: an individual's ability to feed themselves;
2. Diet Supervision: the amount of supervision required by a staff or the need for dietary services.

C. Sensorimotor Development

1. Mobility: capacity for mobility that is not limited to ambulation.
2. Toileting: an individual's ability to toilet themselves.
3. Hygiene: an individual's ability to perform hygiene skills.
4. Dressing: an individual's ability to dress themselves.

D. Affective Development: an individual's ability to express their emotions.

E. Speech and Language Development

1. Expressive: an individual's ability to communicate with others using speck, sign boards, sign language or other substitutes.
2. Receptive: an individual's ability to comprehend what is said to them.

F. Auditory Functioning: an individual's ability to hear and/or benefit from a hearing device.

G. Cognitive Development: an individual's ability to reason, remember, problem solve or transfer skills.

H. Social Development

1. Interpersonal: an individual's ability to establish relationships.
2. Social Participation: an individual's ability to participate in social and recreational activities.

I. Independent Living

1. Home Skills: an individual's ability to perform household skills.
2. Community Skills: an individual's ability to participate in community activities utilizing skills such as street survival, money exchange, ordering in restaurants, running errands and attending recreational events.

J. Adaptive Behaviors

1. Harmful Behavior: are those behaviors that a client exhibits that are harmful to themselves or to others and require staff intervention.

2. Disruptive Behavior: are those behaviors exhibited by a client that are disruptive to others and require staff intervention.
3. Socially Unacceptable or Stereotypical Behavior: behaviors that are socially unacceptable or considered to be stereotypical and require staff intervention.
4. Uncooperative Behavior: uncooperative behaviors that require staff intervention.

The HSD/MAD policy for LOC is 8.312.2-UR , 8.302.5 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:

1. The initial level of care (LOC) evaluation occurs after the individual has received an allocation for waiver services and has chosen a case management agency (selected on the Freedom of Choice form). The case manager contacts the individual immediately and assists the individual in completing the eligibility process.

2. The case manager obtains the LTCAA form and history and physical from the physician, and gathers any other relevant information to substantiate the LOC. The documents are submitted to the TPA Contractor for eligibility determination.

3. The TPA Contractor reviews, evaluates and approves all initial and annual LOC determinations. If the recipient has a change in condition at any time, the case manager obtains a new supports intensity scale assessment and submits it to the TPA Contractor for review.

4. The TPA Contractor is responsible to provide written notification to the case management agency of its determination. The case management agency is responsible for notifying the individual and/or family or legal representative of the LOC determination. If there is a denial in LOC, the letter would include an appeal process.

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 waiver case manager is responsible for tracking the individual's LOC reevaluation to ensure timely completion of the reevaluation process. The case manager must submit the Long-Term Care Assessment Abstract (LTCAA) packet to the TPA Contractor for utilization review. For re-determinations, the submission shall occur between 45 days and 30 days prior to the LOC expiration date. In addition, the TPA Contractor uses a report tracking system to monitor LOC re-determination dates. The TPA Contractor produces the LOC re-determination report on a monthly basis which is shared with case managers to ensure timely reevaluations. DDSD Regional Office staff monitors compliance with required timeframes for initial level of care. As part of its TPA contract compliance review, HSD monitors LOC reevaluations and medical eligibility decisions for timeliness of LOC reviews via various compliance timelines.

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:

The TPA contractor and individual's case manager maintain records of all LOC evaluations and reevaluations. Records are maintained at the TPA Contractor's office for a period of ten (10) years. Records are maintained at the case management agency for a period of at least six (6) years (8.302.1 NMAC).

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

***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:**
**Number and percent of new enrollees who had a level of care (LOC) indicating need for institutional level of care prior to receipt of services. Numerator: Number of new enrollees who had a LOC indicating need for institutional level of care prior to waiver services being provided. Denominator: Total number of new enrollees.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | Specify: |

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.*

**Performance Measure:**
**The number and percent of enrolled individuals who received an annual redetermination of eligibility within 12 months of their last annual LOC evaluation. Numerator: Number of enrolled individuals that received an annual LOC redetermination within 12 months of the last LOC evaluation. Denominator: Total number of enrolled individuals.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**TPA Contractor Reports**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: TPA Contractor | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | | ☐ **Other** |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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:**
**Number and percent of individuals' initial LOC determinations reviewed by the TPA Contractor that adhered to the requirements specified by the State. Numerator: Number of initial LOCs reviewed by the TPA Contractor that adhered to Medicaid requirements. Denominator: Total number of initial LOCs reviewed by the TPA Contractor.**

**Data Source** (Select one):
**Record reviews, off-site**

If 'Other' is selected, specify:
**TPA Contractor reports**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = +/- 5% margin of error and a 95% confidence level |
| ☑ **Other** Specify: TPA Contractor | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of individuals' annual LOC determinations reviewed by the TPA Contractor that adhered to the requirements specified by the State. Numerator: Number of LOC redeterminations reviewed by the TPA Contractor that adhered to Medicaid requirements. Denominator: Total number of LOC redeterminations reviewed by the TPA Contractor.**

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

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = +/- 5% margin of error and a 95% confidence level |
| ☑ **Other**<br>Specify:<br>TPA Contractor | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
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 State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement related to LOC are identified by HSD/MAD, processes are in place to ensure that appropriate and timely action is taken. In addition, the DDSQI Steering Committee routinely collects, aggregates, analyzes, and trends LOC data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

Methods for fixing identified problems include verbal direction, letters of direction, 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 DOH identifies at any time any issues that are inconsistent with Medicaid requirements related to LOC, HSD/MAD ensures that the problem is corrected and that compliance with the Assurance is met.

ii. **Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Other**<br>Specify:<br>DDSQI Steering Committee | ☑ **Annually** |
| | |

| Responsible Party*(check each that applies)*: | Frequency of data aggregation and analysis *(check each that applies)*: |
|---|---|
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

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).

At the time an individual is allocated to the waiver, he/she receives an allocation letter from DOH to begin the medical and financial eligibility process which includes a Primary Freedom of Choice (PFOC) form for the applicant to complete and return to DOH.

The applicant is provided information by DDSD about the services that are available under the waiver and that prior to enrollment into the waiver program; he/she has a choice of either home and community-based services (HCBS) or institutional services - Intermediate Care Facility for the Mentally Retarded (ICF/MR). This choice is indicated on the PFOC form. If the applicant chooses HCBS, then the applicant is given a choice between the DD Waiver or the Mi Via Self-Directed Waiver. This choice is also indicated on the PFOC form.

Additionally, once the individual is deemed eligible for the DD Waiver, the individual is informed of and given information about the freedom to choose all direct service providers by the case management agency and documents his/her choice on a Secondary Freedom of Choice form. The DOH maintains the Secondary Freedom of Choice form that lists the contracted service providers.

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.

Primary Freedom of Choice forms are maintained by the DOH and signed copies are maintained by the case management agency. Records are required to be maintained for a period of at least six (6) years per Medicaid regulations (8.302.1 NMAC)

## 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 Governor's Commission on Disabilities, and New Mexicans with Disabilities Information Center, have bi-lingual staff available. All DD Waiver provider agencies are required to communicate in the language that is functionally required by the individual. As indicated in the application, all waiver provider agencies are required to communicate in the language that is functionally required by the individual and informational material will be translated into other languages as determined necessary. This includes Native American language used in New Mexico.

Informational materials will be translated into the prevalent non-English language. The State defines prevalent non-English language as the language spoken by approximately five percent (5%) or more of the participant population.

# 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 | Case Management |
| Statutory Service | Community Integrated Employment |
| Statutory Service | Customized Community Supports |
| Statutory Service | Living Supports |
| Statutory Service | Personal Support Services |
| Statutory Service | Respite |
| Extended State Plan Service | Nutritional Counseling |
| Extended State Plan Service | Occupational Therapy For Adults |
| Extended State Plan Service | Physical Therapy For Adults |
| Extended State Plan Service | Speech and Language Therapy For Adults |
| Extended State Plan Service | Supplemental Dental Care |
| Other Service | Adult Nursing |
| Other Service | Assistive Technology |
| Other Service | Behavioral Support Consultation |
| Other Service | Crisis Support |
| Other Service | Customized In-Home Supports |
| Other Service | Environmental Modifications |
| Other Service | Independent Living Transition Service |
| Other Service | Intense Medical Living Supports |
| Other Service | Non-Medical Transportation |
| Other Service | Personal Support Technology/On-Site Response Service |
| Other Service | Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior |
| Other Service | Socialization and Sexuality Education |

# 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):**

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

Case Management Services assist individuals to gain access to needed waiver and State plan services by linking the individual to needed medical, social, educational and other services from a variety of funding sources, including natural supports. Case Management services are intended to enhance, not replace, existing natural supports and other available community resources. Services will emphasize and promote the use of natural and generic supports to address the individual's assessed needs. Case Managers facilitate and assist in assessment and service planning activities. Case Management services are person-centered and intended to support individuals in pursuing their desired life outcomes while gaining independence, and facilitating access to services and supports. Case Management is a set of interrelated activities that are implemented in a collaborative manner involving the active participation of the individual, and /or his/her designated representative/guardian, and the entire Interdisciplinary Team. The Case Manager is an advocate for the person they serve, and is responsible for developing the ISP and for the ongoing monitoring of the provision of services included in the Individual Service Plan (ISP).

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

Case management is a monthly unit with a maximum number of 12 units per ISP year.

**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 | Case Management Agency |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**
Agency
**Provider Type:**
Case Management Agency
**Provider Qualifications**

**License** *(specify):*
Licensed social worker as defined by the New Mexico (NM) Board of Social Work Examiners or licensed registered nurse as defined by the NM Board of Nursing (Nursing Practice Act: NMSA, Chapter 61, Article 3 and 16.12.1 New Mexico Administrative Code [NMAC] et seq.)
**Certificate** *(specify):*
Certificate of accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council)
**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

A bachelor's or master's degree in social work, psychology, counseling, nursing, special education, or a closely related field.

Have one (1) year clinical experience related to the target population.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## 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):**

Community Integrated Employment

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Community Integrated Employment 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 results in employment alongside non-disabled co-workers within the general workforce and/or in business ownership. This service may also include small group employment including mobile work crews or enclaves. Individuals are supported to explore and seek opportunity for career advancement through growth in wages, hours, experience and/or movement from group to individual employment. Each of these activities is reflected in the individual career plans.

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; medication administration; nursing support while at the work place; integration of therapy plans; assistance with the use of assistive devices and medical equipment; personal care activities.

Any individual earning below minimum wage must receive career planning designed to transition that individual to at least minimum wage over a specified time period.

Community Integrated Employment consists of Individual Community Integrated Employment and Group Community Integrated Employment models. Community Integrated Employment services must not duplicate services covered under the Rehabilitation Act or the Individuals with Disabilities Education Act (IDEA).

Individual Community Integrated Employment 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. This support may be given to natural supports at the work-site so that they can support the individual to learn new skills. Individuals must have the opportunity for inclusion in work settings where most of the people in the work setting are not disabled. Individual Community Integrated Employment may include competitive jobs in the public or private sector, or business ownership (self-employment). The service delivery model for Individual Community Integrated Employment includes the services of a job coach and a job developer.

Individual Community Integrated Employment includes career planning which is a short-term process that is a flexible blend of strategies designed to identify employment options for the job seeker or job holder/business owner. This results in a documented Vocational Assessment Profile with a related Strategic Action Plan that becomes a Career Plan for job development when integrated and updated into the Individual Service

Plan. Support needs are specified through career planning that identifies the job or business ownership desired with strategies for development, supports needed in the general workforce or anticipated growth in gross income for business ownership. Any individual earning below state minimum wage must receive career planning designed to transition that individual to minimum wage over a specified time period. Career planning is also available to the job seeker or job holder/business owner seeking career advancement or support to make a career change. It is available to individuals with limited exposure to work and career development.

The job developer implements the Career Development Plan, job development activities, employer negotiations and job restructuring, job sampling, and placement in a job related to the individual's desired outcomes.

The job coach provides: training; skill development and employer consultation that an individual may require while learning to perform specific work tasks on the job; co-worker training; job site analysis; implementation of career planning; integration of therapy plans related to the workplace; education of the individual and co-workers on rights and responsibilities; medication administration; and referral for benefits counseling.

Supports for business ownership may include: the development of a business plan; location of business loans and leverage of other financial resources; marketing; advertising; obtaining a business license, permits, tax registration and other legal requirements for a business enterprise; and with banking services, financial management and the development, maintenance of information management systems necessary for business operations, referral for benefits counseling, as well as supports to develop and market any products.

Group Community Integrated Employment is the on-going support needed by an individual to acquire and maintain a paid job as part of a supervised group of workers with disabilities within a community integrated general workforce. This service occurs on a work schedule (days/hours typical for the industry or employer). Individuals have on-going work related opportunities for inclusion with co-workers without disabilities who are not paid support staff and/or with the general public. Individuals receiving this service are in positions related to personal career planning goals. Any individual paid below state minimum wage must receive career planning designed to transition that individual to state minimum wage over a specified time period. Group Community Integrated Employment includes career planning which is a short-term process that is a flexible blend of strategies designed to identify employment options for the job seeker or job holder/business owner. This results in a documented Vocational Assessment Profile with a related Strategic Action Plan that becomes a Career Plan for job development when integrated and updated into the Individual Service Plan.

Individual Community Integrated Employment provides on-site supervision of individuals working as a group in community-based employment 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 | Group Community Integrated Employment |
| Agency | Individual Community Integrated Employment |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Community Integrated Employment**

**Provider Category:**
Agency
**Provider Type:**
Group Community Integrated Employment
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Certificate of accreditation from CARF or The Council
**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

Training in accordance with DDSD Training Policy for Direct Support Professional and Internal Service Coordination.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently

# Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Community Integrated Employment**

**Provider Category:**
Agency
**Provider Type:**
Individual Community Integrated Employment
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Certificate of accreditation from CARF or The Council
**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

Training in accordance with DDSD Training Policy for Direct Support Professional and Internal Service Coordination.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Habilitation

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

Customized Community Supports

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

Customized Community Supports consist of individualized services and support that enable an individual to acquire, maintain, and improve opportunities for independence, community integration and employment.

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 integration and relationship building.

This service provides the necessary support to develop social networks with community organizations to increase the individual's opportunity to expand valued social relationships and build connections within local communities. This promotes self-determination, increases interdependence and enhances the individual's ability to interact with and contribute to his or her community.

Customized Community Supports services will include, based on assessed need, personal support, nursing oversight, medication assistance/administration, and integration of strategies in the therapy and healthcare plans into the individuals daily activities. The Customized Community Supports provider will act as a fiscal management agency for the payment of adult education opportunities as determined necessary for the individual.

Customized Community Support providers are required to coordinate and collaborate with behavior support consultants to implement positive behavior support plans and other behavior support plans as outlined in the ISP. When an individual is approved to receive intense behavior support, then the Customized Community Support agencies will ensure agency direct support professionals get individual specific behavioral training and

access ongoing technical assistance from the behavior support consultant. Customized Community Support agencies will also provide the necessary levels of staffing for individuals approved for intense behavior support. The additional staffing enhancement shall be provided only during times of increased risk of harm to self or others. Support will return to a typical staffing pattern when the circumstances associated with the increased risk have ended.

Customized Community Supports services may be provided regularly or intermittently based on the needs of the individual and are provided during the day, evenings and weekends.

Customized Community Supports may be provided in a variety of settings to include the community, classroom, and site-based locations. Services provided in any location are required to provide opportunities that lead to participation and integration in the community or support the individual to reach his/her growth and development.

Pre-vocational and vocational services are not covered under Customized Community Supports.

Fiscal Management of Educational Opportunities (FMEO), will provide participants the opportunity to enroll and complete courses which increase their skills toward their desired outcomes. This service is for purchase of tuition, fees, and/or related materials associated with educational opportunities as related to the ISP Action Plan and Outcomes. The purpose of continuing education is to offer individuals the opportunity to increase personal competence in regard to their social roles (citizen, worker, parent, and retiree),gain greater fulfillment or enrichment in their personal lives and to establish community connections by meeting and interacting with people who have similar interests. Courses are not formal courses of study and are provided in the community using typical community resources outside of the habilitation program. Examples include: Computer courses, art courses, yoga classes, photography, literacy, spanish, cooking, theatre, ect. Individuals can be assisted to participate in these courses by staff in any service area; habilitation, residential or with natural supports, family or friends, depending on schedule or preference. Children will have their educational needs met through IDEA.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Amount cannot exceed the individual budget allocation per ISP year.

Fiscal Management of Educational Opportunities (FMEO),is not to exceed $550 annually.(including an administrative processing fee of no more than 10% of the total cost).

**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 Provider Agency |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Customized Community Supports**

**Provider Category:**
Agency
**Provider Type:**

Customized Community Supports Provider Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
Certificate of accreditation from CARF or The Council

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

Training in accordance with DDSD Training Policy for Direct Support Professional and Internal Service Coordination.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD

**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## 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:**
Residential Habilitation

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

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Living Supports is a residential habilitation service that is individually tailored to assist individuals eighteen (18) years or older who are assessed to need daily support and/or supervision with the acquisition, retention, or

improvement of skills related to living in the community to prevent institutionalization. Living Supports are intended to increase and promote independence and to support individuals to live as independently as possible in the community in a setting of their own choice.

Living Supports include training and assistance with activities of daily living, such as bathing, dressing, grooming, oral care, eating, transferring, mobility, and toileting. These services also include training and assistance with instrumental activities of daily living including housework, meal preparation, medication assistance, medication administration and monitoring, and healthcare management.

Living Supports include residential instruction, adaptive skill development, community inclusion, money management, shopping, transportation, social skill development, and home and safety skills that assist the individual to live in the most integrated setting appropriate to his/her needs.

Supported Living Services Provider Agencies are required to have a licensed registered nurse (RN) by the State of New Mexico on staff to provide nursing services including nursing assessments, provide technical assistance to the Inter-Disciplinary Team (IDT) on the health care plan and to train the direct support professional on the assessment and health care plans. An agency nurse is required to be on call to respond to emergencies as needed. The provider agency is responsible for providing the level of nursing based on assessed need as specified in the in accordance with the waiver service standards.

Living Supports providers are required to coordinate and collaborate with therapists and therapy assistants to implement therapy plans in accordance with the participatory approach to therapy.

Supported Living Supports providers are required to coordinate and collaborate with behavior support consultants to implement positive behavior support plans and other behavior support plans as outlined in the ISP. When an individual is approved to receive intense behavior support, then the Living Supports agencies will ensure agency direct support professionals get individual specific behavioral training and access ongoing technical assistance from the behavior support consultant. Living Supports agencies will also provide the necessary levels of staffing for individuals approved for intense behavior support. The additional staffing enhancement shall be provided only during times of increased risk of harm to self or others. Support will return to a typical staffing pattern when the circumstances associated with the increased risk have ended.

Living Supports will support individuals to access generic and natural supports, employment, and opportunities to establish or maintain meaningful relationships throughout the community.

Living Supports may be delivered in one of the following models:

Family Living: Family Living is intended for individuals who are assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family Living is direct support and assistance to no more than two individuals residing in the home of a natural or host family member. Providers are required to provide coverage to allow time for sick leave and time off as needed.

Family Living Provider Agencies are required to be an Adult Nursing provider and have a registered nurse (RN) by the State of New Mexico on staff and residing in New Mexico or bordering towns. All family living recipients must receive an annual nursing assessment; if ongoing nursing is needed, it must be budgeted separately through the adult nursing service.

Supported Living: Supported Living is intended for individuals who are assessed to need residential habilitation to ensure health and safety. Supported Living services are designed to address assessed needs and identified individual outcomes. The service is provided to 2-4 individuals in a provider operated and controlled community residence. Supported Living providers are responsible for providing an appropriate level of services and supports twenty-four (24) hours per day, seven (7) days per week.

Payment for Living Supports is not made for the cost of room and board, home maintenance or upkeep and improvement of the residence.

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

Amount cannot exceed 340 days per ISP year.

**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 | Family Living |
| Agency | Supported Living |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Living Supports**

**Provider Category:**
Agency
**Provider Type:**
Family Living
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:
Certificate of accreditation from CARF or The Council
**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

Current CPR and First Aid certification.

Complete a minimum of forty (40) hours of initial training in accordance with DDSD Training Policy for Direct Support Professionals.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Living Supports**

**Provider Category:**
Agency
**Provider Type:**
Supported Living

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
Certificate of accreditation from CARF or The Council

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

Current CPR and First Aid certification.

Training in accordance with DDSD Training Policy for Direct Support Professional and Internal Service Coordination

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD

**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## 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:**
Personal Care

**Alternate Service Title (if any):**
Personal Support Services

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

A range of assistance to enable waiver individuals to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the individual to perform the task. Personal Support Services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by state law. Personal Support Services provided under the waiver differ from personal care provided in the State plan by providing needed assistance to the individual while providing companionship to acquire, maintain or improve social interaction skills in the community or at the job site. Personal Support Services include accompanying the individual to community events and activities of his/her interest; assisting the individual at his/her place of employment; and assisting the individual in his/her home.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Personal Support services are not subjected to limits, as long as the combination of services in the ISP does not exceed the individuals budget allocation.

**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 | Personal Care Agency |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Personal Support Services**

**Provider Category:**
Agency
**Provider Type:**
Personal Care Agency
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:
Certificate of accreditation from CARF or The Council
**Other Standard** *(specify)*:
Have a current business license issued by the state, county or government.

A minimum of forty (40) hours of initial personal support training

Current CPR and First Aid certification
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal

## 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:**

Respite

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

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| **Category 2:** | **Sub-Category 2:** |
| **Category 3:** | **Sub-Category 3:** |
| **Category 4:** | **Sub-Category 4:** |

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

Respite is a flexible family support service furnished on a short-term basis. The primary purpose of respite is to provide support to the individual and give the primary, unpaid caregiver relief and time away from his/her duties.

Respite Services include: assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities; assisting the individual 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 individual to make his/her own choices with regard to daily activities.

Respite services may be provided in the individual's home, the provider's home, in a community setting of the family's choice (e.g. community center, swimming pool, and park); or in a center in which other individuals are provided care.

**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 | Respite Provider Agency |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Agency
**Provider Type:**
Respite Provider Agency
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:
Certificate of accreditation from CARF or The Council
**Other Standard** *(specify)*:
License issued by the state, county or city government.

Current CPR and First Aid certification.

Complete a minimum of forty (40) hours of initial training in accordance with DDSD Training Policy for Direct Support Professionals.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Extended State Plan Service
**Service Title:**

Nutritional Counseling

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope)*:
Nutritional Counseling services include assessment of the individual's nutritional needs, development and/or revision of the individual's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Group Practice |
| Individual | Individual Practitioner |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Nutritional Counseling**

**Provider Category:**
Agency
**Provider Type:**
Group Practice
**Provider Qualifications**

**License** *(specify)*:
Must be registered as a Dietician by the Commission on Dietetic Registration of the American Dietetic Association; Nutrition and Dietetics Practice Act 61-7A-1 et seq., NMSA 1978
**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Nutritional Counseling**

**Provider Category:**
Individual
**Provider Type:**
Individual Practitioner
**Provider Qualifications**

**License** *(specify)*:
Must be registered as a Dietician by the Commission on Dietetic Registration of the American Dietetic Association; Nutrition and Dietetics Practice Act 61-7A-1 et seq., NMSA 1978
**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Extended State Plan Service
**Service Title:**
Occupational Therapy For Adults

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Diagnosis, assessment and management of functional limitations intended to support engagement in everyday life activities that affect health, functioning and quality of life. Occupational Therapy services typically include: customized treatment programs to improve one's or maintain ability to engage in daily activities; comprehensive environmental access evaluations with adaptation recommendations; assessments and treatment for performance skills; assistive technology recommendations and usage training; and training/consultation to family members and direct support personnel. Occupational Therapy services 1) increase, maintain or reduce the loss of functional skills, and/or 2) treat specific conditions clinically related to an individual's developmental disability, and/or 3) support the individual's health and safety needs, and/or 4) identify, implement, and train therapeutic strategies to support the individual and their family/support staff in efforts to meet the individual's ISP desired outcomes and goals.

Based upon therapy goals, services may be delivered in an integrated/natural setting or clinical setting.

Individual Integrated Therapy Model: Interventions within the licensed therapist's scope of service when provided within the natural contexts of an individual's life (such as home, day habilitation site, vocational site, community locations or at ISP planning meetings). This does not include "pull out therapy services" unless a direct skilled therapy service is provided and applied to a functional activity/routine in collaboration with a caregiver during the same session.

Individual Clinical Model: Interventions within the licensed therapist's scope of service when provided in a clinic setting such as a therapy clinic or therapist's office OR when services are delivered in an isolated, non-integrated manner. A clinical context would include any location that an individual would not otherwise visit, if they did not have a therapy appointment.

Adults on the DD Waiver may access therapy services under the State plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to adults under the DD Waiver are for maintenance and community integration purposes.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Amount cannot exceed the individual budget amount per ISP year.

**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 | Provider or group practice, clinics, hospitals |
| Individual | Licensed Independent Occupational Therapist |
| Individual | Certified Occupational Therapy Assistant |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Occupational Therapy For Adults**

**Provider Category:**
Agency

**Provider Type:**
Provider or group practice, clinics, hospitals

**Provider Qualifications**

**License** *(specify):*
Group Practice Agency that employs licensed physical therapists in accordance with New Mexico Regulations & Licensing Department.

**Certificate** *(specify):*

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD

**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Occupational Therapy For Adults**

**Provider Category:**
Individual

**Provider Type:**
Licensed Independent Occupational Therapist

**Provider Qualifications**

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

**Certificate** *(specify):*

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD

**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Occupational Therapy For Adults**

**Provider Category:**
Individual

**Provider Type:**
Certified Occupational Therapy Assistant

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:
Certified Occupational Therapy Assistant

**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD

**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

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

**Service Type:**
Extended State Plan Service

**Service Title:**
Physical Therapy For Adults

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope)*:
Diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy activities 1) increase, maintain or reduce the loss of functional skills, and/or 2) treat a specific condition clinically related to an individual's developmental disability, and/or 3) support the individual's health and safety needs, and 4) identify, implement, and train on therapeutic strategies to support the individual and their family/support staff in efforts to meet the individual's ISP vision and goals.
Based upon therapy goals, services may be delivered in an integrated natural setting or clinical setting.

Individual Integrated Therapy Model: Interventions within the licensed therapist's scope of service when provided within the natural contexts of an individual's life (such as home, day habilitation site, vocational site, community locations or at ISP planning meetings). This does not include "pull out therapy services" unless a direct skilled therapy service is provided and applied to a functional activity/routine in collaboration with a caregiver during the same session.

Individual Clinical Model: Interventions within the licensed therapist's scope of service when provided in a clinic setting such as a therapy clinic or therapist's office OR when services are delivered in an isolated, non-integrated manner. A clinical context would include any location that an individual would not otherwise visit, if they did not have a therapy appointment.

Adults on the DD Waiver may access therapy services under the State plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to adults under the DD Waiver are for maintenance and community integration purposes.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Amount cannot exceed the individual budget amount per ISP year.

**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 | Group Practice |
| Individual | Physical Therapy Assistant |
| Individual | Physical Therapist |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Physical Therapy For Adults**

**Provider Category:**
Agency
**Provider Type:**
Group Practice
**Provider Qualifications**
**License** *(specify):*
Group Practice Agency that employs licensed physical therapists in accordance with New Mexico Regulations & Licensing Department.
**Certificate** *(specify):*

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Physical Therapy For Adults**

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

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Physical Therapy For Adults**

**Provider Category:**
Individual

**Provider Type:**
Physical Therapist

**Provider Qualifications**

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

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD

**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

# Appendix C: Participant Services

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

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

**Service Type:**
Extended State Plan Service

**Service Title:**
Speech and Language Therapy For Adults

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Diagnosis, counseling and instruction related to the development and disorders of communication including speech, fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction (oral pharyngeal or laryngeal) and sensor motor competencies. Speech Language Pathology is also used when an individual requires the use of an augmentative communication device. Services are intended to improve or maintain the individual's capacity for successful communication or to lessen the effects of individual's loss of communication skills and/or to treat a specific condition clinically related to a developmental disability and/or to improve or maintain the individual's ability to eat foods, drink liquids, and manage oral secretions with minimal risk of aspiration or other potential injuries or illness related to swallowing disorders. Activities include identification, implementation and training of therapeutic strategies to support the individual and their family/support staff in efforts to meet the individual's ISP vision and goals.

Based upon therapy goals, services may be delivered in an integrated natural setting or clinical setting.

Individual Integrated Therapy Model: Interventions within the licensed therapist's scope of service when provided within the natural contexts of an individual's life (such as home, day habilitation site, vocational site, community locations or at ISP planning meetings). This does not include "pull out therapy services" unless a direct skilled therapy service is provided and applied to a functional activity/routine in collaboration with a caregiver during the same session.

Individual Clinical Model: Interventions within the licensed therapist's scope of service when provided in a clinic setting such as a therapy clinic or therapist's office OR when services are delivered in an isolated, non-integrated manner. A clinical context would include any location that an individual would not otherwise visit, if they did not have a therapy appointment.

Adults on the DD Waiver may access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to adults under the DD Waiver are for maintenance and community integration purposes.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Amount cannot exceed the individual budget amount per ISP year.

**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 | Clinical Fellow |
| Individual | Speech Language Pathologist |
| Agency | Private or group practice, clinics, and hospitals |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Speech and Language Therapy For Adults**

**Provider Category:**

Individual

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

**Other Standard** *(specify):*
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Speech and Language Therapy For Adults**

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

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Speech and Language Therapy For Adults**

**Provider Category:**
Agency

**Provider Type:**
Private or group practice, clinics, and hospitals
**Provider Qualifications**
**License** *(specify):*
Group Practice Agency that employs licensed speech therapists in accordance with New Mexico Regulations & Licensing Department.
**Certificate** *(specify):*

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Extended State Plan Service
**Service Title:**
Supplemental Dental Care

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Supplemental dental care includes a routine oral examination and cleaning to preserve and/or maintain oral health.

Adults on the DD Waiver may access one (1) routine cleaning a year under the State plan. Dental care provided to adults under the DD Waiver is for individuals who require more than one (1) routine cleaning a year to

preserve and/or maintain oral health.
Children under the age of 21 on the DD Waiver may access two (2) routine cleanings a year under the State plan. Dental care provided to children under the age of 21 under the DD Waiver is for individuals who require more than two (2) routine cleanings a year to preserve and/or maintain oral health.
**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 | Dental Private or group practice, clinics |
| Agency | Supplemental Dental Care Agency |
| Individual | Dental Hygienist |
| Individual | Dentist |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Supplemental Dental Care**

**Provider Category:**
Agency
**Provider Type:**
Dental Private or group practice, clinics
**Provider Qualifications**
**License** *(specify)*:
Licensed as per NM Regulation and Licensing Department , 61-5A-1 et seq., NMSA 1978
**Certificate** *(specify)*:
**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Supplemental Dental Care**

**Provider Category:**
Agency
**Provider Type:**
Supplemental Dental Care Agency
**Provider Qualifications**
**License** *(specify):*
Must contract with New Mexico licensed dentists and dental hygienists
**Certificate** *(specify):*

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

Must demonstrate fiscal solvency, function as a payee for the service.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal.
Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Supplemental Dental Care**

**Provider Category:**
Individual
**Provider Type:**
Dental Hygienist
**Provider Qualifications**
**License** *(specify):*
Licensed as per NM Regulation and Licensing Department, 61-5A-1 et seq., NMSA 1978
**Certificate** *(specify):*

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal.
Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Supplemental Dental Care**

**Provider Category:**
Individual

**Provider Type:**
Dentist

**Provider Qualifications**

**License** *(specify)*:
Licensed as per NM Regulation and Licensing Department , 61-5A-1 et seq., NMSA 1978

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD

**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

# 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:**
Adult Nursing

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |

**Service Definition** *(Scope)*:
Nursing Services are provided based on the needs and location of the individual and include a review of medical history, an assessment, healthcare planning (in collaboration with other members of the IDT), training, monitoring healthcare plan implementation, advice, teaching and consultation and/or treatment for a chronic medical condition or disability. Such activities shall be based upon assessed support needs and may include medication management/administration; aspiration precautions; cardio/pulmonary management; feeding tube management; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; pain management; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; medical management of behavioral symptoms; health education and self-care assistance. May also include teaching and monitoring for delegated nursing tasks at nurse discretion.
Private Duty Nursing services are covered under the State Plan as expanded EPSDT benefits for waiver individuals under the age of 21.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Amount cannot exceed the individual budget allocation per ISP year.

**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 | Private Duty Nursing Individual |
| Agency | Private Duty Nursing Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Adult Nursing**

**Provider Category:**
Individual
**Provider Type:**
Private Duty Nursing Individual
**Provider Qualifications**
**License** *(specify)*:
Must be licensed by the New Mexico State Board of Nursing as a RN or LPN per the Nursing Practice Act: NMSA, Chapter 61, Article 3 and 16.12.1 New Mexico Administrative Code [NMAC] et seq.
**Certificate** *(specify)*:
**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

Have a minimum of one-year experience as a licensed nurse
**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Adult Nursing**

**Provider Category:**
Agency
**Provider Type:**
Private Duty Nursing Agency
**Provider Qualifications**

**License** *(specify):*
Licensed Home Health Agency (7 NMAC 28.2 et seq.) Must be licensed by the New Mexico State Board of Nursing as a RN or LPN per the Nursing Practice Act: NMSA, Chapter 61, Article 3 and 16.12.1 New Mexico Administrative Code [NMAC] et seq.

**Certificate** *(specify):*

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

Have a minimum of one-year experience as a licensed nurse.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## 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:**

**Category 4:** **Sub-Category 4:**

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

The focused use of Assistive Technology (AT) benefits individuals on the waiver program to engage more fully in life through increasing communication; independence and community access. Increased communication allows the individual to freely express their wishes and supports socialization. AT also supports individuals in the work setting thereby increasing their earning potential and independence. AT services are cost effective because they enable the person to function more independently, which decrease reliance on direct support staff.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
The maximum funding allowed under AT services is $250.00 per ISP year. Of the $250.00, no more than $20.00 can be used to purchase batteries.

**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 | Assistive Technology Provider Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Assistive Technology**

**Provider Category:**
Agency

**Provider Type:**
Assistive Technology Provider Agency
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

Must demonstrate fiscal solvency and function as a payee of services.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## 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:**
Behavioral Support Consultation

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

Behavioral Support Consultation service is intended to augment functional skills and positive behaviors that contribute to quality of life and reduce the impact of interfering behaviors that compromise quality of life. This service is provided by an authorized behavioral support consultant and includes an assessment and Positive Behavior Support Plan development; interdisciplinary team (IDT) training and technical assistance; and monitoring of an individuals behavioral support services.

The key quality of life aspects addressed through this service to instruct and mentor the IDT are the opportunity, skills, and supports needed by the individual to:
1. Form and sustain a full range of relationships with natural or non-paid supports;
2. Pursue meaningful community integration and inclusion;
3. Acquire and/or maintain social, communication, daily living, leisure, work, and self care capacities; and
4. Manage and reduce behaviors which pose a health and safety risk to the individual or others.

Behavioral support consultants are licensed mental health professionals authorized by the Department to:

1. Guide interdisciplinary team understanding of contributing factors that influence the individual's behavior such as: genetic and/or syndromal predispositions, developmental and physiological compromises, traumatic events, co-occurring intellectual and/or developmental disabilities and mental illness, communicative intentions, coping strategies, and environmental issues;
2. Describe support strategies to ameliorate the negative impact of contributing factors with the intention of enhancing the individual's autonomy and self-worth;
3. Enhance interdisciplinary team competency to predict, prevent, intervene with, and potentially reduce interfering behaviors;
4. Support effective implementation of an individual's desired outcomes through comprehensive assessments, subsequent Positive Behavioral Support Plan design, and progress reports. Behavioral Crisis Intervention Plans, Risk Management Plans, and PRN Psychotropic Medication Plans are added when deemed necessary by the interdisciplinary team, and, in the case of PRN psychotropic medications, those prescribed by a legally licensed prescriber.
5. Collaborate with medical personnel and ancillary therapies to promote coherent and coordinated efforts; and
6. Advocate for supports that assure the individual is free from aversive, intrusive measures; chemical, mechanical, and non-emergency physical restraint; isolation; incarceration; and neglect, abuse, and exploitation.

Behavioral Support Consultation is reimbursed based on whether the service is delivered in an integrated or individual manner and may include administrative activities such as writing the assessment, plans, and other required reports.

Integrated Behavioral Support Consultation: The behavioral support consultants scope of service is provided through participation and consultation with interdisciplinary team members to support the individual to achieve desired outcomes listed in the ISP.

Individual Behavioral Support Consultation: The service is provided exclusively to the individual, without corresponding participation or subsequent consultation with interdisciplinary team members, and is without regard to service location.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Amount cannot exceed the individual budget amount per ISP year.

**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 Behavioral Support Consultation Provider |
| Agency | Behavioral Support Consultation Provider Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Behavioral Support Consultation**

**Provider Category:**
Individual
**Provider Type:**
Individual Behavioral Support Consultation Provider
**Provider Qualifications**

**License** *(specify):*
Licensed psychiatrist, psychologist, psychologist associate, independent social worker, master social worker, clinical counselor, professional counselor, marriage and family consultant, practicing art consultant, or master degree psychiatric nurse.

**Certificate** *(specify):*

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

Minimum of one year of clinical experience.

Complete training requirements as specified by DDSD.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD

**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Behavioral Support Consultation**

**Provider Category:**
Agency
**Provider Type:**
Behavioral Support Consultation Provider Agency
**Provider Qualifications**

**License** *(specify):*
Licensed psychiatrist, psychologist, psychologist associate, independent social worker, master social worker, clinical counselor, professional counselor, marriage and family consultant, practicing art consultant, or master degree psychiatric nurse.

**Certificate** *(specify):*

**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

Minimum of one year of clinical experience.

Complete training requirements as specified by DDSD.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD

**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## 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:**
Crisis Support

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope)*:
To provide intensive supports by appropriately trained staff to an individual experiencing a behavioral or medical crisis via one of the following models:

1. Crisis Supports in the Individual's Residence: provide crisis response staff to assist in supporting and stabilizing the individual while also training and mentoring staff or family members, who normally support the individual, in order to remediate the crisis and minimize or prevent recurrence.

2. Crisis Supports in an Alternate Residential Setting: arrange an alternative residential setting and provide crisis response staff to support the individual in that setting, to stabilize and prepare the individual to return home or to move into another permanent location. In addition, staff will arrange to train and mentor staff or family members who will provide long-term support to the individual once the crisis has stabilized, in order to minimize or prevent recurrence.

In both of the above models, crisis support staff will deliver such support in a way that maintains the individual's normal routine to the maximum extent possible. This includes support during attendance at employment or customized community supports services, which may be billed on the same dates and times of service as Crisis Supports.

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

Crisis Supports must be prior authorized by the Developmental Disabilities Supports Division (DDSD) Office of Behavioral Supports. Crisis Supports may be authorized in fourteen (14) to thirty (30) calendar day increments, typically not to exceed ninety (90) calendar days. In situations requiring crisis supports in excess of ninety (90) calendar days, the DDSD Director must approve such authorization upon submittal of a written plan to transition the individual from crisis supports to typical menu of DD Waiver services.

**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 | Crisis Support Provider Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Crisis Support**

**Provider Category:**
Agency

**Provider Type:**
Crisis Support Provider Agency

**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Have a current business license issued by state, county or city government

Training in accordance with DDSD training policy

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

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

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope)*:
Customized In-Home Supports is not a residential habilitation service and is intended for individuals that do not require the level of support provided under living supports services. Customized In-Home Supports provide individuals the opportunity to design and manage the supports needed to live in their own home or their family home.

Customized In-Home Supports includes a combination of instruction and personal support activities provided intermittently as they would normally occur to assist the individual with activities of daily living, meal preparation, household services, and money management. The services and supports are individually designed to instruct or enhance home living skills, community skills and to address health and safety as needed.

This service provides assistance with the acquisition, improvement and/or retention of skills that provides the necessary support to achieve personal outcomes that enhance the individual's ability to live independently in the community as specified in the Individual Service Plan (ISP).

Services are delivered by a direct support professional in the individual's own home or family home in the community.

This service may not be provided in conjunction with respite. Individuals using this service may also receive customized community supports and community integrated employment.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Amount cannot exceed the individual budget allocation per ISP year.

**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 In-Home Supports Provider Agency |

## Appendix C: Participant Services

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

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

**Provider Category:**
Agency
**Provider Type:**
Customized In-Home Supports Provider Agency
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:
Certificate of accreditation from CARF or The Council
**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

A minimum of forty (40) hours of initial personal support training.

Current CPR and First Aid certification.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal.
Providers under DOH sanctions may be required to submit more frequently.

## 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:**

**Category 4:** **Sub-Category 4:**

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

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: the installation of ramps and grab-bars; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing); turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light-activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating/cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems and/or signaling devices.

All services shall be provided in accordance with applicable federal, state and local building codes.
The environmental modification provider must ensure that proper design criteria is addressed in planning and design of the adaptation, provide or secure a licensed contractor(s) or approved vendor(s) to provide construction/remodeling services, provide administrative and technical oversight of construction projects, provide consultation to family members, waiver providers and contractors concerning environmental modification projects to the individual's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

Environmental Modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

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

Environmental Modifications are limited to $5,000 every five (5) 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 |
|---|---|
| Agency | Environmental Modifications Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Environmental Modifications**

**Provider Category:**
Agency
**Provider Type:**
Environmental Modifications Agency
**Provider Qualifications**
**License** *(specify)*:
GB-2 Class Construction

License as per NM Regulation and Licensing Department, NMSA 1978, Section 60-13-3.
**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.
Comply with all applicable state laws, rules, regulations, and building codes for the state of New Mexico.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## 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:**

Independent Living Transition Service

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

Independent Living Transition Services are one-time set-up expenses for individuals who transition from a twenty-four (24) hour Living Supports setting into a home or apartment of their own with intermittent support that allows them to live more independently in the community. The service covers expenses associated with security deposits that are required to obtain a lease on an apartment or home, set-up fees or deposits for utilities (telephone, electricity, heating, etc.), furnishings to establish safe and healthy living arrangements: bed, chair, dining table and chairs, eating utensils and food preparation items, and a telephone. The service also covers services necessary for the individual's health and safety such as initial or one-time fees associated with the cost of paying for pest control, allergen control or cleaning services prior to occupancy.

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

Independent Living Transition Services have a one-time only maximum cost of $1,500 for each individual. Funds may not be utilized to pay for food, clothing or rental/mortgage costs excluding deposits as specified above.

**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 | Independent Living Transition Provider Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Independent Living Transition Service**

**Provider Category:**
Agency
**Provider Type:**
Independent Living Transition Provider Agency
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

The provider must demonstrate fiscal solvency and function as the payee of the service.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## 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:**
Intense Medical Living Supports

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Intense Medical Living Supports provide community living supports for individuals in a Supported Living environment who require daily direct skilled nursing, in conjunction with community living supports that promote health and assist the individuals to acquire, retain or improve skills necessary to live in the community and prevent institutionalization, consistent with each individual's ISP. If all persons in the home meet Intense Medical Living Supports criteria, up to five (5) persons are allowed to reside in the home; otherwise the Supported Living cap of four (4) persons in the home applies.

Eligible individuals must meet criteria for intense medical living supports according to eligibility parameters in the standards for this service and require nursing care, ongoing assessment, clinical oversight and health management that must be provided directly by a registered nurse or a licensed practical nurse in accordance with the New Mexico Nursing Practice Act at least once per day. These medical needs include skilled nursing interventions, delivery of treatment, monitoring for change of condition and adjustment of interventions and revision of services and plans based on assessed clinical needs.

In addition to providing support to individuals with chronic health conditions, Intense Medical Living Supports are available to individuals who meet a high level of medical acuity and require short-term transitional support due to recent illness and/or hospitalization which will afford the core living support provider the time to update health status information and health care plans, train staff on new or exacerbated conditions and assure that the home environment is appropriate to meet the needs of the individual.

Short-term stay in this model may also be utilized by those individuals who meet the criteria that are living in a family setting when the family needs a substantial break from providing direct service. Both types of short-term placements require prior approval of the Department of Health.

In order to accommodate referrals for short-term stays, each approved Intense Medical Living Provider must maintain at least one (1) bed available for such short-term placements. If the short-term stay bed is occupied, additional requests for short-term stay will be referred to other providers of this service.

The Intense Medical Living provider will be responsible for providing the appropriate level of supports, twenty-four (24) hours per day seven (7) days a week, including necessary levels of skilled nursing based on assessed need. Daily nursing visits are required, however a nurse is not required to be present in the home during periods of time when skilled nursing services are not required or when individuals are out in the community. An on-call nurse must be available to staff during periods when a nurse is not present. Intense Medical Living Supports require supervision by a registered nurse in compliance with standards for this service.

Direct care professionals will provide services that include training and assistance with activities of daily living, such as bathing, dressing, grooming, oral care, eating, transferring, mobility, and toileting. These services also include training and assistance with instrumental activities of daily living including housework, meal preparation, medication assistance, medication administration, shopping, and money management.

The Intense Medical Living Support provider will be responsible for providing access to Customized Community Support and employment as outlined in the Individual Service Plan (ISP). This includes any skilled nursing needed by the individual to participate in Customized Community Support and Development and employment services.

This service must arrange transportation for all medical appointments, household functions and activities, and to and from day services and other meaningful community options.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Amount cannot exceed 340 days per ISP year.

**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 | Intense Medical Supports Provider Agency |
| Agency | Supported Living Provider Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Intense Medical Living Supports**

**Provider Category:**
Agency
**Provider Type:**
Intense Medical Supports Provider Agency
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

Current CPR and First Aid certification.

Training in accordance with DDSD Training Policy for Direct Support Professional and Internal Service Coordination

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Intense Medical Living Supports**

**Provider Category:**

Agency

**Provider Type:**
Supported Living Provider Agency
**Provider Qualifications**
**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

Current CPR and First Aid certification.

Training in accordance with DDSD Training Policy for Direct Support Professional and Internal Service Coordination
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

# 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:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Non-Medical Transportation Service enables individuals to gain access to waiver and non-medical community services, events, activities and resources, work, volunteer sites, or homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.

This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a), and does not replace them.
**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 | Non-Medical Transportation Agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Non-Medical Transportation**

**Provider Category:**
Agency
**Provider Type:**
Non-Medical Transportation Agency
**Provider Qualifications**
**License** *(specify):*
Valid NM drivers license
**Certificate** *(specify):*
Current CPR and First Aid certification
**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

Valid New Mexico driver's license.

Current CPR and First Aid certification.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**

Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## 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:**

Personal Support Technology/On-Site Response Service

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

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

Personal Support Technology/On-Site Response Service is an electronic device or monitoring system that supports individuals to be independent in the community or in their place of residence with limited assistance or supervision of paid staff. This service provides twenty-four (24) hour response capability and/or prompting through the use of electronic notification and monitoring technologies to ensure the health and safety of the individual in services.

Personal Support Technology/On-Site Response Service is available to individuals who have a demonstrated need for timely response due to health or safety concerns.

Personal Support Technology/On-Site Response Service includes the installation of the rented electronic device, monthly maintenance fee for the electronic device, and hourly response funding for staff that support the individual when the device is activated.

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

A one-time installation fee of $5,000 and services up to 365 days per ISP year

**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 | Personal Support Technology/On-Site Response Service |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Personal Support Technology/On-Site Response Service**

**Provider Category:**
Agency
**Provider Type:**
Personal Support Technology/On-Site Response Service
**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Have a current business license issued by the state, county or city government.

Comply with all laws, rules, and regulations from the Federal Communications Commission for telecommunications.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## 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:**

Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Preliminary Risk Screening and Consultation Related to Inappropriate Sexual Behavior (PRSC) services identify, screen, and provide periodic technical assistance and crisis intervention when needed to the interdisciplinary teams supporting individuals with risk factors for sexually inappropriate or offending behavior. This service is part of a continuum of behavioral support services (including Behavioral Support Consultation and Preliminary Risk Screening and Consultation Related to Inappropriate Sexual Behavior Services) that promote community safety and reduce the impact of interfering behaviors that compromise quality of life. These services are provided by a trained licensed mental health professional.

Even prior to the closing of the institutions in New Mexico, the state recognized the need for a continuum of sexuality services to address the gaps in socialization and sexuality education that existed for individuals with developmental disabilities that were being integrated in the community, as well as those who had always lived in the community.

The Preliminary Risk Screening & Consultation Service was developed over the past several years as an integral part of the overall system of services provided to individuals with developmental disabilities in the state of New Mexico. It is one of the few community-based programs across the country for individuals with developmental disabilities that assesses and manages the risk for individuals that exhibit sexually inappropriate and sexually offending behavior. The preliminary risk screening process tailors supports and community-based treatment options to individuals with developmental disabilities so that they may be successfully integrated and treated in their communities. Often, when an individual is arrested for a sexual crime, the first reaction of the team is to set up a containment/supervision program that often may increase the chance that the individual may reoffend. Outcomes for the individuals supported by this service include an increased capacity to self-manage their behavior, thus allowing them to participate in community-based education, vocational, and leisure activities with increased levels of independence (i.e., less supervision from direct support professionals or other community members).

The Preliminary Risk Screening & Consultation Service utilizes the existing interdisciplinary team to assess, plan, and deliver supports for each individual. Grouping individuals together with a few community providers was attempted, but the model failed due to the geographic and cultural diversity of the state. What has been found to be most beneficial is to create a support for individuals and teams that teach them about the static and dynamic factors that make risk of sexual offending more or less likely, as well as how to modify supports to meet the skills and needs of each individual served in their particular community.

The key functions of PRSC services are:

1. To provide a structured screening of behaviors that may be sexually inappropriate;
2. To develop and document recommendations in the form of a report or consultation note;

3. To assist in the development and periodic revisions of Risk Management Plans, when recommended; and
4. To provide consultation regarding the management and reduction of sexually inappropriate behavioral incidents that may pose a health and safety risk to the individual or others.
A licensed mental health professional trained and authorized by DDSD to provide PRSC services will:

1. Inform the interdisciplinary team members about the static, stable, and acute risk factors that contribute to the individual's ability to manage sexually inappropriate behavior;
2. Improve the interdisciplinary team's competency to prevent, intervene with, and potentially reduce the incidence of sexually inappropriate behavior;
3. Recommend support and supervision strategies to enhance the individual's ability to manage sexually inappropriate behavior;
4. When appropriate, recommend that the behavior support consultant develop a risk management plan;
5. Collaborate with medical personnel and ancillary therapies to promote understanding of risk factors, and coherent and coordinated efforts; and
6. Advocate for supports so that the individual is free from aversive, intrusive measures; chemical, mechanical, and non-emergency physical restraint; isolation; incarceration; and neglect, abuse, and exploitation.
Provision of PRSC services are pre-authorized by DOH/DDSD/Office of Behavioral Supports (OBS) and reimbursed at a per fifteen (15) minute unit rate.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
1. The initial preliminary risk screening shall not exceed twenty-five (25) hours per ISP year. An additional screening, if needed, in a subsequent ISP shall not exceed fifteen (15) hours per ISP year.
2. If periodic consultation is needed beyond the screening, additional units to provide technical assistance shall not exceed fifteen (15) hours per ISP year.

**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 | Preliminary Risk Screening Provider Agency |
| Individual | Preliminary Risk Screening Provider |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior**

**Provider Category:**
Agency
**Provider Type:**
Preliminary Risk Screening Provider Agency
**Provider Qualifications**
**License** *(specify)*:
A current independent practice license, through a Board of the New Mexico Regulation and Licensing Department, in a counseling or counseling-related field (e.g., Counseling and Therapy Practice, Psychologist Examiners, Social Work Examiners)
**Certificate** *(specify)*:

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

A master's or doctoral degree in a counseling or counseling-related field from an accredited college or university.

Training as specified by DDSD.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD

**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior**

**Provider Category:**
Individual

**Provider Type:**
Preliminary Risk Screening Provider

**Provider Qualifications**

**License** *(specify):*
A current, independent practice license, through a Board of the New Mexico Regulation and Licensing Department, in a counseling or counseling-related field (e.g., Counseling and Therapy Practice, Psychologist Examiners, Social Work Examiners)

**Certificate** *(specify):*

**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

A master's or doctoral degree in a counseling or counseling-related field from an accredited college or university.

Training as specified by DDSD.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDSD

**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## 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:**

Socialization and Sexuality Education

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| Category 2: | Sub-Category 2: |
| Category 3: | Sub-Category 3: |
| Category 4: | Sub-Category 4: |

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

The Socialization and Sexuality Education service is intended to provide a proactive educational program about the values and critical thinking skills needed to form and maintain meaningful relationships, and about healthy sexuality and sexual expression. Social skills learning objectives include positive self-image, communication skills, doing things independently and with others, and using paid and natural supports. Sexuality learning objectives include reproductive anatomy, conception and fetal development, safe sex, and health awareness. Positive outcomes for the individual student include safety from negative consequences of being sexual, assertiveness about setting boundaries and reporting violations, expressing physical affection in a manner that is appropriate, and making informed choices about the relationships in his/her life. Independent living skills are enhanced and improved work outcomes result from better understanding of interpersonal boundaries, and improved communication, critical thinking, and self-reliance skills.

Even prior to the closing of the institutions in New Mexico, the state recognized the need for a continuum of sexuality services to address the gaps in socialization and sexuality education that existed for individuals with developmental disabilities that were being integrated in the community, as well as those who had always lived in the community.

The socialization and sexuality service has been developed over the past several years utilizing the collaborative input of self-advocates with I/DD, their family members and guardians, psychologists and psychotherapists, other professionals and direct support professionals that serve individuals with developmental disabilities in the community. The service provides information and support to help the individual to make the strongest connection possible between their personal values and good choices about relationships, particularly intimate ones, and build strong self-advocacy skills in order to achieve the relationships they want. The outcome of this sexuality program is that increasing numbers of people with I developmental disabilities are able to have social

intimacy and sexual relationships in their lives. Additionally, it is recognized that sexual education is needed to improve employment outcomes and safety from sexual abuse. The capacity of people with developmental disabilities to build relationships is also key to creating avenues for participation in communities, and not just be recipients of services.

The Socialization and Sexuality Education Service is taught in a group classroom setting with the support of direct support professionals, family members, and natural supports as well as the guidance of teachers and behavior support consultants where appropriate.

These intentions are carried out through a series of classes:
1. A train-the-trainer model is used where an experienced lead trainer teaches classes and also mentors others with an interest in teaching;
2. Self-advocate mentors participate by demonstrating lessons and leading groups, and supporting students in and out of the classroom, and;
3. Parents, guardians, direct care staff, and others who support students attend and actively participate, thus, the continuity of learning is extended beyond the classroom setting.

Agencies authorized by the Department to provide this service will:
1. Coordinate with DOH/DDSD/Office of Behavioral Supports (OBS) on administrative duties related to assuring classes are held (i.e., logistics, student and teacher eligibility, teacher training, preparation and hiring of self-advocate mentors);
2. Teach classes, utilizing OBS approved teacher(s), student teacher(s) and self-advocate mentor(s);
3. Collaborate with teams, behavior support consultants, and others to assure that the student attends classes, and is supported to use learned skills across all settings; and, if applicable;
4. Provide education to individuals, behavior support consultants, parents, guardians, and other team members regarding individualized socialization and sexuality education when attendance in a formalized classroom setting is not possible.

Reimbursement: The Socialization and Sexuality service is reimbursed based on whether it is delivered on a per class or individualized education basis.

Per class rate: Reimbursement for this service is to include planning, recruiting, teaching, keeping records and reporting on classes, hiring teachers and self-advocate mentors, collaborating with OBS, and other administrative duties, as necessary.

Individualized education rate: Reimbursement for this service is to include needs assessment, consultation, observation, meeting attendance (via phone or in person), and provision of informational and educational materials.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
1. Authorization for per class rate shall not exceed twenty-four (24) classes (total of 48 hours) per student per ISP year; and
2. Authorization for individualized education rate shall not exceed fifteen (15) hours per student per ISP year.

**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 | Socialization and Sexuality Provider Agency |
| Individual | Socialization and Sexuality Provider |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Socialization and Sexuality Education**

**Provider Category:**
Agency
**Provider Type:**
Socialization and Sexuality Provider Agency
**Provider Qualifications**
**License** *(specify):*
Registered Nurse or Licensed Practical Nurse
**Certificate** *(specify):*
Certification in Special Education
**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

Master's degree or higher in Psychology, Counseling, Special Education, Social Work or related field

Training requirements as specified by DDSD
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**
Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Socialization and Sexuality Education**

**Provider Category:**
Individual
**Provider Type:**
Socialization and Sexuality Provider
**Provider Qualifications**
**License** *(specify):*
Registered Nurse or Licensed Practical Nurse
**Certificate** *(specify):*
Certification in Special Education
**Other Standard** *(specify):*
Have a current business license issued by the state, county or city government.

Master's degree or higher in Psychology, Counseling, Special Education, Social Work or related field

Training requirements as specified by DDSD
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDSD
**Frequency of Verification:**

Prior to the approval of the initial provider agreement and every three (3) years upon renewal. Providers under DOH sanctions may be required to submit more frequently.

## Appendix C: Participant Services

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

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

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

*Check each that applies:*

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

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

## Appendix C: Participant Services

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

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

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

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

The 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 the individual beginning employment.

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 is conducted following the provider's completion of a Corrective Action Plan (CAP). A verification review is a desk or on-site review of evidence from the agency that the CAP has been implemented and that the agency is now in compliance.

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):

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 is conducted following the provider's completion of a Corrective Action Plan (CAP).

Corrective action plans require that any identified risk of harm be corrected immediately. 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.

## 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.*

**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/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.

Relatives/legal guardians, who are qualified to provide services as specified in Appendix C-3, may be paid for providing waiver services. Payment to relatives/legal guardians are allowed under the following circumstances:
• Legal guardians or natural family members who meet the DOH/DDSD requirements and are approved to provide Family Living services may be paid for providing services.
• Legal guardians, relatives, or natural family members that meet the DOH/DDSD requirements and are approved to provide Customized In-Home Supports may be paid for providing services.

All waiver services are determined with the individual and the Interdisciplinary Team (IDT) and are documented in the ISP, which includes provision of services provided by a legal guardian.

The case manager is responsible for monitoring the implementation of services on a monthly basis. In addition, the IDT also monitors the provision of service.

Payment is only made for services that are identified in the ISP and the provider agency is responsible for verifying that services have been rendered in accordance with the ISP by completing, signing, and submitting documentation including timesheet to the provider agency.

The DOH/Division of Health Improvement (DHI) conducts provider surveys to ensure services are provided in accordance with the DOH/DDSD DD Waiver Service Standards.

○ **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, enrollment requirements and procedures, timeframes established 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 contacting, via telephone, DOH/DDSD provider enrollment staff. DOH/DDSD staff will 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 completed program section of the provider enrollment application is approved by DOH, it is forwarded to HSD/MAD for final approval including approval of the administrative section of the application. All provider enrollment applications must be approved by HSD/MAD prior to the provision of waiver services. The timeframe for processing provider applications once a completed application is received is approximately eight (8) weeks for new applicants and four (4) weeks for renewals.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

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

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

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| | |

| Responsible Party for data aggregation and analysis *(check each that applies)*: | Frequency of data aggregation and analysis*(check each that applies)*: |
|---|---|
| ☑ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☐ Quarterly |
| ☐ Other<br>Specify: | ☑ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

**Performance Measure:**
**Number and percent of enrolled licensed/certified providers who continually meet required licensure/certification standards. Numerator: Number of providers who continually meet required licensure/certification requirements. Denominator: Total number of enrolled licensed/certified providers.**

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

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

| | | |
|---|---|---|
| | ☐ **Other**<br>Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of agency providers whose direct support staff have required criminal background checks as required by the State. Numerator: Number of staff who have a clearance letter from DOH/Division of Health Improvement. Denominator: Total number of staff who are required to have a criminal background check.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = +/- 5% margin of error and a 95% |

| | | |
|---|---|---|
| | | confidence level |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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:**

**Number and percent of non-licensed/non-certified providers who initially meet waiver requirements. Numerator: Number of non-licensed/non-certified providers that initially meet waiver requirements. Denominator: Total number of new non-licensed/non-certified providers.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of non-licensed/non-certified providers that continue to meet waiver requirements. Numerator: Number of non-licensed/non-certified providers that continue to meet waiver requirements. Denominator: Total number of non-licensed/non-certified providers.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = +/- 5% margin of error and a 95% confidence level |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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:**
**Number and percent of agency staff who are in compliance with training requirements specified in the DD Waiver policies and procedures. Numerator: Number of agency staff that meet training requirements specified in the DD Waiver policies and procedures. Denominator: Total number of agency staff that are required to meet the training requirements.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DOH training database**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| | | |

| | | |
|---|---|---|
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
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 State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement related to qualified providers are identified by the State, processes are in place to ensure that appropriate and timely action is taken. In addition, the DDSQI Steering Committee routinely collects, aggregates, analyzes, and trends provider qualification data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

Additionally, DOH has an Internal Review Committee (IRC) that meets monthly to address provider compliance issues. If remediation and improvements aren't made in accordance with the corrective action plan and other remediation activities, civil monetary penalties may be assessed against a provider, including and up to termination of the provider agreement.

Methods for fixing 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 DOH identifies at any time any issues that are inconsistent with Medicaid requirements related to provider qualifications, HSD/MAD ensures that the problem is corrected and that compliance with the Assurance is met.

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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.*

☑ **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.*

In order to link individual support needs and resource allocations, DOH/DDSD selected the Supports Intensity Scale (SIS) assessment tool developed by the American Association on Intellectual and Developmental Disabilities (AAIDD) to objectively measure individual supports needs. The SIS is a valid and reliable instrument for assessing the level of an individuals supports needs in major domains of daily living as well as behavioral and medical needs.

During the second year of the waiver renewal, individuals will transition into the new resource allocation prototype at their annual ISP year. The amount of service will be based on the individual's level of need for support as determined by the SIS and other factors. The budget limits will apply to all waiver services. Individuals assessed with higher needs, will have higher limits than those assessed with lower needs.

The resource allocation system developed through a contract with the Human Research Institute (HSRI) and Burns and Associates during year one of the waiver, uses data generated from SIS assessments to establish a seven-level system that groups individuals with comparable needs together. The seven level groups referred to as NM SIS Groups were developed using SIS assessments administered to approximately 900 individuals ages eighteen (18) and older selected as part of a stratified random sample of waiver participants.

The resource allocation system assigns service packages based on the NM SIS Groups and residential placement. The goals of the system are:

- Allocate resources so that people get what they need;

• People with the least needs are allocated the least amount of supports (and funding), and those with greater needs
get more;
• People with similar needs receive the same allocation of resources; and
• Resource allocations are based on historical service utilization.

The NM SIS Groups are identified as groups A-G, with NM SIS Group A representing individuals with the fewest needs and NM SIS Group G representing individuals with the greatest needs. A level eight (8) or NM SIS Group H is included for individuals with extenuating circumstances that have support needs that cannot be accommodated in NM SIS Groups A-G. NM SIS Groups F and G are for individuals with extensive medical and behavioral needs respectively.

The service packages for each on the NM SIS Groups are divided into three budget categories:

• Base Budget: Case Management, Residential, Personal Supports, Adult Habilitation, Community Access and Employment.
• Professional Services Budget (PSB): Occupational, Physical and Speech Language Therapies, Nursing, and Behavioral
Support Consultation (BSC). Note that within the PSB, a total amount will be authorized for all therapies and BSC.
• Other Services: Services that will be available for all eligible individuals as needed. Examples include Adult
Nursing, initial Therapy Assessments, Non-medical Transportation, Environmental Modifications and Assistive
Technology.

The Individual Service Plan (ISP) process will continue to focus on the goals of the individual and will identify the specific services and amounts of service needed for the individual to achieve their outcomes within the total resource allocation amount available.

In December 2011, a clinical validation study was conducted by a team of DDSD staff, HSRI, Burns and Associates, and other professionals to determine whether the service packages assigned to each NM SIS Group are reflective of the needs of individuals assigned to each group. The clinical validation sample consisted of 89 cases out of approximately 900 individuals that had a completed SIS assessment.

The result of the clinical validation process determined that the proposed service packages to be adequate or more than adequate for 85% of the cases reviewed. Adjustments were made to the service packages based on the study and feedback from DDSD in both the base and professional services budgets.

DDSD will implement an appropriate review and appeals process for situation when an individual does not think they are placed in the correct NM SIS Group. Additionally, individuals will have due process rights through the Medical Assistance Division (MAD).

The proposed service packages were posted to the DDSD's website for public comment on February 22, 2012. The public comment period to submit feedback on the service packages was approximately five weeks, through March 30, 2012. During the public comment period, DDSD sent out email weekly reminders encouraging providers and other interested stakeholders to submit comments. Based on the feedback received, adjustments were made to the base and professional service budgets.

The service plan budget limits or spending caps will be adjusted over the course of the waiver period based on changes in utilization patterns and changes to State general fund appropriations from the legislature to operate the waiver.

The service plan budget limit or spending caps will also be adjusted if the limit is not sufficient to meet the individuals health and safety needs.

Individuals and their families will be notified by the case manager of the spending caps based on the individuals' level of support need.

☐ **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, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

Assessment Process:
The Department of Health (DOH) along with Human Services Department/Medical Assistance Division (HSD/MAD) completed an initial assessment of the extent to which its standards, rules, and other requirements comply with the HCBS residential setting requirements. The state's 1915(c) Home and Community-Based Services Waiver, the Developmental Disabilities Waiver (DDW) Service Standards, and the New Mexico Administrative Code (NMAC) Rules were analyzed against the HCBS setting requirements.

Based on the assessment, the State identified which document outlines compliance for each requiement in the Federal Rule. The Key below identifies each of the documents.

Key for Compliance:
Current 1915 (c) Home and Community-Based Services Waiver = AW
Developmental Disabilities Waiver (DD Waiver) Service Standards = S
New Mexico Administrative Code (NMAC) Regulations = R
Policies = P
Comments = C

CMS RULE HCBS SETTING REQUIREMENTS

1. IS INTERGRATED IN AND SUPPORTS ACCESS TO THE GREATER COMMUNITY =
S
2. PROVIDES OPPORTUNITY TO SEEK EMPLOYMENT AND WORK IN COMPETITIVE INTEGRATED SETTING, ENGAGE IN COMMUNITY LIFE, AND CONTROL
PERSONAL RESOURCES = AW, S, R
3. ENSURES THE INDIVIDUAL RECEIVES SERVICES IN THE COMMUNITY TO THE SAME DEGREE OF ACCESS AS INDIVIDUALS NOT RECEIVING
MEDICAID HOME AND COMMUNITY BASED SERVICES = AW, S, R
4. THE SETTING IS SELECTED BY THE INDIVIDUAL FROM AMOUNG SETTING OPTIONS INCLUDING NON-DISABILITY SPECIFIC SETTINGS AND AN OPTION FOR A PRIVATE UNIT IN A RESIDENTIAL SETTING = S, R
5. THE SETTING OPTIONS ARE IDENTIFIED AND DOCUMENTED IN THE PERSON-CENTERED SERVICE PLAN AND ARE BASED ON THE INDIVIDUAL'S NEEDS, PREFERENCES, AND FOR RESIDENTIAL SETTINGS,RESOURCES AVAILABLE FOR ROOM AND BOARD = R
6.ENSURES AN INDIVIDUAL'S RIGHTS OF PRIVACY, DIGNITY, RESPECT, AND FREEDOM FROM COERCION AND RESTRAINT = S, R, P
7. OPTIMIZED INDIVIDUAL INITIATIVE, AUTONOMY, AND INDEPENDENCE IN MAKING LIFE CHOICES = S,R
8. FACILITATES INDIVIDUAL CHOICE REGARDING SERVICES AND SUPPORTS, AND WHO PROVIDE THEM.

= S, C-Implied as a member in the IDT in Regs. 7.26.5.11A

PROVIDER-OWNED OR CONTROLLED RESIDENTIAL SETTINGS

1. SPECIFIC UNIT/DWELLING IS OWNED, RENTED OR OCCUPIED UNDER LEGALLY ENFORCEABLE AGREEMENT = S
2. SAME RESPONSIBILITIES/PROTECTIONS FROM EVICTION AS ALL TENANTS UNDER LANDLORD LAW OF STATE, COUNTY, CITY OR
OTHER DESIGNATED ENTITY = S
3. IF TENANT LAWS DO NOT APPLY, STATE ENSURES LEASE, RESIDENCY AGREEMENT OR OTHER WRITTEN AGREEMENT IS IN PLACE PROVIDING PROTECTIONS TO ADDRESS EVICTION PROCESSES AND APPEALS COMPARABLE TO THOSE PROVIDED UNDER THE JURISDICTION'S LANDLORD TENANT LAW = N/A Tenant Laws do Apply to State of NM
4. EACH INDIVIDUAL HAS PRIVACY IN THEIR SLEEPING OR LIVING UNIT =
S
5. INDIVIDUALS SHARING UNITS HAVE A CHOICE OF ROOMMATES =
S
6. INDIVIDUALS HAVE THE FREEDOM TO FURNISH AND DECORATE THEIR SLEEPING OR LIVING UNITS WITHIN THE LEASE
OR OTHER AGREEMENT. = S
7. INDIVIDUALS HAVE FREEDOM AND SUPPORT TO CONTROL THEIR SCHEDULES AND ACTIVITIES =
S
8. SETTING IS PHYSICALLY ACCESSIBLE TO THE INDIVIDUAL = S

PERSON CENTERED PLANNING

1.THE PERSON-CENTERED PLANNING PROCESS IS DRIVEN BY THE INDIVIDUAL = AW, S,
R
2. INCLUDES PEOPLE CHOSEN BY THE INDIVIDUAL = AW, S, R
3. PROVIDES NECESSARY INFORMATION AND SUPPORT TO THE INDIVIDUAL TO ENSURE THAT THE INDIVIDUAL DIRECTS THE PROCESS TO THE MAXIMUM
EXTENT POSSIBLE = AW, S, R
4. IS TIMELY AND OCCURS AT TIMES/LOCATIONS OF CONVENIENCE TO THE INDIVIDUAL AW, S,
R
5. REFLECTS CULTURAL CONSIDERATIONS/USES PLAIN LANGUAGE = S,
R
6. INCLUDES STRATEGIES FOR SOLVING DISAGREEMENT = AW
7. OFFERS CHOICES TO THE INDIVIDUAL REGARDING SERVICES AND SUPPORTS THE INDIVIDUAL RECEIVES AND FROM WHO = AW, S
8. PROVIDES METHOD TO REQUEST UPDATES = AW, S, R
9. CONDUCTED TO REFLECT WHAT IS IMPORTANT TO THE INDIVIDUAL TO ENSURE DELIVERY OF SERVICES IN A MANNER REFLECTING
PERSONAL PREFERENCES AND ENSURING HEALTH AND WELFARE = AW, S,
R
10. IDENTIFIES THE STRENGTH, PRESERENCES, NEEDS (CLINICIAL AND SUPPORT), AND DESIRED OUTCOMES OF THE INDIVIDUAL = S, R
11. MAY INCLUDE WHETHER AND WHAT SERVICES ARE SELF-DIRECTED =
R

WRITTEN PLAN REFLECTS

1.SETTING IS CHOSEN BY THE INDIVIDUAL AND IS INTERGRATED IN, AND SUPPORTS FULL ACCESS TO THE GREATER COMMUNITY = R
2. OPPORTUNITIES TO SEEK EMPLOYMENT AND WORK IN COMPETITIVE INTERGRATED SETTINGS = AW, S, R
3. OPPORTUNITY TO ENGAGE IN COMMUNITY LIFE, CONTROL PERSONAL RESOURCES, AND RECEIVE SERVICES IN THE COMMUNITY TO THE SAME
DEGREE OF ACCESS AS INDIVIDUALS NOT RECEIVING MEDICAID HCBS = S,
R

4. INCLUDES INDIVIDUALLY IDENTIFIED GOALS AND PREFERENCES RELATED TO RELATIONSHIPS, COMMUNITY PARTICIPATION, EMPLOYMENT, INCOME
AND SAVINGS, HEALTHCARE AND WELLNESS, EDUCATION AND OTHERS =
S
5. INCLUDES RISK FACTORS AND PLANS TO MINIMIZE THEM = AW, S
6. IS SIGNED BY ALL INDIVIDUALS AND PROVIDERS RESPONSIBLY FOR ITS IMPLEMENTATION AND A COPY OF THE PLAN MUST BE PROVIDED TO THE
INDIVIDUAL AND HIS/HER REPRESENTATIVE = R
7.DISTRIBUTED TO THE INDIVIDUAL AND OTHERS INVOLVED IN PLAN =
S,R
8.INCLUDES PURCHASE/CONTROL OF SELF-DIRECTED SERVICES =
R
9. EXCLUDE UNNECESSARY OR INAPPROPRIATE SERVICES AND SUPPORTS S,R

## 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 (ISP)

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:*

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

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

b. **Service Plan Development Safeguards.** *Select one:*

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

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

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

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

During the initial steps in the development of the Individual Service Plan (ISP), the case manager engages the individual (and/or family or legal representative, as appropriate) in developing the ISP. The case manager meets with the individual prior to service planning meetings to explain the waiver process, provide information, and encourage his/her leadership and full participation in the service plan meetings.

Working together, the case manager, individual, and/or family or legal representative, as appropriate, identify the individual's strengths, and assist the individual in identifying his/her dreams, goals, preferences and outcomes for service.

The case manager:

- Explains the supports and services available in the waiver that are necessary to obtain the goals and outcomes;
- Explains the risk associated with the outcomes and services identified and possible options to mitigate the risks;
- Provides information and linkage for enhancing natural supports;
- Explains the rights and responsibilities of the individual, guardian, family, and other team members;
- Provides a list of the specific service providers available in the individual's area from which the individual may select his/her providers;
- Explains the team process and composition of the team;
- Encourages the individual and/or family or legal representative to include others of his/her choice as team members;
- Supports the individual to lead the team meeting;
- Advocates for the individual on an ongoing basis; and
- Informs the individual of the option of using a personal planning facilitator prior to the ISP meeting.

The individual has the authority and is encouraged to make his/her own choices and decisions regarding services, and has control over how his/her annual resource allotment (ARA) budget is expended.

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

### D-1: Service Plan Development (4 of 8)

d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Participants will meet first with their case manager to review the results of the SIS, and NM SIS Group designation. Individuals and/or their guardians, with their Interdisciplinary teams, will then review the results of the SIS, NM SIS Group service package and residential placement. Information from the SIS, including level of support needed and level of independence will be utilized to craft strategies including needed supports to ensure health and safety- for achieving desired individual outcomes. The NM SIS Group Service Package will include an array of supports/services designed to increase independence, ensure health and safety, and promote growth, as part of the

person-centered planning process. An individualized plan is completed when the team has identified:

1.The individual's interests and preferences.
2.The needed support areas and activities.
3.The settings the individual is most likely to be in, as well as the activities in which the individual will participate.
4.The specific support functions which will address the identified supportneeds.
5.Natural supports available for the person.
6.Valued personal outcomes.
7.Mechanism to monitor the provision and effectiveness of the support provided.

The SIS is a valuable tool for providing the information needed to support this process.

The State does not develop Individual Service Plans; ISPs are developed by the participant with support from their Inter-disciplinary team. In addition to the SIS assessment, DDSD utilizes:

1. The Electronic Health Assessment Tool (ECHAT), documents and tracks health conditions and informs planning.
2. Medication Administration Assessment Tool (MAAT) clarifies the level and type of assistance needed with the delivery of medications.
3. There are assessment and evaluation tools for therapies.
4. Aspiration Risk Assessment Tool, a screening for aspiration risk, supports informed decision making on the part of the individual and their guardian, collaborative development of a Comprehensive Aspiration Risk Management Plan (CARMP), training and monitoring.

The Electronic Health Assessment Tool, (ECHAT), is an electronic Comprehensive Health Assessment Tool, maintained on a secure website under contract with Therap Services. The tool must be completed for each adult served through Developmental Disabilities Waiver funding two weeks prior to their annual Individual Service Plan (ISP) meeting, upon hospital discharge and upon significant change of condition.)

The Medication Administration Assessment Tool (MAAT) applies to all models of Community Living, Adult Habilitation and/or Employment Services provided to adults through the DD Waiver Program. The MAAT is determines the need for assistance with medications and criteria for various levels of assistance with medication delivery.

The Therapy Assessments and evaluation tools apply to all DD Waiver participants receiving therapy services. The therapist must perform comprehensive assessment evaluation for each recipient to determine appropriate therapy and coordinate services with the case manager.

Aspiration Risk Assessment Tool, a screening for aspiration risk, administered , Tto all adults served through the DD Waiver , and annually at least two weeks prior to the annual ISP meeting, or upon significant change of condition, for all adults who were determined to be at low risk during their prior screening or assessment.

The MAAT is performed initially and annually. The Initial Therapy Assessment is completed within 30 days of receipt of initial prior authorization to provide therapy services. The subsequent evaluation report shall be submitted to the IDT within the following fourteen (14) calendar days. The ECHAT is completed for each adult served through Developmental Disabilities Waiver funding two weeks prior to their annual Individual Service Plan (ISP) meeting, upon hospital discharge and upon significant change of condition. The Aspiration Risk Assessment Tool is administered to all adults annually at least two weeks prior to the annual ISP meeting, or upon significant change of condition.

The case manager explains the individual's rights and responsibilities and the services available through the waiver and other resources. The case manager meets with the individual to arrange a team meeting to develop the Individual Service Plan (ISP). The ISP is based on relevant clinical information and other individualized assessments, as needed.

Assessment activities that occur prior to the Interdisciplinary Team (IDT) meeting include the Comprehensive Individual Assessment (CIA), a norm-referenced assessment, individual history and physical by primary care physician (PCP), review of other pertinent medical historical documents, and the level of care (LOC) determination. These assessments assist in the development of an accurate and functional plan. The CIA is conducted in preparation of the LOC determination process which addresses the following needs of a person:

medical (including current medications), adaptive behavior skills, nutritional, functional, and community/social factors. Assessments occur on an annual basis, or as needed, during significant changes in circumstance.
The team includes the individual (and/or family or legal representative), service providers, core members as identified in waiver service standards and any other members of the individual's choosing. The case manager schedules the meeting and notifies the individual. The case manager invites and supports the individual to lead the team meeting.

An initial ISP must be developed and approved within ninety (90) days from the effective date of level of care. The team develops an ISP at least thirty days (30) prior to expiration of the current plan or as needed based upon the individual's needs, interests and preferences. At the meeting, the case manager supports the individual to express his/her outcomes for services and supports, preferences, current goals and steps needed to achieve those goals. The ISP goals, activities to accomplish goals, services, and amount, frequency and duration of waiver services, services through other resources, and natural supports are developed based on the individual's outcomes, preferences, assessed needs and goals. The ISP addresses the individual's needed waiver services and includes reference to services and supports that are not waiver-funded.

The ISP includes:
- Demographic sheet;
- Description of the individual's background, outcomes, preferences, goals, needs, natural supports and important relationships;
- List of related health, therapy and crisis plans;
- Action Plan with goals and steps needed to accomplish the goals;
- Individual specific training needs that the staff serving the individual need to complete;
- Basic health and safety related supports;
- Services to be provided both through the waiver and through other resources;
- Parties responsible for providing the service;
- Waiver services to be furnished to the individual;
- Amount, frequency and duration of the waiver services;
- Waiver provider responsible for delivering all action steps outlined in the ISP; and
- Signatures of team members.

Waiver and other services are coordinated through ongoing communication between the case manager, service providers, and the individual and/or family or legal representative as appropriate.
The ISP delineates the roles and responsibilities of each service provider related to the implementation of the plan. Pursuant to the waiver service standards, the case manager is responsible for monitoring implementation of the plan on a monthly or quarterly basis, or more frequently as needed.
The ISP must be updated annually, when requested by the individual, or when the individual experiences one of the following circumstances:
- Major medical changes;
- Risk of significant harm;
- Loss of primary caregiver or other significant person;
- Serious accident, illness, injury or hospitalization that disrupts the implementation the ISP;
- Serious or sudden change in behavior;
- Change in living situation;
- Changes to or completion of ISP outcomes or vision;
- Loss of job;
- Proposed change in services or providers;
- Abuse, neglect or exploitation is substantiated;
- Criminal justice system involvement;
- Any team member requests a meeting;
- Individual and case manager have not been able to resolve issues and barriers, concerns or proposed changes; or
- Request by DOH/DDSD.

The State does not use temporary, interim service plans to initiate services until a more detailed service plan can be finalized.

Based upon an interdisciplinary team review process of DD waiver participant services, the DD case manager completes and submits the ISP form to the HSD/MAD TPA Contractor for review initially, annually and in the following circumstances:

• The individual will be accessing a Residential Service for the first time,
• The individual is changing from one type of Residential Services to another, (this does not include a change of provider for the same type of Residential Services), or
• DOH requests a review.

The TPA Contractor reviews the ISP submission to ensure that all documents are present, complete, and criteria are met. If the ISP packet has missing, incomplete or insufficient documentation to approve the ISP, it is returned to the case manager for correction. When the ISP is denied by the TPA Contractor, the case manager may request a reconsideration review by a UR TPA Contractor.

The TPA Contractor approves each participant individual's ISP annually, or more often, according to the circumstances listed above. Upon approval of the ISP, the TPA contractor enters the approved budget into the Medicaid Management Information System. The TPA contractor conducts random monthly quality audits on ISP reviews and reports findings to HSD. As part of the quality assurance process, HSD reviews the findings, identifies any trends or issues and works with the TPA contractor to resolve problems.

## 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.

In order to adequately assess and mitigate risks, the individual, family or legal representative, and others who provide supports must be involved throughout the process. The process begins with the case manager's completion of the LOC packet. Based on the LOC packet and the norm-referenced assessment, the case manager then works with the individual and/or family or legal representative, as applicable, to identify the individual's health and safety needs. The provider completes assessments as needed to more clearly identify the individual's potential risk factors within the service delivery environment.

A discussion among the team members occurs about the identified and potential risks and the benefits and consequences of various courses of action, and the conditions under which the individual is willing and able to assume responsibility for the risks.
The team discussion regarding risks is documented on the Basic Health & Safety Related Supports page. In addition, Health Care and Therapy Plans are "checked off" the list and the service provider is responsible for developing a detailed treatment plan in conjunction with appropriate physicians and ensuring that a copy of the plan is given to the case manager to be maintained in the primary record. Plans are incorporated by reference into the ISP.

The ISP includes a training plan for staff, primary caregivers or other family members, as needed, and is related to the potential risks identified. Additionally, specific action steps are identified on the ISP to address potential risks. Healthcare and therapy plans are developed by the specific service provider and identify specific strategies to reduce risk and to address back-up plans and arrangements for back up.

For individuals with chronic medical conditions with potential to exacerbate into a life-threatening situation, providers are required to develop and implement an individualized Medical Emergency Response Plan. Likewise, for individuals with challenging behaviors that periodically escalate to the point of potential harm to self or others, the IDT with the Behavior Support Consultant must develop a Crisis Intervention Plan.

Back-up plans are in addition to the ISP and are developed by the team and individual providers in collaboration with the appropriate specialists as needed. Depending on the need of the individual and the type of plan, the specialist may be a nurse, doctor, a therapist, or behavioral consultant.

Providers are also required to have back-up plans and an on-call system in the event staff should call in sick, or are unable to work. This back-up plan must also address what to do in emergency, as well as more anticipated events such as inclement weather, illness, or if day services are closed.

All referenced back-up plans described above are based on the indentified needs of the individual and are incorporated into the ISP.

## 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.

When funding becomes available to serve additional individuals on the waiver, a letter from DOH/DDSD is sent to the individuals on the Central Registry based on the date of the application. When an applicant is interested in receiving waiver services, he/she completes and returns the form entitled, Primary Freedom of Choice Form, contained in the allocation packet from DOH/DDSD to select a case management agency. This form includes a list of case management agencies that have been authorized to provide waiver services in the individual's county. Once the form is returned, DOH/DDSD informs the case management agency of the selection and the case manager begins the LOC process.

Waiver recipients may select a different case management agency at any time after case management services begin by completing a new Primary Freedom of Choice Form.
Once eligibility is determined, the case manager assists the individual and his/her family in an exploration of service options and provides the individual with relevant Secondary Freedom of Choice Forms. Eligible providers in the individual's county for the services anticipated are listed on a Secondary Freedom of Choice Form. Individuals and families are encouraged to research and visit service providers before making selections and to ask providers to describe their programs. Once the individual makes a provider selection, he/she indicates the selection and signs the Secondary Freedom of Choice Form.

At the initial team meeting, the ISP document is developed. The ISP describes the waiver services that the individual needs and the service providers selected to provide these services. Individuals may elect to change service providers at any time. Secondary Freedom of Choice Forms are provided to the individual by the case manager, and completed by the individual whenever there is a change in providers. DOH/DDSD maintains the Secondary Freedom of Choice Forms through the Provider Enrollment Unit.

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

### D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.**Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

HSD/MAD contracts with a Third-Party Assessor (TPA) Contractor for utilization review and approval of DD waiver individual service plans (ISPs). The TPA Contractor conducts quarterly internal audits on a representative random sample of service plans to validate consistent, accurate application of criteria and program requirements. Findings are reported to the State. The State reviews a representative sample of the TPA Contractor's ISP reviews during the annual contract compliance review. If HSD/MAD identifies any issues that are inconsistent with Medicaid requirements at any time, HSD/MAD ensures that the TPA Contractor takes corrective action to address problem areas within the contractually required timeframes.

Based upon an interdisciplinary team review process of DD waiver participant services, the DD case manager completes and submits the ISP form to the HSD/MAD TPA Contractor for review initially, annually and in the following circumstances:

- The individual will be accessing a Residential Service for the first time,
- The individual is changing from one type of Residential Services to another, (this does not include a change of provider for the same type of Residential Services), or
- DOH requests a review.

The TPA Contractor reviews the ISP submission to ensure that all documents are present, complete, and criteria are met. If the ISP packet has missing, incomplete or insufficient documentation to approve the ISP, it is returned to the case manager for correction. When the ISP is denied by the TPA Contractor, the case manager may request a

reconsideration review by a UR TPA Contractor.

The TPA Contractor approves each participant individual's ISP annually, or more often, according to the circumstances listed above. Upon approval of the ISP, the TPA contractor enters the approved budget into the Medicaid Management Information System. The TPA contractor conducts random monthly quality audits on ISP reviews and reports findings to HSD. As part of the quality assurance process, HSD reviews the findings, identifies any trends or issues and works with the TPA contractor to resolve problems.

## 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:*

TPA Contractor

## 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.

The case manager is responsible for monitoring the implementation of the ISP, continued appropriateness or need for ISP revision, and the health and welfare of the individual being served by the waiver at any location where he/she is receiving waiver services. This monitoring is done through visits with the individual, reviews of incident reports, telephone contacts, reviews of quarterly reports from therapists and providers and/or reviews of HSD/MAD Prior Authorization reports.

During the monitoring, the case manager is responsible for assuring that:

- Individuals have access to waiver services as identified in the service plan;
- Individuals have access to non-waiver services as identified in the service plan, including access to health services;
- Services meet the needs of the individual;
- Individuals exercise free choice of providers;
- Back-up plans are effective;
- Individual health and welfare is assured; and
- Services are furnished in accordance with the service plan.

Face-to-face visits with individuals other than children must occur monthly or at least quarterly, as determined by the team, and must be documented on a site visit form in the individual's primary file. For children under 18, the team may also determine that the case manager visit the individual/family a minimum of four (4) times a year. The site visits for adults may occur in the home, day habilitation program, community employment site or during therapy sessions. At least every other month, this visit takes place in the individual's home. If monitoring is occurring by phone, the case manager must reflect the issues discussed and follow-up needed in case notes in the file. Follow-up must be completed by the case manager within a timely manner. A team meeting must be convened as described in Appendix D-1 d.

As part of the monitoring process, if a serious incident is identified, staff must secure the safety of the individual first. Then the staff person with the most direct knowledge of the incident must report the incident and inform the case manager, preferably within one day of the incident. The incident report must be faxed to the DOH/DHI within 24 hours of knowledge of incident. For adults, any abuse, neglect or exploitation must be reported to Adult Protective Services, at ALTSD and for children it is reported to the Children, Youth and Families Dept, by either FAX or phone.

Any team member may also fill out a "request for Developmental Disabilities Supports Division Regional Office Intervention" form to report persistent issues to regional offices and to obtain assistance. This form is only to be filled out and sent after the case manager has attempted to resolve the issue with everyone involved. Timelines are indicated on the report.

The HSD/MAD MMIS contractor supplies providers and case managers with Prior Authorization Reports, and weekly updates of prior authorization and utilization of service units. Case managers and providers are responsible for tracking and monitoring utilization to ensure services are being provided in accordance with the ISP. The provider is responsible for requesting additional service units through the case manager.

The DOH/DHI also conducts provider site visits every three (3) years or more frequently if needed and monitors implementation of service plans and health and safety for waiver recipients. Problems are identified by reviewing files, incident reports and complaints, by interviewing staff and waiver individuals, and by direct observations. DOH/DHI develops Corrective Action Plans (CAPs) with providers when crucial items are missing or incomplete and the CAPs are forwarded to DOH/DDSD. DOH/DHI is responsible to track and follow-up with agencies to ensure that the Corrective Action Plans are completed successfully, or referred for further Provider Agreement review and/or action.

b. **Monitoring Safeguards.** *Select one:*

- (◉) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

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

### Quality Improvement: Service Plan

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

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

***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:**
**Number and percent of individuals who had a plan of care that addressed their needs as indicated in the assessment package. Numerator: The number of individuals who had a plan of care that addressed their needs. Denominator: All individuals with plans of care.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**TPA Contractor reports**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: TPA Contractor | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**The number and percent of service plan that have measurable outcomes that address identified support needs of the individuals served. Numerator: Number of service plans that have measurable outcomes. Denominator: Total number of service plans reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**TPA reports submitted to HSD/MAD**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | | ☐ **Other** |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

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.*

**Performance Measure:**
**Number and percent of plans of care developed in accordance with State requirements. Numerator: Number of Plans of Care developed in accordance with State Requirements. Denominator: All Plans of Care developed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**TPA Contractor Report**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: TPA Contractor | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's 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:**
**Number and percent of plans of care which were reviewed and revised, as warranted, by changes in waiver individuals' needs, at least annually. Numerator: Number of plans of care updated/revised annually Denominator: Total number of plans of care for individuals receiving waiver services.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = +/- 5% margin of error and a 95% confidence level |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

| | |
|---|---|
| | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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:**
**Number and percent of individuals who received services in the type and amount specified in the plan of care. Numerator: Number and percent of individuals who received services in the type and amount specified in their plan of care. Denominator: Total number of plans of care.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ☑ State Medicaid Agency | ☐ Weekly | ☑ 100% Review |
| ☐ Operating Agency | ☐ Monthly | ☐ Less than 100% Review |
| ☐ Sub-State Entity | ☐ Quarterly | ☐ Representative Sample<br>Confidence Interval = |
| ☐ Other<br>Specify: | ☐ Annually | ☐ Stratified<br>Describe Group: |
| | ☑ Continuously and Ongoing | ☐ Other<br>Specify: |
| | ☐ Other<br>Specify: | |

**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):* |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☑ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☐ Quarterly |
| ☐ Other<br>Specify: | ☑ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

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

**Performance Measures**

*For each performance measure 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:**
**Number and percent of individual records reviewed with a completed and signed Primary Freedom of Choice form that specified choice was offered between institutional care and waiver services. Numerator: Number of records reviewed which contained Primary Freedom of Choice forms. Denominator: Total number of record reviews for individuals on the DD Waiver.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = +/- 5% margin of error and a 95% confidence level |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: at allocation | |

**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):* |
|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of individual records reviewed with a completed and signed Secondary Freedom of Choice form that specifies choice was offered among waiver services and providers. Numerator: Number of records reviewed which contained current Secondary Freedom of Choice forms for all services being received. Denominator: Total number of record reviews for individuals on the DD Waiver.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = +/- 5% margin of error and a 95% confidence level |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | | |
| | ☑ Continuously and Ongoing | ☐ Other Specify: |
| | ☐ Other Specify: | |

**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):* |
|---|---|
| ☐ State Medicaid Agency | ☐ Weekly |
| ☑ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☐ Quarterly |
| ☐ Other Specify: | ☑ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other Specify: |

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
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 State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement related to service plans are identified by the State, processes are in place to ensure that appropriate and timely action is taken. In addition, the DDSQI Steering Committee routinely collects, aggregates, analyzes, and trends service plan data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

Methods for fixing identified problems include verbal direction, letters of direction, 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 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)**

| **Responsible Party***(check each that applies)*: | **Frequency of data aggregation and analysis** *(check each that applies)*: |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>DDSQI Steering Committee | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise. |

c. **Timelines**

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

◉ **No**

○ **Yes**

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

## Appendix E: Participant Direction of Services

**Applicability***(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one)*:

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

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

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

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

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The waiver rules promulgated by HSD provide that the State must grant an opportunity for an administrative hearing pursuant to, in addition to state statute and regulations, 42 CFR Section 431.220(a)(1) and (2). The participant or their authorized representative is initially given information by their Case Managers (CM) during the initial training on Developmental Disabilities Waiver. The training describes the participant's 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. CMs are trained in this process and available to assist participants or their authorized representative in understanding how to request a Fair Hearing. The State and the Third-Party Assessor (TPA) can also provide information on how to request the Fair Hearing.

Various agencies are responsible for providing the waiver participant with additional notice of his/her right to a Fair Hearing as defined by 8.352.2 NMAC. The participant or their authorized representative is initially given information by their case mananger (CM) at the initial meeting upon entrance to the Developmental Disabilities Waiver. A participant may request a Fair Hearing when s/he believes that Medicaid has taken an action erroneously. The participant or their authorized representative is informed by the TPA, 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 giving notice to individuals or their authorized representatives of their rights to Fair Hearings are responsible for maintaining documentation of the notification. Notices of adverse actions and the opportunity to request a Fair Hearing are maintained at the DOH, HSD Income Support Division and the TPA Contractor offices.

1. The TPA notifies the participant when the participant does not meet level of care criteria.
2. The TPA Contractor provides notice when services are denied, reduced, terminated, modified, or suspended.
3. The DOH/Developmental Disabilities Supports Division (DDSD) provides notice when DOH/DDSD determines that an individual does not meet the definition of developmental disabilities.
4. The HSD/Income Support Division (ISD) office provides notice when an individual does not meet financial and/or medical eligibility criteria.
6. The DOH/DDSD provides notice when an individual receives a New Mexico DD Waiver (NM DDW) Group Assignment.
7. The DOH/DDSD provides notice when an individual receives a Group H determination.
8. The DOH/DDSD provides notice when an individual receives a SIS Reassessment determination.

Within the first six months of the waiver renewal, the State projects to complete the work necessary through its contractors to develop the resource allocation methodology. Information about the resource allocation methodology and resource allocation levels will be presented to the individuals on the waiver, providers, and other stakeholders for public comment. Additionally, in collaboration with the contractors, the State will develop an implementation strategy to consistently implement the resource allocation levels.

Individuals and guardians, and their case managers, are notified by DOH/DDSD when there is a change in their resource allocation (NM DDW) group. Individuals who do not agree with their SIS score have a right to appeal to the DOH/DDSD for a reassessment.

If the NM DDW Group assignment results in a reduction of services an individual currently receives, the individual will receive timely notice of the right to a fair hearing by the Medicaid TPA contractor.

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.

The State, through its contractors, completed the work necessary to develop the resource allocation methodology during the six months immediately following approval of the waiver. Information about the NM Groups and service packages has been presented to the individuals currently on the waiver, to providers, and to other stakeholders for public comment. Additionally, in collaboration with the contractors, the State is finalizing an implementation strategy to consistently implement the resource allocation levels.

During the initial twelve months following implementation, current waiver recipients will be notified by their case managers regarding their assigned NM Group based on the results of a SIS assessment. In addition to the fair hearing rights cited above, if an individual (i) does not agree with his or her assignment to a NM Group, or (ii) alleges that the assessment was done in a manner that did not substantially follow the standard procedures for conduction such an assessment, he or she may request a fair hearing. Alternatively, the individual may request a second SIS assessment from the DOH without waiving his or her fair hearing rights. The recipient may still request a hearing for the reasons cited in this paragraph after receiving the results of the second SIS assessment. However, individuals will receive written notice from the DOH that if they opt to proceed to fair hearing without having a second assessment performed they will waive their right to have a second SIS assessment provide by DOH.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Individual Assistance and Advocacy Unit (IAA Unit), within DOH/DDSD, operates an additional statewide due process (Team Facilitation Process) for all recipients of services within the DDSD, which includes the Developmental Disabilities Medicaid Waiver. The Manager of the IAA Unit informs the individual that the Team Facilitation Process is not a prerequisite or substitute for a fair hearing when the individual is informed that the dispute has been accepted and a mediator has been assigned.

The Team Facilitation Process was established to allow all individuals and their team members to have a voluntary means to present and address their concerns or issues in the presence of a neutral third party (trained mediator). Issues or conflicts that can be disputed apply to the individual's service plan (ISP) when an individual or team believes the ISP is not being implemented appropriately. Conflict resolution consensus is developed with the team and implemented by the interdisciplinary team. This process is offered in addition to the Medicaid fair hearing process.

The process includes the following:
1. Requestor contacts the Manager of the IAA Unit either by telephone, in writing, by fax, or in person to request team facilitation.
2. IAA Manager reviews and determines to accept or deny the request per criteria (has five (5) working days to review).
3. If accepted, the case is assigned to a trained mediator.
4. If not accepted, a letter is sent to the requestor stating the reason for denial within ten (10) working days.
5. If accepted, the mediator has thirty (30) days to complete the team facilitation.

During the thirty (30) days, the Mediator:
a. Speaks to the requestor and other pertinent parties;
b. Collects necessary documents;
c. Schedules a meeting with the requestor and other pertinent parties;

d. Facilitates the meeting and has team participants sign an agreement to approving the mediation;
e. Documents, in writing, at the meeting the resolution(s) on an agreement sheet that is signed by all team participants; and
f. Hands out the agreement sheet(s) to all team participants (agreements amend the service plans, and therefore, are binding)

The role of the mediator is to provide strategies to facilitate communication, act as a resource, and provide technical assistance to the team.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Both HSD/MAD and DOH/DDSD are responsible for the operation of the grievance/complaint system.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A Medicaid participant may file a grievance with HSD/MAD about any issue with which he/she is dissatisfied. Complaints are referred to the appropriate HSD/MAD staff in charge of the program. The HSD/MAD staff member who receives the complaint informs the individual that the process is not a prerequisite or substitute for a fair hearing. Issues must be resolved within thirty (30) calendar days; however, a fourteen-day (14) extension may be requested, if necessary. Complaints may be resolved using state policies and procedures or other mechanisms as appropriate to the program. HSD/MAD staff regularly communicate with DOH/DDSD staff to coordinate this process.

The individual and/or family or legal representative may also register complaints, about any issue with which he/she is dissatisfied, with DOH/DDSD via email, mail, or by phone. The DOH/DDSD Regional Directors 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. If the complaint/grievance is not resolved within fourteen (14) days, an action plan with additional timeframes is put in place to resolve the complaint/grievance. The DOH/DDSD Regional Directors monitors resolution to complaints received by DOH.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- ◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DOH/Division of Health Improvement (DHI)/Incident Management Bureau (IMB) receives, triages, and investigates 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 Developmental Disabilities Waiver (DDW) 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 Children Youth and Families Department (CYFD)/Child Protective Services (CPS) for individuals under the age of 18 or to the Department of Health/Division of Health Improvement Incident Management Bureau for those over the age of 18. Additionally, per the NMAC 7.1.14, those providing DDW services are directed to immediately report abuse, neglect, exploitation, suspicious injuries, any death and also environmentally hazardous conditions which creates an immediate threat to life or health to the Department of Health/Division of Health Improvement (DHI) hotline. Per NMAC 7.1.14 any consumer, family member, or legal guardian may contact this hotline to report abuse, neglect, and/or exploitation. In addition to calling the IMB hotline those providing DDW services are also directed to report these types of incidents utilizing the DHI abuse, neglect, and exploitation or report of death form within 24 hours of the verbal report. 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 Plan will be developed at intake to assure health and safety for the individual.

When an incident is reported late a letter is sent to the provider stating that an incident report was not received beyond the required timeline for reporting. The letter further reiterates that requirement to immediate reporting incidents. The consequences of non-compliance may result in sanctions, as set forth in NMAC 7.1.14.11.

With respect to waiver services provided by an employee, contractor, or vendor other than a community-based waiver service agency, any suspected abuse, neglect, or exploitation must be reported to the DOH/Division of Health Improvement (DHI)/Incident Management Bureau (IMB) for all Developmental Disabilities Waiver participants by first contacting the IMB hotline and then faxing the Division's abuse, neglect and exploitation or report of death form. For participants under the age of 18 there is a joint protocol between DOH/DHI and CYFD/CPS who can also receive reports of abuse, neglect or exploitation. Regulations are found in NMSA 1978, Sections 32A-4-34 (Child Abuse and Neglect Act) and NMAC 7.1.14.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Training and information on reporting critical incidents is provided several ways: training and information, including incident reporting forms and phone numbers, is provided to participants and/or family members or legal representatives at the initial enrollment meetings, and during the annual plan renewal meetings. As noted in Appendix E-1e., the basic Developmental Disabilities Waiver training includes a section on self-protection, how to recognize abuse, neglect and exploitation, and where to go for help. All Case Manager trainings are documented on a form signed by the individual and/or family or legal representative acknowledging this training and that s/he understand how to report and get help. The signed acknowledgement form is maintained in the case management file.

The Information is reinforced by the Case Managers, 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.

**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 and exploitation. The entire intake process must be completed by close of business the day following the date of receipt. Upon receipt of the Incident Report, DOH intake staff,however, the IMB does have an extended intake process that can be requested by the intake specialist in order to receive appropriate documents :
I. Search for and print a history from the database of prior reported incidents (past 12 months) on the individual participant
II. Verify or attain the funding source
III. Triage/Intake Investigation is the decision process utilized by Intake staff to determine priority, severity and assignment of the case. Intake staff will triage the case within one (1) working day of receipt, however, the IMB does have an extended intake process that can be requested by the intake specialist in order to receive appropriate documents.

A. Reportable Incidents
A decision is made regarding whether the reported incident meets the definition of at least one of the eight categories of reportable incidents listed below. Categories include:
Abuse
Neglect
Environmental hazard
Suspicious Injury and Death
Emergency services

If the incident meets the definition of what is reportable, the following steps are taken:
1. Review Participant History : Identify possible trends
2. Determine Severity and Priority: Medical Triggers that receive priority: Aspiration, fractures, dehydration, and a history of multiple emergency room (ER) visits (in a short period of time).

Priority is described as:
Emergency case: Reports very serious cases of Abuse, Neglect, or Exploitation resulting in physical harm, including sexual abuse, or mental anguish which leave affected consumers at continued risk for injury or harm. Due to the severity of the case, the investigator will respond within (3) hours.
Priority 1 Case: Reports of urgent cases of Abuse, Neglect, or Exploitation. Due to the severity of the case, the investigator will respond within twenty-four (24) hours, but does not require more immediate action.
Priority 2 Case: Reports of cases of Abuse, Neglect, or Exploitation. Due to the severity of the case, the investigation will be initiated within five (5) calendar days.

3. Assign Investigator
Region of the incident occurrence: DHI/IMB has divided the State into five (5) regions (consistent with DOH/Developmental Disabilities Support Division (DDSD) Regional designations). DHI investigators are located in each region.

Participant specific: Investigator with an existing case involving the participant or with the most knowledge of the participant. Cultural or language needs of the participant are also given consideration.

Provider specific: Investigator with an existing case involving the responsible provider.

Caseload based: Cases will be assigned with a caseload maximum.

Level of urgency: Cases may be assigned based on the most available investigator.

Gender based Deaths: All deaths are assigned to the DHI Clinical Team for investigation.

4. Determine ALTSD/APS or CFYD Status: Reconciling Cases with ALTSD Adult Protective Services (APS), and Children, Youth and Families Department (CYFD) Child Protective Services (CPS)
Was the case received from ALTSD or CYFD Statewide Central Intake (SCI)? If yes and ALTSD or CYFD (APS, CPS) has accepted the case for investigation, and DOH has jurisdiction then the case will be assigned a DHI investigator and will be a collaborative investigation process.
If no, and the case involves an allegation of abuse, neglect, or exploitation, it will be referred to APS or CPS after the Triage process.

5. The intake staff will then document the Triage decisions

6. Database Entries will be made as appropriate. See also Appendix F: Incident Management Database Users Manual.

7. Notifications will be made to the following entities, as appropriate:
Office of the General Counsel (OGC), DOH
DOH/DDSD
ALTSD (APS)
ALTSD/Elderly and Disability Services Division (EDSD)
CYFD (CPS)
DOH/DHI and DDSD Director's Office
Law Enforcement
Human Services Department (HSD)/Medical Assistance Division (MAD),
Medicaid Fraud Control Unit, NM Attorney General's Office
Office of Internal Audit (OIA), DOH
Responsible Provider in cases of late reporting or failure to report

8. After Data entry, the IR and attachments are given to the support staff for faxing to the assigned investigator and notifications to the appropriate entities within 24 hours.

9. Once all faxing has been completed, the support staff will file the entire packet in the appropriate file and make a file folder for cases closed during the Intake process. Closure notifications will be sent at this time for each case completed during Intake to case managers, participants (who are over the age of 18 and are their own guardians), guardians and the provider.

B. Non-Reportable Incidents and Non-Jurisdictional Incidents (NRI/NJ)
1. Data Entry of information into the separate NRI/NJ Database.

2. As appropriate Notifications should be made to the following entities:
Office of the General Counsel (OGC), DOH
DOH/DDSD
ALTSD (APS)
ALTSD (EDSD)
CYFD (CPS)
DOH/DHI and DDSD Director's Office
Law Enforcement
HSD/MAD
Medicaid Fraud Control Unit, NM Attorney General's Office
OIA, DOH

Referral of Law Enforcement
A. All cases involving the use of law enforcement initiated by a community-based waiver service agency in the course of services to a DD Waiver participant will be reported automatically to DOH/DHI.
B. Notification of the use of law enforcement will also be faxed to the DOH/DDSD/Office of Behavioral Supports.
C. Investigations must be initiated within the assigned priority. The investigations must be completed within a 45 day timeline. If problems were identified and not corrected within the course of the investigation, the follow-up process will begin to assure the health and safety of the participant and the correction of the identified issues. Case closure letters are sent to the participant, and/or his/her guardian, Consultant and, if appropriate, the provider.

Reports and Trends

Numerous reports are generated and trends are addressed, including:
A. Multiple allegations for participants in one quarter are discussed by the ALTSD/APS or DOH (DDSD/DHI) and APS staff and appropriate interventions are taken as needed.
B. Multiple incidents for a participant are discussed by the ALTSD/APS or DOH (DDSD/DHI) and APS staff and appropriate interventions are taken as needed.
C. DHI conducts quarterly meetings in each region with DDSD and APS staff.
D. The DOH/HSD Developmental Disabilities Services Quality Improvement (DDSQI) Steering Committee meets regularly throughout the year and will receive standard reports on the waiver assurances and other information as requested about the DD Waiver Program. DDSQI will make recommendations to DOH/ALSTD regarding systemic actions needed in response to their analysis/review.

When a report of abuse or neglect of a child (person under age 18) is being made, the call comes into the toll-free number. The SCI worker asks a series of questions (demographics of each participant) and records the issues and concerns of abuse or neglect. The SCI worker then enters the information into the FACTS system. A Structured Decision Making Tool in the FACTS system is done on each report. This assists the worker to determine a priority status for each report ranging from an emergency (1 to 3 hour response time for face-to-face contact), P-1 (face to face contact within 24 hours), P-2 (1-5 calendar days to respond with face-to-face contact) or Screen-Out (no investigation).

- Emergency (1-3 hour response time) requires face-to-face contact and is staffed with a Supervisor who has the discretion of lowering or raising the status on any report. The report is generated electronically and submitted to the Supervisor for review to insure all the information is correct and the allegations match the narrative. The Supervisor then processes and assigns the report to the county where the family resides. The report is called out telephonically and an electronic report is created in the FACTS system, accessible by the particular county.
- P-1 (face-to-face contact within 24 hours) requires face-to-face contact and is staffed with a Supervisor who has the discretion of lowering or raising the status on any report. The report is generated electronically and submitted to the Supervisor for review to insure all the information is correct and the allegations match the narrative. The Supervisor then processes and assigns the report to the county where the family resides. The report is called out telephonically and an electronic report is created in the FACTS system, accessible by the particular county.
- P-2 (1-5 calendar days to respond with face-to-face) - The report IS NOT called out but is sent to the county as soon as it is processed.
- Screen-Out which requires no investigation – These reports are faxed to law enforcement and the New Mexico Regulation & Licensing Department (as needed). Hard copies are kept at SCI for 18 months and then archived.

All reports generated at SCI whether investigated by CYFD or not are cross reported to local law enforcement agency. CYFD's Investigations Unit in each County then takes over the case.

Notification to the Participant:
In each situation that critical incident investigations are completed by ALTSD/APS, CYFD/CPS, or DOH/DHI, the DD Waiver participant or the participant's guardian receives a letter stating the results of the investigation. The investigator has up to 45 days to complete the investigation and up to seven (7) days for writing the investigation report. Therefore, informing the participant or guardian and other relevant parties of the investigation results occurs no more than 52 days following DOH/DHI/IMB's receipt of the investigation report. (Under extenuating circumstances, i.e., necessary documentary evidence is not yet available, a 30-day extension to the 45-day timeline may be granted by the investigator's supervisor. With the extension, relevant parties may be notified up to 82 days following the incident report.)

Regulations are found in NMSA 1978, Sections 27-7-14 through 27-7-31 (Adult Protective Services Act) and in NMSA 1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect Act).

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 are 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.

Technical assistance for individual specific critical incident follow-ups and/or identification and remediation of health and safety challenges is available through the DOH as requested by the case manager. Issues brought to the DOH/DDSD by concerned case managers will be addressed in terms of options or resources for the participant to pursue in mitigating their risks. The DOH 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 DD Waiver recipients. 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:

Restraints are prohibited pursuant to the DDSD Aversive Intervention Prohibitions Policy.

The Department of Health (DOH) is responsible for detecting the unauthorized use of restraints or seclusion through its Incident Management System, Significant Events reporting, and through the DOH/Division of Health Improvement (DHI) quality reviews.

The Incident Management System reporting is ongoing. Trends are tracked and reported quarterly and are also submitted to the DDSQI Steering Committee.

Significant Events reporting is tracked and trended quarterly and is also submitted to the DDSQI Steering Committee.

DOH/DHI quality reviews are conducted every three (3) years or more frequently as needed. Data is tracked and trended quarterly and is also submitted to the DDSQI Steering Committee.

○ **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:

# 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:

Restrictive interventions are prohibited pursuant to the DDSD Aversive Intervention Prohibitions Policy.

The Department of Health (DOH) is responsible for detecting the unauthorized use of restrictive interventions through its Incident Management System, Significant Events reporting, and through the DOH/Division of Health Improvement (DHI) quality reviews.

The Incident Management System reporting is ongoing. Trends are tracked and reported quarterly and are also submitted to the DDSQI Steering Committee.

Significant Events reporting is tracked and trended quarterly and is also submitted to the DDSQI Steering Committee.

DOH/DHI quality reviews are conducted every three (3) years or more frequently as needed. Data is tracked and trended quarterly and is also submitted to the DDSQI Steering Committee.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

# Appendix G: Participant Safeguards

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

**c. Use of Seclusion.** *(Select one): (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:

○ **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.

For individuals who receive residential services of any type, the residential provider has primary responsibility. However, the day program is responsible for medication delivered during the time the individual is participating in the day program.

The agency nurse is responsible for medication management oversight, tracking and reporting all adverse medication events and/or medication errors as part of the agency's required Continuous Quality Improvement program. Monitoring of the medication management for individuals occurs by the agency nurse at a minimum on a monthly basis.

Second-line monitoring is the responsibility of the Division of Health Improvement (DHI) and the case management agency.

DHI/Incident Management Bureau (IMB) investigates when adverse medication events occur that involve possible abuse, neglect, and exploitation or the unplanned use of emergency services. When abuse, neglect or exploitation is confirmed, the provider is required to take preventative/corrective action and report that action to the investigator. Failure to take adequate actions may result in a referral to the Internal Review Committee (IRC) and sanctions. The IMB reviews data monthly and quarterly to identify any problematic trends of harmful practices within an agency, concerning an individual, or within the region. The trends are discussed at monthly and quarterly Regional Quality Management Meetings with additional information provided by participants, as applicable. Meeting participants develop and implement actions plans to resolve correct or

prevent harmful practices, as needed. The Regional Quality Management Meetings include participants from DHI/IMB, DHI/Quality Management Bureau (QMB) and DDSD Regional Offices.

The DHI/QMB conducts periodic agency compliance surveys during which they check for the presence of adequate agency policies, procedures and practices relative to medication management. QMB also monitors for evidence of the agency's implementation of these policies, procedures and practices. During these surveys, DHI/QMB reviews medication administration records for individuals in the review sample in addition to data collected by the provider agency on medication management to identify any non-compliance including harmful practices. Each provider agency receives a routine survey between one and three years, based upon compliance history from previous surveys. Every agency receives a survey at least every three years. New agencies are surveyed prior to the approval of their provider application and within 12-18 months following the award of their contract. Agencies may also be monitored at any time as a result of a request for a focused survey, based upon complaints or concerns raised by DDSD or DHI staff.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The DHI/QMB oversees the provider agency's medication management monitoring through periodic agency routine compliance surveys. During a routine survey QMB reviews medication management policies, procedures, and practices to identify compliance with regulation and to identify potentially harmful practices. DHI/QMB reviews medication administration documentation for consumers in the review sample in addition to data collected by the provider agency on medication management to identify any non-compliance including harmful practices. Specifically, the QMB reviews harmful practices

Compliance with "Assisting With Medication Delivery" (AWMD) training requirements are reviewed during the survey to determine whether all staff who assist with the administration or oversight of medication administration have completed this class initially and annually. Additionally, documentation is reviewed to determine whether the duties and privileges of medication administration or over site have been delegated to each staff by an agency nurse.

QMB determines through interview, observation and record review if the individuals in the sample are receiving medications as prescribed. The survey team determines what medications the individual is currently taking and what medication allergies the individual has. QMB then compares this information with the actual medications in the home, the medications listed on the Medication Administration Record (MAR) and the official orders from the prescriber to determine the accuracy and consistency of the information. The actual medications are examined in order to ascertain whether: the medications have been administered as prescribed (correct dose, time, amount, form, route, etc.); the medications are stored correctly; no stock-medications or sample medications are in the home; each medication is labeled correctly; and each medication is documented correctly in the MAR. This is done for all routinely given and PRN medications.

Each provider agency receives a routine survey between one (1) and three (3) years, based upon compliance history from previous surveys. Every agency receives a survey at least every three (3) years. New agencies are surveyed prior to the approval of their provider application and within 12-18 months following the award of their contract. Agencies may also be monitored at any time as a result of a request for a focused survey, based upon complaints or concerns raised by DDSD or DHI staff.

If DHI/QMB identifies non-compliance including harmful practices, the provider agency is required to write and implement a corrective action plan to obtain and maintain compliance. The plan is approved and monitored by DHI/QMB to ensure it is implemented as written. If DHI/QMB identifies non-compliance including harmful practices, the provider agency is required to write and implement a corrective action plan to obtain and maintain compliance. The plan is approved and monitored by DHI/QMB to ensure it is implemented as written.

DOH compiles all relevant medication management data and information through the Health and Welfare workgroup of the DDSQI Steering Committee. The workgroup trends and analyzes the data from QMB surveys, IMB investigations, and other relevant sources regarding reported medication events/errors and

harmful practices. The workgroup then presents the analysis to the DDSQI Steering Committee for review and consideration of potential action needed for systemic continuous quality improvement. If systemic issues are identified, the DDSQI Steering Committee ensures an action plan is developed and implemented to improve quality.

The Human Services Department, Medical Assistance Division (HSD/MAD) is provided oversight results in three ways: 1) DHI/QMB provides a copy of all QMB provider survey reports to HSD/MAD; 2) an HSD/MAD staff member is a voting member of the IRC; and 3) staff from HSD/MAD participates on the Health and Welfare workgroup and are members of the DDSQI Steering Committee.

# Appendix G: Participant Safeguards

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

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Medication Administration Assessment Policy and Procedure also identifies the role of the agency nurse, including responsibilities for annual and event-driven medication assessments, and training and procedures for delivery of PRN medication.

The DDSD Medication Assessment and Delivery Policy (M-001 effective November 1, 2006) applies to all waiver providers for living supports, customized community supports, supported employment, intense medical living supports, and supported employment.

The policy outlines the requirements regarding the assessment of an individual's ability and/or needs regarding medication delivery. Additionally, the policy outlines criteria for self-administration of medications, physical assistance by staff when needed, medication delivery by staff, and criteria for medication administration by licensed/certified personnel. When medication is administered by licensed/certified personnel the requirements set forth in the New Mexico Nursing Practice Act, 1978 NMAC 16.12.1 et seq. must be complied with.

**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:

  Agencies are required to provide a summary of medication errors reviewed by their internal Quality Improvement committee to the Developmental Disabilities Supports Division (DDSD) on quarterly basis. This information is reviewed by the Significant Events Committee consisting of representatives from both DDSD and the Division of Health Improvement (DHI). As determined by the Significant Events Committee, trends identified by the Significant Events Committee may be taken to the DDSQI Steering Committee for further review and action.

  (b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record all medication errors including documentation errors, administering medication to the wrong person/patient or at the wrong time, missed doses, dosage errors, delivery errors, and medication reactions/interactions.

(c) Specify the types of medication errors that providers must *report* to the State:

Providers are required to record all medication errors including documentation errors, administering medications to the wrong person/patient or at the wrong time, missed doses, dosage errors and delivery errors.

○ **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.

DOH/DHI is responsible for the ongoing oversight of compliance with the performance of providers for appropriate medication delivery. Monitoring is performed during on-site routine and focused reviews.

DHI is responsible for monitoring providers for appropriate medication delivery as specified above.

QMB determines through interview, observation and record review if the individuals in the sample are receiving medications as prescribed. The survey team determines what medications the individual is currently taking and what medication allergies the individual has. QMB then compares this information with the actual medications in the home, the medications listed on the Medication Administration Record (MAR) and the official orders from the prescriber to determine the accuracy and consistency of the information. The actual medications are examined in order to ascertain whether: the medications have been administered as prescribed (correct dose, time, amount, form, route, etc.); the medications are stored correctly; no stock-medications or sample medications are in the home; each medication is labeled correctly; and each medication is documented correctly in the MAR. This is done for all routinely given and PRN medications.

DOH compiles all relevant medication management data and information through the Health and Welfare workgroup of the DDSQI Steering Committee. The workgroup trends and analyzes the data from QMB surveys, IMB investigations, and other relevant sources regarding reported medication events/errors and harmful practices. The workgroup then presents the analysis to the DDSQI Steering Committee for review and consideration of potential action needed for systemic continuous quality improvement. If systemic issues are identified, the DDSQI Steering Committee ensures an action plan is developed and implemented to improve quality.

The Human Services Department, Medical Assistance Division (HSD/MAD) is provided oversight results in three ways: 1) DHI/QMB provides a copy of all QMB provider survey reports to HSD/MAD; 2) an HSD/MAD staff member is a voting member of the IRC; and 3) staff from HSD/MAD participates on the Health and Welfare workgroup and are members of the DDSQI Steering Committee.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

**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 instancesof 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:**
**Number and percent of individual records reviewed where the individual (and/or family or legal guardian) received information/education about how to report abuse, neglect, exploitation (A,N,E) and other critical incidents. Numerator: Number record reviews which showed receipt of information about reporting A.N.E. or other critical incidents. Denominator: Total number of records reviewed.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = +/- 5% margin of error and a 95% confidence level |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | | ☐ **Other** |

| | | |
|---|---|---|
| | ☑ **Continuously and Ongoing** | Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of incidents that were reported within timeframes required by the State. Numerator: Number of incidents reported within required timeframes. Denominator: The number of reportable incidents.**

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

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

| | | |
|---|---|---|
| | | |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other** Specify: reported to DDSQI Steering Committee every six (6) months |

**Performance Measure:**
**Number and percent of incident reviews/investigations that were completed within timeframes required by the State. Numerator: Number of incident review/investigations completed within required timeframes. Denominator: Total number of incident reviews/investigations.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| | | |
|---|---|---|
| ☐ State Medicaid Agency | ☐ Weekly | ☑ 100% Review |
| ☑ Operating Agency | ☐ Monthly | ☐ Less than 100% Review |
| ☐ Sub-State Entity | ☑ Quarterly | ☐ Representative Sample<br>Confidence Interval = |
| ☐ Other<br>Specify: | ☐ Annually | ☐ Stratified<br>Describe Group: |
| | ☐ Continuously and Ongoing | ☐ Other<br>Specify: |
| | ☐ Other<br>Specify: | |

**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):* |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☑ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☐ Quarterly |
| ☐ Other<br>Specify: | ☑ Annually |
| | ☐ Continuously and Ongoing |
| | ☑ Other<br>Specify:<br>reported to DDSQI Steering Committee every six (6) months |

**Performance Measure:**
**Number and percent of unexplained, suspicious and untimely deaths for which review resulted in the identification of preventable causes. Numerator: Number of reviews which resulted in identifying preventable causes. Denominator: Total number of reviews.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | Specify: |

**Performance Measure:**
**Number and percent of individuals who reported satisfaction with their in-home services. Numerator: Number of individuals who reported satisfaction with their in-home services. Denominator: Total number of individuals participating in survey.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**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):* |
|---|---|
| | |

| Responsible Party for data aggregation and analysis *(check each that applies)*: | Frequency of data aggregation and analysis*(check each that applies)*: |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☑ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☐ Quarterly |
| ☐ Other<br>Specify: | ☑ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

**Performance Measure:**
**Number and percent of medication errors that resulted in a waiver participant requiring medical treatment. Numerator: Number of medication errors that resulted in a participant requiring medical treatment. Denominator: Total number of medication errors.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DOH reports.**

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

| | | |
|---|---|---|
| | | |
| | ☐ Other<br>Specify: | |

**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):* |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☑ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☑ Quarterly |
| ☐ Other<br>Specify: | ☐ Annually |
| | ☐ Continuously and Ongoing |
| | ☐ Other<br>Specify: |

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.*

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.*

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.*

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.
The Operating Agency employs multiple strategies to monitor satisfaction with DD Waiver Services. DDSD participates in an annual NCI Survey, measuring consumer satisfaction. Case Management agencies conduct annual Consumer Satisfaction Surveys. Data collected is provided to the DDSQI Steering committee for overall tracking and recommendations to improve system quality.

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

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Assistance with individual problems occurs through the DDSD regional offices. Regional Office Request for Intervention Forms (RORIs) are routed to the appropriate staff and are tracked and trended for system improvement.

Data is also collected by DHI and entered into a database. Reports are generated from the database and are reviewed to identify trends. DHI and DDSQI Steering Committee review the data and determine if any action is necessary. The Steering Committee meets bi-monthly.

ii. **Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |

| Responsible Party*(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| | ☐ **Other**<br>Specify: |

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

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the 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;
- 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 2)

### H-1: Systems Improvement

**a. System Improvements**

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The primary goals for the Developmental Disabilities (DD) Waiver Quality Improvement Strategy (QIS) are to administer and evaluate a quality improvement system that:

- Ensures individuals may choose among a variety of waiver services as long as the total cost of services does not exceed the maximum dollar amount allocated to their level of care and does not exceed the limits on the number of allowable units;
- Allows for the provision of services to eligible recipients as 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) Steering Committee (comprised of HSD/MAD, DOH/DDSD, and DOH/DHI) utilizes the following measures and processes to ensure that the DD 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 DD Waiver assurance workgroups report 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 Steering Committee is to ensure continuous quality improvement. The DDSQI Steering Committee is responsible for making systemic improvements to the DD Waiver based on compliance monitoring. This committee meets every other month and has an annual schedule by which it reviews data collected from various waiver programs. Workgroups, each of which are composed of at least one State agency representative, meet every other month or more frequently, as needed, to develop and implement quality improvement strategies which are reported back to the DDSQI Steering Committee. The assurance workgroups include: LOC/Eligibility; Service Plans; Qualified Providers; Health and Welfare; and Administrative and Financial Accountability. All workgroups use a standardized template to report data findings.

Recommendations made by the DDSQI Steering Committee 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 Steering Committee informs the workgroups. DD 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 at least thirty (30) days prior to implementation. Information-sharing may include letters, announcements at scheduled meetings, website updates and state-wide meetings. If DD Waiver Service Standards or State regulation changes are needed, the State follows applicable State rules.

DOH/DDSD works with providers and families to obtain stakeholder input and to assist the State with the on -going evaluation of the DD Waiver. The Advisory Committee on Quality (ACQ) is statutorily required to advise the DOH on policy related to the programs administered by DOH. The ACQ meets regularly and is comprised of DD Waiver stakeholders, including individuals and their families. The ACQ participants give feedback and recommendations to DOH/DDSD. Additionally, a group comprised of DD Waiver provider agencies meets regularly with the DOH/DDSD to exchange information and provide recommendations for program improvement. The results of these meetings are reported to the appropriate DDSQI Steering Committee workgroup(s), which in turn report to the DDSQI Steering Committee. These family and provider stakeholder groups are a key source of feedback for evaluating the State's performance.

Although the DDSQI Steering Committee continuously assesses its own effectiveness, an annual meeting is conducted to evaluate: the effectiveness of both the assurance workgroup strategies in improving the functions of the Waiver; the effectiveness of the DDSQI Steering Committee's oversight of the strategies; and the established priorities for the coming year. The findings of this assessment are distributed to the Steering Committee, applicable senior management, the workgroups, and identified stakeholders. This report also includes information about current remediation activities and projections of future quality management plans in relation to the operational success of the waiver, identifies opportunities for improvement and ensures that the State meets each of the required assurances to CMS.

**ii. System Improvement Activities**

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Quality Improvement Committee** | ☑ **Annually** |
| ☑ **Other**<br>Specify:<br>DDSQI Steering Committee | ☑ **Other**<br>Specify:<br>Every other month and additional monitoring/analysis will be done, as necessary. |

**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 Steering Committee and its assurance specific workgroups monitor and analyze the effectiveness of system design changes by utilizing the ongoing process described in H.1.a.i. The workgroups utilize the data collection and strategies; the DDSQI Steering Committee utilizes the review and analysis processes and reports that are sent by the workgroups. As part of its ongoing review of data collected, the DDSQI Steering Committee considers the findings related to system design changes and incorporates them into an annual report.

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

The annual meeting of the DDSQI Steering Committee has an extended scope of work. It includes an evaluation of the effectiveness of both the assurance specific work groups' strategies in improving the

function of the Waiver and an evaluation of the effectiveness of the DDSQI Steering Committee's oversight of the strategies. The final report of this assessment is distributed to senior management, the workgroups, the DDSQI Steering Committee, and identified stakeholders. This report also includes information about current remediation activities and projections of future quality management plans in relation to the operational success of the waiver, identifies opportunities for improvement and ensures that the State meets each of the required assurances to CMS.

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

HSD/MAD contracts with a fiscal intermediary to provide claims processing services on behalf of the Department. The MMIS claims payment system is set up with edits to use in claims processing in order to assure financial integrity of services billed prior to designation of each claim as paid, suspended for manual review or denied. These edits include checks for client eligibility and budget approval for all claim categories at the date of service billed. Budget claim edits include review of authorization for the specific procedure billed and assurance that units billed are available in the approved budget balance.

The New Mexico Office of the State Auditor contracts with an independent auditor to conduct a post-payment annual audit of the entire HSD in keeping with accepted and regulated certified auditing principles and procedures. This audit scope includes a financial statement audit as well as an audit of the program including allowable costs.

The HSD/MAD Quality Assurance Bureau (QAB) conducts audits of Medicaid providers as indicated through referrals and other received information. In addition, the HSD/MAD/QAB may refer providers for audit by the Medicaid Fraud Control Unit of the State Attorney General's Office.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*** *(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:**
**Number and percent of claims coded and paid for in accordance with the reimbursement codes and rates approved by Medicaid. Numerator: Number of claims coded and paid for in accordance with codes and rates approved by Medicaid. Denominator: Total number of claims coded and paid.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**MMIS claims data**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise. | |

**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):* |
|---|---|
| ☑ State Medicaid Agency | ☐ Weekly |
| ☑ Operating Agency | ☐ Monthly |
| ☐ Sub-State Entity | ☐ Quarterly |
| ☐ Other<br>Specify: | ☑ Annually |
| | ☐ Continuously and Ongoing |
| | ☑ Other<br>Specify:<br>Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise. |

**Performance Measure:**
**Number and percent of paid waiver service claims for individuals who were enrolled in the waiver on the date the service was delivered. Numerator: Number of paid service claims that were submitted for individuals who were enrolled in the waiver on the date the service was delivered. Denominator: Total number of claims paid.**

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

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach *(check each that applies):* |
|---|---|---|
| ☑ State Medicaid Agency | ☐ Weekly | ☑ 100% Review |
| ☐ Operating Agency | ☐ Monthly | ☐ Less than 100% Review |
| ☐ Sub-State Entity | ☑ Quarterly | ☐ Representative Sample<br>Confidence Interval = |
| ☐ Other<br>Specify: | ☐ Annually | ☐ Stratified<br>Describe Group: |
| | | |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: Additionl data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise. | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other** Specify: Additionl data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise. |

**Performance Measure:**
**Number and percent of paid waiver service claims for which the service and service units are specified in the individual's approved individual service plan (ISP). Numerator: Number of paid waiver service claims for which the service and service units are specified in the individual's approved ISP. Denominator: Total number of claims paid for services.**

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

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| | | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☑ **Other**<br>Specify:<br>Additionl data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise. | |

**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):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Additionl data collection, analysis, and aggregation will be |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | done, as necessary, to address unusual or urgent issues that may arise. |

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.*

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 State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement related to financial accountability are identified by HSD/MAD, processes are in place to ensure that appropriate and timely action is taken. In addition, the HSD and DOH DDSQI Steering Committee 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, 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 DOH identifies at any time any issues that are inconsistent with Medicaid requirements related to financial accountability, HSD/MAD ensures that the problem is corrected and that compliance with the Assurance is met.

ii. **Remediation Data Aggregation**

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

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☑ **Other**<br>Specify:<br>DDSQI Steering Committee | ☑ **Annually** |

| Responsible Party*(check each that applies):* | Frequency of data aggregation and analysis *(check each that applies):* |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Additional data collection, analysis, and aggregation will be done if necessary to address unusual issues that may arise. |

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

The Developmental Disabilities Waiver (DDW) program utilizes a prospective rate schedule for provider payments. Rate determination and oversight is a joint responsibility between the Department of Health (DOH) and the Human Services Department (HSD).

The transition to the new rates will be done on a client-by-client basis based on their Individual Service Plan date, beginning May 1, 2013. The transition will conclude on April 30, 2014.

As part of the States efforts to enhance the fairness and sustainability of the DDW program and to reduce the number of clients waiting to enroll, DOH commissioned a study of provider rates in July 2011 for the services covered under the DDW.

The result of this work is the development of rate models that, like the currently approved rates, are intended to account for the various cost factors associated with each service. These rate models are completely transparent with the assumptions associated with each individual cost factor explicitly stated. These factors include:

- Wages paid to direct service staff
- Fringe benefits for direct service staff
- Direct service staff productivity (i.e., an allowance to account for staff's non-billable, but program-related, time, such as traveling to a client's home, attending mandated training, etc.)
- Program support costs (e.g., supervision, program development, quality assurance, etc.)
- Administrative costs (e.g., executive management, finance, human resources, etc.)
- Other service-specific costs such as mileage costs for traveling to a client location, building and supply costs for facility-based programs, staffing ratios for group services, etc.

Although the rate models include specific assumptions for each cost factor, these assumptions are not prescriptive. That is, providers must manage to the bottom-line rate, but do not, for example, have to pay the wages or offer the benefits assumed in the rate models. This flexibility allows providers to respond to local market conditions, create individually-tailored programs, etc.

The rate models were developed with significant input from the provider community and the public generally. To allow for input throughout the process, a rate-setting Steering Committee consisting of providers of the various waiver services was established. The Steering Committee was provided opportunity to offer suggestions regarding the overall project, a provider survey sent to all providers in order to capture cost data, and the structure of the rate models.

The provider survey sought information regarding the costs associated with each individual waiver service that a given provider offered. The data collected through the survey was a key informant of the cost factors included in the rate models. After drafting the survey and revising it based on feedback from the Steering Committee, the State emailed the survey to all service providers, giving them approximately one month to complete it. Participation was voluntary.

In addition to the provider survey, the State identified other independent data to inform the rate models, including Bureau of Labor Statistics wage data, various benefit benchmarks, mileage reimbursement rates, etc. Working from this data, rate models were developed for each service, outlining the specific assumptions associated with each cost factor.

In several instances, there are multiple rate models for an individual service for a variety of reasons, including:

- Clients' intensity of care. There are multiple rates for services in which the intensity of support delivered by providers will vary based upon clients' level of need. For example, Individuals with greater support needs will generally require more supervision in Supported Living environments and be served in smaller groups in day programs. Services with rates that vary according to a client's intensity of care are Supported Living, Customized Community Supports-Group, and Supported Employment-Group. The State is using the Supports Intensity Scale (SIS) to assess clients' support needs.
- Provider qualifications. There are multiple rates for services in which there are different classes of providers that may deliver a service. For example, there are different rates for occupational therapy services delivered by an occupational therapist than for services delivered by certified occupational therapist assistant. Services with rates that vary according to provider qualifications are nursing, behavioral support consultation, and therapies.
- Geographic differences. The State is overwhelming rural with a number of large, sparsely populated regions. It is often difficult to recruit providers, particularly those with professional licenses, to deliver services in these areas. In response, the State created special under-served rates for behavioral support consultation and therapy services, which recognizes counties of the state where there are currently few practicing therapists and behavior support consultants.

The draft rate models were presented by DOH to the Steering Committee and emailed to all contracted providers, which were given approximately five weeks to offer comments. DOH conducted town hall forums across the State for clients and families and anyone else who wished to attend to discuss changes in the DDW program, including the rate models. Based on feedback from the comment period and forums, DOH revised the rates as necessary and submitted the final rates to HSD, which will, in turn, publish the rates and give providers and other stakeholders another opportunity to submit comments.

Information regarding rates is available to clients through their case manager, the Interdisciplinary Team process, the DOH/DDSD website, and the HSD website. In addition, if requested, DOH disseminates the rates via mail.

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:

The New Mexico MMIS claims processing system processes all waiver claims. Providers may submit electronic claims to the current contracted fiscal agent directly or through a clearinghouse. Claims are processed for payment by the MMIS and paid by the State's fiscal agent

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures** *(select one)*:

◉ **No. State or local government agencies do not certify expenditures for waiver services.**

○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The 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.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

## 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:*

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

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- ◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

**No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

**The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

**The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

# Appendix I: Financial Accountability

## I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

**Appropriation of State Tax Revenues to the State Medicaid agency**

**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

*Check each that applies:*

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**
*Check each that applies:*

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The waiver cost study specifically excluded the cost of room and board in setting rates for residential services. Rates are based on the provision of direct care services and do not include payment for room and board. Pursuant to DOH/DDSD Waiver Service Standards, providers are prohibited from using Medicaid payment for room and board.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

## I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

# Appendix J: Cost Neutrality Demonstration

## J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.**Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-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 | | 6865.00 | 6865.00 | 92744.00 | 4917.00 | 97661.00 | 90796.00 |
| 2 | | 7071.00 | 7071.00 | 95526.00 | 5064.00 | 100590.00 | 93519.00 |
| 3 | | 7283.00 | 7283.00 | 98392.00 | 5216.00 | 103608.00 | 96325.00 |
| 4 | 75166.98 | 7501.00 | 82667.98 | 101344.00 | 5373.00 | 106717.00 | 24049.02 |
| 5 | | 7726.00 | 7726.00 | 104384.00 | 5534.00 | 109918.00 | 102192.00 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (1 of 9)

**a. Number Of Unduplicated Participants Served.**Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: 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 | 3737 | 3737 |
| Year 2 | 3692 | 3692 |
| Year 3 | 3648 | 3648 |
| Year 4 | 4229 | |

| 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 |
| | | 4229 |
| Year 5 | 4356 | 4356 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) is reduced by one percent (1%) each year in accordance with the reductions of Factor D described in Apendix J-2-c-i.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimate of Factor D for each waiver year is based on State Fiscal Year 2010 actual paid claims and projected service utilization.

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:

Non-Waiver Acute Care D' expenses are increased by three percent (3%) per client per year, using FY10 actual cost, for projected inflation of medical costs.

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 Institutional Expenses are increased by three percent (3%) a year, using FY10 actual cost, for projected inflation of medical costs.

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:

Non-Institutional Acute Care G' expenses are increased by three percent (3%) a year, using FY10 actual cost, for projected inflation of medical costs.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

| Waiver Services | |
|---|---|
| Case Management | |
| Community Integrated Employment | |
| Customized Community Supports | |
| Living Supports | |

| Waiver Services | |
|---|---|
| Personal Support Services | |
| Respite | |
| Nutritional Counseling | |
| Occupational Therapy For Adults | |
| Physical Therapy For Adults | |
| Speech and Language Therapy For Adults | |
| Supplemental Dental Care | |
| Adult Nursing | |
| Assistive Technology | |
| Behavioral Support Consultation | |
| Crisis Support | |
| Customized In-Home Supports | |
| Environmental Modifications | |
| Independent Living Transition Service | |
| Intense Medical Living Supports | |
| Non-Medical Transportation | |
| Personal Support Technology/On-Site Response Service | |
| Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior | |
| Socialization and Sexuality Education | |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (5 of 9)

### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **11206964.04** |
| Case Management, On-Going (Old) | Month | 3737 | 12.00 | 249.91 | **11206964.04** | |
| Case Management, On-going (New) | Month | 0 | 0.00 | 0.01 | **0.00** | |
| **Community Integrated Employment Total:** | | | | | | |
| Supported Employment Job Developer (Old) | Each | 6 | 2.00 | 754.54 | **9054.48** | |
| Supported Employment, Level 1, Group (Old) | 15 minutes | 45 | 1661.00 | 3.57 | **266839.65** | |
| | | | | | | |
| | | | **GRAND TOTAL:** | | | |
| | | | **Total Estimated Unduplicated Participants:** | | | **3737** |
| | | | **Factor D (Divide total by number of participants):** | | | |
| | | | **Average Length of Stay on the Waiver:** | | | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Supported Employment, Level 2, Group (Old) | 15 minutes | 159 | 2650.00 | 2.54 | 1070229.00 | |
| Supported Employment, Level 3, Group (Old) | 15 minutes | 71 | 3538.00 | 2.04 | 512443.92 | |
| Supported Employment/Self-Employment (Old) | 15 minutes | 3 | 900.00 | 6.65 | 17955.00 | |
| Supported Employment, Individual (Old) | Hour | 579 | 35.00 | 201.21 | 4077520.65 | |
| Supported Employment, Intensive (Old) | Hour | 186 | 216.00 | 37.22 | 1495350.72 | |
| Supported Employment, Level 1, Group, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Level 2, Group, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Level 3, Group, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Individual, Exception (Old) | Hour | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Intensive, Exception (Old) | Hour | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment Job Development (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment Job Aide (New) | Hour | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Group, Category 1 (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Group, Category 2 (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Individual Job Maintenance (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment/Self Employment (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Intensive (New) | | | | | | |
| Supported Employment-Individual Job Maintenence Per Month | | | | | | |
| **Customized Community Supports Total:** | | | | | | 37268164.52 |
| Customized Community Supports, Individual (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized Community Supports, Individual, Intense Behavioral Supports (New) | 15 minutes | 342 | 4380.00 | 3.00 | 4493880.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3737 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Community Access (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Community Inclusion Aide (New) | Hour | 0 | 0.00 | 0.01 | 0.00 | |
| Adult Habilitation Level 1 (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Adult Habilitation Level 1, Outlier (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Adult Habilitation Level 2 (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Adult Habilitation Level 2, Outlier (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Adult Habilitation Level 3 (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Adult Habilitation Level, 3, Outlier (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized Community Supports, Group, Category 1 (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized Community Supports, Group, Category 2 (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized Community Supports, Group, Community Only (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized Community Supports, Community | 15 minutes | 995 | 1054.00 | 5.70 | 5977761.00 | |
| Customized Community Supports, Center | 15 minutes | 2188 | 3328.00 | 3.68 | 26796523.52 | |
| Fiscal Management of Educational Opportunities (FMEO) | Per Dollar | 0 | 0.00 | 0.01 | 0.00 | |
| **Living Supports Total:** | | | | | | 152449448.33 |
| Non-Ambulatory Stipend (New) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Awake Outlier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Asleep Outlier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 2, Awake Oulier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 2, Asleep Outlier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Awake Outlier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| | | | | | 0.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3737 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Supported Living, Level 3, Asleep Outlier (Old) | Day | 0 | 0.00 | 0.01 | | |
| Supported Living, Level 1, Awake (Intense Behavioral Supports) (Old) | Day | 227 | 281.00 | 83.70 | 5338971.90 | |
| Supported Living, Level 1, Asleep (Intense Behavioral Supports) (Old) | Day | 37 | 247.00 | 157.99 | 1443870.61 | |
| Supported Living, Level 2, Awake (Intense Behavioral Supports) (Old) | Day | 48 | 227.00 | 186.21 | 2028944.16 | |
| Supported Living, Level 2, Asleep (Intense Behavioral Supports) (Old) | Day | 23 | 280.00 | 227.58 | 1465615.20 | |
| Supported Living, Level 3, Awake (Intense Behavioral Supports) (Old) | Day | 1 | 224.00 | 229.46 | 51399.04 | |
| Supported Living, Level 3, Asleep (Intense Behavioral Supports) (Old) | Day | 1 | 225.00 | 258.62 | 58189.50 | |
| Shared Living | Day | 25 | 339.00 | 93.31 | 790802.25 | |
| Shared Living (Intense Behavioral Supports) | Day | 5 | 339.00 | 93.31 | 158160.45 | |
| Supported Living, Level 1, Awake (Old) | Day | 570 | 325.00 | 268.65 | 49767412.50 | |
| Supported Living, Level 2, Awake (Old) | Day | 155 | 274.00 | 166.60 | 7075502.00 | |
| Supported Living, Level 3, Awake (Old) | Day | 7 | 241.00 | 122.07 | 205932.09 | |
| Supported Living, Level 1, Asleep (Old) | Day | 131 | 288.00 | 193.49 | 7299990.72 | |
| Supported Living, Level 2, Asleep (Old) | Day | 203 | 307.00 | 123.00 | 7665483.00 | |
| Supported Living, Level 3, Asleep (Old) | Day | 47 | 263.00 | 93.31 | 1153404.91 | |
| Family Living (Old) | Day | 1800 | 339.00 | 111.35 | 67945770.00 | |
| Family Living (New) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living Category H (New) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living Category 2 (New) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living Category 3 (New) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| **Personal Support Services Total:** | | | | | | 483702.38 |
| Home Visit Day Life Activity | | | | | 483702.38 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3737 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Hour | 53 | 658.00 | 13.87 | | |
| **Respite Total:** | | | | | | **6881279.64** |
| Respite | 15 minutes | 743 | 2732.00 | 3.39 | **6881279.64** | |
| Respite (New) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Respite, Group (New) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Respite/Substitute Care (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| **Nutritional Counseling Total:** | | | | | | **2929.68** |
| Nutritional Counseling | Visit | 12 | 6.00 | 40.69 | **2929.68** | |
| Nutritional Counseling (New) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| **Occupational Therapy For Adults Total:** | | | | | | **4349715.36** |
| Occupational Integrated Therapy (Old) | 15 minutes | 1139 | 152.00 | 22.77 | **3942124.56** | |
| Occupational Therapy Assistant (Certified) (Old) | 15 minutes | 44 | 97.00 | 13.25 | **56551.00** | |
| Occupational Therapy, Clinic Based (Old) | 15 minutes | 1139 | 23.00 | 13.40 | **351039.80** | |
| Occupational Integrated Therapy, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Occupational Therapy Assistant (Certified), Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Occupational Therapy, Clinic Based, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Occupational Therapy, Standard (New) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Occupational Therapy, Incentive (New) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Occupational Therapy, Evaluation (New) | Each | 0 | 0.00 | 0.01 | **0.00** | |
| Certified Occupational Therapy Assistant, Standard (New) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Certified Occupational Therapy Assistant, Incentive (New) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| **Physical Therapy For Adults Total:** | | | | | | **4334810.56** |
| | | | | | **4006791.36** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **3737** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Physical Integrated Therapy (Old) | 15 minutes | 1128 | 156.00 | 22.77 | | |
| Physical Therapy Assistant (PTA) (Old) | 15 minutes | 16 | 50.00 | 13.25 | 10600.00 | |
| Physical Therapy, Clinic Based (Old) | 15 minutes | 1128 | 21.00 | 13.40 | 317419.20 | |
| Physical Therapy (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Physical Integrated Therapy, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Physical Therapy Assistant (PTA), Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Physcial Therapy, Clinic Based, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Physical Therapy, Standard (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Physical Therapy, Incentive (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Physical Therapy, Evaluation (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| Physical Therapy Assistant (PTA), Standard (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Physcial Therapy Assistant (PTA), Incentive (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| **Speech and Language Therapy For Adults Total:** | | | | | | 6476466.35 |
| Speech Integrated Therapy (Old) | 15 minutes | 1805 | 141.00 | 22.77 | 5795078.85 | |
| Speech Therapy, Clinic Based (Old) | 15 minutes | 1805 | 25.00 | 15.10 | 681387.50 | |
| Speech Integrated Therapy, Exception (Old) | 15minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Speech Therapy Clinic Based, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Speech Group Therapy Clinic Based (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Speech Therapy, Standard (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Speech Therapy, Incentive (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Speech Therapy, Evaluation (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| | | | | | | |
| | | | GRAND TOTAL: | | | |
| | | | Total Estimated Unduplicated Participants: | | | 3737 |
| | | | Factor D (Divide total by number of participants): | | | |
| | | | Average Length of Stay on the Waiver: | | | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Supplemental Dental Care Total:** | | | | | | **2850.00** |
| Supplemental Dental Care (Old) | Visit | 25 | 1.00 | 114.00 | **2850.00** | |
| Supplemental Dental Care (New) | Visit | 0 | 0.00 | 0.01 | **0.00** | |
| **Adult Nursing Total:** | | | | | | **6454233.12** |
| Private Duty Nursing, LPN (Old) | 15 minutes | 324 | 48.00 | 6.45 | **100310.40** | |
| Private Duty Nursing, RN (Old) | 15 minutes | 324 | 48.00 | 10.36 | **161118.72** | |
| Adult Nursing, RN (New) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Nursing, LPN (New) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Residential Habilitation Private Duty Nursing, LPN | 15 minutes | 2456 | 150.00 | 6.45 | **2376180.00** | |
| Residential Habilitation Private Duty Nursing, RN | 15 minutes | 2456 | 150.00 | 10.36 | **3816624.00** | |
| **Assistive Technology Total:** | | | | | | **37500.00** |
| Assistive Technology | Each | 150 | 250.00 | 1.00 | **37500.00** | |
| **Behavioral Support Consultation Total:** | | | | | | **6345314.60** |
| Behavior Consultant, Client Location (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Behavior Consultant, Center Based (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Behavior Consultant, Center Based, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Behavior Consultant, Client Location, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Behavioral Support Consultation, Standard (New) | 15 minutes | 2128 | 49.00 | 11.63 | **1212683.36** | |
| Behavioral Support Consultation, Incentive (New) | 15 minutes | 2162 | 121.00 | 19.62 | **5132631.24** | |
| Behavioral Support Consultation, Evaluation (New) | Each | 0 | 0.00 | 0.01 | **0.00** | |
| **Crisis Support Total:** | | | | | | **378981.60** |
| Tier III Crisis (Support in Alternative Residential Setting) (Old) | Day | 9 | 60.00 | 410.40 | **221616.00** | |
| | | | | | **157365.60** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **3737** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Tier III Crisis (Support in Individual's Residence) (Old) | 15 minutes | 4 | 6902.00 | 5.70 | | |
| Tier III Crisis (Support in Alternative Residential Setting) (New) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Tier III Crisis (Support in Individual's Residence) (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Crisis Support | Day | 0 | 0.00 | 0.01 | 0.00 | |
| **Customized In-Home Supports Total:** | | | | | | 7290000.00 |
| Customized In-Home Supports | Hour | 324 | 1500.00 | 15.00 | 7290000.00 | |
| Independent Living (Old) | Month | 0 | 0.00 | 0.01 | 0.00 | |
| Intensive Independent Living (Old) | Month | 0 | 0.00 | 0.01 | 0.00 | |
| Customized In-Home Supports, Living Independently (2 clients) (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized In-Home Supports, Living Independently (3 clients) (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized In-Home Supports, Living with Natural Supports (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| **Environmental Modifications Total:** | | | | | | 966178.50 |
| Environmental Modifications | Each | 167 | 609.00 | 9.50 | 966178.50 | |
| Environmental Modifications (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| **Independent Living Transition Service Total:** | | | | | | 225000.00 |
| Independent Living Transition (New) | Item | 150 | 1500.00 | 1.00 | 225000.00 | |
| **Intense Medical Living Supports Total:** | | | | | | 17716140.00 |
| Intense Medical Living Supports | Day | 130 | 339.00 | 402.00 | 17716140.00 | |
| **Non-Medical Transportation Total:** | | | | | | 465458.67 |
| Non-Medical Transportation Pass/Ticket (Old) | Item | 71 | 381.00 | 0.97 | 26239.47 | |
| Non-Medical Transportation Per Mile (Old) | Per Mile | 380 | 3612.00 | 0.32 | 439219.20 | |
| | | | | | 0.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3737 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Non-Medical Transportation Pass/Ticket (New) | Item | 0 | 0.00 | 0.01 | | |
| Non-Medical Transportation Per Mile (New) | Per Mile | 0 | 0.00 | 0.01 | 0.00 | |
| **Personal Support Technology/On-Site Response Service Total:** | | | | | | 1730000.00 |
| Personal Technology/On-site Response (New) | Daily | 200 | 365.00 | 10.00 | 730000.00 | |
| Personal Technology/On-site Response (Installation) (New) | Each | 200 | 5000.00 | 1.00 | 1000000.00 | |
| **Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior Total:** | | | | | | 254195.00 |
| Preliminary Risk Screening, Incentive (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Preliminary Risk Screening, Standard (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Preliminary Risk Screening, Individual | 15 minutes | 250 | 52.00 | 11.63 | 151190.00 | |
| Preliminary Risk Screening, Integrated | 15 minutes | 250 | 21.00 | 19.62 | 103005.00 | |
| **Socialization and Sexuality Education Total:** | | | | | | 400500.00 |
| Socialization and Sexuality Education, Incentive (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| Socialization and Sexuality Education, Standard (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| Socialization and Sexuality Individual | Series | 250 | 192.00 | 6.00 | 288000.00 | |
| Socialization and Sexuality Classes | Series | 250 | 60.00 | 7.50 | 112500.00 | |
| | | | | **GRAND TOTAL:** | | |
| | | | | **Total Estimated Unduplicated Participants:** | | 3737 |
| | | | | **Factor D (Divide total by number of participants):** | | |
| | | | | **Average Length of Stay on the Waiver:** | | 343 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (6 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **11280347.29** |
| Case Management, On-Going (Old) | Month | 3689 | 10.90 | 264.81 | **10648036.58** | |
| Case Management, On-going (New) | Month | 1137 | 2.10 | 264.82 | **632310.71** | |
| **Community Integrated Employment Total:** | | | | | | |
| Supported Employment Job Developer (Old) | Each | 7 | 1.10 | 764.25 | **5884.72** | |
| Supported Employment, Level 1, Group (Old) | 15 minutes | 32 | 2091.50 | 3.62 | **242279.36** | |
| Supported Employment, Level 2, Group (Old) | 15 minutes | 145 | 2668.10 | 2.57 | **994267.46** | |
| Supported Employment, Level 3, Group (Old) | 15 minutes | 68 | 3260.00 | 2.07 | **458877.60** | |
| Supported Employment/Self-Employment (Old) | 15 minutes | 12 | 540.50 | 6.72 | **43585.92** | |
| Supported Employment, Individual (Old) | Hour | 547 | 25.50 | 203.18 | **2834056.23** | |
| Supported Employment, Intensive (Old) | Hour | 156 | 204.80 | 37.59 | **1200955.39** | |
| Supported Employment, Level 1, Group, Exception (Old) | 15 minutes | 1 | 112.90 | 3.62 | **408.70** | |
| Supported Employment, Level 2, Group, Exception (Old) | 15 minutes | 12 | 910.60 | 2.57 | **28082.90** | |
| Supported Employment, Level 3, Group, Exception (Old) | 15 minutes | 6 | 1286.60 | 2.07 | **15979.57** | |
| Supported Employment, Individual, Exception (Old) | Hour | 172 | 19.10 | 195.17 | **641172.48** | |
| Supported Employment, Intensive, Exception (Old) | Hour | 113 | 280.50 | 37.63 | **1192739.30** | |
| Supported Employment Job Development (New) | 15 minutes | 0 | 0.00 | 9.13 | **0.00** | |
| Supported Employment Job Aide (New) | Hour | 43 | 14.40 | 17.91 | **11089.87** | |
| Supported Employment, Group, Category 1 (New) | 15 minutes | 67 | 572.90 | 1.98 | **76000.91** | |
| Supported Employment, Group, Category 2 (New) | 15 minutes | 6 | 359.80 | 2.99 | **6454.81** | |
| Supported Employment, Individual Job Maintenance (New) | 15 minutes | 215 | 137.20 | 8.12 | **239523.76** | |
| | | | | | **2784.97** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **3692** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Supported Employment/Self Employment (New) | 15 minutes | 4 | 103.30 | 6.74 | | |
| Supported Employment, Intensive (New) | | | | | | |
| Supported Employment-Individual Job Maintenence Per Month | | | | | | |
| **Customized Community Supports Total:** | | | | | | **37166525.20** |
| Customized Community Supports, Individual (New) | 15 minutes | 271 | 190.30 | 7.12 | **367187.66** | |
| Customized Community Supports, Individual, Intense Behavioral Supports (New) | 15 minutes | 0 | 0.00 | 8.36 | **0.00** | |
| Community Access (Old) | 15 minutes | 879 | 1127.20 | 5.84 | **5786323.39** | |
| Community Inclusion Aide (New) | Hour | 54 | 20.10 | 18.25 | **19808.55** | |
| Adult Habilitation Level 1 (Old) | 15 minutes | 1226 | 3783.00 | 3.78 | **17531481.24** | |
| Adult Habilitation Level 1, Outlier (Old) | 15 minutes | 281 | 3331.10 | 2.22 | **2078006.80** | |
| Adult Habilitation Level 2 (Old) | 15 minutes | 967 | 3096.00 | 2.73 | **8173161.36** | |
| Adult Habilitation Level 2, Outlier (Old) | 15 minutes | 49 | 2856.20 | 3.22 | **450651.24** | |
| Adult Habilitation Level 3 (Old) | 15 minutes | 145 | 2162.00 | 2.22 | **695947.80** | |
| Adult Habilitation Level, 3, Outlier (Old) | 15 minutes | 3 | 496.00 | 3.72 | **5535.36** | |
| Customized Community Supports, Group, Category 1 (New) | 15 minutes | 441 | 857.20 | 2.66 | **1005547.03** | |
| Customized Community Supports, Group, Category 2 (New) | 15 minutes | 262 | 1009.70 | 3.98 | **1052874.77** | |
| Customized Community Supports, Group, Community Only (New) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Customized Community Supports, Community | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Customized Community Supports, Center | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Fiscal Management of Educational Opportunities (FMEO) | Per Dollar | 0 | 0.00 | 0.01 | **0.00** | |
| **Living Supports Total:** | | | | | | **158242843.78** |
| | | | | | | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **3692** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Non-Ambulatory Stipend (New) | Day | 57 | 56.30 | 63.49 | 203745.76 | |
| Supported Living, Level 1, Awake Outlier (Old) | Day | 196 | 246.40 | 87.36 | 4218998.78 | |
| Supported Living, Level 1, Asleep Outlier (Old) | Day | 23 | 220.80 | 164.98 | 837834.43 | |
| Supported Living, Level 2, Awake Oulier (Old) | Day | 43 | 186.60 | 193.91 | 1555895.06 | |
| Supported Living, Level 2, Asleep Outlier (Old) | Day | 11 | 216.00 | 237.57 | 564466.32 | |
| Supported Living, Level 3, Awake Outlier (Old) | Day | 5 | 111.50 | 239.87 | 133727.52 | |
| Supported Living, Level 3, Asleep Outlier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 2, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 2, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Shared Living | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Shared Living (Intense Behavioral Supports) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Awake (Old) | Day | 611 | 289.80 | 314.07 | 55611683.95 | |
| Supported Living, Level 2, Awake (Old) | Day | 180 | 260.40 | 199.36 | 9344401.92 | |
| Supported Living, Level 3, Awake (Old) | Day | 15 | 164.80 | 150.05 | 370923.60 | |
| Supported Living, Level 1, Asleep (Old) | Day | 140 | 259.70 | 229.83 | 8356159.14 | |
| Supported Living, Level 2, Asleep (Old) | Day | 263 | 273.50 | 150.87 | 10852154.54 | |
| Supported Living, Level 3, Asleep (Old) | Day | 52 | 239.10 | 117.58 | 1461895.66 | |
| | | | | | | |
| | | | GRAND TOTAL: | | | |
| | | | Total Estimated Unduplicated Participants: | | | 3692 |
| | | | Factor D (Divide total by number of participants): | | | |
| | | | Average Length of Stay on the Waiver: | | | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Family Living (Old) | Day | 1849 | 302.90 | 99.34 | 55636569.01 | |
| Family Living (New) | Day | 570 | 57.90 | 121.83 | 4020755.49 | |
| Supported Living Category H (New) | Day | 85 | 54.00 | 200.42 | 919927.80 | |
| Supported Living Category 2 (New) | Day | 113 | 56.70 | 233.20 | 1494135.72 | |
| Supported Living Category 3 (New) | Day | 152 | 59.50 | 294.07 | 2659569.08 | |
| **Personal Support Services Total:** | | | | | | 357146.68 |
| Home Visit Day Life Activity | Hour | 36 | 703.10 | 14.11 | 357146.68 | |
| **Respite Total:** | | | | | | 23669446.36 |
| Respite | 15 minutes | 411 | 3513.70 | 3.53 | 5097781.37 | |
| Respite (New) | 15 minutes | 127 | 682.90 | 4.80 | 416295.84 | |
| Respite, Group (New) | 15 minutes | 0 | 0.00 | 2.72 | 0.00 | |
| Respite/Substitute Care (Old) | 15 minutes | 1757 | 2969.30 | 3.48 | 18155369.15 | |
| **Nutritional Counseling Total:** | | | | | | 3863.86 |
| Nutritional Counseling | Visit | 10 | 7.30 | 43.54 | 3178.42 | |
| Nutritional Counseling (New) | 15 minutes | 3 | 16.80 | 13.60 | 685.44 | |
| **Occupational Therapy For Adults Total:** | | | | | | 4038362.75 |
| Occupational Integrated Therapy (Old) | 15 minutes | 1012 | 76.30 | 24.00 | 1853174.40 | |
| Occupational Therapy Assistant (Certified) (Old) | 15 minutes | 23 | 93.00 | 9.87 | 21111.93 | |
| Occupational Therapy, Clinic Based (Old) | 15 minutes | 970 | 16.20 | 12.91 | 202867.74 | |
| Occupational Integrated Therapy, Exception (Old) | 15 minutes | 715 | 98.90 | 24.00 | 1697124.00 | |
| Occupational Therapy Assistant (Certified), Exception (Old) | 15 minutes | 8 | 40.70 | 9.87 | 3213.67 | |
| Occupational Therapy, Clinic Based, Exception (Old) | 15 minutes | 299 | 17.40 | 12.90 | 67113.54 | |
| | | | | | 166735.80 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3692 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Occupational Therapy, Standard (New) | 15 minutes | 385 | 18.00 | 24.06 | | |
| Occupational Therapy, Incentive (New) | 15 minutes | 44 | 18.00 | 30.68 | 24298.56 | |
| Occupational Therapy, Evaluation (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| Certified Occupational Therapy Assistant, Standard (New) | 15 minutes | 8 | 17.20 | 19.79 | 2723.10 | |
| Certified Occupational Therapy Assistant, Incentive (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| **Physical Therapy For Adults Total:** | | | | | | 4116142.89 |
| Physical Integrated Therapy (Old) | 15 minutes | 1018 | 86.70 | 24.59 | 2170328.15 | |
| Physical Therapy Assistant (PTA) (Old) | 15 minutes | 6 | 75.20 | 10.38 | 4683.46 | |
| Physical Therapy, Clinic Based (Old) | 15 minutes | 989 | 15.40 | 13.69 | 208506.91 | |
| Physical Therapy (Old) | 15 minutes | 1 | 2.80 | 13.75 | 38.50 | |
| Physical Integrated Therapy, Exception (Old) | 15 minutes | 643 | 94.60 | 24.61 | 1496972.16 | |
| Physical Therapy Assistant (PTA), Exception (Old) | 15 minutes | 2 | 60.20 | 10.38 | 1249.75 | |
| Physcial Therapy, Clinic Based, Exception (Old) | 15 minutes | 227 | 14.40 | 13.70 | 44782.56 | |
| Physical Therapy, Standard (New) | 15 minutes | 380 | 18.00 | 24.06 | 164570.40 | |
| Physical Therapy, Incentive (New) | 15 minutes | 44 | 18.00 | 30.68 | 24298.56 | |
| Physical Therapy, Evaluation (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| Physical Therapy Assistant (PTA), Standard (New) | 15 minutes | 2 | 18.00 | 19.79 | 712.44 | |
| Physcial Therapy Assistant (PTA), Incentive (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| **Speech and Language Therapy For Adults Total:** | | | | | | 6999230.24 |
| Speech Integrated Therapy (Old) | 15 minutes | 1695 | 89.40 | 24.52 | 3715589.16 | |
| Speech Therapy, Clinic Based (Old) | 15 minutes | 1628 | 19.40 | 16.26 | 513542.83 | |
| Speech Integrated Therapy, Exception (Old) | | | | | 2334136.32 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3692 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | 15minutes | 992 | 96.00 | 24.51 | | |
| Speech Therapy Clinic Based, Exception (Old) | 15 minutes | 449 | 17.90 | 16.21 | 130281.39 | |
| Speech Group Therapy Clinic Based (Old) | 15 minutes | 1 | 11.30 | 5.77 | 65.20 | |
| Speech Therapy, Standard (New) | 15 minutes | 616 | 18.00 | 24.03 | 266444.64 | |
| Speech Therapy, Incentive (New) | 15 minutes | 71 | 18.00 | 30.65 | 39170.70 | |
| Speech Therapy, Evaluation (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| **Supplemental Dental Care Total:** | | | | | | 0.00 |
| Supplemental Dental Care (Old) | Visit | 0 | 0.00 | 114.00 | 0.00 | |
| Supplemental Dental Care (New) | Visit | 0 | 0.00 | 0.01 | 0.00 | |
| **Adult Nursing Total:** | | | | | | 142024.24 |
| Private Duty Nursing, LPN (Old) | 15 minutes | 0 | 0.00 | 6.45 | 0.00 | |
| Private Duty Nursing, RN (Old) | 15 minutes | 6 | 113.20 | 11.07 | 7518.74 | |
| Adult Nursing, RN (New) | 15 minutes | 345 | 9.30 | 20.13 | 64587.10 | |
| Adult Nursing, LPN (New) | 15 minutes | 345 | 13.90 | 14.58 | 69918.39 | |
| Residential Habilitation Private Duty Nursing, LPN | 15 minutes | 0 | 0.00 | 6.45 | 0.00 | |
| Residential Habilitation Private Duty Nursing, RN | 15 minutes | 0 | 0.00 | 10.36 | 0.00 | |
| **Assistive Technology Total:** | | | | | | 19691.60 |
| Assistive Technology | Each | 76 | 259.10 | 1.00 | 19691.60 | |
| **Behavioral Support Consultation Total:** | | | | | | 7881548.14 |
| Behavior Consultant, Client Location (Old) | 15 minutes | 2021 | 133.60 | 20.90 | 5643117.04 | |
| Behavior Consultant, Center Based (Old) | 15 minutes | 2013 | 53.60 | 12.42 | 1340078.26 | |
| Behavior Consultant, Center Based, Exception (Old) | 15 minutes | 150 | 31.70 | 12.36 | 58771.80 | |
| | 15 minutes | | | | 427505.72 | |
| | | | | **GRAND TOTAL:** | | |
| | | | | **Total Estimated Unduplicated Participants:** | | 3692 |
| | | | | **Factor D (Divide total by number of participants):** | | |
| | | | | **Average Length of Stay on the Waiver:** | | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Behavior Consultant, Client Location, Exception (Old) | | 267 | 76.50 | 20.93 | | |
| Behavioral Support Consultation, Standard (New) | 15 minutes | 599 | 24.90 | 19.22 | 286668.22 | |
| Behavioral Support Consultation, Incentive (New) | 15 minutes | 203 | 24.90 | 24.81 | 125407.11 | |
| Behavioral Support Consultation, Evaluation (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| **Crisis Support Total:** | | | | | | 776469.48 |
| Tier III Crisis (Support in Alternative Residential Setting) (Old) | Day | 11 | 115.60 | 433.12 | 550755.39 | |
| Tier III Crisis (Support in Individual's Residence) (Old) | 15 minutes | 9 | 3365.60 | 6.04 | 182954.02 | |
| Tier III Crisis (Support in Alternative Residential Setting) (New) | Day | 3 | 22.10 | 365.71 | 24246.57 | |
| Tier III Crisis (Support in Individual's Residence) (New) | 15 minutes | 3 | 643.50 | 9.59 | 18513.50 | |
| Crisis Support | Day | 0 | 0.00 | 0.01 | 0.00 | |
| **Customized In-Home Supports Total:** | | | | | | 5319243.85 |
| Customized In-Home Supports | 15 minutes | 88 | 655.20 | 6.49 | 374197.82 | |
| Independent Living (Old) | Month | 190 | 9.50 | 1813.18 | 3272789.90 | |
| Intensive Independent Living (Old) | Month | 77 | 8.40 | 2585.43 | 1672256.12 | |
| Customized In-Home Supports, Living Independently (2 clients) (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized In-Home Supports, Living Independently (3 clients) (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized In-Home Supports, Living with Natural Supports (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| **Environmental Modifications Total:** | | | | | | 291121.32 |
| Environmental Modifications | Each | 65 | 446.20 | 9.48 | 274948.44 | |
| Environmental Modifications (New) | Each | 20 | 85.30 | 9.48 | 16172.88 | |
| **Independent Living Transition Service Total:** | | | | | | 30736.68 |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3692 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Independent Living Transition (New) | Each | 76 | 396.50 | 1.02 | 30736.68 | |
| **Intense Medical Living Supports Total:** | | | | | | 323683.08 |
| Intense Medical Living Supports | Day | 12 | 61.00 | 442.19 | 323683.08 | |
| **Non-Medical Transportation Total:** | | | | | | 403760.55 |
| Non-Medical Transportation Pass/Ticket (Old) | Item | 83 | 523.10 | 1.01 | 43851.47 | |
| Non-Medical Transportation Per Mile (Old) | Per Mile | 294 | 3476.80 | 0.33 | 337319.14 | |
| Non-Medical Transportation Pass/Ticket (New) | Item | 26 | 100.00 | 1.01 | 2626.00 | |
| Non-Medical Transportation Per Mile (New) | Per Mile | 91 | 664.80 | 0.33 | 19963.94 | |
| **Personal Support Technology/On-Site Response Service Total:** | | | | | | 123689.13 |
| Personal Technology/On-site Response (New) | Day | 62 | 65.60 | 10.43 | 42420.90 | |
| Personal Technology/On-site Response (Installation) (New) | Each | 101 | 781.20 | 1.03 | 81268.24 | |
| **Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior Total:** | | | | | | 7006.38 |
| Preliminary Risk Screening, Incentive (New) | 15 minutes | 28 | 9.40 | 26.62 | 7006.38 | |
| Preliminary Risk Screening, Standard (New) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Preliminary Risk Screening, Individual | 15 minutes | 0 | 0.00 | 11.63 | 0.00 | |
| Preliminary Risk Screening, Integrated | 15 minutes | 0 | 0.00 | 19.62 | 0.00 | |
| **Socialization and Sexuality Education Total:** | | | | | | 19676.47 |
| Socialization and Sexuality Education, Incentive (New) | Each | 0 | 0.00 | 708.00 | 0.00 | |
| Socialization and Sexuality Education, Standard (New) | Each | 93 | 0.50 | 423.15 | 19676.48 | |
| Socialization and Sexuality Individual | Series | 0 | 0.00 | 6.00 | 0.00 | |
| Socialization and Sexuality Classes | | | | | 0.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3692 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 343 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Series | 0 | 0.00 | 7.50 | | |
| | | | | GRAND TOTAL: | | |
| | | | | Total Estimated Unduplicated Participants: | | 3692 |
| | | | | Factor D (Divide total by number of participants): | | |
| | | | | Average Length of Stay on the Waiver: | | 343 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (7 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | 11325426.23 |
| Case Management, On-Going (Old) | Month | 2356 | 3.30 | 264.81 | 2058844.79 | |
| Case Management, On-going (New) | Month | 3645 | 9.60 | 264.82 | 9266581.44 | |
| **Community Integrated Employment Total:** | | | | | | |
| Supported Employment Job Developer (Old) | Each | 4 | 0.30 | 764.25 | 917.10 | |
| Supported Employment, Level 1, Group (Old) | 15 minutes | 21 | 625.00 | 3.62 | 47512.50 | |
| Supported Employment, Level 2, Group (Old) | 15 minutes | 92 | 803.30 | 2.57 | 189932.25 | |
| Supported Employment, Level 3, Group (Old) | 15 minutes | 44 | 974.20 | 2.07 | 88730.14 | |
| Supported Employment/Self-Employment (Old) | 15 minutes | 8 | 161.50 | 6.72 | 8682.24 | |
| Supported Employment, Individual (Old) | Hour | 349 | 7.60 | 203.18 | 538914.63 | |
| Supported Employment, Intensive (Old) | Hour | 99 | 61.20 | 37.59 | 227750.29 | |
| Supported Employment, Level 1, Group, Exception (Old) | 15 minutes | 1 | 33.70 | 3.62 | 121.99 | |
| Supported Employment, Level 2, Group, Exception (Old) | 15 minutes | 8 | 272.10 | 2.57 | 5594.38 | |
| | | | | GRAND TOTAL: | | |
| | | | | Total Estimated Unduplicated Participants: | | 3648 |
| | | | | Factor D (Divide total by number of participants): | | |
| | | | | Average Length of Stay on the Waiver: | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Supported Employment, Level 3, Group, Exception (Old) | 15 minutes | 4 | 384.50 | 2.07 | 3183.66 | |
| Supported Employment, Individual, Exception (Old) | Hour | 110 | 5.70 | 195.17 | 122371.59 | |
| Supported Employment, Intensive, Exception (Old) | Hour | 72 | 83.80 | 37.63 | 227044.37 | |
| Supported Employment Job Development (New) | 15 minutes | 0 | 0.00 | 9.13 | 0.00 | |
| Supported Employment Job Aide (New) | Hour | 138 | 65.90 | 17.91 | 162877.12 | |
| Supported Employment, Group, Category 1 (New) | 15 minutes | 215 | 2632.50 | 1.98 | 1120655.25 | |
| Supported Employment, Group, Category 2 (New) | 15 minutes | 19 | 1653.30 | 2.99 | 93923.97 | |
| Supported Employment, Individual Job Maintenance (New) | 15 minutes | 691 | 630.30 | 8.12 | 3536562.88 | |
| Supported Employment/Self Employment (New) | 15 minutes | 12 | 474.90 | 6.74 | 38409.91 | |
| Supported Employment, Intensive (New) | | | | | | |
| Supported Employment-Individual Job Maintenence Per Month | | | | | | |
| **Customized Community Supports Total:** | | | | | | 42746500.18 |
| Customized Community Supports, Individual (New) | 15 minutes | 902 | 853.20 | 7.12 | 5479455.17 | |
| Customized Community Supports, Individual, Intense Behavioral Supports (New) | 15 minutes | 0 | 0.00 | 8.36 | 0.00 | |
| Community Access (Old) | 15 minutes | 561 | 336.80 | 5.84 | 1103437.63 | |
| Community Inclusion Aide (New) | Hour | 180 | 89.90 | 18.25 | 295321.50 | |
| Adult Habilitation Level 1 (Old) | 15 minutes | 783 | 1130.50 | 3.78 | 3345986.07 | |
| Adult Habilitation Level 1, Outlier (Old) | 15 minutes | 180 | 995.50 | 2.22 | 397801.80 | |
| Adult Habilitation Level 2 (Old) | 15 minutes | 617 | 925.20 | 2.73 | 1558416.13 | |
| Adult Habilitation Level 2, Outlier (Old) | 15 minutes | 31 | 853.50 | 3.22 | 85196.37 | |
| Adult Habilitation Level 3 (Old) | 15 minutes | 92 | 646.10 | 2.22 | 131959.46 | |
| | | | | | | |
| | | | | **GRAND TOTAL:** | | |
| | | | | **Total Estimated Unduplicated Participants:** | | 3648 |
| | | | | **Factor D (Divide total by number of participants):** | | |
| | | | | **Average Length of Stay on the Waiver:** | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Adult Habilitation Level, 3, Outlier (Old) | 15 minutes | 2 | 148.20 | 3.72 | 1102.61 | |
| Customized Community Supports, Group, Category 1 (New) | 15 minutes | 1414 | 3944.90 | 2.66 | 14837715.68 | |
| Customized Community Supports, Group, Category 2 (New) | 15 minutes | 840 | 4639.30 | 3.98 | 15510107.76 | |
| Customized Community Supports, Group, Community Only (New) | 15 minutes | 0 | 0.00 | 3.96 | 0.00 | |
| Customized Community Supports, Community | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized Community Supports, Center | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Fiscal Management of Educational Opportunities (FMEO) | Per Dollar | 0 | 0.00 | 0.01 | 0.00 | |
| **Living Supports Total:** | | | | | | 161825940.71 |
| Non-Ambulatory Stipend (New) | Day | 183 | 258.90 | 63.49 | 3008073.66 | |
| Supported Living, Level 1, Awake Outlier (Old) | Day | 125 | 73.60 | 87.36 | 803712.00 | |
| Supported Living, Level 1, Asleep Outlier (Old) | Day | 15 | 66.00 | 164.98 | 163330.20 | |
| Supported Living, Level 2, Awake Oulier (Old) | Day | 28 | 55.80 | 193.91 | 302964.98 | |
| Supported Living, Level 2, Asleep Outlier (Old) | Day | 7 | 64.50 | 237.57 | 107262.86 | |
| Supported Living, Level 3, Awake Outlier (Old) | Day | 3 | 33.30 | 239.87 | 23963.01 | |
| Supported Living, Level 3, Asleep Outlier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 2, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 2, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3648 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Shared Living | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Shared Living (Intense Behavioral Supports) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Awake (Old) | Day | 390 | 86.60 | 314.07 | 10607400.18 | |
| Supported Living, Level 2, Awake (Old) | Day | 115 | 77.80 | 199.36 | 1783673.92 | |
| Supported Living, Level 3, Awake (Old) | Day | 10 | 49.20 | 150.05 | 73824.60 | |
| Supported Living, Level 1, Asleep (Old) | Day | 89 | 77.60 | 229.83 | 1587297.91 | |
| Supported Living, Level 2, Asleep (Old) | Day | 168 | 81.70 | 150.87 | 2070781.27 | |
| Supported Living, Level 3, Asleep (Old) | Day | 33 | 71.40 | 117.58 | 277042.00 | |
| Family Living (Old) | Day | 1180 | 90.50 | 99.34 | 10608518.60 | |
| Family Living (New) | Day | 1826 | 262.90 | 121.83 | 58485149.38 | |
| Supported Living Category H (New) | Day | 272 | 238.00 | 200.42 | 12974389.12 | |
| Supported Living Category 2 (New) | Day | 361 | 260.70 | 233.20 | 21947081.64 | |
| Supported Living Category 3 (New) | Day | 486 | 258.90 | 294.07 | 37001475.38 | |
| **Personal Support Services Total:** | | | | | | 68183.75 |
| Home Visit Day Life Activity | Hour | 23 | 210.10 | 14.11 | 68183.75 | |
| **Respite Total:** | | | | | | 10546758.12 |
| Respite | 15 minutes | 262 | 1050.00 | 3.53 | 971103.00 | |
| Respite (New) | 15 minutes | 428 | 2995.80 | 4.80 | 6154571.52 | |
| Respite, Group (New) | 15 minutes | 0 | 0.00 | 2.72 | 0.00 | |
| Respite/Substitute Care (Old) | 15 minutes | 1100 | 893.70 | 3.48 | 3421083.60 | |
| **Nutritional Counseling Total:** | | | | | | 11087.53 |
| Nutritional Counseling | Visit | 6 | 2.20 | 43.54 | 574.73 | |
| | | | | | 10512.80 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3648 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Nutritional Counseling (New) | 15 minutes | 10 | 77.30 | 13.60 | | |
| **Occupational Therapy For Adults Total:** | | | | | | **3507171.26** |
| Occupational Integrated Therapy (Old) | 15 minutes | 646 | 22.80 | 24.00 | **353491.20** | |
| Occupational Therapy Assistant (Certified) (Old) | 15 minutes | 15 | 27.80 | 9.87 | **4115.79** | |
| Occupational Therapy, Clinic Based (Old) | 15 minutes | 619 | 4.90 | 12.91 | **39157.32** | |
| Occupational Integrated Therapy, Exception (Old) | 15 minutes | 457 | 29.60 | 24.00 | **324652.80** | |
| Occupational Therapy Assistant (Certified), Exception (Old) | 15 minutes | 5 | 12.20 | 9.87 | **602.07** | |
| Occupational Therapy, Clinic Based, Exception (Old) | 15 minutes | 191 | 5.20 | 12.90 | **12812.28** | |
| Occupational Therapy, Standard (New) | 15 minutes | 1199 | 82.60 | 24.06 | **2382839.84** | |
| Occupational Therapy, Incentive (New) | 15 minutes | 137 | 82.60 | 30.68 | **347181.02** | |
| Occupational Therapy, Evaluation (New) | Each | 0 | 0.00 | 453.48 | **0.00** | |
| Certified Occupational Therapy Assistant, Standard (New) | 15 minutes | 27 | 79.20 | 19.79 | **42318.94** | |
| Certified Occupational Therapy Assistant, Incentive (New) | 15 minutes | 0 | 0.00 | 25.96 | **0.00** | |
| **Physical Therapy For Adults Total:** | | | | | | **3456492.19** |
| Physical Integrated Therapy (Old) | 15 minutes | 650 | 25.90 | 24.59 | **413972.65** | |
| Physical Therapy Assistant (PTA) (Old) | 15 minutes | 4 | 22.50 | 10.38 | **934.20** | |
| Physical Therapy, Clinic Based (Old) | 15 minutes | 632 | 4.60 | 13.69 | **39799.57** | |
| Physical Therapy (Old) | 15 minutes | 1 | 0.80 | 13.75 | **11.00** | |
| Physical Integrated Therapy, Exception (Old) | 15 minutes | 410 | 28.30 | 24.61 | **285549.83** | |
| Physical Therapy Assistant (PTA), Exception (Old) | 15 minutes | 1 | 18.00 | 10.38 | **186.84** | |
| Physcial Therapy, Clinic Based, Exception (Old) | 15 minutes | 145 | 4.30 | 13.70 | **8541.95** | |
| Physical Therapy, Standard (New) | 15 minutes | 1184 | 82.60 | 24.06 | **2353029.50** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **3648** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Physical Therapy, Incentive (New) | 15 minutes | 136 | 82.60 | 30.68 | 344646.85 | |
| Physical Therapy, Evaluation (New) | Each | 0 | 0.00 | 453.49 | 0.00 | |
| Physical Therapy Assistant (PTA), Standard (New) | 15 minutes | 6 | 82.70 | 19.79 | 9819.80 | |
| Physcial Therapy Assistant (PTA), Incentive (New) | 15 minutes | 0 | 0.00 | 25.96 | 0.00 | |
| **Speech and Language Therapy For Adults Total:** | | | | | | 5638289.30 |
| Speech Integrated Therapy (Old) | 15 minutes | 1082 | 26.70 | 24.52 | 708368.09 | |
| Speech Therapy, Clinic Based (Old) | 15 minutes | 1039 | 5.80 | 16.26 | 97986.01 | |
| Speech Integrated Therapy, Exception (Old) | 15minutes | 633 | 28.70 | 24.51 | 445275.62 | |
| Speech Therapy Clinic Based, Exception (Old) | 15 minutes | 287 | 5.30 | 16.21 | 24657.03 | |
| Speech Group Therapy Clinic Based (Old) | 15 minutes | 1 | 3.40 | 5.77 | 19.62 | |
| Speech Therapy, Standard (New) | 15 minutes | 1917 | 82.60 | 24.03 | 3805011.13 | |
| Speech Therapy, Incentive (New) | 15 minutes | 220 | 82.60 | 30.65 | 556971.80 | |
| Speech Therapy, Evaluation (New) | Each | 0 | 0.00 | 453.08 | 0.00 | |
| **Supplemental Dental Care Total:** | | | | | | 0.00 |
| Supplemental Dental Care (Old) | Visit | 0 | 0.00 | 0.01 | 0.00 | |
| Supplemental Dental Care (New) | Visit | 0 | 0.00 | 0.01 | 0.00 | |
| **Adult Nursing Total:** | | | | | | 2002180.03 |
| Private Duty Nursing, LPN (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Private Duty Nursing, RN (Old) | 15 minutes | 4 | 33.80 | 11.07 | 1496.66 | |
| Adult Nursing, RN (New) | 15 minutes | 2111 | 22.60 | 20.13 | 960374.12 | |
| Adult Nursing, LPN (New) | 15 minutes | 2111 | 33.80 | 14.58 | 1040309.24 | |
| Residential Habilitation Private Duty Nursing, LPN | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| | | | | **GRAND TOTAL:** | | |
| | | | | **Total Estimated Unduplicated Participants:** | | 3648 |
| | | | | **Factor D (Divide total by number of participants):** | | |
| | | | | **Average Length of Stay on the Waiver:** | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Residential Habilitation Private Duty Nursing, RN | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| **Assistive Technology Total:** | | | | | | 32355.65 |
| Assistive Technology | Each | 149 | 208.80 | 1.04 | 32355.65 | |
| **Behavioral Support Consultation Total:** | | | | | | 7124501.72 |
| Behavior Consultant, Client Location (Old) | 15 minutes | 1291 | 39.90 | 20.90 | 1076577.81 | |
| Behavior Consultant, Center Based (Old) | 15 minutes | 1286 | 16.00 | 12.42 | 255553.92 | |
| Behavior Consultant, Center Based, Exception (Old) | 15 minutes | 96 | 9.50 | 12.36 | 11272.32 | |
| Behavior Consultant, Client Location, Exception (Old) | 15 minutes | 171 | 22.90 | 20.93 | 81959.79 | |
| Behavioral Support Consultation, Standard (New) | 15 minutes | 1801 | 114.50 | 19.22 | 3963442.69 | |
| Behavioral Support Consultation, Incentive (New) | 15 minutes | 611 | 114.50 | 24.81 | 1735695.20 | |
| Behavioral Support Consultation, Evaluation (New) | Each | 0 | 0.00 | 366.96 | 0.00 | |
| **Crisis Support Total:** | | | | | | 804976.21 |
| Tier III Crisis (Support in Alternative Residential Setting) (Old) | Day | 7 | 34.50 | 433.12 | 104598.48 | |
| Tier III Crisis (Support in Individual's Residence) (Old) | 15 minutes | 6 | 1005.80 | 6.04 | 36450.19 | |
| Tier III Crisis (Support in Alternative Residential Setting) (New) | Day | 11 | 101.60 | 365.71 | 408717.50 | |
| Tier III Crisis (Support in Individual's Residence) (New) | 15 minutes | 9 | 2956.90 | 9.59 | 255210.04 | |
| Crisis Support | Day | 0 | 0.00 | 0.01 | 0.00 | |
| **Customized In-Home Supports Total:** | | | | | | 6480785.74 |
| Customized In-Home Supports | 15 minutes | 283 | 3009.70 | 6.49 | 5527825.70 | |
| Independent Living (Old) | Month | 121 | 2.90 | 1813.18 | 636244.86 | |
| Intensive Independent Living (Old) | Month | 49 | 2.50 | 2585.43 | 316715.18 | |
| Customized In-Home Supports, Living | 15 minutes | | | | 0.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3648 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Independently (2 clients) (New) | | 0 | 0.00 | 3.84 | | |
| Customized In-Home Supports, Living Independently (3 clients) (New) | 15 minutes | 0 | 0.00 | 3.30 | 0.00 | |
| Customized In-Home Supports, Living with Natural Supports (New) | 15 minutes | 0 | 0.00 | 4.60 | 0.00 | |
| **Environmental Modifications Total:** | | | | | | 290908.97 |
| Environmental Modifications | Each | 42 | 133.30 | 9.48 | 53074.73 | |
| Environmental Modifications (New) | Each | 64 | 392.00 | 9.48 | 237834.24 | |
| **Independent Living Transition Service Total:** | | | | | | 194149.38 |
| Independent Living Transition (New) | Each | 149 | 1252.90 | 1.04 | 194149.38 | |
| **Intense Medical Living Supports Total:** | | | | | | 4954296.76 |
| Intense Medical Living Supports | Day | 40 | 280.10 | 442.19 | 4954296.76 | |
| **Non-Medical Transportation Total:** | | | | | | 404223.61 |
| Non-Medical Transportation Pass/Ticket (Old) | Item | 53 | 156.30 | 1.01 | 8366.74 | |
| Non-Medical Transportation Per Mile (Old) | Per Mile | 188 | 1039.00 | 0.33 | 64459.56 | |
| Non-Medical Transportation Pass/Ticket (New) | Item | 82 | 459.60 | 1.01 | 38064.07 | |
| Non-Medical Transportation Per Mile (New) | Per Mile | 291 | 3054.60 | 0.33 | 293333.24 | |
| **Personal Support Technology/On-Site Response Service Total:** | | | | | | 1482809.33 |
| Personal Technology/On-site Response (New) | Day | 198 | 301.60 | 10.43 | 622846.22 | |
| Personal Technology/On-site Response (Installation) (New) | Each | 198 | 4176.20 | 1.04 | 859963.10 | |
| **Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior Total:** | | | | | | 101874.74 |
| Preliminary Risk Screening, Incentive (New) | 15 minutes | 89 | 43.00 | 26.62 | 101874.74 | |
| Preliminary Risk Screening, Standard (New) | 15 minutes | 0 | 0.00 | 20.72 | 0.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 3648 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Preliminary Risk Screening, Individual | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Preliminary Risk Screening, Integrated | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| **Socialization and Sexuality Education Total:** | | | | | | 315246.75 |
| Socialization and Sexuality Education, Incentive (New) | Each | 0 | 0.00 | 708.00 | 0.00 | |
| Socialization and Sexuality Education, Standard (New) | Each | 298 | 2.50 | 423.15 | 315246.75 | |
| Socialization and Sexuality Individual | Series | 0 | 0.00 | 0.01 | 0.00 | |
| Socialization and Sexuality Classes | Series | 0 | 0.00 | 0.01 | 0.00 | |
| | | | | **GRAND TOTAL:** | | |
| | | | | **Total Estimated Unduplicated Participants:** | | 3648 |
| | | | | **Factor D (Divide total by number of participants):** | | |
| | | | | **Average Length of Stay on the Waiver:** | | 347 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | 13005672.29 |
| Case Management, On-Going (Old) | Month | 297 | 11.90 | 264.87 | 936130.04 | |
| Case Management, On-going (New) | Month | 3929 | 11.60 | 264.82 | 12069542.25 | |
| **Community Integrated Employment Total:** | | | | | | 9262480.26 |
| Supported Employment Job Developer (Old) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Level 1, Group (Old) | 15 minutes | 0 | 0.00 | 1.00 | 0.00 | |
| Supported Employment, Level 2, Group (Old) | 15 minutes | | | | 0.00 | |
| | | | | **GRAND TOTAL:** | | 317881141.97 |
| | | | | **Total Estimated Unduplicated Participants:** | | 4229 |
| | | | | **Factor D (Divide total by number of participants):** | | 75166.98 |
| | | | | **Average Length of Stay on the Waiver:** | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | | 0 | 0.00 | 0.01 | | |
| Supported Employment, Level 3, Group (Old) | 15 minutes | 1 | 6246.00 | 2.04 | 12741.84 | |
| Supported Employment/Self-Employment (Old) | 15 minutes | 3 | 777.30 | 6.63 | 15460.50 | |
| Supported Employment, Individual (Old) | Hour | 38 | 26.60 | 204.64 | 206850.11 | |
| Supported Employment, Intensive (Old) | Hour | 22 | 255.40 | 37.61 | 211323.07 | |
| Supported Employment, Level 1, Group, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Level 2, Group, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Level 3, Group, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Employment, Individual, Exception (Old) | Hour | 24 | 21.50 | 204.91 | 105733.56 | |
| Supported Employment, Intensive, Exception (Old) | Hour | 20 | 293.80 | 34.56 | 203074.56 | |
| Supported Employment Job Development (New) | 15 minutes | 134 | 223.60 | 9.13 | 273556.71 | |
| Supported Employment Job Aide (New) | Hour | 148 | 79.80 | 17.91 | 211524.26 | |
| Supported Employment, Group, Category 1 (New) | 15 minutes | 232 | 3185.80 | 1.98 | 1463429.09 | |
| Supported Employment, Group, Category 2 (New) | 15 minutes | 20 | 2000.90 | 2.99 | 119653.82 | |
| Supported Employment, Individual Job Maintenance (New) | 15 minutes | 436 | 362.60 | 8.12 | 1283720.03 | |
| Supported Employment/Self Employment (New) | 15 minutes | 13 | 574.70 | 6.74 | 50355.21 | |
| Supported Employment, Intensive (New) | Hour | 169 | 263.00 | 43.47 | 1932111.09 | |
| Supported Employment-Individual Job Maintenence Per Month | Month | 436 | 7.50 | 970.32 | 3172946.40 | |
| **Customized Community Supports Total:** | | | | | | 61781532.03 |
| Customized Community Supports, Individual (New) | 15 minutes | 1128 | 1195.50 | 7.12 | 9601490.88 | |
| Customized Community Supports, Individual, Intense Behavioral Supports (New) | 15 minutes | 87 | 3635.30 | 8.36 | 2644026.40 | |
| | | | | | | |
| | | | | GRAND TOTAL: | | 317881141.97 |
| | | | | Total Estimated Unduplicated Participants: | | 4229 |
| | | | | Factor D (Divide total by number of participants): | | 75166.98 |
| | | | | Average Length of Stay on the Waiver: | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Community Access (Old) | 15 minutes | 38 | 1380.80 | 5.97 | 313248.29 | |
| Community Inclusion Aide (New) | Hour | 226 | 126.00 | 18.25 | 519687.00 | |
| Adult Habilitation Level 1 (Old) | 15 minutes | 238 | 4681.50 | 3.75 | 4178238.75 | |
| Adult Habilitation Level 1, Outlier (Old) | 15 minutes | 69 | 4014.20 | 2.21 | 612125.36 | |
| Adult Habilitation Level 2 (Old) | 15 minutes | 41 | 3906.40 | 2.68 | 429235.23 | |
| Adult Habilitation Level 2, Outlier (Old) | 15 minutes | 8 | 2961.10 | 3.24 | 76751.71 | |
| Adult Habilitation Level 3 (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Adult Habilitation Level, 3, Outlier (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized Community Supports, Group, Category 1 (New) | 15 minutes | 1524 | 5056.80 | 2.74 | 21115983.17 | |
| Customized Community Supports, Group, Category 2 (New) | 15 minutes | 904 | 5614.50 | 4.10 | 20809582.80 | |
| Customized Community Supports, Group, Community Only (New) | 15 minutes | 126 | 2550.60 | 4.08 | 1311212.45 | |
| Customized Community Supports, Community | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Customized Community Supports, Center | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Fiscal Management of Educational Opportunities (FMEO) | Per Dollar | 300 | 550.00 | 1.03 | 169950.00 | |
| **Living Supports Total:** | | | | | | 177308551.88 |
| Non-Ambulatory Stipend (New) | Day | 197 | 313.30 | 63.49 | 3918609.15 | |
| Supported Living, Level 1, Awake Outlier (Old) | Day | 48 | 265.90 | 85.70 | 1093806.24 | |
| Supported Living, Level 1, Asleep Outlier (Old) | Day | 7 | 218.00 | 156.94 | 239490.44 | |
| Supported Living, Level 2, Awake Oulier (Old) | Day | 6 | 235.00 | 192.92 | 272017.20 | |
| Supported Living, Level 2, Asleep Outlier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Awake Outlier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| | | | | | 0.00 | |
| | | | | GRAND TOTAL: | | 317881141.97 |
| | | | | Total Estimated Unduplicated Participants: | | 4229 |
| | | | | Factor D (Divide total by number of participants): | | 75166.98 |
| | | | | Average Length of Stay on the Waiver: | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Supported Living, Level 3, Asleep Outlier (Old) | Day | 0 | 0.00 | 0.01 | | |
| Supported Living, Level 1, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 2, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 2, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Shared Living | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Shared Living (Intense Behavioral Supports) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Awake (Old) | Day | 183 | 330.60 | 307.62 | 18610948.48 | |
| Supported Living, Level 2, Awake (Old) | Day | 18 | 284.40 | 195.30 | 999779.76 | |
| Supported Living, Level 3, Awake (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Asleep (Old) | Day | 30 | 326.50 | 221.40 | 2168613.00 | |
| Supported Living, Level 2, Asleep (Old) | Day | 15 | 315.80 | 144.50 | 684496.50 | |
| Supported Living, Level 3, Asleep (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Family Living (Old) | Day | 58 | 319.50 | 95.24 | 1764892.44 | |
| Family Living (New) | Day | 1837 | 264.00 | 121.83 | 59083651.44 | |
| Supported Living Category H (New) | Day | 226 | 246.40 | 200.42 | 11160668.29 | |
| Supported Living Category 2 (New) | Day | 388 | 315.50 | 234.40 | 28693841.60 | |
| Supported Living Category 3 (New) | Day | 525 | 313.30 | 295.58 | 48617737.35 | |
| **Personal Support Services Total:** | | | | | | 0.00 |
| Home Visit Day Life Activity | | | | | 0.00 | |
| | | | | **GRAND TOTAL:** | | 317881141.97 |
| | | | | **Total Estimated Unduplicated Participants:** | | 4229 |
| | | | | **Factor D (Divide total by number of participants):** | | 75166.98 |
| | | | | **Average Length of Stay on the Waiver:** | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Hour | 0 | 0.00 | 0.01 | | |
| **Respite Total:** | | | | | | 9003372.72 |
| Respite | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Respite (New) | 15 minutes | 409 | 3387.00 | 4.80 | 6649358.40 | |
| Respite, Group (New) | 15 minutes | 175 | 3387.00 | 2.72 | 1612212.00 | |
| Respite/Substitute Care (Old) | 15 minutes | 56 | 3731.40 | 3.55 | 741802.32 | |
| **Nutritional Counseling Total:** | | | | | | 14002.56 |
| Nutritional Counseling | Visit | 0 | 0.00 | 0.01 | 0.00 | |
| Nutritional Counseling (New) | 15 minutes | 11 | 93.60 | 13.60 | 14002.56 | |
| **Occupational Therapy For Adults Total:** | | | | | | 4368462.78 |
| Occupational Integrated Therapy (Old) | 15 minutes | 156 | 67.20 | 23.99 | 251491.97 | |
| Occupational Therapy Assistant (Certified) (Old) | 15 minutes | 8 | 40.40 | 12.83 | 4146.66 | |
| Occupational Therapy, Clinic Based (Old) | 15 minutes | 151 | 18.30 | 12.94 | 35757.10 | |
| Occupational Integrated Therapy, Exception (Old) | 15 minutes | 133 | 105.40 | 24.03 | 336857.35 | |
| Occupational Therapy Assistant (Certified), Exception (Old) | 15 minutes | 2 | 8.00 | 9.87 | 157.92 | |
| Occupational Therapy, Clinic Based, Exception (Old) | 15 minutes | 61 | 18.30 | 12.89 | 14389.11 | |
| Occupational Therapy, Standard (New) | 15 minutes | 1231 | 100.10 | 24.06 | 2964747.79 | |
| Occupational Therapy, Incentive (New) | 15 minutes | 141 | 100.10 | 30.68 | 433020.59 | |
| Occupational Therapy, Evaluation (New) | Each | 87 | 1.00 | 453.48 | 39452.76 | |
| Certified Occupational Therapy Assistant, Standard (New) | 15 minutes | 28 | 95.90 | 19.79 | 53140.11 | |
| Certified Occupational Therapy Assistant, Incentive (New) | 15 minutes | 55 | 164.80 | 25.96 | 235301.44 | |
| **Physical Therapy For Adults Total:** | | | | | | 4270606.43 |
| | | | | | 311596.74 | |

| | |
|---|---|
| **GRAND TOTAL:** | 317881141.97 |
| **Total Estimated Unduplicated Participants:** | 4229 |
| **Factor D (Divide total by number of participants):** | 75166.98 |
| **Average Length of Stay on the Waiver:** | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Physical Integrated Therapy (Old) | 15 minutes | 170 | 74.60 | 24.57 | | |
| Physical Therapy Assistant (PTA) (Old) | 15 minutes | 3 | 52.00 | 16.31 | 2544.36 | |
| Physical Therapy, Clinic Based (Old) | 15 minutes | 177 | 16.60 | 13.56 | 39841.99 | |
| Physical Therapy (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Physical Integrated Therapy, Exception (Old) | 15 minutes | 126 | 94.90 | 24.51 | 293075.87 | |
| Physical Therapy Assistant (PTA), Exception (Old) | 15 minutes | 1 | 32.00 | 19.96 | 638.72 | |
| Physcial Therapy, Clinic Based, Exception (Old) | 15 minutes | 46 | 14.70 | 13.50 | 9128.70 | |
| Physical Therapy, Standard (New) | 15 minutes | 1215 | 100.10 | 24.06 | 2926213.29 | |
| Physical Therapy, Incentive (New) | 15 minutes | 140 | 100.10 | 30.68 | 429949.52 | |
| Physical Therapy, Evaluation (New) | Each | 75 | 1.00 | 453.49 | 34011.75 | |
| Physical Therapy Assistant (PTA), Standard (New) | 15 minutes | 7 | 100.10 | 19.79 | 13866.85 | |
| Physcial Therapy Assistant (PTA), Incentive (New) | 15 minutes | 47 | 171.90 | 25.96 | 209738.63 | |
| **Speech and Language Therapy For Adults Total:** | | | | | | 6394708.89 |
| Speech Integrated Therapy (Old) | 15 minutes | 242 | 72.60 | 24.46 | 429742.63 | |
| Speech Therapy, Clinic Based (Old) | 15 minutes | 242 | 20.00 | 16.22 | 78504.80 | |
| Speech Integrated Therapy, Exception (Old) | 15minutes | 173 | 88.10 | 24.31 | 370516.00 | |
| Speech Therapy Clinic Based, Exception (Old) | 15 minutes | 84 | 20.50 | 16.27 | 28016.94 | |
| Speech Group Therapy Clinic Based (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Speech Therapy, Standard (New) | 15 minutes | 1968 | 100.10 | 24.03 | 4733833.10 | |
| Speech Therapy, Incentive (New) | 15 minutes | 226 | 100.10 | 30.65 | 693382.69 | |
| Speech Therapy, Evaluation (New) | Each | 134 | 1.00 | 453.08 | 60712.72 | |
| | | | | | | |
| | | | | GRAND TOTAL: | | 317881141.97 |
| | | | | Total Estimated Unduplicated Participants: | | 4229 |
| | | | | Factor D (Divide total by number of participants): | | 75166.98 |
| | | | | Average Length of Stay on the Waiver: | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Supplemental Dental Care Total:** | | | | | | **2850.00** |
| Supplemental Dental Care (Old) | Visit | 0 | 0.00 | 0.01 | **0.00** | |
| Supplemental Dental Care (New) | Visit | 25 | 1.00 | 114.00 | **2850.00** | |
| **Adult Nursing Total:** | | | | | | **3278226.65** |
| Private Duty Nursing, LPN (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Private Duty Nursing, RN (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Nursing, RN (New) | 15 minutes | 2063 | 37.80 | 20.13 | **1569765.58** | |
| Adult Nursing, LPN (New) | 15 minutes | 2063 | 56.80 | 14.58 | **1708461.07** | |
| Residential Habilitation Private Duty Nursing, LPN | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Residential Habilitation Private Duty Nursing, RN | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| **Assistive Technology Total:** | | | | | | **41600.00** |
| Assistive Technology | Each | 160 | 250.00 | 1.04 | **41600.00** | |
| **Behavioral Support Consultation Total:** | | | | | | **7672390.64** |
| Behavior Consultant, Client Location (Old) | 15 minutes | 179 | 110.30 | 20.82 | **411063.83** | |
| Behavior Consultant, Center Based (Old) | 15 minutes | 176 | 60.30 | 12.33 | **130855.82** | |
| Behavior Consultant, Center Based, Exception (Old) | 15 minutes | 15 | 26.90 | 12.41 | **5007.44** | |
| Behavior Consultant, Client Location, Exception (Old) | 15 minutes | 32 | 60.70 | 21.00 | **40790.40** | |
| Behavioral Support Consultation, Standard (New) | 15 minutes | 1715 | 148.50 | 19.22 | **4894901.55** | |
| Behavioral Support Consultation, Incentive (New) | 15 minutes | 583 | 148.50 | 24.81 | **2147938.16** | |
| Behavioral Support Consultation, Evaluation (New) | Each | 114 | 1.00 | 366.96 | **41833.44** | |
| **Crisis Support Total:** | | | | | | **882517.67** |
| Tier III Crisis (Support in Alternative Residential Setting) (Old) | Day | 0 | 0.00 | 0.01 | **0.00** | |
| | | | | | **0.00** | |
| | | | **GRAND TOTAL:** | | | **317881141.97** |
| | | | **Total Estimated Unduplicated Participants:** | | | **4229** |
| | | | **Factor D (Divide total by number of participants):** | | | **75166.98** |
| | | | **Average Length of Stay on the Waiver:** | | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Tier III Crisis (Support in Individual's Residence) (Old) | 15 minutes | 0 | 0.00 | 0.01 | | |
| Tier III Crisis (Support in Alternative Residential Setting) (New) | Day | 12 | 122.90 | 365.71 | 539349.11 | |
| Tier III Crisis (Support in Individual's Residence) (New) | 15 minutes | 10 | 3578.40 | 9.59 | 343168.56 | |
| Crisis Support | Day | 0 | 0.00 | 0.01 | 0.00 | |
| **Customized In-Home Supports Total:** | | | | | | 10747362.83 |
| Customized In-Home Supports | 15 minutes | 304 | 3642.30 | 6.79 | 7518289.97 | |
| Independent Living (Old) | Month | 3 | 10.70 | 1773.30 | 56922.93 | |
| Intensive Independent Living (Old) | Month | 1 | 12.00 | 2726.90 | 32722.80 | |
| Customized In-Home Supports, Living Independently (2 clients) (New) | 15 minutes | 39 | 3257.50 | 2.74 | 348096.45 | |
| Customized In-Home Supports, Living Independently (3 clients) (New) | 15 minutes | 12 | 769.90 | 4.10 | 37879.08 | |
| Customized In-Home Supports, Living with Natural Supports (New) | 15 minutes | 87 | 4661.10 | 6.79 | 2753451.60 | |
| **Environmental Modifications Total:** | | | | | | 359646.37 |
| Environmental Modifications | Each | 10 | 458.90 | 9.77 | 44834.53 | |
| Environmental Modifications (New) | Each | 70 | 474.40 | 9.48 | 314811.84 | |
| **Independent Living Transition Service Total:** | | | | | | 249600.00 |
| Independent Living Transition (New) | Each | 160 | 1500.00 | 1.04 | 249600.00 | |
| **Intense Medical Living Supports Total:** | | | | | | 6295901.22 |
| Intense Medical Living Supports | Day | 42 | 339.00 | 442.19 | 6295901.22 | |
| **Non-Medical Transportation Total:** | | | | | | 440412.16 |
| Non-Medical Transportation Pass/Ticket (Old) | Item | 0 | 0.00 | 0.01 | 0.00 | |
| Non-Medical Transportation Per Mile (Old) | Per Mile | 12 | 2381.50 | 0.32 | 9144.96 | |
| | | | | | 49435.06 | |

| | |
|---|---|
| **GRAND TOTAL:** | 317881141.97 |
| **Total Estimated Unduplicated Participants:** | 4229 |
| **Factor D (Divide total by number of participants):** | 75166.98 |
| **Average Length of Stay on the Waiver:** | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Non-Medical Transportation Pass/Ticket (New) | Item | 88 | 556.20 | 1.01 | | |
| Non-Medical Transportation Per Mile (New) | Per Mile | 313 | 3696.70 | 0.33 | 381832.14 | |
| **Personal Support Technology/On-Site Response Service Total:** | | | | | | 1927487.30 |
| Personal Technology/On-site Response (New) | Day | 214 | 365.00 | 10.43 | 814687.30 | |
| Personal Technology/On-site Response (Installation) (New) | Each | 214 | 5000.00 | 1.04 | 1112800.00 | |
| **Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior Total:** | | | | | | 138274.24 |
| Preliminary Risk Screening, Incentive (New) | 15 minutes | 96 | 52.00 | 26.62 | 132887.04 | |
| Preliminary Risk Screening, Standard (New) | 15 minutes | 5 | 52.00 | 20.72 | 5387.20 | |
| Preliminary Risk Screening, Individual | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Preliminary Risk Screening, Integrated | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| **Socialization and Sexuality Education Total:** | | | | | | 435483.06 |
| Socialization and Sexuality Education, Incentive (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| Socialization and Sexuality Education, Standard (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| Socialization and Sexuality Individual | Series | 5 | 1.00 | 708.00 | 3540.00 | |
| Socialization and Sexuality Classes | Series | 318 | 3.21 | 423.15 | 431943.06 | |
| | | | | **GRAND TOTAL:** | | 317881141.97 |
| | | | | **Total Estimated Unduplicated Participants:** | | 4229 |
| | | | | **Factor D (Divide total by number of participants):** | | 75166.98 |
| | | | | **Average Length of Stay on the Waiver:** | | 347 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (9 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **13395805.11** |
| Case Management, On-Going (Old) | Month | 297 | 11.90 | 264.87 | **936130.04** | |
| Case Management, On-going (New) | Month | 4056 | 11.60 | 264.82 | **12459675.07** | |
| **Community Integrated Employment Total:** | | | | | | |
| Supported Employment Job Developer (Old) | Each | 0 | 0.00 | 0.01 | **0.00** | |
| Supported Employment, Level 1, Group (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Supported Employment, Level 2, Group (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Supported Employment, Level 3, Group (Old) | 15 minutes | 1 | 6246.00 | 2.04 | **12741.84** | |
| Supported Employment/Self-Employment (Old) | 15 minutes | 3 | 777.30 | 6.63 | **15460.50** | |
| Supported Employment, Individual (Old) | Hour | 38 | 26.60 | 204.64 | **206850.11** | |
| Supported Employment, Intensive (Old) | Hour | 22 | 255.40 | 37.61 | **211323.07** | |
| Supported Employment, Level 1, Group, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Supported Employment, Level 2, Group, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Supported Employment, Level 3, Group, Exception (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Supported Employment, Individual, Exception (Old) | Hour | 24 | 21.50 | 204.91 | **105733.56** | |
| Supported Employment, Intensive, Exception (Old) | Hour | 20 | 293.80 | 34.56 | **203074.56** | |
| Supported Employment Job Development (New) | 15 minutes | 138 | 223.60 | 9.13 | **281722.58** | |
| Supported Employment Job Aide (New) | Hour | 154 | 79.80 | 17.91 | **220099.57** | |
| Supported Employment, Group, Category 1 (New) | 15 minutes | 239 | 3185.80 | 1.98 | **1507584.28** | |
| Supported Employment, Group, Category 2 (New) | 15 minutes | 21 | 2000.90 | 2.99 | **125636.51** | |
| Supported Employment, Individual Job Maintenance (New) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| | | | | | **54228.69** | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | **4356** |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Supported Employment/Self Employment (New) | 15 minutes | 14 | 574.70 | 6.74 | | |
| Supported Employment, Intensive (New) | | | | | | |
| Supported Employment-Individual Job Maintenence Per Month | | | | | | |
| **Customized Community Supports Total:** | | | | | | **65907683.53** |
| Customized Community Supports, Individual (New) | 15 minutes | 1164 | 1605.60 | 7.12 | **13306699.01** | |
| Customized Community Supports, Individual, Intense Behavioral Supports (New) | 15 minutes | 89 | 3635.30 | 8.36 | **2704808.61** | |
| Community Access (Old) | 15 minutes | 38 | 1380.80 | 5.97 | **313248.29** | |
| Community Inclusion Aide (New) | Hour | 233 | 169.20 | 18.25 | **719480.70** | |
| Adult Habilitation Level 1 (Old) | 15 minutes | 238 | 4681.50 | 3.75 | **4178238.75** | |
| Adult Habilitation Level 1, Outlier (Old) | 15 minutes | 69 | 4014.20 | 2.21 | **612125.36** | |
| Adult Habilitation Level 2 (Old) | 15 minutes | 41 | 3906.40 | 2.68 | **429235.23** | |
| Adult Habilitation Level 2, Outlier (Old) | 15 minutes | 8 | 2961.10 | 3.24 | **76751.71** | |
| Adult Habilitation Level 3 (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Habilitation Level, 3, Outlier (Old) | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Customized Community Supports, Group, Category 1 (New) | 15 minutes | 1573 | 4766.60 | 2.74 | **20544141.33** | |
| Customized Community Supports, Group, Category 2 (New) | 15 minutes | 934 | 5614.50 | 4.10 | **21500166.30** | |
| Customized Community Supports, Group, Community Only (New) | 15 minutes | 130 | 2550.60 | 4.08 | **1352838.24** | |
| Customized Community Supports, Community | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Customized Community Supports, Center | 15 minutes | 0 | 0.00 | 0.01 | **0.00** | |
| Fiscal Management of Educational Opportunities (FMEO) | Per Dollar | 300 | 550.00 | 1.03 | **169950.00** | |
| **Living Supports Total:** | | | | | | **177401920.90** |
| | | | | | | |
| | | | **GRAND TOTAL:** | | | |
| | | | **Total Estimated Unduplicated Participants:** | | | **4356** |
| | | | **Factor D (Divide total by number of participants):** | | | |
| | | | **Average Length of Stay on the Waiver:** | | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Non-Ambulatory Stipend (New) | Day | 202 | 313.30 | 63.49 | 4018066.23 | |
| Supported Living, Level 1, Awake Outlier (Old) | Day | 48 | 265.90 | 85.70 | 1093806.24 | |
| Supported Living, Level 1, Asleep Outlier (Old) | Day | 7 | 218.00 | 156.94 | 239490.44 | |
| Supported Living, Level 2, Awake Oulier (Old) | Day | 6 | 235.00 | 192.92 | 272017.20 | |
| Supported Living, Level 2, Asleep Outlier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Awake Outlier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Asleep Outlier (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 2, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 2, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Awake (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 3, Asleep (Intense Behavioral Supports) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Shared Living | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Shared Living (Intense Behavioral Supports) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Awake (Old) | Day | 183 | 330.60 | 307.62 | 18610948.48 | |
| Supported Living, Level 2, Awake (Old) | Day | 18 | 284.40 | 195.30 | 999779.76 | |
| Supported Living, Level 3, Awake (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Supported Living, Level 1, Asleep (Old) | Day | 30 | 326.50 | 221.40 | 2168613.00 | |
| Supported Living, Level 2, Asleep (Old) | Day | 15 | 315.80 | 144.50 | 684496.50 | |
| Supported Living, Level 3, Asleep (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| | | | | | | |
| | | | GRAND TOTAL: | | | |
| | | | Total Estimated Unduplicated Participants: | | | 4356 |
| | | | Factor D (Divide total by number of participants): | | | |
| | | | Average Length of Stay on the Waiver: | | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Family Living (Old) | Day | 58 | 319.50 | 95.24 | 1764892.44 | |
| Family Living (New) | Day | 1611 | 322.10 | 121.83 | 63217964.67 | |
| Supported Living Category H (New) | Day | 76 | 300.50 | 200.42 | 4577191.96 | |
| Supported Living Category 2 (New) | Day | 401 | 315.50 | 234.40 | 29655233.20 | |
| Supported Living Category 3 (New) | Day | 541 | 313.30 | 295.58 | 50099420.77 | |
| **Personal Support Services Total:** | | | | | | 0.00 |
| Home Visit Day Life Activity | Hour | 0 | 0.00 | 0.01 | 0.00 | |
| **Respite Total:** | | | | | | 10303351.73 |
| Respite | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Respite (New) | 15 minutes | 422 | 3797.40 | 4.80 | 7692013.44 | |
| Respite, Group (New) | 15 minutes | 181 | 3797.40 | 2.72 | 1869535.97 | |
| Respite/Substitute Care (Old) | 15 minutes | 56 | 3731.40 | 3.55 | 741802.32 | |
| **Nutritional Counseling Total:** | | | | | | 14002.56 |
| Nutritional Counseling | Visit | 0 | 0.00 | 0.01 | 0.00 | |
| Nutritional Counseling (New) | 15 minutes | 11 | 93.60 | 13.60 | 14002.56 | |
| **Occupational Therapy For Adults Total:** | | | | | | 4493413.46 |
| Occupational Integrated Therapy (Old) | 15 minutes | 156 | 67.20 | 23.99 | 251491.97 | |
| Occupational Therapy Assistant (Certified) (Old) | 15 minutes | 8 | 40.40 | 12.83 | 4146.66 | |
| Occupational Therapy, Clinic Based (Old) | 15 minutes | 151 | 18.30 | 12.94 | 35757.10 | |
| Occupational Integrated Therapy, Exception (Old) | 15 minutes | 133 | 105.40 | 24.03 | 336857.35 | |
| Occupational Therapy Assistant (Certified), Exception (Old) | 15 minutes | 2 | 8.00 | 9.87 | 157.92 | |
| Occupational Therapy, Clinic Based, Exception (Old) | 15 minutes | 61 | 18.30 | 12.89 | 14389.11 | |
| | | | | | 3061084.03 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 4356 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Occupational Therapy, Standard (New) | 15 minutes | 1271 | 100.10 | 24.06 | | |
| Occupational Therapy, Incentive (New) | 15 minutes | 146 | 100.10 | 30.68 | 448375.93 | |
| Occupational Therapy, Evaluation (New) | Each | 89 | 1.00 | 453.48 | 40359.72 | |
| Certified Occupational Therapy Assistant, Standard (New) | 15 minutes | 30 | 95.90 | 19.79 | 56935.83 | |
| Certified Occupational Therapy Assistant, Incentive (New) | 15 minutes | 57 | 164.80 | 25.96 | 243857.86 | |
| **Physical Therapy For Adults Total:** | | | | | | 4386650.56 |
| Physical Integrated Therapy (Old) | 15 minutes | 170 | 74.60 | 24.57 | 311596.74 | |
| Physical Therapy Assistant (PTA) (Old) | 15 minutes | 3 | 52.00 | 16.31 | 2544.36 | |
| Physical Therapy, Clinic Based (Old) | 15 minutes | 177 | 16.60 | 13.56 | 39841.99 | |
| Physical Therapy (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Physical Integrated Therapy, Exception (Old) | 15 minutes | 126 | 94.90 | 24.51 | 293075.87 | |
| Physical Therapy Assistant (PTA), Exception (Old) | 15 minutes | 1 | 32.00 | 19.96 | 638.72 | |
| Physcial Therapy, Clinic Based, Exception (Old) | 15 minutes | 46 | 14.70 | 13.50 | 9128.70 | |
| Physical Therapy, Standard (New) | 15 minutes | 1254 | 100.10 | 24.06 | 3020141.12 | |
| Physical Therapy, Incentive (New) | 15 minutes | 144 | 100.10 | 30.68 | 442233.79 | |
| Physical Therapy, Evaluation (New) | Each | 77 | 1.00 | 453.49 | 34918.73 | |
| Physical Therapy Assistant (PTA), Standard (New) | 15 minutes | 7 | 100.10 | 19.79 | 13866.85 | |
| Physcial Therapy Assistant (PTA), Incentive (New) | 15 minutes | 49 | 171.90 | 25.96 | 218663.68 | |
| **Speech and Language Therapy For Adults Total:** | | | | | | 6569538.05 |
| Speech Integrated Therapy (Old) | 15 minutes | 242 | 72.60 | 24.46 | 429742.63 | |
| Speech Therapy, Clinic Based (Old) | 15 minutes | 242 | 20.00 | 16.22 | 78504.80 | |
| Speech Integrated Therapy, Exception (Old) | | | | | 370516.00 | |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 4356 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | 15 minutes | 173 | 88.10 | 24.31 | | |
| Speech Therapy Clinic Based, Exception (Old) | 15 minutes | 84 | 20.50 | 16.27 | 28016.94 | |
| Speech Group Therapy Clinic Based (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Speech Therapy, Standard (New) | 15 minutes | 2031 | 100.10 | 24.03 | 4885373.49 | |
| Speech Therapy, Incentive (New) | 15 minutes | 233 | 100.10 | 30.65 | 714859.14 | |
| Speech Therapy, Evaluation (New) | Each | 138 | 1.00 | 453.08 | 62525.04 | |
| **Supplemental Dental Care Total:** | | | | | | 2850.00 |
| Supplemental Dental Care (Old) | Visit | 0 | 0.00 | 0.01 | 0.00 | |
| Supplemental Dental Care (New) | Visit | 25 | 1.00 | 114.00 | 2850.00 | |
| **Adult Nursing Total:** | | | | | | 2930222.95 |
| Private Duty Nursing, LPN (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Private Duty Nursing, RN (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Adult Nursing, RN (New) | 15 minutes | 1844 | 37.80 | 20.13 | 1403125.42 | |
| Adult Nursing, LPN (New) | 15 minutes | 1844 | 56.80 | 14.58 | 1527097.54 | |
| Residential Habilitation Private Duty Nursing, LPN | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Residential Habilitation Private Duty Nursing, RN | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| **Assistive Technology Total:** | | | | | | 42900.00 |
| Assistive Technology | Each | 165 | 250.00 | 1.04 | 42900.00 | |
| **Behavioral Support Consultation Total:** | | | | | | 7900009.13 |
| Behavior Consultant, Client Location (Old) | 15 minutes | 179 | 110.30 | 20.82 | 411063.83 | |
| Behavior Consultant, Center Based (Old) | 15 minutes | 176 | 60.30 | 12.33 | 130855.82 | |
| Behavior Consultant, Center Based, Exception (Old) | 15 minutes | 15 | 26.90 | 12.41 | 5007.44 | |
| | 15 minutes | | | | 40790.40 | |
| | | | | **GRAND TOTAL:** | | |
| | | | | **Total Estimated Unduplicated Participants:** | | 4356 |
| | | | | **Factor D (Divide total by number of participants):** | | |
| | | | | **Average Length of Stay on the Waiver:** | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Behavior Consultant, Client Location, Exception (Old) | | 32 | 60.70 | 21.00 | | |
| Behavioral Support Consultation, Standard (New) | 15 minutes | 1771 | 148.50 | 19.22 | 5054735.07 | |
| Behavioral Support Consultation, Incentive (New) | 15 minutes | 601 | 148.50 | 24.81 | 2214255.28 | |
| Behavioral Support Consultation, Evaluation (New) | Each | 118 | 1.00 | 366.96 | 43301.28 | |
| **Crisis Support Total:** | | | | | | 927463.43 |
| Tier III Crisis (Support in Alternative Residential Setting) (Old) | Day | 0 | 0.00 | 0.01 | 0.00 | |
| Tier III Crisis (Support in Individual's Residence) (Old) | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Tier III Crisis (Support in Alternative Residential Setting) (New) | Day | 13 | 122.90 | 365.71 | 584294.87 | |
| Tier III Crisis (Support in Individual's Residence) (New) | 15 minutes | 10 | 3578.40 | 9.59 | 343168.56 | |
| Crisis Support | Day | 0 | 0.00 | 0.01 | 0.00 | |
| **Customized In-Home Supports Total:** | | | | | | 11100555.06 |
| Customized In-Home Supports | 15 Minutes | 315 | 3642.30 | 6.79 | 7790333.36 | |
| Independent Living (Old) | Month | 3 | 10.70 | 1773.30 | 56922.93 | |
| Intensive Independent Living (Old) | Month | 1 | 12.00 | 2726.90 | 32722.80 | |
| Customized In-Home Supports, Living Independently (2 clients) (New) | 15 minutes | 41 | 3257.50 | 2.74 | 365947.55 | |
| Customized In-Home Supports, Living Independently (3 clients) (New) | 15 minutes | 12 | 769.90 | 4.10 | 37879.08 | |
| Customized In-Home Supports, Living with Natural Supports (New) | 15 minutes | 89 | 4661.10 | 6.79 | 2816749.34 | |
| **Environmental Modifications Total:** | | | | | | 368640.99 |
| Environmental Modifications | Each | 10 | 458.90 | 9.77 | 44834.53 | |
| Environmental Modifications (New) | Each | 72 | 474.40 | 9.48 | 323806.46 | |
| **Independent Living Transition Service Total:** | | | | | | 257400.00 |

| | |
|---|---|
| **GRAND TOTAL:** | |
| **Total Estimated Unduplicated Participants:** | 4356 |
| **Factor D (Divide total by number of participants):** | |
| **Average Length of Stay on the Waiver:** | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Independent Living Transition (New) | Item | 165 | 1500.00 | 1.04 | 257400.00 | |
| **Intense Medical Living Supports Total:** | | | | | | 6745608.45 |
| Intense Medical Living Supports | Day | 45 | 339.00 | 442.19 | 6745608.45 | |
| **Non-Medical Transportation Total:** | | | | | | 455516.47 |
| Non-Medical Transportation Pass/Ticket (Old) | Item | 0 | 0.00 | 0.01 | 0.00 | |
| Non-Medical Transportation Per Mile (Old) | Per Mile | 12 | 2381.50 | 0.32 | 9144.96 | |
| Non-Medical Transportation Pass/Ticket (New) | Item | 91 | 556.20 | 1.01 | 51120.34 | |
| Non-Medical Transportation Per Mile (New) | Per Mile | 324 | 3696.70 | 0.33 | 395251.16 | |
| **Personal Support Technology/On-Site Response Service Total:** | | | | | | 1990535.95 |
| Personal Technology/On-site Response (New) | Day | 221 | 365.00 | 10.43 | 841335.95 | |
| Personal Technology/On-site Response (Installation) (New) | Each | 221 | 5000.00 | 1.04 | 1149200.00 | |
| **Preliminary Risk Screening and Consultation Related To Inappropriate Sexual Behavior Total:** | | | | | | 137039.76 |
| Preliminary Risk Screening, Incentive (New) | 15 minutes | 99 | 52.00 | 26.62 | 137039.76 | |
| Preliminary Risk Screening, Standard (New) | 15 minutes | 0 | 52.00 | 20.72 | 0.00 | |
| Preliminary Risk Screening, Individual | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| Preliminary Risk Screening, Integrated | 15 minutes | 0 | 0.00 | 0.01 | 0.00 | |
| **Socialization and Sexuality Education Total:** | | | | | | 424997.40 |
| Socialization and Sexuality Education, Incentive (New) | Each | 0 | 0.00 | 708.00 | 0.00 | |
| Socialization and Sexuality Education, Standard (New) | Each | 0 | 0.00 | 0.01 | 0.00 | |
| Socialization and Sexuality Individual | Series | 5 | 1.00 | 708.00 | 3540.00 | |
| Socialization and Sexuality Classes | | | | | 421457.40 | |
| | | | | **GRAND TOTAL:** | | |
| | | | | **Total Estimated Unduplicated Participants:** | | 4356 |
| | | | | **Factor D (Divide total by number of participants):** | | |
| | | | | **Average Length of Stay on the Waiver:** | | 347 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Series | 332 | 3.00 | 423.15 | | |
| | | | | GRAND TOTAL: | | |
| | | | | Total Estimated Unduplicated Participants: | | 4356 |
| | | | | Factor D (Divide total by number of participants): | | |
| | | | | Average Length of Stay on the Waiver: | | 347 |