

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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
There is one significant change being made in this renewal application. New Mexico is adding "Specialized Medical Equipment and Supplies" to its list of waiver services. This service has an individual limit of \$1,000, per ISP year.

Also, it should be noted that although not a significant change, the approved service of Psychosocial Counseling has been renamed Behavior Support Consultation and the service specifications have been modified.

Both services have been listed as "Other Service" in Appendices C-1/C-3.

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*):
Medically Fragile Renewal Waiver
- C. Type of Request: renewal

Migration Waiver - this is an existing approved waiver

Renewal of Waiver:

Provide the information about the original waiver being renewed

Base Waiver Number: 0223

Amendment Number

(if applicable):

Effective Date: (mm/dd/yy) 07/01/05

Waiver Number: ~~NM.0223.R04.00~~

Draft ID: NM.17.04.00

Renewal Number: 04

D. Type of Waiver (select only one):

Regular Waiver

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

Approved Effective Date: 07/01/10

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

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

Nursing Facility

Select applicable level of care

Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

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

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.

This application is to renew the New Mexico Medically Fragile Waiver (MF Waiver), a program administered through a partnership between the Human Services Department (HSD) and the Department of Health/Developmental Disabilities Supports Division (DOH/DDSD). The New Mexico MF Waiver is a Medicaid home and community-based services (HCBS) waiver program which has been available since 1984.

Purpose of Waiver: The New Mexico MF Waiver program serves individuals of all ages who are eligible for services prior to their 22nd birthday based on the determination that they have a medically fragile condition and a developmental disability or are developmentally delayed or at risk for developmental delay and meet ICF/MR criteria. The program is designed to keep medically fragile individuals with conditions that require frequent and ongoing medical supervision out of institutions.

The MF Waiver is bound by the cost-effectiveness mandate of Federal authorization: the total cost for services cannot exceed the cost of institutional care. MF Waiver services are to be combined with informal supports of family, friends, community programs and other funding sources to help contain costs. The participant's budget is based on a capped dollar amount (CDA) for each assessed level of care determination. The State sets specific dollar amounts of services and supports that can be offered based on an individual's age and assessed level of support need.

Goals of the MF Waiver: 1) Continue to maintain participants in a safe and comfortable home environment; 2) Maximize the level of functioning of waiver participants; 3) Continue to provide participants with timely and consistent waiver services.

Roles of State, local, and other entities: The State secures public input into the development and management of the MF Waiver through a variety of committees and methods. The Joint Powers Agreement (JPA) between HSD and DOH articulates provisions for operating the waiver for which HSD holds DOH accountable. Service quality is reviewed and improved through ongoing feedback from the Developmental Disabilities Services Quality Improvement (DDSQI) Steering Committee. Each participant receives services as indicated on an Individual Service Plan (ISP) which are overseen by the case management agency.

Service Delivery Methods: This waiver program uses traditional service delivery methods.

Throughout this application, the term "participant/participant representative" refers to waiver participants. As it is common that the participant is a minor, the representative includes a parent, legal guardian, or other legal representative deemed necessary by the State.

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 inpatients of a hospital, nursing facility or ICF/MR.
- 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 State secures public input on the development of the MF Waiver renewal through a variety of committees and methods. Input is received from the following: the Family Advisory Board (FAB); Home Health Agency Providers; the Professional Advisory Committee (PAC); the Managed Care Organizations (MCO) and fee-for-service providers; the Strategic Planning Committee; and the DOH/DDSD website that includes an email address for public communication. The FAB is a group of participants and families that meet at least every six (6) months. The meeting is held in Albuquerque, New Mexico but the families may also attend via videoconference from multiple sites throughout the state. This board recently contributed their input by reviewing and revising the Rights and Responsibilities which are reviewed and signed by the participant/participant representative initially and annually. The PAC meets at least annually to learn about the current successes and problems encountered and to make recommendations. This committee is comprised of: nursing educators; community physicians; MCO and fee-for-service representatives; staff from the Center for Developmental Disabilities (CDD); case managers; the Medically Fragile Waiver Manager; representatives from the Human Services Department (HSD); the UNM Case Management Program (UNMCMP) Operations Director; and others as identified as needed. The Strategic Planning Committee was formed to address whether the current system of care has sufficient statewide service delivery capacity to support individuals who are medically fragile and their families. The MCOs and fee-for-service providers have provided input as needed. The most recent example of their active participation working with the MF Waiver is the parameter project. This project brings together the MF Waiver Manager, the UNMCMP Operations Director, HSD and DOH/DDSD representatives, MCO and fee-for-services representatives, case managers, and physicians to review, revise, and update the parameters used to determine the Level of Care for each participant receiving MF Waiver, EPSDT, and/or MCO services. DDSD maintains a web address for anyone to communicate concerns, recommendations, and inquiries about the MF Waiver services. The web address is reviewed each work day and the inquiry is forwarded to the appropriate agency for action. Additional committees will be developed to address specific needs that may arise.
- 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: Barth
First Name: Sarah
Title: Bureau Chief, Long-Term Services and Support
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) 827-3185
E-mail: Sarah.Barth@state.nm.us

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

Last Name: Thorne-Lehman
First Name: Jennifer
Title: Deputy Director, Developmental Disabilities Supports Division
Agency: Department of Health
Address: 5301 San Mateo N.E., Suite 1100
Address 2:
City: Albuquerque
State: New Mexico
Zip: 87108
Phone: (505) 222-6693 **Ext:** TTY
Fax: (505) 222-6690
E-mail: Jennifer.Thorne-Lehman@state.nm.us

8. Authorizing Signature

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

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

Signature:
 State Medicaid Director or Designee

Submission Date:	May 7, 2010
Last Name:	Ingram
First Name:	Carolyn
Title:	Director, Medical Assistance Division
Agency:	Human Services Department
Address:	2025 S. Pacheco
Address 2:	P.O. Box 2348
City:	Santa Fe
State:	New Mexico
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Phone:	(505) 827-3106
Fax:	(505) 827-3185
E-mail:	Carolyn.Ingram@state.nm.us

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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:

Department of Health (DOH)/Developmental Disabilities Services Division (DDSD) operates the Medically Fragile (MF) Waiver, and Human Services Department/Medical Assistance Division (HSD/MAD) is responsible for the oversight of the waiver. DOH monitors program quality and compliance with program requirements through participation in the DOH/Developmental Disabilities Services Quality Improvement (DDSQI) Steering Committee as described in Appendix H of this application. As part of this process, DOH collects and aggregates data including: number of participants served; number of services and supports offered; number of providers participating; number, types and resolutions of participant complaints and fair hearings; number, types and resolutions of critical incidents reported; whether level of care (LOC) reviews have been conducted and approved as required; whether service and support plans and budgets are completed and authorized, as required; and whether Freedom of Choice (FOC) has been provided, as requested.

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

- The Joint Powers Agreement (JPA) between HSD and DOH sets forth provisions for operating the MF Waiver, for which HSD holds DOH accountable for various responsibilities relative to this application. HSD/MAD monitors DOH for compliance with the JPA, to ensure that DOH has fulfilled its

operational responsibilities and performed the functions listed in the section A-7 chart. HSD/MAD monitors these activities, in part, through monthly meetings and provides access to Medicaid data to the DOH for its use as described above. As part of its oversight, HSD requires DOH to report on waiver activities at these monthly meetings. For any area of non-compliance, DOH is required to submit a plan of correction to HSD.

- As explained in Appendix H, HSD/MAD also oversees DOH's operational responsibilities through the DDSQI Steering Committee which reviews the MF 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. HSD's role is to attend all DDSQI Steering Committee meetings, receive the reports, and ensure program improvements and action plan activities are completed.

- 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 MF 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.

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 entity referenced in A-7 refers to the Third-Party Assessor (TPA) 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 participants transferring from existing waivers. 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.

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 assesses the Contractor's performance in conducting its respective waiver operational and administrative functions based on the 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 participant 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.

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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Performance Measure:

The number and percent of delegated functions specified in the JPA with which DOH is compliant. Numerator: Number of delegated functions that DOH is compliant with on an annual basis. Denominator: All delegated functions identified in the JPA as the responsibility of DOH.

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

Performance Measure:

The number and percent of delegated functions specified as contractual requirements in the TPA contract with which the TPA Contractor is compliant. Numerator: Number of contractual requirements that the TPA Contractor is compliant with on an annual basis. Denominator: All contractual requirements identified in the contract as the responsibility of the TPA Contractor.

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

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

Performance Measure:

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 50px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100px;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	

Data Source (Select one):

Trends, remediation actions proposed / taken

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

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

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, review of actions taken by the operating agency, and a separate annual formal JPA review. In addition, 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.

b. Methods for Remediation/Fixing Individual Problems

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

Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement related to HSD/MAD’s administrative authority are identified by HSD/MAD, processes are in place to ensure that appropriate and timely action is taken whether the situation is in regard to participants, providers and vendors of services and supports, contractors, or the State'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 problem 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.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 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 a group 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 waiver target group, check each of the subgroups in the selected target group 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					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
⊙ Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Medically Fragile	0		<input checked="" type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
⊙ Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
⊙ Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

In addition to the Aged or Disabled, or Both - Specific Recognized Subgroups target group indicated in B-1.a. above, the individual must: 1) have a developmental disability (according to the New Mexico state definition; and 2) meet ICF/MR level of care; and 3) have a medically fragile condition that meets the definition below; and 4) meet financial eligibility. An individual must meet all four (4) criteria to be eligible for this waiver.

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

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

Developmental disability is defined as a severe chronic disability, other than mental illness that: a) is attributable to a mental or physical impairment, including the result of trauma to the brain or a combination of mental and physical impairment; b) is manifested before the person reaches the age of twenty-two (22); c) is expected to continue indefinitely; d) results in a substantial functional limitation in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, and economic self-sufficiency; and e) reflects the person’s need for a combination and sequence of special or interdisciplinary treatment, generic or other support and services that are of lifelong or extended duration and are individually planned and coordinated.

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	225
Year 2	250
Year 3	275
Year 4 (renewal only)	300
Year 5 (renewal only)	325

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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:

It is the policy of the DOH/DDSD MF Waiver program to consider all applications to the MF Waiver, but only applicants who meet the Pre-Assessment Screening Tool determination and who are deemed potentially eligible are placed on the Central Registry. As stated in Appendix B-1-b, to be eligible for the MF Waiver, an applicant/recipient must meet the level of care required for medical fragility and for admission to an ICF/MR and meet all other applicable financial and non-financial eligibility requirements. Regulations are found at 8.100.130 NMAC and 8.290.400 NMAC.

The process for the selection of entrants to the waiver is:

1. Individual completes and submits an application. At this point, he/she can apply for ICF/MR placement, the MF Waiver or both.
2. If the individual checked the box on the application for the MF Waiver, a pre-assessment determination is completed to make sure the individual has a developmental disability and a medically fragile condition (this is considered a screening and is not determination of eligibility). At this point, level of care is NOT assessed and eligibility is NOT confirmed. If the individual does not have a developmental disability or does not have a medically fragile condition, he/she is referred to a more appropriate resource and closed on the Central Registry. If the individual does have a developmental disability and a medically fragile condition, then he/she is placed on the Central Registry until an opening on the MF Wwaiver becomes available.
3. Once funding becomes available on the MF Waiver, an "allocation" letter is sent to the next individual at the top of the Central Registry – by date of application. At this point, the individual is offered the choice between the MF Waiver and ICF/MR placement again but also given the choice to select the Mi Via Waiver. If the individual picks Mi Via – the eligibility determination process proceeds according to that Waiver. If the individual picks the MF Waiver, then the eligibility determination process begins for both medical/clinical and financial criteria. Eligibility is not confirmed at this point.
4. For the individual that selects the MF Waiver, the completed LOC packet is submitted to the TPA Contractor for verification of clinical/medical eligibility and the family works with ISD to confirm financial eligibility. Once both

are confirmed, the individual is officially eligible - the family and case manager then proceed to the service planning phase.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State
 SSI Criteria State
 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No
 Yes

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act
 SSI recipients
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
 Optional State supplement recipients
 Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

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

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA 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:

- 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 LOC for MF Waiver applicants include licensed physicians, physician assistants, clinical nurse practitioners, and registered nurses. If a registered nurse completes the Medically Fragile Long-Term Care Assessment Abstract (DOH 378), then a licensed physician, physician assistant or clinical nurse practitioner is required to review and sign upon approval.

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

The ICF/MR LOC criteria are consistent with CFR 435.1009. The Medically Fragile Long-Term Care Assessment Abstract (LTCAA-DOH 378) includes not only the ICF/MR eligibility criteria but also the criteria for medical fragility, as measured in the LOC determination. To be eligible for the MF Waiver program, participants must meet both the ICF/MR LOC criteria and the medical fragility criteria. The nurse reviewer applies the information derived from the assessment instrument against the ICF/MR LOC.

The ICF/MR LOC criteria is comprised of these factors:

Sensory Motor Development:

Mobility –Capacity for mobility appropriate to the participant's developmental age; not limited to ambulation.

Toileting –Ability of participant to toilet him/herself appropriate to his/her developmental age.

Hygiene –Ability to perform hygiene skills appropriate to his/her developmental age.

Dressing –Ability to dress him/herself appropriate to his/her developmental age.

Affective Development: Ability to express his/her emotions.

Speech & Language Development:

Expressive –Ability of participant to communicate with others appropriate to his/her developmental age

Receptive –Ability to comprehend what is said to him/her appropriate to his/her developmental age

Auditory Functioning: Ability to hear and/or benefit from a hearing device.

Cognitive Development: Ability to reason, remember, problem solve or transfer skills.

Social Development:

Interpersonal –Ability to establish relationships.

Social Participation –Ability to participate in social and recreational activities.

Independent Living Skills:

Interpersonal –Ability to perform household skills.

Community Skills –Ability to participate in community activities utilizing skills such as street survival, money exchange, ordering in restaurants, running errands and attending recreational events.

Adaptive Behaviors:

Harmful Behaviors –Behaviors the participant exhibits that are harmful to him/herself or others and require staff intervention.

Disruptive Behaviors –Behaviors the participant exhibits that are disruptive to others and require staff intervention.

Socially Unacceptable, Stereotypic Behaviors–Socially unacceptable behaviors the participant exhibits such as inappropriate touching, fondling or masturbation, inappropriate kissing, licking, squeezing or hugging others, talking to close to other faces, directing profane, hostile language at others, refusing to wear clothing or object attachment.

Uncooperative Behaviors –Uncooperative behaviors the participant exhibits which require staff intervention.

- 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:

The Medically Fragile Case Manager (MFCM) is a registered nurse who initiates the Level of Care (LOC) evaluation packet consisting of a Comprehensive Individual Assessment (CIA), the Medically Fragile Long-Term Care Assessment Abstract (LTCAA-DOH 378), History and Physical (H&P) and medical documentation. The LOC process begins when a MFCM meets with the participant/participant representative to obtain medical, functional, social and developmental information for the CIA. The MFCM is responsible for obtaining a H&P from the primary care physician (PCP). The Human Services Division (HSD) notifies the participant/participant representative to set up an interview for determination of financial eligibility. Once all steps as stated above have been completed and documents obtained, the Abstract is completed using the following tools:

- Medically Fragile Long-Term Care Assessment Abstract (Form DOH 378)
- Instructions for Completing the Medically Fragile Long-Term Care Assessment Abstract (Form DOH 378);
- Comprehensive Individual Assessment/Family-Centered Review (CIA); and
- Medically Fragile Criteria used to determine medical eligibility.

The Abstract along with the current H&P and CIA are compiled in a formal packet that is submitted for internal review at the case management agency. The case management agency reviews and sends the packet to the TPA Contractor for LOC determination. The TPA Contractor is responsible to provide written notification to the case management agency of its determination. If there is a denial or reduction in LOC, the letter would include an appeal process. The case management agency is responsible for notifying the participant/participant representative of the LOC determination.

The participant/participant representative completes the financial eligibility with HSD. Upon receipt of LOC approval and confirmation of financial eligibility, the process for development and implementation of an Individual Service Plan (ISP) begins.

The reevaluation process is the same as the initial evaluation 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 TPA Contractor uses a report tracking system to ensure that LOC reevaluations are completed on an annual basis and according to the timeliness requirements. Report tracking is done via a database system. The TPA Contractor enters all pertinent dates into the database that applies to any date specific requirement. This system triggers when notifications are to be sent out as well as the date the notification is sent out to ensure timely notifications. 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:

LOC evaluation and reevaluation records are maintained at the office of the TPA Contractor for ten (10) years. Duplicate evaluation and reevaluation records are maintained at the office of the case management agency for ten (10) years or a period of seven (7) years after the person reaches the age of maturity (21), whichever period of time is greater.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

- i. Sub-Assurances:**

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

Performance Measures

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

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

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The percentage of new MF Waiver applicants with completed LOC evaluations.
Numerator: Number of LOC evaluations performed. **Denominator:** Number of new waiver applicants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

TPA Contractor reports on LOC reviews

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

TPA Contractor DDSQI Steering Committee	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, if necessary, to address unusual issues that may arise.

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

TPA Contractor reports on LOC reevaluation reviews.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 50px;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: TPA Contractor	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.	

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

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% margin of error and a 95% confidence level
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Annually up to every 3 years, depending upon compliance history and trends data for	

	complaints and incidents	
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Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

The percentage of LOC determinations for waiver allocants that comply with the processes and use the instruments specified in the approved waiver. Numerator: Number of compliant LOC determinations for new waiver allocants. Denominator: Total number of LOC determinations for new waiver allocants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

TPA Contractor reports on LOC reviews

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):

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: TPA Contractor DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

Performance Measure:

The percentage of LOC reevaluations for waiver participants that comply with the processes and use the instruments specified in the approved waiver. Numerator:

Number of compliant LOC reevaluations for waiver participants. Denominator:
Total number of LOC reevaluations for waiver participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

TPA Contractor reports on LOC reevaluation reviews

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: TPA Contractor DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
 Formal quality improvement processes are in place, as described in detail in the DDSQI Steering Committee description and structure in Appendix H.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

The applicant is offered freedom of choice with the initial contact at the time of allocation. The MF Waiver Manager sends out the Letter of Interest which includes a Primary Freedom of Choice (PFOC) form for the applicant to complete and return. The applicant is provided information about the services that are available under the waiver and that prior to enrollment into the waiver program, he/she has a choice of home and community-based services (HCBS) and institutional services - Intermediate Care Facility for the Mentally Retarded (ICF/MR). If the applicant chooses HCBS, then the applicant is given a choice between the MF Waiver or the Mi Via Self-Directed Waiver.

After the individual is confirmed to be eligible for the MF Waiver, the participant/participant representative meets with the Case Manager who explains, orally and in writing, about the available MF Waiver services and various other options. The participant/participant representative is given a Family Handbook that contains information about MF Waiver services, all other waivers, and ICF/MR placement. The participant/participant representative is informed by the Case Manager, orally and in writing, of the available MF Waiver services in order to make an informed choice of services.

Upon selection of the requested MF Waiver services and prior to the Interdisciplinary Team (IDT) meeting, the participant/participant representative is encouraged to contact the agencies and interview potential providers of these services. Once the participant/participant representative selects waiver services and providers, he/she signs the Secondary Freedom of Choice (SFOC) form for each waiver service that has been selected. The SFOC form includes notification to the participant regarding his/her free choice of providers and only lists the approved MF Waiver agencies for each service.

- 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.

Records of freedom of choice are maintained by the Medically Fragile Case Management Program (MFCMP) agency that is located at the Center for Development and Disability at the University of New Mexico (UNM) in the participant's file and are available to the State upon request. These records are maintained by the case management agency for a period of ten (10) years, or for seven (7) years after the person reaches the age of maturity (21), whichever period of time is greater.

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/HSD 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. The~~

provider agencies are required to communicate in the language that is functionally required by the participant.

Informational materials will be translated into the prevalent non-English language. The State defines prevalent non-English language as the language spoken by approximately 5 percent (%) 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	Home Health Aide
Statutory Service	Respite
Extended State Plan Service	Nutritional Counseling
Extended State Plan Service	Skilled Therapy for Adults
Other Service	Behavior Support Consultation
Other Service	Private Duty Nursing
Other Service	Specialized Medical Equipment and Supplies

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):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Case Management services assist participants in gaining access to needed waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services. Case Management serves as a means for achieving participant wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. Case Management services are best offered in a climate that allows direct communication between the case manager, the participant, the family and appropriate service personnel, in order to optimize the outcome for all concerned.

The Case Manager is responsible for the initial evaluation and reevaluations.

The Case Manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain value for

both the participant and the reimbursement source. The Case Manager monitors, reports and participates, as appropriate, in modifying service delivery when indicated. At least every other month, the Case Manager conducts a face-to-face contact with the participant and on a monthly basis conducts a telephonic or electronic contact with the participant and/or the participant's representative.

Case Management services include:

- Identifying medical, social, educational, family and community support resources;
- Scheduling and coordinating timely Interdisciplinary Team (IDT) meetings to develop and modify the Individual Service Plan (ISP) annually and as needed by any team member;
- Documenting contacts with the participant and providers responsible for delivery of services to the participant;
- Verifying eligibility on an annual basis;
- Ensuring the Medically Fragile Long-Term Care Assessment Abstract (LTCAA) is completed and signed by the physician, physician assistant or clinical nurse practitioner (CNP);
- Timely submission of the level of care (LOC) packet including the LTCAA to the TPA Contractor for prior authorization;
- Ensuring the Waiver Review Form (MAD 046) is submitted, timely, annually and as needed;
- Initiating an ongoing monitoring process that provides for evaluation of delivery, effectiveness, appropriateness of services and support provided to the participant as identified in the ISP;
- Performing an annual participant satisfaction survey; and
- Coordinating services provided through the MF Waiver and other sources (State Plan, Family Infant Toddler (FIT), Commercial Insurance, Educational and Community).

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	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*):

Nurses licensed by the New Mexico State Board of Nursing as a RN (Nursing Practice Act: NMSA, Chapter 61, Article 3 and 16.12.1 New Mexico Administrative Code [NMAC] et seq.)

Certificate (*specify*):

Case Management Agencies are required to have national accreditation. These accrediting organizations are CARF, the Joint Commission or another nationally recognized accrediting authority.

Other Standard (specify):

Case Managers must have the skills and abilities necessary to perform case management services for participants who are medically fragile, as defined by the DOH MF Waiver standards. Case managers must be RNs as defined by the NM State Board of Nursing and have a minimum of two (2) years of supervised experience with the target population in one or more areas of pediatrics, critical care or public health.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

Initially and annually or up to every 3 years

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

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

Service Type:

Statutory Service

Service:

Home Health Aide

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Home Health Aide services provide total care or assist a participant in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampoo (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake. The Home Health Aide services assist the participant in a manner that promotes an improved quality of life and a safe environment for the participant. Home Health Aide services can be provided outside the participant's home. State Plan Home Health Aide services are intermittent and provided primarily on a short-term basis; whereas, in the MF Waiver, Home Health Aide services are provided hourly, for participants who need this service on a more long-term basis. Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home Health Aides perform an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulation and exercise, household services essential to health care at home, assisting with medications that are normally self-administered, reporting changes in patient conditions and needs, and completing appropriate records.

Home Health Aide services are covered under the State Plan as expanded EPSDT benefits for waiver participants under the age of 21.

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	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
 Service Name: Home Health Aide

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home Health Agency, Rural Health Clinic or Federally Qualified Health Center (42 CFR 484.36; 7.28.2.30 NMAC)

Certificate (specify):

Other Standard (specify):

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Initially and annually or up to every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Respite services are provided to participants unable to care for themselves that are furnished on a short-term basis to allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. By permitting the caregiver a specific and limited break from the daily routine of providing care, burnout is avoided and the primary caregiver receives a source of support and encouragement to continue home care services.

Respite may be provided in the following locations: participant’s home or private place of residence, the private residence of a respite care provider, specialized foster care home, Medicaid certified hospital, Medicaid certified nursing facility, or a Medicaid certified ICF/MR.

The participant and/or participant representative has the option and gives final approval of where the respite services are provided. The institution(s) and agency(s) are required to coordinate all services with the participant and/or the participant representative.

Respite services include: medical and non-medical health care; personal care bathing; showering; skin care; grooming; oral hygiene; bowel and bladder care; catheter and supra-pubic catheter care; preparing or assisting in preparation of meals and eating; as appropriate, administering enteral feedings; providing home management skills; changing linens; making beds; washing dishes; shopping; errands; and calls for maintenance; assisting with enhancing self-help skills; promoting use of appropriate interpersonal communication skills and language; working independently without constant supervision/observation; providing body positioning, ambulation and transfer skills; arranging for transportation to medical or therapy services; assisting in arranging health care needs and follow-up as directed by the primary care giver, physician, and case manager; ensuring the health and safety of the recipient at all times.

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

Respite services are furnished up to a maximum of fourteen (14) days or 336 hours per annualized budget.

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	Home Health Agency
Agency	Institutional Respite Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications**License (specify):**

Licensed Home Health Agency, Licensed Rural Health Clinic or Licensed Federally Qualified Health Center

Certificate (specify):

Other Standard (specify):

A home health agency must have a current business license, proof of financial solvency, proof of compliance with training and personnel qualification standards, quality assurance policies and procedures and proof of records being maintained in accordance with MF Waiver standards.

The RNs and LPNs who work for the home health agency and provide respite services must be licensed by the NM State Board of Nursing as a RN or LPN (Nursing Practice Act: NMSA, Chapter 61, Article 3 and 16.12.1 New Mexico Administrative Code [NMAC] et seq.)

The Home Health Aide

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

Initially and annually or up to every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Institutional Respite Provider

Provider Qualifications**License (specify):**

Hospital, Skilled Nursing Facility, ICF/MR

Certificate (specify):

Certified Specialized Foster Care Provider, certified by New Mexico Children, Youth and Families Department

Other Standard (specify):

An institutional respite provider must have proof of compliance with training and personnel qualification standards, quality assurance policies and procedures and proof of records being maintained in accordance with MF Waiver standards for respite services. For Institutional Respite providers that are Certified Specialized Foster Care Providers, provider must also supply a business license and proof of financial solvency.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

Initially and annually or up to every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Nutritional Counseling

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Nutritional Counseling is designed to meet the unique food and nutrition requirements of participants with developmental disabilities and/or chronic conditions(s) which allow them to be eligible for the MF Waiver. These Nutritional Counseling services differ from the State Plan nutritional assessment and counseling services in that the State Plan service is limited to pregnant women and children under 21 years of age who are receiving EPSDT services. Under the State Plan, these services must be provided under the direction of a physician.

Services covered by this waiver are provided to participants who do not fall within the scope of State Plan coverage and who may require nutritional counseling, with specific illnesses such as: failure to thrive; gastroesophageal reflux; dysmotility of the esophagus and stomach; or who require specialized formulas, or receive tube feedings or parenteral nutrition. These services can be delivered in the home.

The MF Waiver includes assessment of the participant's nutritional needs, regimen development, and/or revisions of the participant's nutritional plan, counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan. These services advise and help participants obtain appropriate nutritional intake by integrating information from the nutritional assessment with information on food, other sources of nutrients, and meal preparation consistent with cultural backgrounds and socioeconomic status.

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	Nutritional Counseling Agency

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:

Nutritional Counseling Agency

Provider Qualifications**License (specify):**

Licensed Dietician registered 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):

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

Initially and annually or up to every 3 years

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

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

Service Type:

Extended State Plan Service

Service Title:

Skilled Therapy for Adults

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Skilled therapy services include Physical Therapy, Occupational Therapy or Speech and Language Therapy. Adults 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. Waiver services are provided when the limits of State Plan skilled therapy services are exhausted. The scope and nature of these services do not otherwise differ from the services furnished under the State Plan.

Skilled Maintenance Therapy services specifically include:

Physical Therapy: Physical Therapy services promote gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include: professional assessment(s), evaluation(s) and monitoring for therapeutic purposes; physical therapy treatments and interventions; training regarding

physical therapy activities, use of equipment and technologies or any other aspect of the individual’s physical therapy services; designing, modifying or monitoring use of related environmental modifications; designing, modifying, and monitoring use of related activities supportive to the ISP goals and objectives; and consulting or collaborating with other service providers or family members, as directed by the participant.

Occupational Therapy: Occupational Therapy Services promote fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. Specific services may include: teaching of daily living skills; development of perceptual motor skills and sensory integrative functioning; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment; use of specifically designed crafts and exercise to enhance function; training regarding occupational therapy activities; and consulting or collaborating with other service providers or family members, as directed by the participant.

Speech Language Therapy: Speech Language Therapy services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology, and/or prevent progressive disabilities. Specific services may include: identification of communicative or oropharyngeal disorders and delays in the development of communication skills; prevention of communicative or oropharyngeal disorders and delays in the development of communication skills; development of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the participant’s environment to meet his/her needs; training regarding speech language therapy activities; and consulting or collaborating with other service providers or family members, as directed by the participant.

Skilled Therapy services are covered under the State Plan as expanded EPSDT benefits for waiver participants under the age of 21.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Therapy Practitioner
Agency	Group Practice/Home Health Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Individual Therapy Practitioner

Provider Qualifications**License (specify):**

Physical Therapist: Licensed as per NM Regulation and Licensing Dept; Physical Therapy Act, NMSA 1978, Section 61-12D-1 et.seq.

Occupational Therapist: Licensed as per NM Regulation and Licensing Dept; Occupational Therapy Act, NMSA 1978, Section 61-12A-1 et.seq.

Speech and Language Pathologist: Licensed as per NM Regulation and Licensing Dept; Speech and Language Pathology Act, NMSA 1978, Section 61-14B-1 et.seq.

Certificate (specify):

Other Standard (specify):

Proof of fiscal solvency, proof of compliance with service standards, and meet bonding required by DOH.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

Initially and annually or up to every 3 years

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

Service Type: Extended State Plan Service

Service Name: Skilled Therapy for Adults

Provider Category:

Agency

Provider Type:

Group Practice/Home Health Agency

Provider Qualifications**License (specify):**

Physical Therapist: Licensed as per NM Regulation and Licensing Dept; Physical Therapy Act, NMSA 1978, Section 61-12D-1 et.seq.

Occupational Therapist: Licensed as per NM Regulation and Licensing Dept; Occupational Therapy Act, NMSA 1978, Section 61-12A-1 et.seq.

Speech and Language Pathologist: Licensed as per NM Regulation and Licensing Dept; Speech and Language Pathology Act, NMSA 1978, Section 61-14B-1 et.seq.

Licensed Home Health Agency that employs licensed therapist(s)

Certificate (specify):

Occupational Therapy Assistant: Certified Occupational Therapy Assistant

Physical Therapy Assistant: Certified Physical Therapy Assistant

Other Standard (specify):

Group Practice/Home Health Agency that employs licensed occupational therapists, physical therapists, and/or speech therapists in accordance with New Mexico Regulations & Licensing Department.

Physical Therapy Assistant: Works only under the direction and supervision of a Licensed Physical Therapist, 16.20.6 NMAC

Occupational Therapy Assistant: Works only under the direction and supervision of a Licensed Occupational Therapist, 16.15.3.7 NMAC

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

Initially and annually or up to every 3 years

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

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

Service Type:

Other Service

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

Service Title:

Behavior Support Consultation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Behavior Support Consultation is the provision of assessment, treatment, evaluation and follow-up services to assist the participant, parents, family members and/or primary caregivers with coping skills which promote maintaining the participant in a home environment. Behavior Support Consultation: 1) informs and guides the participant's providers with the services and supports as they relate to the participant's behavior and his/her medically fragile condition; 2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s); 3) supports effective implementation based on a functional assessment; 4) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the participant and his/her service and support providers. Based on the participant's ISP, services are delivered in an integrated/natural setting or in a clinical setting.

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

--

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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Provider Category	Provider Type Title
Agency	Behavioral Support Consultant Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support Consultation

Provider Category:

Agency

Provider Type:

Behavioral Support Consultant Agency

Provider Qualifications

License (specify):

Counselors employed by the agency must be licensed as per NM Regulation and Licensing Dept; Counseling and Therapy Act 61-9A-1 through 61-9A-30, NMSA 1978;
 Psychologists/Psychoanalysts must be licensed as per NM Regulation and Licensing Dept., 42 CFR 440.90, NMAC 16.22.4, Psychologists Act 61-9-1 through 61-9-19, NMSA 1978;
 Social Workers must be licensed as per NM Regulation and Licensing Dept., 42 CFR 440.90, NMAC 16.63.3, Social Work Practice 61-31-1 through 61-31-25, NMSA 1978;
 Psychiatrists must be a physician licensed in New Mexico who has been certified by the American Board of Psychiatry and Neurology in the specialty of psychiatry or the subspecialty of child and adolescent psychiatry, 42 CFR 440.90;
 Licensed Psychologist Associates must meet the education requirements and conditions of practice, per 16.22.12 NMAC; and
 Licensed Psychiatric Nurses (MSN/RNCS) must be licensed as per the Nursing Practice Act (NMSA, Chapter 61, Article 3)

Certificate (specify):

Other Standard (specify):

Behavior Support Consultation may be provided through a corporation, partnership or sole proprietor. Regardless of whether a corporation, partnership or sole proprietor the agency must assure that all direct services are provided by individuals who meet the following qualifications, whether working as an owner, employee or subcontractor. All Behavioral Support Consultant agencies must be approved MF Waiver providers through the Provider Enrollment process carried out jointly by DOH and HSD. Providers of Behavior Support Consultation must have a minimum of one year of experience working with medical fragility or developmental disabilities. All Behavior Support Consultants must maintain current New Mexico licensure with their professional field licensing body.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Initially and up to every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service

not specified in statute.

Service Title:

Private Duty Nursing

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Private Duty Nursing is the provision of nursing services on a continuous or full-time basis, as defined in 42 CFR 440.80, and provided by licensed nurses within the scope of State law. Private Duty Nursing services are provided to a participant at home and include activities, procedures, and treatment for a physical condition, physical illness, or chronic disability. Services include medication management; administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance.

Private Duty Nursing services are covered under the State Plan as expanded EPSDT benefits for waiver participants under the age of 21.

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	Licensed Home Health Agency/ Rural Health Clinic/ FQHC

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency/ Rural Health Clinic/ FQHC

Provider Qualifications

- License (specify):**
 Licensed Home Health Agency (7 NMAC 28.2 et seq.)
 Licensed Rural Health Clinic (7 NMAC 11.2 et seq.)
 Federally Qualified Health Center
- Certificate (specify):**

--

Other Standard (specify):

RNs and LPNs 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. and have a minimum of one year of supervised nursing experience; nursing experience preferably with individuals with developmental disabilities or who are medically fragile.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

Initially and annually or up to every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Specialized Medical Equipment and Supplies include: (a) devices, controls or appliances specified in the plan of care that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State Plan that is necessary to address participant functional limitations; and (e) necessary medical supplies not available under the State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. The costs of maintenance and upkeep of equipment are included in the cost of equipment and supplies. All items shall meet applicable standards of manufacture, design, and installation. Medical equipment and supplies that are furnished by the State Plan are not covered in the Specialized Medical Equipment and Supplies. This service does not include nutritional or dietary supplements, disposable diapers or bed pads, or disposable wipes.

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

Limited to \$1,000 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	Vendor

Appendix C: Participant Services

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

Service Type: Other Service
 Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Vendor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The vendor must have a business license for the locale they are in, a tax ID for state and federal government, proof of fiscal solvency, proof of use of approved accounting principles, meet bonding required by DOH, comply with timeliness standards for this service

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Initially and annually or up to every 3 years

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) Act requires that persons, whose employment or contractual service includes direct care or routine and unsupervised physical or financial access to any care recipient served by that provider, must undergo a nationwide criminal history screening to ensure to the highest degree possible the prevention of abuse, neglect or financial exploitation of individuals receiving care. This law prevents persons who have been convicted of certain crimes from working with individuals receiving health care.

Employers have 20 days after hiring an employee to submit the caregivers' criminal history screen application packet that includes an application, fingerprints and processing fee to the DOH/Division of Health Improvement (DHI) Caregivers Criminal History Screening Program (CCHSP). When DOH/DHI/CCHSP receives the application packet, they scan the application and fingerprints and submit them electronically to the DOH/Department of Public Safety (DPS). DPS completes the state criminal background check, then forwards the application and fingerprints to the United States Federal Bureau of Investigation (FBI) for the national criminal background check. Both the DPS and FBI screens are returned to the CCHSP for review and identification of disqualifying conditions. Letters are sent to the employee and employer either clearing the employee or disqualifying the employee. The employee has an opportunity to request an informal reconsideration of the decision if disqualifying convictions are identified.

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/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 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.

Criminal histories and background investigations are performed pursuant to 7.1.9 NMAC, Caregivers Criminal History Screening Requirements, and in accordance with NMSA 1978, Section 29-17-1 of the Caregivers Criminal History Screening Act.

- 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 (DOH) has established and maintains an electronic registry of all unlicensed persons 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 from a provider and have met the severity standard for the substantiated incident. 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.

The Employee Abuse Registry Act is available for review, and can be found in Sections 27-7A-1 through 27-7A-8 NMSA 1978. Regulations are found at 7.1.12 NMAC, and 8.11.6.1 NMAC.

Additionally, the Adult Protective Services Department of ALTSD and the Department of Health report substantiated incidences of abuse, neglect or exploitation of a person receiving services from a licensed individual health care provider directly to that person's licensure board. Each board has protocols established to investigate and resolve such reports.

By statute, New Mexico providers must conduct screenings and document that screening has occurred. Documentation is required to be maintained in the employ's personnel record. 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).

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.

- 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:

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

**The percentage of enrolled licensed/certified providers who meet licensure/certification requirements prior to furnishing waiver services.
 Numerator: Number of compliant enrolled licensed/certified providers.
 Denominator: Total number of enrolled licensed/certified providers.**

Data Source (Select one):

Other

If 'Other' is selected, specify:

DOH/DDSD/Provider Enrollment Unit (PEU) 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input checked="" type="checkbox"/> Other Specify: upon enrollment	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

DOH/DDSD/Provider Enrollment Unit (PEU)

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:	
	<input checked="" type="checkbox"/> Other Specify: up to every 3 years		

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input checked="" type="checkbox"/> Other Specify: Annually up to every 3 years , depending upon compliance history and trends data for complaints and incidents.	

Data Aggregation and Analysis:

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

Performance Measure:

The percentage of provider agency staff who have required criminal history screenings completed. Numerator: Number of compliant provider agency staff. Denominator: Total number of provider agency staff.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Annually up to every 3 years,	

	depending upon compliance history and trends data for complaints and incidents.	
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Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

The percentage of non-licensed/non-certified providers who adhere to waiver requirements. Numerator: Number of non-licensed/non-certified providers who adhere to 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Annually up to every 3 years, depending upon compliance history and trends data for complaints and incidents.	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

c. **Sub-Assurance:** *The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

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

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

Performance Measure:

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

Data Source (Select one):

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Annually up to every 3 years, depending upon compliance history and trends data for complaints and incidents.	

Data Aggregation and Analysis:

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Formal quality improvement processes are in place, as described in detail in the DDSQI Steering Committee description and structure in Appendix H.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the 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.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

**Other**

Specify:

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

Private Duty Nursing and Home Health Aide: These services are only available for participants age 21 and older because participants under 21 receive these services through the State Plan. Any combination of these services is allowed, but must not exceed the following limits within the participant's acuity level:

Level I: Up to 173 hours per month or 2080 hours annually. This limit is based upon coverage equivalent to one Full-Time Employee (40 hours/week) worth of support and historical utilization for the population of participants with level of support Level I.

Level II: Up to 130 hours per month or 1560 hours annually. This limit is based upon coverage equivalent to 30 hours per week worth of support and historical utilization for the population of participants with level of support Level II.

Level III: Up to 87 hours per month of 1040 annually. This limit is based upon coverage equivalent to 20 hours per week worth of support and historical utilization for the population of participants with level of support Level III.

The case manager verbally notifies the participant/participant representatives of these limits each year when meeting with the individual and family to prepare for the annual meeting to develop the Individual Service Plan (ISP).

These limits are reviewed by DOH & HSD annually based upon utilization and annual survey of family needs; depending upon results these limits may be adjusted in future Waiver years.

This is a waiver designed for participants living in their home environment with primary caregiver (s). This/these caregivers are responsible for the participant at all times. The services offered in this Waiver are designed to support the primary caregiver(s) and provide short period of relief from constant care giving responsibilities. Safeguards for participants whose needs exceed that which can be provided within the budget caps (below) and limits above include:

- 1) a carefully planned and managed annual MF Waiver budget;
- 2) the MF Waiver case manager coordinates with the state plan to request and obtain additional support services when MF Waiver services have been exhausted and there is a demonstrated need for more services. (There is a long history of the State Plan approving in home care in these instances.);
- 3) participant may choose to transition to another Waiver that offers residential services, on a space available basis;
- 4) as a last resort, the individual may transition to an ICF/MR when the caregiver(s) is no longer able to support the individual at home.

- 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.

Each participant is assigned to a funding level based on his/her level of support needs. Completion of the Long-Term Care Assessment Abstract (LTCAA) results in a point total which indicates acuity: Level I (8-18 points), Level II (19-23 points) and Level III (24-31 points). A capped dollar amount is applied to each level of support; all Medically Fragile Waiver services the individual is to receive must fit within this capped dollar amount (see C.1.a). The Case Manager verbally notifies the participant/participant representatives of these limits each year when meeting with the individual and family to prepare for the annual meeting to develop the Individual Service Plan (ISP).

The capped dollar amount and level of support has been used since the early 1990's. This method has been successful in meeting the needs of the participants. However, it was based upon a percentage of the ICF/MR average costs at the time. Annually the average cost of providing Waiver services is reviewed to determine if it is necessary to adjust the budget limits for each level of support in order to continue to meet the participant's medical needs and assure health and safety. Budget caps have been increased historically based upon increases in rates in order to assure that the quantity of services that can be purchased through the budgets are not reduced. When changes are made to rate and/or budget caps, HSD publishes the proposed changes and holds public hearings to receive input from the public.

As described in Appendix B-1-b, a participant's level of medical fragility is determined by a set of eight (8) parameters. These parameters ensure that a medically fragile condition exists and contribute to the determination of the level of support that is required by the participant. The parameters reflect the amount of care a participant requires from his/her caregiver on a daily/24 hour basis.

Annual capped dollar amounts are as follows; the total cost of all services cannot total an amount in excess

of these caps:

Age	Level I	Level II	Level III
21 & over	\$70,000	\$60,000	\$48,000
Under 21	\$25,000	\$25,000	\$25,000

Because participants under age 21 receive the bulk of their services through the State Plan, there is a single budget cap for that age group.

This is a waiver designed for participants living in their home environment with a primary caregiver (s). This/these caregivers are responsible for the participant at all times. The services offered in this Waiver are designed to support the primary caregiver(s) and provide a short period of relief from constant caregiving responsibilities. Safeguards for participants whose needs exceed that which can be provided within the budget caps above include:

- 1) a carefully planned and managed annual MF Waiver budget;
- 2) the MF Waiver case manager coordinates with the State Plan to request and obtain additional support services when MF Waiver services have been exhausted and there is a demonstrated need for more services (there is a long history of the State Plan approving in-home care in these instances);
- 3) participant may choose to transition to another Waiver that offers residential services, on a space available basis;
- 4) as a last resort, the individual may transition to an ICF/MR when the caregiver(s) is no longer able to support the individual at home.

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

Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
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 participant/participant representative in developing the ISP. At the initial meeting with the Case Manager, the participant/participant representative is given the Family Handbook which contains information about ISP development. During the Case Manager's meetings with the participant/participant representative before the Interdisciplinary Team (IDT) meeting, the Case Manager explains the waiver process and encourages his/her leadership and full participation in the service plan meetings.

Working together, the Case Manager and participant/participant representative identify the participant's strengths, and assist the participant 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 risks 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 participant/participant representative;
- Provides a list of the specific service providers available in the participant's area from which the participant may select his/her providers;
- Explains the team process and the composition of the team;
- Encourages the participant/participant representative to include others of his/her choice as team members;
- Supports the participant to lead the team meeting; and
- Advocates for the participant on an ongoing basis.

The participant/participant representative has the authority to determine who is included in the ISP process and is encouraged to make his/her own choices and decisions regarding services. He/she has control over how his/her budget is expended. The participant/participant representative may request an IDT meeting at anytime during the ISP cycle.

Appendix D: Participant-Centered Planning and Service Delivery

- 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):

An initial ISP for services must be completed within ninety (90) days of receipt of the allocation letter from the Medically Fragile (MF) Waiver program.

Interdisciplinary Team (IDT) meetings are held to develop the person-centered Individual Service Plan (ISP). The planning meetings are held at least annually and as needed for change of condition or circumstance and are scheduled at times and locations convenient to the participant/participant representative.

The Case Manager obtains information about the participant's strengths, capacities, preferences, desired outcomes and risk factors. This information is gained through a review of the level of care (LOC) assessment; through interviews between the Case Manager and participant/participant representative; and through the person-centered planning process that takes place between the Case Manager and participant/participant representative to develop the ISP.

Assessments

Assessment activities that occur prior to the IDT meeting include the Comprehensive Individual Assessment/Family Centered Review (CIA), participant history and physical by primary care physician (PCP), review of other pertinent medical historical documents, and the 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 medical fragility and developmental disability factors. Assessments occur on an annual basis or as needed, during significant changes in circumstance. The Case Manager then makes results available to the participant/participant representative. All parties ensure that the ISP addresses the information and/or concerns identified through the assessment process.

At the annual IDT meeting, the participant's ISP is developed with input from each member of the team. The ISP may be revised during the year to address any life changes (medical or social). Specifically, the ISP addresses: activities of daily living assistance needs, health care needs, equipment needs, relationships in the home and community, personal safety and provider responsibilities. The ISP must address areas of need, as recognized in the CIA.

Pre-Planning

During the pre-planning process, the Case Manager provides the participant/participant representative with information about the MF Waiver. The Case Manager provides information about the range and scope of service choices and options, as well as the rights, risks, and responsibilities associated with the MF Waiver. The Case Manager then gives the participant/participant representative a Family Handbook that contains information about the MF Waiver, community resources, and ways to interface with providers, physicians and support groups. The handbook also has tips on organizing day-to-day activities to accommodate the medical needs of the participant. The Case Manager is responsible for completing the CIA and obtaining other medical assessments needed for the ISP; completing the annual LOC redetermination process; and referring the participant/participant representative to HSD for financial eligibility determination annually and as needed.

Interdisciplinary Team (IDT) Meeting

The Case Manager works with the participant/participant representative to identify service providers to participate in the IDT meeting. State approved providers are selected from a list provided by the Case Manager. The Case Manager encourages the participant/participant representative to meet with the provider agencies and specific providers before making a choice of agency or specific provider. The participant/participant sets the date and time of the IDT meeting. **The Case Manager works with the participant/participant representative to plan the IDT meeting and encourages him/her to lead the IDT meeting to the extent possible.**

During the IDT meeting, the Case Manager assists the participant/participant representative in ensuring that the ISP

addresses the participant's goals, health, safety and risks along with addressing the information and/or concerns identified through the assessment process. The Case Manager writes up the ISP as identified in the IDT meeting. Each provider develops care activities and strategies for each outcome, goal, and objective identified at the IDT meeting. The Case Manager assures the ISP budget is within the Capped Dollar Amount (CDA) before submitting the MF Waiver budget (MAD 046). Implementation of the ISP begins when provider service plans have been received by the Case Manager and participant, and the plan and budget have been approved by the Third-Party Assessor (TPA) Contractor. The State does not use temporary, interim service plans to get services initiated until a more detailed service plan can be finalized.

The Case Manager ensures for each participant that:

- The planning process addresses the participant's needs and personal goals in medical supports needed at home for health and wellness;
- Services selected address the participant's needs as identified during the assessment process. Needs not addressed in the ISP are addressed through resources outside the MF Waiver Program;
- The outcomes of the assessment process for assuring health and safety are considered in the plan;
- Services do not duplicate or supplant those available to the participant through the Medicaid State Plan or other public programs;
- Services are not duplicated in more than one service code;
- The parties responsible for implementing the plan are identified and listed within the document;
- The back-up plans are complete; and
- The ISP is submitted to the TPA Contractor in compliance with the MF Waiver Service Standards.

Non-waiver services, i.e.: EPSDT services, durable medical equipment, therapies and medical specialists services are coordinated by the Case Manager with the managed care organizations, Medicaid school-based services providers and Early Intervention teams.

The ISP is updated if personal goals, needs and/or life circumstances change that may or may not result in a change of the LOC. Revisions may be requested by the participant. Each member of the IDT may request an IDT meeting to address changes and/or challenges. The Case Manager contacts the participant/participant representative to initiate revisions to the budget. The Case Manager initiates the scheduling of IDT meetings and assures the IDT meeting is in compliance with the MF Waiver Service Standards.

Monitoring

The Case Manager is responsible for monitoring the ISP pre-planning and development process. The case management agency conducts internal quality improvement monitoring of service plans. The ISP is monitored monthly via phone, electronically, and face-to-face by the Case Manager. The ISP is reviewed with the IDT members at least every six (6) months for the initial ISP and no less than every twelve (12) months for the annual reassessment. The ongoing ISP review includes a formal method of checking and documenting that services and supports are provided to the medically fragile participant as identified in the ISP. This review also determines if the goals and objectives of the ISP are being achieved and remain appropriate and realistic.

The Case Manager meets with these teams at least annually and as needed to discuss the needs of the participant and the participant's progress/lack of progress to determine what, if any, additional needs are to be addressed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Medically Fragile (MF) Waiver reflects a strong commitment throughout the planning process to supporting the participant/participant representative and family in the decision to have the participant in a home environment with a primary caregiver. However, the State must assure the participant's safety, and the Case Manager is required to work with the participant/participant representative in developing a plan that addresses risks that have been identified during the participant's LOC assessment, Comprehensive Individual Assessment/Family Center Review (CIA) and Individual Service Plan (ISP) development process.

The MF Waiver provider always involves the participant/participant representative with identifying risk areas and ensuring the back-up plan addresses risks so that his/her preferences are incorporated during the planning process.

The LOC packet (Medically Fragile Long-Term Care Assessment Abstract [LTCAA]), CIA, History & Physical (H&P), and other pertinent medical documentation address the participant's medical fragility factors and developmental disabilities factors.

The assessment process allows the Case Manager, participant/participant representative and other professionals (PDNs, physicians, and therapists) to identify potential risk areas to be addressed in the ISP and considered in developing the back-up plan. A back-up plan unique to the individual's circumstance is developed and incorporated into the ISP. Examples of back-up plans include a plan for substitute staffing or access to physician or emergency services. Back-up plans are required for primary caregivers.

The Home Health Agency is also responsible for developing a back-up plan in conjunction with the participant/participant representative. All waiver providers are required to have a back-up plan. The Case Manager monitors the use and effectiveness of back-up plans during monthly contacts to mitigate any future health and safety risks and equipment needs.

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.

At the initial meeting with the participant/participant representative, the Case Manager describes every type of service offered in the MF Waiver along with services that are available through the State Plan and in the community. The participant/participant representative receives a Family Handbook that contains information about the MF Waiver, State Plan and community services.

The State requires the Case Manager to ensure that the participant/participant representative is given freedom of choice between available qualified providers. This is accomplished by giving both written and verbal contact information for each qualified provider so that the individual/family may contact the provider to interview them about their services. Individuals/families are encouraged to use contact information to arrange such interviews by phone or in person, but are not required to do so. Individuals/families may also wish to confer with other individuals/families they know about their experiences with various providers prior to making a choice. In order to avoid undue influence on individual/family choice, Case Managers are cautioned to only provide factual information about qualified providers such as length of time they have been providing services to the MF Waiver population, counties the provider serves, or whether they offer a special area of expertise. Individuals/families may also request information from the Division of Health Improvement regarding the findings of the providers' recent compliance survey. When DOH/DHI reviews Case Management Providers for compliance with state requirements, they look for evidence that written contact information for each qualified provider was provided to the participant/participant representative.

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 approval of MF Waiver ISPs and Waiver Review forms (MAD 046). After completing its own quality review, the case management agency submits the ISP and the MAD 046 to the TPA Contractor for approval. This process is duplicated when an ISP or MAD 046 needs revision. The TPA Contractor conducts internal audits quarterly on a representative random sample of service plans to validate that utilization management functions are performed in an accurate and timely manner for the MF Waiver. Findings are reported to the State. HSD/MAD reviews a representative sample of the TPA Contractor's service plan approvals during the annual contract compliance review. If HSD/MAD identifies any issues that are inconsistent with Medicaid requirements at any time, HSD/MAD ensures that the TPA Contractor corrects the problem within the contractually required timeframes.

Appendix D: Participant-Centered Planning and Service Delivery

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The case management agency is the entity responsible for monitoring the implementation of the service plan and the participant's health and welfare. The MF Waiver is a medically driven, community-based program and provides case management services by RNs. The Case Manager and participant/participant representative work together face-to-face and electronically initially and ongoing to assess, plan, implement, evaluate, and monitor the implementation of service plan delivery, health and welfare. The role of the Case Manager has developed over the years as a comprehensive, dynamic, individualized and family-centered approach. The responsibilities of the Case Manager include coordination, management and oversight of all activities related to the participant's care in a predominantly rural and culturally diverse state. The Case Manager performs as the initiator and facilitator of community services and resources relative to the participant's and family's needs. The Case Manager promotes community awareness of individuals who are medically fragile, as well as developmentally disabled. The Case Manager conducts at least every other month face-to-face contact with the participant and telephonic or electronic contact with the participant and/or the participant's representative every month. The Case Manager and participant/participant representative review all services implemented and identified in the Individual Service Plan (ISP) and other services being provided for desired outcomes. The Case Manager maintains ongoing contacts with waiver providers, community providers, and state agencies as a necessary part of monitoring and coordination of services. The Case Manager follows up with the appropriate agency when the participant, participant representative or Case Manager has concerns about services being delivered. The Case Manager participates in the resolution of problems as needed. The Case Manager is required to review the ISP at least annually, or more often, if needed, to assess if the desired outcomes are being

achieved and that the participant/family's priorities are being addressed.

The Case Manager and participant/participant representative work together to determine the waiver services which will be included in the service plan. The Case Manager also assists the participant/participant representative to identify needed EPSDT services. When the services identified are benefits with the State Plan, a referral is made. The Case Manager assists the participant/participant representative to identify services available through the waiver. Once the type of service is identified, the participant/participant representative is given a Secondary Freedom of Choice (SFOC) to choose the provider agency. Once the provider agency is selected, the Case Manager makes the referral. The participant/participant representative interviews the prospective provider and has the right to accept or deny the provider prior to the start of services. The participant/participant representative has the right to decline services from a provider at any time. The Case Manager is available to assist the participant/participant representative in evaluating risk versus benefit when declining services and following up with the provider agency to try and resolve problems between the participant/participant representative as needed.

Due to the national and state shortage of nurses and therapists, occasionally there are no service providers available. The Case Manager works with specific agencies in the recruitment of specific providers. Health and welfare is not compromised because a primary caregiver is available. The primary caregiver is not always the participant representative. The participant representative is responsible for training the primary caregiver in coordination with the participant's physician(s). Frequently, all members of the family over eighteen (18) years of age are appropriate, qualified primary caregivers. In an effort to support primary caregivers, the utilization of home health aides (HHAs) has proven to be helpful. The HHA may provide services of activities of daily living such as bathing, ambulating, lifting and other duties within the scope of a HHA which relieves the family of the physical stress. This allows the primary caregiver to, for example, take a nap, read, or bathe, knowing the participant is being monitored and his/her needs are being met, but yet the primary caregiver is still available in case skilled needs suddenly arise. The limitations of the HHAs are that they may not give medications, skilled treatments, or be independent caregivers. In addition, a qualified designated primary caregiver must be available in the home while the HHA is on duty. The primary caregiver is ultimately responsible for providing the in-home care. The primary caregiver also has a back-up plan that is referenced in the ISP. The home health agency has provided the primary caregiver the agency back-up plan to follow when a provider fails to show or there is a change in schedule. The primary caregiver is the person responsible for confirming home health agency staff hours worked and signing provider time sheets from the home health agency.

At least every three (3) years, the DOH/Division of Health Improvement (DHI) is responsible for assuring through auditing:

- 1) Services are furnished in accordance with the service plan;
- 2) Back-up plans are effective;
- 3) Participant health and welfare is assured;
- 4) Participants exercise free choice of providers;
- 5) Participants have access to waiver services as identified in the ISP; and
- 6) Documentation is present that information has been received on how to report abuse, neglect, and exploitation.

The MF Waiver Manager is responsible for assuring through auditing at least bi-annually:

- 1) Participants have access to waiver services as identified in the service plan;
- and
- 2) Participants have access to non-waiver services as identified in the service plan, including access to health services.

The MF Waiver Manager collects information about monitoring results from DOH/DHI surveys. This data is reported to HSD upon completion of each audit. In addition, the case management agency conducts quarterly internal quality reviews and reports its findings on a quarterly basis to the State.

When problems are identified through audits, DOH/DHI requires a plan of correction be implemented. When problems are identified by the MF Waiver Manager, the Manager ensures prompt follow-up and remediation through verbal or written direction or requests that a focused survey be conducted by DOH/DHI.

b. Monitoring Safeguards. Select one:

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

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



Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

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

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

Performance Measure:

Percentage of service plans (new and annual recertifications) that adequately address needs identified through the LOC assessment. Numerator: Number of service plans determined to adequately address needs identified through the LOC assessment. Denominator: Total number of service plans developed.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% margin of error and a 95% confidence level
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe

DOH/DHI/QMB		Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Annually up to very 3 years, depending upon compliance history and trends data for complaints and incidents.	

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

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.

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

Performance Measures

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

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

Performance Measure:

Percentage of service plans developed in accordance with the MF Waiver Service Standards. Numerator: Number of service plans developed within 90 days of initial enrollment. Denominator: Total number of initial service plans developed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

UNM-MFCMP tracking log

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

		Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: UNM-MFCMP	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.

Performance Measure:

Percentage of service plans developed in accordance with state policies and procedures. Numerator: Number of service plans in the provider agency that are developed in accordance with state policies and procedures. Denominator: Number of service plans in the provider agency.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% margin of error and a 95% confidence level
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:

Percentage of service plans that have been reviewed/updated for MF Waiver participants with continuous enrollment of 12 months and/or a change in needs. Numerator: Number of service plans reviewed/updated for participants with continuous enrollment of 12 months and/or a change in needs. Denominator: Total number of participants with continuous enrollment of 12 months and/or a change in needs.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Third-Party Assessor (TPA) Contractor reports

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

	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% margin of error and a 95% confidence level
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

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):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: TPA Contractor DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.

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

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

Performance Measure:

Percentage of MF Waiver participants receiving services consistent with their service plan, including the type, scope, amount, duration, and frequency of service. Numerator: Number of MF Waiver participants in the provider agency who are receiving services consistent with their ISP. Denominator: Total number of MF Waiver participant ISPs in the provider agency.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		+/- 5% margin of error and a 95% confidence level
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Annually up to every 3 years depending upon compliance history and trends data for complaints and incidents	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant Satisfaction Surveys

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

<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Data Aggregation and Analysis:

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

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

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

Performance Measure:

Percentage of MF Waiver participants who are afforded choice between waiver services or institutional care. Numerator: Number of MF Waiver participants in the provider agency who signed the Primary Freedom of Choice (PFOC) documents (indicating choice of either waiver services or institutional care). Denominator: Total number of MF waiver participants in the provider agency.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<i>(check each that applies):</i>		
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% margin of error and a 95% confidence level
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

DOH/DDSD/Intake and Eligibility Bureau (IEB) database

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

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB DOH/DDSD/IEB DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.

Performance Measure:

Percentage of MF Waiver participants who are afforded the choice between/among waiver services and providers. Numerator: Number of MF Waiver participants in the provider agency who signed the Secondary Freedom of Choice documents (indicating choice of services/providers). Denominator: Total number of MF Waiver participants in the provider agency.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100%

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% margin of error and a 95% confidence level
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: All providers are reviewed on a 3 year schedule	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.

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

Formal quality improvement processes are in place, as described in detail in the DDSQI Steering Committee

description and structure in Appendix H.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the 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, 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 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 (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 (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.

During the initial MF Waiver enrollment meeting which occurs after the participant returns the Primary Freedom of Choice (PFOC) form choosing the MF Waiver, the participant/participant representative receives information from the Case Manager about the MF Waiver services, level of care (LOC) process and eligibility. The Case Manager also gives the participant/participant representative written information about his/her rights and responsibilities and the Case Manager's responsibilities. Along with this information, the participant/participant representative is given information by the Case Manager about his/her rights and how to request a Fair Hearing, as set forth in the Medical Assistance Division (MAD) Regulations 8.352.2 NMAC, Recipient Hearing Policies. When any action is taken regarding services, the budget, LOC, and other waiver decisions that result in a reduction, termination, modification, suspension or denial, the participant/participant representative is notified in writing about the right to a Fair Hearing. The State, the case management agency, and the Third-Party Assessor (TPA) Contractor can provide information to the participant on how to request the Fair Hearing. If requested by the participant, these entities can also assist the participant in making the request for a Fair Hearing.

The Case Manager is responsible for assisting the participant/participant representative in pursuing a Fair Hearing. This type of assistance includes offering support to the participant/participant representative in requesting a Fair Hearing, working with the participant/participant representative to prepare for the Fair Hearing, attending the Fair Hearing, and/or referring the participant/participant representative to an appropriate advocacy agency.

Various agencies are responsible for notifying the waiver participant of his/her right to a Fair Hearing as defined by 8.352.2 NMAC. A participant/participant representative may request a Fair Hearing when he/she believes that Medicaid has taken an action erroneously. The participant is informed by the TPA Contractor and the Human Services Department (HSD), in

writing, of the opportunity to request a Fair Hearing when Medicaid services are terminated, modified, reduced, suspended or denied. The denial letter sent by the TPA Contractor explains the participant/family's right to continue to receive services during the hearing process and the time frame to request continued services. The agencies responsible for notification of Fair Hearings are responsible for maintaining documentation of the notification.

1. The TPA Contractor provides notice to the Department of Health (DOH) and the case management agency when an individual does not meet level of care criteria, or when services are denied.
2. The DOH/Developmental Disabilities Services Division(DDSD) provides notice when DOH determines that an individual does not meet the medically fragile waiver criteria.
3. The HSD/Income Support Division (ISD) office provides notice when an individual does not meet financial and non-financial criteria.
4. The DOH/DDSD reminds the individual of his/her right to a fair hearing when the individual is not given a choice between home and community-based services as an alternative to institutional care.
5. The DOH/DDSD reminds an individual of his/her right to a fair hearing when the individual is not provided the opportunity to select the providers of his/her choice.

Notices of adverse actions and the opportunity to request a Fair Hearing are maintained at the HSD, DOH, and TPA Contractor offices.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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 participant 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 participant/participant representative may also register complaints, about any issue with which he/she is dissatisfied, with DOH/DDSD via email, mail, or by phone. The MF Waiver Manager follows up within two (2) business days from the date the complaint/grievance is received and informs the participant 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 MF Waiver Manager monitors resolutions and maintains a performance grid that tracks all MF Waiver complaints received by DOH. Additionally, the MF Waiver Manager forwards the performance grid to HSD on a quarterly basis, and HSD and DOH trend complaint/grievance data from all sources to identify areas for system improvement. These activities are reported to DDSQI annually as part of the Quality Improvement Strategy.

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) investigates reports of alleged abuse, neglect, exploitation, and other reportable incidents. Other reportable incidents include environmental hazards, the involvement of law enforcement in a participant's life, the use of emergency services, and expected and unexpected deaths. Per 7.1.13 NMAC, the following definitions of these reportable incidents are as follows:

Abuse: means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish;

Neglect: means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness;

Exploitation (Misappropriation of property): means the deliberate misplacement of the participant's property, or wrongful temporary or permanent use of a participant's belongings or money without the participant's consent;

Environmental Hazard: is an unsafe condition which creates an immediate threat to life or health;

Emergency Services: refers to admission to a hospital or psychiatric facility or the provision of emergency services

that results in medical care which is unanticipated and/or scheduled for the participant and which would not routinely be provided by a primary care provider;

Law Enforcement Intervention: is the arrest or detention of a person by law enforcement, involvement of law enforcement in an incident or event, or placement of a person in a correctional facility;

Unexpected Death: is any death caused by an accident, unknown or unanticipated cause; and

Expected Death: is any death caused by a long-term illness, a diagnosed chronic medical condition, or other natural/expected conditions resulting in death.

The reporting of incidents is mandated pursuant to 7.1.13. NMAC. Per the regulation, anyone may report an incident; however, all waiver providers are required to report incidents. DHI expects that the person within the agency with the most direct knowledge of the incident report the incident.

Per the regulation, any suspected abuse, neglect, or exploitation must be reported to the Children Youth and Families Department (CYFD)/Child Protective Services (CPS) for individuals under the age of 18 or to the Aging & Long-Term Services Department (ALTSB)/Adult Protective Services (APS) for individuals age 18 or older by reporting or faxing an incident report (IR). Additionally, the IR form must be faxed, emailed, or reported on the website to DOH/DHI within 24-hours of knowledge of an incident or the following business day in the event of a weekend or holiday.

When an incident is reported late, a letter is sent to the MF Waiver service provider stating that an incident report was received beyond the required 24-hour timeline for reporting. The letter further reiterates the requirement to report incidents within 24 hours. The consequences of non-compliance may result in sanctions, as set forth in NMAC 7.1.13.12.

Regulations are found in NMSA 1978, Sections 27-7-14 through 27-7-31 (Adult Protective Services Act) and in NMSA 1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect Act).

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Trained case managers and home health agency staff provide direction and support to participants and their informal caregivers in recognizing and reporting critical incidents. Initially and annually, the Case Manager meets with the participant/participant representative and reviews the who, what, when, and how to report any instances of abuse, neglect and exploitation (A.N.E.).

All training regarding the detection of abuse, neglect, and exploitation and who to notify when the participant may have experienced A.N.E. is documented on a form signed by the participant/participant representative acknowledging this training and that he/she understands how to report and get help. This signed acknowledgement form is maintained in the case management file.

- 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:

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 working day of receipt.

A. Reportable Incidents

A decision is made regarding whether the reported incident meets the definition of at least one of the eight categories of reportable incidents listed below. Categories include:

Abuse
 Neglect
 Misappropriation, e.g., exploitation
 Unexpected death
 Natural/expected death
 Environmental hazard
 Law enforcement intervention
 Emergency services

If the incident meets the definition of what is reportable, the following steps are taken:

1. Review 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:

Emergent: investigator must initiate response no later than the following working day from the investigator's assignment

Urgent: investigator must initiate response no later than five working days from the investigator's assignment

Routine: investigator must initiate response no later than 10 working days from the investigator's assignment

Unknown: responsibility of the intake staff to make an assignment within one working day.

Severity is described as:

Severity 3 (S3): harm or potential for harm that is life threatening or could result in long-term disability, or an unexpected death

Severity 2 (S2): harm or potential for harm that is moderate to serious but not life-threatening

Severity 1 (S1): expected death, minimal harm, or low potential for harm

3. Assign Investigator

Region of the incident occurrence: DHI/IMB has divided the State into five regions (consistent with DOH/Developmental Disabilities Support Division (DDSD) Regional designations). DHI investigators are located in each region.

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 (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/DDS
 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 MF Waiver participant will be reported automatically to DOH/DHI.

B. Notification of the use of law enforcement will also be faxed to the DOH/DDS/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 (DDS/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 (DDS/DHI) and APS staff and appropriate interventions are taken as needed.

C. DHI conducts quarterly meetings in each region with DDS 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 MF 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 MF 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/DHI/IMB is responsible for investigating all alleged instances of abuse, neglect and exploitation. When such allegations are substantiated, IMB requires the involved provider(s) to submit a corrective action plan designed to prevent future recurrence. Technical Assistance for individual specific critical incident follow-ups and/or identification and remediation of health and safety challenges is available through the Department of Health as requested by the Case Manager. Issues brought to the DOH MF Waiver Manager will be addressed in terms of options or resources for the participant to pursue in mitigating his/her risks. The Department of Health may consult with knowledgeable professionals within other state departments or other relevant community resources to explore potential options.

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. DOH is responsible for designing, implementing and evaluating the effectiveness of quality assurance and quality improvement plans for this waiver. Meetings with DOH/DHI and HSD/MAD about the Quality Improvement Strategy occur quarterly at the DDSQI Steering Committee meetings to communicate information and findings. Trending and analysis of the data are used to prioritize improvements of the quality management system.

Data collection and the identification of trends for a waiver participant begins at the time an incident report is received on an individual and is assigned for investigation. A history of recent incidents filed is sent to the investigator along with the incident report. The investigator reviews the history to identify any relevant trends prior to beginning the investigation. Additionally, aggregate and trend data is generated by individual and by provider for review on a quarterly basis. Specifically, reports of all providers with three (3) incidents reported within the quarter and all waiver participants with three (3) incidents reported within the quarter are reviewed. However, because there are so few MF Waiver participants with reported incidents there have not been any trends that reached this threshold in the past. Through the DDSQI Health and Welfare workgroup, DHI reports and reviews all incidents and identifies trends every six (6) months and reviews the data with the MF Waiver Manager.

The State has a system to monitor, track and investigate critical incidents for MF Waiver participants. DOH/DHI investigates and follows up regarding waiver providers and critical incidents. ALTSD/APS and CYFD/CPS have

systems to monitor, track and investigate critical incidents that occur outside of the service delivery system.

Appendix G: Participant Safeguards

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

a. Use of Restraints or Seclusion. (Select one):

- The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

As with any event or incident that occurs during service delivery, there is a system in place for reporting and follow-up. The participant or any one with knowledge of the event can contact law enforcement, 911, the State Incident Management System, his/her case manager or Child/Adult Protective Services to report his/her concerns. Participants and their families are provided with contact information for Child Protective Services, Adult Protective Services and the Division of Health Improvement by their case manager or the home health agency. The Case Manager, during home visits, inquires if there are any issues or concerns regarding service delivery. The MF Waiver program does not authorize the use of restraints or seclusion.

For participants with behavioral support needs seeking support through the MF Waiver program, planning should include strategies for positive behavioral support and effective intervention that reduce risk resulting from the behavior.

- The use of restraints or seclusion 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 or Seclusion.** 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 or 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 restraints or 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-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. (Select one):

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

As with any event or incident that occurs during service delivery, there is a system in place for reporting and

follow-up. The participant or any one with knowledge of the event can contact law enforcement, 911, the State Incident Management System, his/her case manager or Child/Adult Protective Services to report his/her concerns. Participants and their families are provided with contact information for Child Protective Services, Adult Protective Services and the Division of Health Improvement by their case manager or the home health agency. The Case Manager, during home visits, inquires if there are any issues or concerns regarding service delivery. The MF Waiver program does not authorize the use of restrictive interventions.

For participants with behavioral support needs seeking support through the MF Waiver program, planning should include strategies for positive behavioral support and effective intervention that reduce risk resulting from the behavior.

The use of restrictive interventions is permitted during the course of the delivery of waiver services

Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- No. This Appendix is not applicable** (*do not complete the remaining items*)
- Yes. This Appendix applies** (*complete the remaining items*)

b. **Medication Management and Follow-Up**

- i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards**Appendix G-3: Medication Management and Administration (2 of 2)****c. Medication Administration by Waiver Providers**

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

i. Provider Administration of Medications. *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:
(c) Specify the types of medication errors that providers must *report* to the State:

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the 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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

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

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

Performance Measure:

Percentage of MF Waiver participants and/or participant representatives who received training on detecting signs of abuse, neglect, and exploitation (A.N.E.) and understand how and where to report it and/or get help. Numerator: Number of MF waiver participants and/or participant representatives who received A.N.E. training as described above. Denominator: Total number of MF Waiver participants.

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

	<input checked="" type="checkbox"/> Other Specify: All providers are reviewed on a 3 year schedule	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Telephone Interviews

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% margin of error and a 95% confidence level
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100px; height: 20px;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Annually up to every 3 years, depending upon compliance history and trends data for complaints and incidents	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee DOH/DHI/QMB	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

Performance Measure:

The percentage of unexplained, suspicious and untimely deaths for which review resulted in the identification of preventable causes. Numerator: Number of unexplained, suspicious and untimely deaths for which review resulted in the identification of preventable causes. Denominator: Total number of deaths.

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

Data Aggregation and Analysis:

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

Performance Measure:

The percentage of critical incidents with confirmed abuse, neglect and exploitation (A,N,E) that are reported with follow-up/resolution within required timelines.

Numerator: Number of critical incidents with confirmed A,N,E reported with follow-up/resolution within required timelines. Denominator: Total number of critical incidents with confirmed A,N,E reported.

Data Source (Select one):

Critical events and incident reports

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

	collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.	
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Data Aggregation and Analysis:

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

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

Formal quality improvement processes are in place, as described in detail in the DDSQI Steering Committee description and structure in Appendix H.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the 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 health and welfare 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 health and welfare data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

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

- ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise.

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The primary goals for the Medically Fragile (MF) Waiver Quality Improvement Strategy (QIS) are to administer and evaluate a quality improvement system that:

- Ensures participants 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 of Private Duty Nursing (PDN), Home Health Aide (HHA), Respite, and Specialized Medical Equipment and Supplies;
- 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 MF 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 MF Waiver program reports to the DDSQI Steering Committee where data are reviewed and actions are discussed and reported back to the program for implementation and remediation as required by CMS. Action plans must include an evaluative component to determine the effectiveness of actions once implemented.
- **Processes:** The role of the DDSQI Steering Committee is to ensure continuous quality improvement. The DDSQI Steering Committee is responsible for making systemic improvements to the MF 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 is implemented, the DDSQI Steering Committee informs the workgroups. MF 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 30 days prior to implementation. Information-sharing may include letters, announcements at scheduled meetings, website updates and state-wide meetings. If MF Waiver Service Standards or State regulation changes are needed, the State follows applicable State rules.

The DOH MF Waiver Manager works with providers and families to obtain stakeholder input and to assist the State with the on-going evaluation of the MF Waiver. The Family Advisory Board (FAB) is made up of MF Waiver participants and families who meet regularly. The DOH MF Waiver Manager and UNM Case Management Program Operations Director are ex-officio members of the committee. The FAB participants give feedback and recommendations to the DOH MF Waiver Manager. Additionally, a provider group comprised of MF Waiver home health agencies meets regularly with the DOH MF Waiver Manager 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. The Professional Advisory Committee (PAC) meets at least annually to provide feedback and recommendations. This Committee’s membership is comprised of: at least one physician; nursing educators; providers; Center for Developmental Disabilities (CDD) management; the DOH MF Waiver Manager; and case managers. Recommendations are forwarded 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 is distributed to the Steering Committee, applicable senior management, the workgroups, the DOH MF Waiver Manager, 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 <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Other Specify: 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 workgroups' 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).

The HSD/MAD contracts with an audit agent to conduct field audits and desk reviews on long-term care providers. These audits are to ensure that only allowable costs are included in the cost reports thus ensuring that Medicaid only pays for allowable costs. These audits take place on an ongoing basis. The cumulative number of MF Waiver Providers in this state is divided into three groups and each group is audited on an annual basis. Each MF Waiver providers are audited once every three years unless a problem arises and a focused audit is performed. HSD/MAD also contracts with a fiscal intermediary to provide claims processing services on behalf of the Department. This fiscal intermediary reviews claims for proper billing based on the methodologies outlined in the State Plan. The intermediary pays, suspends, or denies claims to providers. The New Mexico Office of the State Auditor contracts with an independent auditor to conduct an annual audit of the entire HSD. This audit scope includes a financial statement audit as well as an audit of the program including allowable costs.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

- 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.

- i. **Performance Measures**

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

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

Performance Measure:

The percentage of claims coded and paid for in accordance with the reimbursement methodology specified in the waiver. Numerator: Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator: Total number of claims submitted.

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

Specify: DDSQI Steering Committee	
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise.

Performance Measure:

The percentage of paid claims with supporting documentation on file at the provider agency. Numerator: Number of participant files reviewed which contain documentation to support billing. Denominator: Total number of participant files 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 50px;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: DOH/DHI/QMB	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 50px;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 50px;" type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Annually up to every 3 years depending upon compliance history and trends data for complaints and incidents	

Data Aggregation and Analysis:

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

Performance Measure:

The percentage of identified MF Waiver claims processing errors that are resolved within the required timeframe. Numerator: Number of MF Waiver claims processing errors that are resolved within the required timeframe. Denominator: Number of all MF Waiver claims processing errors that are identified.

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

	Specify:	
	<input style="width: 100%; height: 20px;" type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise.

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

Formal quality improvement processes are in place, as described in detail in the DDSQI Steering Committee description and structure in Appendix H.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the 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 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 financial data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

Methods for fixing identified problems include verbal direction, letters of direction, formal corrective action plans; documentation is kept at HSD and/or DOH 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input checked="" type="checkbox"/> Other Specify: DDSQI Steering Committee	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 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).

Rate determination and oversight is a joint responsibility of HSD and DOH. However, HSD must approve all rates and any changes to these rates.

Provider payment rates for each of the waiver services were established by a rate validation study conducted by Myers and Stauffer, Certified Public Accountants, in the year 2000 that largely relied upon wage proxies, estimates of staffing levels, and other estimates of incurred costs. Periodic adjustments have been made based on cost of living appropriations from the NM State Legislature. Payment rates for waiver services are uniform for every provider of a waiver service.

When changes to rates are necessary, providers and other stakeholders are notified via mail and the HSD website and are given the opportunity to provide input. All MF Waiver rates are available on the HSD and DOH websites. Information about payment rates is made available to waiver participants by the case manager, through the HSD website, and/or upon request by the participant to the State.

- 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:

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 the state operating agencies and HSD/MAD. Retrospective audits include verification that the services were provided as billed. Additionally DOH/DHI verifies that the services were provided as billed during case manager and provider on-site compliance monitoring reviews.

- 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: *Complete item I-3-e.*

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

FROM A SPECIAL FINANCING PLAN (1915)

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:

The source of funds utilized to provide the non-federal share of costs associated with the MF Waiver is state tax revenues appropriated each fiscal year as a state General Fund appropriation to the New Mexico Department of Health/Developmental Disabilities Supports Division (DOH/DDSD) which operates the MF Waiver. Provider billings are paid using the MMIS system at the Human Services Department (HSD) which is the designated Medicaid agency for the State of New Mexico.

The HSD then bills monthly the DOH/DDSD by submitting an invoice and a supporting MMIS report detailing the expenditures for the state General Fund match related to the costs of services provided through the HCBS waiver programs. DOH/DDSD reviews the billed amount, ensures the correct FMAP has been applied and prepares and submits a payment voucher to the New Mexico Department of Finance and Administration who makes payment to HSD, thereby making an intergovernmental transfer to the Medicaid agency.

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:

[Empty text box]

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:

[Empty text box]

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:

[Empty text box]

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

[Empty text box]

Appendix I: Financial Accountability

4. 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:

[Empty rectangular box for providing details on cost sharing arrangement]