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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Medically Fragile Waiver

C. Waiver Number:NM.0223
Original Base Waiver Number: NM.0223.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/22

Approved Effective Date of Waiver being Amended: 07/01/21

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The key components of proposed changes under the waiver amendments are as follows:

1. As approved in New Mexico's American Recovery Plan Act (ARPA) spending plan:
a) Implement Phased Economic Recovery Payments for all HCBS direct service providers of 10% and 5% respectively in waiver years 2 and 3. Updates were made to I-2(a), J-2(c), J-2 Table (d)(i) Waiver Years 2 and 3.
b) Temporary increase to Environmental Modifications benefit limits from $5000 to $6000 every 5 years through March 2024. Updates were made to C1/C3, J-2 Table (d)(i) Waiver Years 2 and 3.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)	
☒ **Waiver**	Purpose, Main Public Input	

Component of the Approved Waiver Application	Subsection(s)
☐ Appendix A Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	C-1/3
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	I-2a
☒ Appendix J Cost-Neutrality Demonstration	J-2c, J-2d

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☒ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

Implement Phased Economic Recovery Payments for all HCBS direct service providers of 10% and 5% respectively in waiver years 2 and 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 Waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NM.0223
Draft ID: NM.017.06.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/21
Approved Effective Date of Waiver being Amended: 07/01/21

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

Purpose of Waiver: The New Mexico MFW program serves individuals of all ages who have been diagnosed with a a medically fragile condition and a developmental disability or are developmentally delayed or at risk for developmental delay and meet ICF/IID level of care prior to their 22 birthday. The program is designed to keep medically fragile individuals with conditions that require frequent and ongoing medical supervision out of institutions.

The MFW is bound by the cost-effectiveness mandate of Federal authorization: the total cost for services cannot exceed the cost of institutional care. MFW 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 MFW: 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 MFW through a variety of committees and methods. The Joint Powers Agreement (JPA) between HSD/MAD and DOH/DDSD articulates provisions for operating the waiver for which HSD/MAD holds DOH/DDSD 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 in-patients of a hospital, nursing facility or ICF/IID.

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

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

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

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

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

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

I. Public Input. Describe how the state secures public input into the development of the waiver:

The State secured public input on the development of the MFW renewal through a variety of committees and methods. Input was 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, as well as the Strategic Planning Committee. The FAB is a group of participants and families that meet monthly who act as an advisory to the State on the Medically Fragile Waiver. Targeted stakeholder meetings were held with FAB members and stakeholders. Beginning July 2019 to October 2019, meetings were held throughout the state to provide information about the waiver renewal and gather feedback from participants, families, and stakeholders. FAB meetings were held in Albuquerque, New Mexico and families also attended via phone conference from multiple sites throughout the state.
In December 2020, the state implemented a formal public comment process for the waiver renewal. This included a sixty (60) day Tribal Notification period, thirty (30) days for tribes to review proposed changes and thirty (30) days to provide feedback; and a thirty (30) day general public comment period, both of which culminated in a public hearing. Notices were released on December 18, 2020 (Tribal Notification) and January 18, 2021 (General Public). Public notice distribution includes mailings to interested parties, emails, newspaper announcements in the Las Cruces Sun and Albuquerque Journal, and web postings. The public was invited to submit comments via postal mail, email, fax, phone or in person at the public hearing. The public hearing was held was held via conference call on February 22, 2021. Public comment period was extended to February 26, 2021 to allow the public to access and view documents on the new HSD website.
Public comments received:
1. Multiple comments in support of the proposed additional services, increased budgetary caps, and expansion of settings; that proposed changes provided children and adults who access this waiver will support a better quality of life. No changes were made to the waiver application based on this comment.
2. Comment that the waiver renewal needs to be more person specific with greater opportunity for community access. No changes were made to the waiver application based on this comment.
3. Comment requesting the addition of music therapy, aquatic therapy, and therapeutic horsemanship be included under specialized therapy for the proposed waiver renewal. No changes were made to the waiver application based on this comment.
4. Comment that the State must also address provider shortages. No changes were made to the waiver application based on this comment.
5. Comment requesting clarification on timeliness triage by the Department of Health Division of Health Improvement of incident reports that involve abuse and neglect and exploitation reviews. No changes were made to the waiver application based on this comment.
6. Comment that the limitations under Vehicle Modifications included language not applicable to this service. Limitations to Vehicle Modifications will be updated to only the following language: “Limitations: $5000, once every five years”.

AMENDMENT NM.017.06.01 PUBLIC INPUT

On March 29, 2022, HSD sent out public notice to inform tribal leaders and tribal healthcare providers. A contact name, number and email were provided on the public notice for individuals who had questions or needed more information. HSD invited the tribes to send comments by close of business on May 30, 2022.

On April 28, 2022, the state intends to send a notice to all interested parties summarizing the proposed changes to the waiver renewal and notification of the public hearing. The notice will provide the web link to the full waiver application website posting on the HSD webpage. A contact name, number and email were provided on the public notice for individuals who had questions or needed more information. Notices for Public Comment will be published in the Las Cruces Sun and Albuquerque Journal on April 15, 2022. The Albuquerque Journal is distributed statewide.

HSD and DOH will hold a public hearing session on May 30, 2022.

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: Buenviaje

First Name: Melanie

Title: Bureau Chief, Excempt Services and Programs

Agency: Human Services Department

Address: 1 Plaza de Prensa

Address 2:

City: Santa Fe

State: **New Mexico**

Zip: 87507

Phone: (505) 490-2460 **Ext:** ☐ **TTY**

Fax: (505) 827-3185

E-mail: melanie.buenviaje@state.nm.us

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

Last Name: Jason

First Name: Cornwll

Title: 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) 660-3453 **Ext:** ☐ **TTY**

Fax: (505) 222-6690

E-mail: scott.doan@state.nm.us

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: New Mexico

Zip:

Phone:

Ext: TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

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

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

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

○ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Department of Health, Developmental Disabilities Supports Division (DOH/DDSD)

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the

State Medicaid agency. Thus this section does not need to be completed.

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

The DOH/DDSD operates the MF Waiver and the HSD/MAD is responsible for the oversight of the waiver and provides ongoing monitoring through a Joint Powers Agreement (JPA) that specifies the roles and responsibilities of each department. Strong on-going collaboration and cooperation exist between the agencies to achieve desired outcomes. HSD/MAD is responsible for the overall administration and oversight of the Waivers and DOH/DDSD is responsible for overall implementation and operations of the Waiver. These methods include:

•Collaborating with DOH/DDSD to review and analyze program findings, develop strategies for improvement, and make timely changes to the waiver program as determined necessary; and
•Meetings with DOH/DDSD on a monthly basis to monitor the progress and to oversee the operations of the waiver program and to ensure compliance with Medicaid and CMS requirements.
•Joint agency participation in the Developmental Disabilities Services Quality Improvement (DDSQI) Committee as described in Appendix H of this application. DDSQI follows a comprehensive quality improvement strategy (QIS) which addresses compliance with waiver assurances among other quality improvement strategies and key performance indicators (KPI) designed to help the DD Waiver service system achieve better outcomes for consumers, their communities, and the New Mexico public at large.
•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.
•Ad hoc and regular waiver specific and cross-agency workgroups related to promulgations of state regulations and the development and implementation of standards, policies and procedures in alignment with all state and federal authorities related to home and community-based services (HCBS) waivers.
•Monthly meetings, or more frequently if needed, informally with DOH/DDSD staff to: exchange information about the JPA; discuss department roles and responsibilities; identify and resolve program issues; identify and resolve client specific issues, complaints and concerns; identify needed changes; problem-solve; review and update the work plan developed to track and monitor progress on assignments and projects related to the operation of the waiver; and provide technical assistance. Examples of issues that would trigger a meeting prior to a regular monthly meeting include but are not limited to special requests from policy makers; needed regulatory changes; provider issues; and constituent complaints.

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

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Contracted entity referenced in Appendix A-7 refer to the Third-Party Assessor (TPA) Contractor.

The TPA Contractor: The role of the TPA is to conduct the level of care evaluation (LOC) review, review participant service plans and budgets, and approve prior authorization of waiver services. The Medicaid Agency oversees the TPA to assure compliance with all policies and regulations. The Medicaid Agency makes the final decision for level of care through the review and recommendations of the contracted TPA. The Medicaid Agency retains the authority to exercise administrative discretion and issues policies, rules and regulations for waiver operations.

Any third-party contractor that conducts level of care and assessments and determines medical eligibility for the waiver cannot be enrolled as a waiver provider.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

HSD/MAD contracts with the TPA Contractor and is responsible for assessing the TPA's performance and compliance in conducting its respective waiver operational and administrative functions based on the terms of its contract.

Appendix A: Waiver Administration and Operation

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

HSD/MAD conducts periodic on-site operational and performance reviews of the 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 evaluations, review of individual service plans and prior authorization of waiver services and review, approval and entry of all budgets into the MMIS,.

HSD/MAD reviews TPA reports monthly to monitor compliance with the terms of the contract and performance. HSD/MAD conducts a bi-weekly TPA contract management meeting and additional meetings are scheduled as needed to address identified issues or concerns. On an annual basis, HSD/MAD reviews and approves the TPA Contractor's quality improvement/quality management work plan.

In addition, HSD/MAD requires monthly and quarterly reports from the TPA to assess performance and compliance with contract requirements. DOH provides HSD/MAD with any data, complaints or other information DOH has obtained from any source regarding the TPA Contractor's performance. If any problems are identified, HSD/MAD addresses performance issues with the TPA Contractor through weekly meetings and letters of direction. If non-performance continues, HSD/MAD may pursue a corrective action plan from the TPA Contractor.

The TPA is not responsible for monitoring waiver expenditures against approved levels. This is the function of Medically Fragile Nurse Case Managers as outlined in Appendix D-2 Service Implementation and Monitoring.

The Human Services Department Income Support Division (ISD) determines an individual’s Medicaid eligibility for the waiver.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☐	☐
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☒
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☒	☐
Establishment of a statewide rate methodology	☒	☒	☐

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

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

Where possible, include numerator/denominator.

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify:

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

Performance Measure:
Percentage of MFW Waiver data reports specified in the TPA contract with the Medicaid Agency (HSD) that were submitted on time and in the correct format. Numerator: Number of data reports submitted on time and in the correct format Denominator: Total number data reports required to be submitted

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports received from the TPA as outlined in their contract with the Medicaid Agency

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☒ **Other** 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 and DOH through the JPA ensures that the DOH has fulfilled its operational responsibilities, based on the JPA, and performs the functions listed in the section A-7 chart. HSD/MAD monitors these activities through monthly meetings, review of quarterly and annual reports, and review of actions taken by the operating agency. Formal quality improvement processes are in place, as described in detail in the Developmental Disabilities Systems 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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

Problems with functions performed by the TPA Contractor as identified by various discovery methods may result in placing the TPA Contractor on corrective action, and/or sanctions may be implemented, including possible contract termination.

If the contractor fails to improve performance after receiving technical assistance from the state, a corrective action plan (CAP) may be required. The contractor is required to submit a corrective action plan to the state within 30 days of the request from the state. Based on state approval of the corrective action plan, the contractor is required to remediate the identified performance issues.

DOH/DDSD provides technical assistance, documents and tracks the issues with the contractors listed in this section. When performance issues are identified with waiver functions performed by contractors, DOH/DDSD meets regularly in person and by phone. Meetings may occur as frequently as weekly if needed with the contractors to provide technical assistance and guidance. If issues are not resolved, the Contractor may be placed on corrective action, and/or sanctions will be implemented, including possible contract termination.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **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 one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☒	Medically Fragile	0		☒
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	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 as defined below; and 2) meet ICF/IID 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.

The definition for Intellectual and Developmental Disability (IDD) is as follows: Developmental disabilities is limited to intellectual disability (ID) or a related condition as determined by DOH/DDSD. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated. The eligible recipient must also require the level of care provided in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), in accordance with 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements.
An individual is considered to have an intellectual disability if she or he has significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

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

An individual is considered to have a related condition if she or he has a severe, chronic disability that meets all of the following:
a. Is attributable to a condition, other than mental illness, found to be closely related to ID because this condition results in limitations in general intellectual functioning or adaptive behavior similar to that of persons with ID and requires similar treatment or services
b. Is manifested before the person reaches age twenty-two (22) years
c. Likely to continue indefinitely
d. Results in Substantial Functional Limitations (Adaptive Behavior scores ≤ 70) in 3 or more of the following areas:

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

Medically Fragile individuals who have been diagnosed with a medically fragile condition before reaching age 22; and who have a developmental disability or developmental delay, or who are at risk for developmental delay; and a medically fragile condition defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention in 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 on 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.

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	210
Year 2	210
Year 3	210
Year 4	210
Year 5	210

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	
Year 5	

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Individuals are allocated to the waiver on a statewide basis in chronological order by date of waiver registration.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

○ **No**

◉ **Yes**

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

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

☐ **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☐ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

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

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

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

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

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

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

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

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

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

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

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

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

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

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

need waiver services is: 1

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

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

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

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

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

Specify the entity:

The TPA conducts the level of care (LOC) evaluation. The Medicaid Agency oversees the TPA to assure compliance with all policies and regulations. The Medicaid Agency makes the final decision for level of care through the review and recommendations of the contracted TPA. The Medicaid Agency retains the authority to exercise administrative discretion and issues policies, rules and regulations for waiver operations.

- ( ) **Other**

Specify:

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

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver individuals include: a physician, a certified nurse practitioner, a registered nurse licensed in New Mexico, or a qualified intellectual disabilities professional (QIDP) as defined in 42 CFR 483.430.

The TPA contractor must be a designated Quality Improvement Organization (QIO) or QIO-like entity as described in CFR 475. The current TPA contractor is a Quality Innovation Network-QIO.

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

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

The individual must meet the level of care required in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The State's Long-Term Care Assessment Abstract (LTCAA) is used to determine ICF/IID level of care.

The ICF/IID LTCAA is used to evaluate if an individual meets the ICF/IID LOC criteria.
The ICF/IID Level of Care Criteria includes the following:

A. Physical Development and Health

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

B. Nutritional Status

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

C. Sensorimotor Development

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

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

E. Speech and Language Development

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

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

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

H. Social Development

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

I. Independent Living

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

J. Adaptive Behaviors

1. Harmful Behavior: are those behaviors that a client exhibits that are harmful to themselves or to others and require staff intervention.
2. Disruptive Behavior: are those behaviors exhibited by a client that are disruptive to others and require staff intervention.
3. Socially Unacceptable or Stereotypical Behavior: behaviors that are socially unacceptable or considered to be stereotypical and require staff intervention.

4. Uncooperative Behavior: uncooperative behaviors that require staff intervention.
After the level of care is determined with the LTCAA, other documents are used to further substantiate the level of care. The Comprehensive Individual Assessment & Family Centered Review delineates medical, functional, social and developmental information; the Medically Fragile Parameters determine level of medical fragility; and the History and Physical are reviewed for any inaccuracies that may dispel the level of care determined in the Long-Term Care Assessment Abstract.
The rule criteria for LOC are set forth at 8.314.3 NMAC.

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

For eligibility to the waiver and prior to receiving services, participants must meet both financial and medical eligibility requirements. The Human Services Department (HSD) makes the final determination whether participants meet the financial and medical eligibility requirements in order to issue approval of waiver eligibility. Medical eligibility is determined through the level of care (LOC) evaluation and verification that the individual meets the LOC.

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

2.The case manager obtains the LTCAA form and history and physical from the physician, and gathers any other relevant information (i.e. client individual assessment) to substantiate the LOC. The documents are submitted to the TPA Contractor for LOC evaluation.

3.The TPA Contractor reviews and evaluates initial and annual LOCs applying the criteria established by HSD.

4.The TPA Contractor provides notification to HSD of the approval or denial of the LOC. HSD reviews the LOC notification in conjunction with the assessment of financial eligibility to make the final eligibility determination for the waiver. The HSD provides notification to the participant of the approval or denial of waiver eligibility. If there is a denial of LOC, the denial letter is sent to the individual and/or family or legal representative and includes information on the HSD reconsideration process and fair hearing rights.

The process is the same for both initial LOC evaluations and LOC re-evaluations.

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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

The waiver case manager is responsible for tracking the individual's LOC reevaluation to ensure timely completion of the reevaluation process. The case manager must submit the Long-Term Care Assessment Abstract (LTCAA) packet to the TPA Contractor for LOC determination.

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Percentage of MF Waiver applicants, for whom there is reasonable indication that services may be needed in the future, with an initial completed LOC evaluation. Numerator: Number of initial MF waiver LOC evaluations performed. Denominator: Total number of new MF 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: TPA Contractor	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: TPA Contractor DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measures

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

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

Performance Measure:
Percentage of initial LOC evaluations for waiver participants that comply with the processes and instruments specified in the approved waiver. Numerator: Number of compliant initial LOC evaluations for waiver participants. Denominator: Total number of initial LOC evaluations 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: TPA Contractor	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: TPA Contractor DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement related to LOC are identified by HSD/MAD, processes are in place to ensure that appropriate and timely action is taken. This applies to both current and new waiver applicants with a reasonable indication that services may be needed.

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Annually**
	☐ **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 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 MFW DOH/DDSD 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 Individuals with Intellectual Disabilities (ICF/IID). If the applicant chooses HCBS, then the applicant is given a choice between the MFW or the Mi Via Self-Directed Waiver.

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

Upon selection of the requested MFW 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 MFW 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/ISD offices and at HSD and DOH statewide toll-free numbers. Statewide disability resource agencies, such as ALTSD Resource Center, Governor's Commission on Disabilities, and New Mexicans with Disabilities Information Center, Independent Living Resource Centers, have bi-lingual staff available. The DOH/DDSD can arrange for variety of translators for planning meetings upon participant requests. Translated documents can also be arranged for through the DOH/DDSD upon participant request. The case management, provider agencies, and TPA are required to communicate in the language that is functionally required by the participant and have "language lines" available for participants who speak a language other than Spanish or English.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Case Management		
Statutory Service	Customized Community Group Supports		
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	Environmental Modifications		
Other Service	Individual Directed Goods and Services		
Other Service	Private Duty Nursing		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Specialized Therapies		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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 though 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):*

Agency licensed by the State of New Mexico; nurses licensed by the New Mexico State Board of Nursing as a RN.
Licensure requirement for Case Management Agency as per NMAC 8.314.5.10, C.
Licensure requirements for Case Managers as per NMAC 8.314.5.10, D.

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:

Day Habilitation

Alternate Service Title (if any):

Customized Community Group Supports

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Customized community group supports can include participation in congregate community day programs and community centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills for an eligible recipient. Customized community group supports may include adult day habilitation programs, and other day support models. Customized community group supports are provided in integrated community settings such as day programs and community centers which can take place in non-institutional and non-residential settings. These services are available at least four or more hours per day one or more days per week. Service hours and days are specified in the eligible recipient's individual support plan.

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Customized Community Group Supports Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Customized Community Group Supports Provider

Provider Qualifications

License *(specify):*

Agencies providing community group support services must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements.

Certificate *(specify):*

Other Standard *(specify):*

A Customized Community Group Support Provider Agency must meet requirements including a business license, financial solvency, training requirements, records management, quality assurance policy and processes.
Providers, whether an agency staff or an individual provider must meet the following qualifications: (i) must be at least 18 years of age; (ii) pass criminal background check and abuse registry screen; (iii) demonstrate capacity to perform required tasks; (iv) complete training on critical incident, abuse, neglect, and exploitation reporting; and (v) have the ability to successfully communicate with the eligible recipient.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Home Health Aide

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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)
Licensure as per NMAC 8.314.5.10, E, F

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 or certified nursing assistants,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.

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):

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Respite 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 settings: participant's home or private place of residence, the private residence of a respite care provider, specialized foster care home, other medically qualified foster care home, or an intensive medical living supports provider.
The participant and/or participant representative has the option and gives final approval of where the respite services are provided. The 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	Specialized Foster Care
Agency	Intensive Medical Living Supports 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. Respite provider agencies must hold a current business license, and meet financial solvency, training, records management and quality assurance rules and requirements.

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:

Specialized Foster Care

Provider Qualifications

License *(specify):*

Licensed specialized foster care home. Respite provider agencies must hold a current business license, and meet financial solvency, training, records management and quality assurance rules and requirements.
Licensure requirements as per NMAC 8.314.5.10, I.

Certificate *(specify):*

Specialized Foster Care Provider, certified by New Mexico Children, Youth and Families Department.
Certification requirements as per NMAC 8.26.4.18,C.

Other Standard *(specify):*

A Specialized Foster Care 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 Specialized Foster Care Provider providers that are 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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Intensive Medical Living Supports Provider

Provider Qualifications

License *(specify):*

An intensive medical living services provider 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.

Certificate *(specify):*

Other Standard *(specify):*

The RNs and LPNs who work for an intensive living medical provider 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.)

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Nutritional Counseling

HCBS Taxonomy:

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

Service Definition (Scope):

Nutritional Counseling 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 participants nutritional needs, regimen development, and/or revisions of the participants 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):*

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

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

HCBS Taxonomy:

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

Service Definition *(Scope):*

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.
A therapist in the MFW may use a variety of modality to deliver this service, including but limited to music, art and animal therapy.
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 individuals 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 participants 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
Agency	Group Practice/Home Health Agency
Individual	Individual Therapy Practitioner

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

Physical Therapy Assistants and Occupational Therapy Assistants must meet all requirements outlined in NMAC 16.20.6.

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: 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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Support Consultation

HCBS Taxonomy:

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

Service Definition *(Scope):*

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:

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):*

Licensure: A mental health professional that wants to provide BSC services must possess one of the following licenses approved by a New Mexico licensing board as per NMAC 8.314.5.10, H. Psychiatrist; Clinical Psychologist; Independent Social Worker (LISW); Professional Clinical Mental Health Counselor (LPCC); Professional Art Therapist (LPAT); Marriage and Family Therapist (LMFT); Clinical Social Worker (LCSW); Mental Health Counselor (LMHC); Master Social Worker (LMSW); Psychiatric Nurse; or Psychologist Associate (PA).

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:

Environmental Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

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

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

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

Limitations: $5000, once every five (5) years in waiver years 1,4 and 5; $6000, once every five (5) years in waivers years 2 and 3 due to availability of funding through the American Rescue Plan Act (ARPA) of 2021, Section 9817.

To the extent that any listed items are covered under the state plan, the items under the waiver would be limited to additional items not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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	GB-2 Class Construction

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

GB-2 Class Construction

Provider Qualifications

License *(specify):*

License as per NM Regulation and Licensing Department, NMSA 1978, Section 60-13-3.
Have a current business license issued by the state, county or city government.

Certificate *(specify):*

Other Standard *(specify):*

Comply with all applicable state laws, rules, regulations, and building codes for the state of New Mexico.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Individual directed goods and services: Individual directed goods and services are equipment, supplies or services, not otherwise provided through the Medically Fragile Waiver Specialized Medical Equipment and Supplies Services, Medicaid state plan, or Medicare. Individual directed goods and services must directly relate to the member's qualifying condition or disability. Individual directed goods and services must explicitly address a clinical, functional, medical, or habilitative need.
Individual directed goods and services must address a need identified in the participant's ISP and meet the following requirements:

(i) supports the eligible recipient to remain in the community and reduces the risk for institutionalization; and
(ii) promote personal safety and health; and afford the eligible recipient an accommodation for greater independence; and
(iii) decrease the need for other Medicaid services; and
(iv) accommodate the eligible recipient in managing his or her household or facilitate activities of daily living.

The participant receiving this service does not have the funds to purchase the Individual Directed Goods and Services (s) or the Individual Directed Goods and Services (s) is/are not available through another source. These items are purchased from the participant's individual budget. Experimental or prohibited treatments and goods are excluded.

Individual Directed Goods and Services is an optional benefit that may be utilized by participants of all ages. It is not an age-related benefit. Individual Directed Goods and Services may only be used for goods and services that are not available under the state plan or EPSDT.

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

Limit is $1200 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: Individual Directed Goods and Services

Provider Category:

Agency

Provider Type:

Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual directed goods and services vendors must hold a current business license and tax identification for New Mexico and the federal government. Vendors for individual directed goods and services are retail stores, community health centers, or medical supply stores.
Comply with all applicable state laws, rules, regulations, and building codes for the state of New Mexico.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Private Duty Nursing

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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.)
icensure requirements for Federally Qualified Health Centers as per: NMAC 8.26.4.18,E,F.

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

HCBS Taxonomy:

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

Service Definition *(Scope):*

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.

Specialized Medical Equipment and Supplies may be utilized by participants of all ages. It is not an age-related benefit. The SME benefit may only be used for DME or medical supplies that are not available under the state plan.

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

Limited to $1200 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/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Therapies

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Specialized Therapies are non-experimental massage therapies or techniques that have been proven effective for certain conditions.

Massage therapy: Massage therapy is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, an eligible recipient's ability to be more independent in the performance of activities of daily living; thereby, decreasing dependency upon others to perform or assist with basic daily activities. See 16.7.1 NMAC.

Massage Therapy may be utilized by participants of all ages. It is not an age-related benefit. Massage therapy provided under a licensed Physical Therapist or Occupational therapist is not covered under this benefit.

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

$2000 per budget year

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Group practice/vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Therapies

Provider Category:

Agency

Provider Type:

Group practice/vendor

Provider Qualifications

License *(specify):*

Qualifications: a RLD license in massage therapy.
Licensure requirements as per: NMAC 16.7.4.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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

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

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

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

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

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

Limitations: $5000, once every five (5) years

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Individual

Provider Type:

Individual or company

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Appropriate mechanic or body work license; appropriate technical certification to perform the modification;

Other Standard *(specify):*

Hold a current business license issued by the State, county or city government.
Comply with all applicable state laws, rules, regulations, and building codes for the state of New Mexico.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Initially and 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.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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):

Background checks are required for all providers rendering waiver services in the State of New Mexico.

The Department of Health (DOH), Division of Health Improvement (DHI), is responsible for conducting criminal history and/or background investigations.

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

DOH/DHI criminal history and/or background investigations include both statewide and nationwide checks. This screening collects information concerning a person's arrests, indictments, or other formal criminal charges, and any dispositions arising there from, including convictions, dismissals, acquittals, sentencing, and correctional supervision. If the person's nationwide and statewide criminal history record reflects a disqualifying conviction and results in a final determination of disqualification, then this person cannot be hired or continue to be employed.

To ensure that mandatory investigations for criminal history record checks has been completed, the DOH Quality Management Bureau (QMB) conducts reviews of 100% of agency personnel records in regards to completion of background checks. QMB requires a plan of correction for all deficiencies. Plans of correction are not closed until each deficiency is addressed and corrected. DOH regional staff monitors the completion and outcome of plans of correction. Audit findings are forwarded to the DOH Provider Enrollment Unit to store in the master file for each provider agency. This information is one factor used to determine future provider agreement terms.

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 persons 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 persons 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.*

☐ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

◉ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

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

○ **Other policy.**

Specify:

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

Provider enrollment is a continuous, open enrollment. Enrollment requirements and procedures and applications for enrollment are available on the DOH/DDSD website. Interested providers may also request information and a provider enrollment application at any time by contacting, via telephone, DOH/DDSD provider enrollment staff. DOH/DDSD staff will meet with interested providers to provide technical assistance on the application process and review criteria. In addition, DOH/DDSD issues a formal call for providers when provider capacity does not meet the demands of the waiver.

New providers are required to complete a DOH/DDSD provider application packet that includes, among other documents, policies and procedures regarding provider licensure/certifications, QM plan etc. The DOH/DDSD Regional Office is responsible for reviewing and approving the programmatic "Factors" portion of the application, while the DOH/Program Enrollment Unit reviews other portions of the application. If approved, the provider receives a one-year provisional contract. The provider then receives a Medicaid number and is placed on the "freedom of choice" list. DOH/QMB may schedule a routine survey within the first 6 months from that date or 6 months from the date the agency starts serving its first participants. If the 6-month review is satisfactory, the agency can be placed on a three-year cycle.

Once the completed provider enrollment application is approved by DOH, it is forwarded to HSD/MAD for final approval. All provider enrollment applications must be approved by HSD/MAD prior to the provision of waiver services. The timeframe for processing new and renewal provider agreements is eight (8) weeks once a completed application is received.

At a minimum, Medically Fragile Waiver providers receive a "routine" survey by the DOH/Quality Management Bureau every 1 - 3 years. This is based on the Provider Agreement dates established by DOH/DDSD. A "Routine" survey is scheduled annually to every three years depending on the provider agreement, compliance history and trends data for complaints and incidents. DOH/QMB may conduct an unannounced survey at any time. Surveys may be conducted as regularly scheduled, upon referral or other triggers as indicated.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
The percentage of licensed/certified providers who meet required licensure and/or certification standards prior to furnishing waiver services. Numerator: Number of

newly enrolled licensed/certified providers who meet licensure/certification standards. Denominator: Total number of newly enrolled licensed/certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: upon enrollment	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: 100% of providers selected based on provider agreement dates. For details see text box C-QIS-c-ii
	☒ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
The percentage of enrolled non-licensed/non-certified providers who are in compliance with required background checks. Numerator: Number of compliant enrolled non-licensed/non-certified providers. Denominator: Total number of enrolled non-licensed/non-certified providers.

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

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

		100% of providers selected based on provider agreement dates. For details see text box C-QIS-c-ii
	☒ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DOH/DHI/QMB DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **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 the State will use to assess compliance with the statutory assurance,

complete the following. Where possible, include numerator/denominator.

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DOH/DHI/QMB	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: 100% of providers selected based on provider agreement dates. For details see text box C-QIS-c-ii
	☒ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **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.

SAMPLING APPROACH: PERFOMANCE MEASURE QIS C a & b:

New providers are required to complete a DOH/DDSD provider application packet that includes, among other documents, policies and procedures regarding provider licensure/certifications, QM plan etc. The DOH/DDSD Regional Office is responsible for reviewing and approving the programmatic "Factors" portion of the application, while the DOH/Program Enrollment Unit reviews other portions of the application. If approved, the provider receives a one-year provisional contract. The provider then receives a Medicaid number and is placed on the "freedom of choice" list. DOH/QMB may schedule a routine survey within the first 6 months from that date or 6 months from the date the agency starts serving its first participants. If the 6-month review is satisfactory, the agency can be placed on a three-year cycle.

At a minimum, MFW providers receive a "routine" survey by the DOH/Quality Management Bureau every 1 - 3 years. This is based on the Provider Agreement dates established by DOH/DDSD. A "Routine" survey is scheduled annually to every three (3) years depending on the provider agreement, compliance history and trends data for complaints and incidents. DOH/ QMB may conduct an unannounced survey at any time. Surveys may be conducted as regularly scheduled, upon referral or other triggers as indicated.

SAMPLING APPROACH: PERFOMANCE MEASURE QIS C c:

During QMB compliance audits, 100% of agency staff are reviewed for compliance with training requirements through record review and interview. Agency personal records are reviewed to verify on-going staff training. Interviews are completed with staff providing services to the individuals on the sample to verify staff is competent to provide the individual's needed services.

b. Methods for Remediation/Fixing Individual Problems

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

Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement are identified by the State related to qualified providers, processes are in place to ensure that appropriate and timely action is taken.

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☒ **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 or 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/IID when the caregiver(s) is no longer above 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 or 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 listed below. 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 1990s. This method has been successful in meeting the needs of the participants. However, it was based upon a percentage of the ICF/IID 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 participants 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.

Effective July 1, 2021 CMS approved the increased rates for Case Management, Private Duty Nursing -RN, Private Duty Nursing LPN, Home Health Aide, Occupational Therapy, Physical Therapy, and Speech Language Pathology, Respite, Nutritional Counseling and Behavioral Support Consultation in order to provide critical funding support needed to sustain the current waiver provider system. The State proposed an increase to capped amounts to avoid a reduction to assure that the quantity of services can be provided.

Annual capped dollar amounts are as follows; the total cost of all services cannot total an amount in excess of these caps unless additional funding is approved as described below:

Age	Level 1	Level II	Level III
21 & over	$190,000	$145,000	$100,000
Under 21	$42,000	$42,000	$42,000

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. An additional $5000 is available to each participant every five years for the purpose of Environmental Modifications.

To ensure continuity of care additional funding is available for participants who exceed their budget limit due to the impact of provider rate increases. Requests for additional funding are submitted by the MFCM to the Third Party Assessor (TPA) for review. The TPA will review the request and approve, partially approve, or deny the request for additional funding. A fair hearing process is available for denials rendered by the TPA. The state will review claims data, with application of the revised rates, prior to the waiver renewal to determine impact to the budget limits.

This is a waiver designed for participants living in their home environment with a primary caregiver(s). 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/IID when the caregiver(s) is no longer able to support the individual at home.

The Long-Term Care Assessment Abstract (LTCAA) is completed by the Medically Fragile Waiver Nurse Case Manager and participants' primary care practitioner. The PCP must sign and date the LTCAA form, stating that the PCP has seen and evaluated the person.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

New services added to the waiver under the renewal application NM.0223.R06.00, comport with the 2014 Home and Community-Based Services Waiver Settings Regulation. The services settings are included in other HCBS programs and are already included in the State's Statewide Transition Plan.

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 MFCM engages the participant/participant representative in developing the ISP. At the initial meeting with the MFCM, the participant/participant representative is given the Family Handbook which contains information about ISP development. During the MFCM meetings with the participant/participant representative before the Interdisciplinary Team (IDT) meeting, the MFCM explains the waiver process and encourages his/her leadership and full participation in the service plan meetings.

Working together, the MFCM and participant/participant representative identify the participants 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 participants 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-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

Interdisciplinary Team (IDT) meetings are held to develop the person-centered 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.

The CM 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 CM and participant; and through the person-centered planning process that takes place between the CM and participant 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 (H&P) 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 CM then makes results available to the participant. 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, anticipated or known transitions, 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 CM provides the participant with information about the MFW. The CM provides information about the range and scope of service choices and options, as well as the rights, risks, and responsibilities associated with the MFW. The CM then gives the participant a Family Handbook in electronic or hard copy that contains information about the MFW, 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 CM 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 to HSD Income Support Division (ISD) for financial eligibility determination annually and as needed.

The participant/guardian has the opportunity to be involved in all aspects of the ISP. The purpose of IDT meetings is to develop the ISP, review effectiveness of the ISP and revise the ISP.
Pre-planning are informal calls/-in persons visits use to prepare for an IDT meeting where the CM will offer the participant/participant's representative a list of waiver services as appropriate and will document selected services.

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

The IDT will be comprised of the participant/participant's representative, the PCP and all MFW providers and external providers. The MFW providers are expected to attend ISP meetings and all others are encouraged to attend. The participant, the participant's guardian, the nurse case manager and all provider agencies must be present at the IDT meeting or provide their input to the CM or designee before the IDT meeting. The care coordinator from the MCO is invited to attend in person or by phone. IDT meetings are held at a location and time that is convenient to the participant and the person(s) he/she wants to participate.

During the IDT meeting, the CM assists the participant 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 CM 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 CM assures the ISP budget is within the Capped Dollar Amount (CDA) before submitting the MFW budget to the Third-Party Assessor (TPA). Implementation of the ISP begins when provider service plans have been received by the CM and participant, and the plan and budget have been approved by the TPA. The State does not use temporary, interim service plans to get services initiated until a more detailed service plan can be finalized.

The CM 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 MFW 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 MFW New Mexico Administrative Code (NMAC) and Service Standards.

Non-waiver services, i.e.: EPSDT services, durable medical equipment, therapies and medical specialists services are coordinated by the CM 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 CM contacts the participant to initiate revisions to the budget. The CM initiates the scheduling of IDT meetings and assures the IDT meeting is in compliance with the MFW Service Standards.

MONITORING
The CM 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 CM. 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 CM 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 MFW reflects a strong commitment throughout the planning process to supporting the participant and family in the decision to have the participant in a home environment with a primary caregiver. Additionally, the State must assure the participant's safety, and the CM is required to work with the participant in developing a plan that addresses risks that have been identified during the participant's LOC assessment, CIA and ISP development process.
The MFW provider always involves the participant 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, which includes the LTCAA, CIA, H&P, and other pertinent medical documentation address the participant's medical fragility factors and developmental disabilities factors.

The assessment process allows the CM, participant and other professionals (Private Duty Nurses (PDN), 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. All waiver providers are required to have a back-up plan. The CM 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, the CM describes the services offered in the MFW as well as services, and other resources, that are available through the State Plan and in the community. The participant receives a Family Handbook in electronic or hard copy that contains information about the MFW, State Plan and community services.

As required by the MFW, the CM provides information to each participant regarding choices for each service entered on the MFW budget. This information is shared via the Secondary Freedom of Choice (SFOC) Form. The CM assists the participant in an exploration of service options and provides the participant with relevant SFOC Forms. The SFOC lists eligible providers in the participant's county for available services. Participants and families are encouraged to research and visit service providers before making selections and to ask providers to describe their programs. The CM also uses the tip sheet titled "How to Choose a Home Care Agency" with questions to consider when choosing this most frequently used service. Once the participant makes a provider selection, he/she indicates the selection and signs the SFOC Form. DOH/DDSD also provides a web-based list of currently approved and qualified waiver providers by service type, region and county. DDSD has staff available to provide technical assistance to CMs, providers, individuals and guardians regarding the freedom of choice and person-centered planning process as outlined in the waiver standards and regulations.

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):

After completing an internal review of the ISP and budget the CM submits the ISP and budget to the TPA Contractor for approval.

HSD contracts with the TPA Contractor to approve each participant's ISP annually or more often if there is a change in the participant's needs or circumstances. The TPA Contractor is required to monitor reviewers' approval accuracy and compliance with criteria during its monthly quality assurance activities and report findings to HSD/MAD quarterly. If HSD/MAD identifies any issues that are inconsistent with Medicaid requirements at any time, HSD/MAD ensures that the TPA Contractor corrects the problem. Corrective measures may begin with detailed letters of direction (LODs) and can escalate, if necessary, to corrective action plans and contract sanctions. This review and approval of every service plan is the State's oversight of service plans. The Third-Party Assessor reviews 100% of initial plans, annual plans and revisions.

The Medicaid agency's contracted nurse auditor will review, on an annual basis, a representative sample of service plans retrospectively to ensure the ISPs approved by the TPA have been developed in accordance with applicable policies and procedures and plans ensure the health and welfare of participants. HSD/MAD will develop the review criteria jointly with the DOH/DDSD.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☒ **Other**

Specify:

TPA

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 (CM) agency is the entity responsible for monitoring the implementation of the ISP and the participant's health and welfare. The MFW is a medically driven, community-based program and includes provision of CM services by RNs. The CM and participant work together face-to-face and electronically initially and ongoing to assess, plan, implement, evaluate, and monitor the implementation of ISP delivery, health and welfare. The role of the CM has developed over the years as a comprehensive, dynamic, individualized and family-centered approach. The responsibilities of the CM include:

- coordination, management and oversight of all activities related to the participant's care in a predominantly rural and culturally diverse state;
- performs as the initiator and facilitator of community services and resources relative to the participant's and family's needs;
- promotes community awareness of individuals who are medically fragile, as well as developmentally disabled; conducts at least every other month face-to-face contact with the participant and telephonic or electronic contact with the participant and every month;
- with the participant reviews all services implemented and identified in the ISP and other services being provided for desired outcomes;
- maintains ongoing contacts with waiver providers, community providers, and state agencies as a necessary part of monitoring and coordination of services;
- follows up with the appropriate agency when the participant, participant representative or CM has concerns about services being delivered;
- participates in the resolution of problems as needed;

The CM 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 CM and participant work together to determine the waiver services which will be included in the service plan. The CM also assists the participant to identify needed EPSDT services. When the services identified are benefits with the State Plan, a referral is made. The CM assists the participant to identify services available through the waiver. Once the type of service is identified, the participant is given a Secondary Freedom of Choice (SFOC) to choose the provider agency. Once the provider agency is selected, the CM makes the referral. The participant interviews the prospective provider and has the right to accept or deny the provider prior to the start of services. The participant the right to decline services from a provider at any time. The CM is available to assist the participant in evaluating risk verses benefit when declining services and following up with the provider agency to try and resolve problems between the participant as needed. Back-up plans are required and are referenced in the ISP which is implemented by the primary care giver or any home health agency providing services as necessary.

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

1) Services are furnished in accordance with the service plan;
2) Back-up plans are in place;
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 DOH MFW program 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 DOH MFW program manager collects information about monitoring results from DOH/DHI surveys. 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 surveys, DOH/DHI requires a plan of correction be completed for all deficiencies identified for the individual, as well as systemically to ensure overall improvement of the provider. When problems are identified by the DOH MFW program manager, the program 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Percentage of service plans that adequately address needs, health and safety, and personal goals, identified through LOC assessment and the ISP. Numerator: Number of new and annual service plans determined to adequately address needs, health and safety risk, and personal goals identified through LOC assessment and the ISP. Denominator: Total number of new and annual service plans submitted.

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5% margin of error and a 95% confidence level
☒ **Other** Specify: DOH/DHI/QMB	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: 100% of providers selected based on provider agreement dates. For details see text box C-Quality Improvement-a-ii
	☒ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measures

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

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

Performance Measure:
Percentage of individual service plans (ISP) that were reviewed annually or revised,

as warranted, by changes in individuals' needs, for individuals with continuous enrollment of 12 months. Numerator: Number of ISP's reviewed annually/revised for individuals with enrollment of 12 months. Denominator: Total number of ISP's for individuals with continuous enrollment of 12 months.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Third-Party Assessor (TPA) Contractor reports

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: TPA Contractor DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Percentage of participants receiving services consistent with their service plan in type, scope, amount, duration and frequency of services. Numerator: Number of individuals who receive all services identified in the ISP including the specified type, scope, amount, duration, and frequency. Denominator: Number of individuals with reviewed records.

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

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

Agency		
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: UNM Case Management Agency	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

		+/- 5% margin of error and a 95% confidence level
☒ **Other** Specify: DOH/DHI/QMB	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Percentage of participants who are afforded the choice between/among waiver services and providers. Numerator: Number of records reviews which contain Secondary Freedom of Choice documents (indicating choice of services/providers). Denominator: Total number of records reviews for individuals on the MF waiver.

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

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

Specify: DOH/DHI/QMB		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DOH/DHI/QMB DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **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.

SAMPLING APPROACH and FREQUENCY OF REVIEW:

New providers are required to complete a DOH/DDSD provider application packet that includes, among other documents, policies and procedures regarding provider licensure/certifications, QM plan etc. The DOH/DDSD Regional Office is responsible for reviewing and approving the programmatic "Factors" portion of the application, while the DOH/Program Enrollment Unit reviews other portions of the application. If approved, the provider receives a one-year provisional contract. The provider then receives a Medicaid number and is placed on the "freedom of choice" list. DOH/QMB schedules a routine survey approximately 6 months from the date the agency starts serving its first participants. If the 6-month review is satisfactory, the agency can be placed on a three-year cycle.
At a minimum, MFW providers receive a "routine" survey by the DOH/Quality Management Bureau every 1 - 3 years. This is based on the Provider Agreement dates established by DOH/DDSD. A "Routine" survey is scheduled annually to every three (3) years depending on the provider agreement, compliance history and trends data for complaints and incidents. DOH/ QMB may conduct an unannounced survey at any time. Surveys may be conducted as regularly scheduled, upon referral or other triggers as indicated.

b. Methods for Remediation/Fixing Individual Problems

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

Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement related to 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify:

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The waiver rules promulgated by HSD (8.352.2 NMAC; 8.354.2 NMAC), provide that the State must grant an opportunity for an administrative hearing pursuant to state statute and regulations and 42 CFR Section 43 I .220(a)(I) and (2).

All participants are afforded the opportunity to request a Fair Hearing in all instances when they are denied the service(s) of their choice or that provider(s) of their choice.

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

1. The participant is given information by the Case Manager (CM) during the initial enrollment meeting about his or her right and how to request a Fair Hearing, as set forth in the Medical Assistance Division (MAD) Regulations 8.352.2 NMAC Recipient Hearing Policies. When services, the budget, LOC, and other waiver decisions result in a reduction, termination, modification, suspension, or denial of services, the participant is notified in writing about the right to a Fair Hearing. CMs are trained in this process and available to assist participants in understanding how to request a Fair Hearing.
2. Various agencies are responsible for notifying the waiver participant of his or her right to a Fair Hearing as defined by 8.352.2 NMAC. A participant may request a Fair Hearing when he or she believes that Medicaid has taken an action erroneously. The participant is informed by the Third Party Assessor (TPA), or the Human Services Department (HSD), in writing, of the opportunity to request a Fair Hearing when Medicaid services are terminated, modified, reduced, suspended or denied, also called an adverse action. The adverse action letter explains the participant's right to continue to receive services during the Hearing process and the time frame to request continued services. The agencies responsible for notification of Fair Hearings are responsible for maintaining documentation of the notification.

a. The TPA Contractor provides notice to the Department of Health (DOH), HSD, and the individual when an individual does not meet level of care criteria.
b. The TPA Contractor provides notice when services are denied, reduced, terminated, modified, or suspended.
c. The DOH/Developmental Disabilities Supports Division (DDSD) provides notice when DOH/DDSD determines that an individual does not meet the definition of medically fragile or developmental disabilities.
d. The HSD/Income Support Division (ISD) office provides notice when an individual does not meet financial and/or medical eligibility criteria.
3. Website postings (see current information here: http://actnewmexico.org/fair-hearing-rights.html);
4. Hard copy informational documents distributed by DOH/DDSD and Office of Constituent Affairs at regular stakeholder meetings and public forums;
5. Written notice of rights accompanies the waiver application provided to the applicant, guardian and authorized representative at the start of the application process; and
6. Verbal explanation provided by DDSD regional Offices as requested

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the

types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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).

The DOH/DDSD Office of Constituent Support (OSC) monitors resolution to complaints received by DOH. The individual and/or family or legal representative may also register complaints, about any issue with which he/she is dissatisfied, with DOH/DDSD via email, mail, or by phone. The DOH/DDSD OCS / follow up within two (2) business days from the date the complaint/grievance is received and informs the individual that the process is not a prerequisite or substitute for a fair hearing. A database is used to track and monitor the requests and actions taken. Complaints may be resolved using state policies and procedures or other mechanisms as appropriate to the program. If the complaint or grievance is not resolved within fourteen (14) days, an action plan with additional timeframes is put in place to resolve the complaint/grievance.

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DOH operates a reporting systems for critical events or incidents involving individuals receiving MFW services through the Division of Health Improvement (DHI)/Incident Management Bureau (IMB) protocols for incidents of abuse, neglect, exploitation, suspicious injury, environmental hazard and deaths.

DOH/DHI/IMB REPORTING PROTOCOLS:

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

Abuse
Neglect
Exploitation
Suspicious Injury
Environmental hazard
Death

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

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

Trained case managers (CM) 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 CM meets with the participant and reviews the who, what, when, and how to report any instances of abuse, neglect and exploitation (ANE).

All training regarding the detection of ANE and who to notify when the participant may have experienced ANE is documented on a form signed by the participant acknowledging this training and that they understand 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, exploitation and death. The DOH/DHI/IMB prioritizes allegations of ANE based on the seriousness of the allegation. The DOH/DHI/IMB must initiate an investigation within three hours if the allegation is determined to be an Emergency, within 24-hours if the allegation is determined to be a Priority One and within five days if the allegation is determined to be a Priority Two. DOH/DHI has 45 days for the completion of the case investigation regardless of the priority assignment.

Upon receipt of the Incident Report, DOH intake staff:

I. Review a history from the database of prior reported incidents (past 12 months) on the individual consumer
II. Verify the funding source to determine if they have the proper jurisdiction or if the incident should be transferred to another jurisdiction. Once DOH/DHI has determined jurisdiction, they assign severity and priority.
III. Triage/Intake Investigation is the decision process utilized by Intake staff to determine priority, severity and assignment of the case. Intake staff will triage the case within one working day of receipt; the IMB does have an extended intake process that can be requested by the intake specialist in order to receive appropriate documentation.

A. 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; Exploitation; Death; Environmental hazard; Suspicious Injury. If the incident meets the definition of reportable, the following steps are taken:

1. REVIEW CONSUMER HISTORY
Identify possible trends

2. DETERMINE SEVERITY AND PRIORTY
Medical Triggers that receive priority: Aspiration, fractures, dehydration, and a history of multiple emergency room (ER) visits (in a short period of time)

Priority is described as:

Emergency Case: Harm or potential for harm that is life threatening or could result in long term disability, or an unexpected death. Allegations that the consumer is in a state of serious harm or potential for harm that is life threatening or could result in long term disability or unexpected death. IMB responds within three hours of the receipt of the report. Priority 1: triage and assignment of the case occurs within 3 hours of the receipt of the report. Priority 2: triage and assignment of the case occurs within three business days; option of obtaining a one-day extension if needed for a total of four days to assign the case.

Emergency Allegations include but are not limited to:
- Serious injuries – fractures, head injuries, lacerations requiring sutures, serious burns, internal injuries
- Lack of life sustaining medications
- Sexual abuse where there is danger of repeated abuse
- Severe lack of basic physical necessities that could result in dehydration or starvation
- Need for immediate medical attention to treat conditions that could result in irreversible physical harm – severe respiratory distress, unconsciousness, gangrene, advanced bedsores
- No caregiver is available, and the consumer is unable to perform critical personal care activities

Investigation Emergency Factor: serious risk that delay will impede collection of evidence.

Priority One: Harm or potential for harm that is moderate to serious but not life threatening; allegations that the consumer is abused, neglected, financially exploited and as a result is at risk of moderate to serious harm. The investigator will respond within twenty-four (24) hours but does not require more immediate action.

Allegations include but are not limited to:
- Falling or being pushed, hit or scratched which is alleged to have resulted in bruises or other injuries or severe mental anguish
- Critical need for medical or mental health treatment – disease or illness that is acute but not life threatening, small bedsores or pressure spots, insufficient food or medicine but not life-threatening
- Sexual abuse of consumer but clearly no danger of repeated abuse

- Threats of physical violence or harm to the consumer
- Improper use of the consumer's income or resources such that they are unable to meet basic needs or is threatened with substantial loss of income or resources.

Priority Two: Low or minimal potential for harm; all other allegations that the victim is in a state of abuse or neglect. The investigation will be initiated within five (5) calendar days.

Allegations include but are not limited to:
- Verbal abuse – harassment, cursing, degrading remarks, intimidation
- Being pushed or scratched when there are no bruises, other injuries or severe mental anguish
- Marginal care
- Need for medical or mental health treatment that is not urgent – poor nutrition that is not acute
- Improper use of resources or income but the consumers' needs are being met

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

Consumer specific: Investigator with an existing case involving the consumer or with the most knowledge of the consumer. Cultural or language needs of the consumer are also given consideration.

Provider specific: Investigator with an existing case involving the responsible provider.

Caseload based: Cases will be assigned with a caseload maximum. Level of urgency: Cases may be assigned based on the most available investigator.

Deaths: All deaths are assigned to the DHI Clinical Team for investigation.

4. DETERMINE CHILDREN YOUTH AND FAMILIES STATUS: Reconciling Cases Children, Youth and Families Department (CYFD) Child Protective Services (CPS)

If CYFD (CPS) has accepted the case for investigation, and DOH has jurisdiction then the case will be assigned a DHI investigator and will be a collaborative investigation process.

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

5. The intake staff will then document the Triage decisions

6. NOTIFICATIONS
Notifications will be made to the following entities, as appropriate:
Office of General Counsel (OGC), DOH, DOH/DDSD, ALTSD (APS, ALTSD (EDSD, CYFD (CPS), DOH, DHI and DDSD Director's Office, Law Enforcement, Human Services Department (HSD) Medical Assistance Division (MAD), Medicaid Fraud Control Unit, NM Attorney General's Office, Office of Internal Audit (OIA), DOH Responsible Provider in cases of late reporting or failure to report

7.Support staff provide notifications to the appropriate entities within 24 hours.

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 the required timeline dependent on priority.

B. Non-Reportable Incidents and Non-Jurisdictional Incidents (NRI/NJ)

1. Data Entry of information into the separate NRI/NJ Database.
2. As appropriate Notifications should be made to the following entities:
Office of the General Counsel (OGC), DOH, DOH/DDSD, ALTSD (APS), ALTSD (EDSD), CYFD (CPS), DOH/DHI

and DDSD Director's Office, Law Enforcement, HSD/MAD, Medicaid Fraud Control Unit, NM Attorney General's Office, OIA, DOH

When an individual is at imminent risk for continued harm the immediate steps required to protect the safety is to contact law enforcement for intervention. The appropriate state agencies will follow up as applicable.

REPORTS AND TRENDS

Numerous reports are generated, and trends are addressed, including:
A. Multiple allegations for participants in one quarter are discussed by the DOH (DDSD/DHI) and appropriate interventions are taken as needed.
B. Multiple incidents for a participant are discussed by the DOH (DDSD/DHI) and appropriate interventions are taken as needed.
C. DHI conducts quarterly meetings in each region with DDSD.
D. The DOH/HSD Developmental Disabilities Quality Improvement Steering Committee (DDSQI) meets regularly throughout the year and will receive standard reports on the waiver assurances and other information as requested about the MFW Program. DDSQI will make recommendations to DOH/HSD regarding systemic actions needed in response to their analysis/review.

With respect to waiver services provided by any employee, contractor or vendor other than a community-based waiver service provider, incidents are reported to DOH/DHI/IMB for individuals over age 18 and/or CYFD/CPS for individuals under age 18 for review, investigation, and response. The Division's efforts are targeted toward preventing and/or alleviating conditions that result in abuse, neglect and/or exploitation; preserving families; and maintaining individuals in their homes and communities.

If a report of abuse or neglect of a child (person under age 18) is being made to CYFD/CPS, the call comes into the toll-free number. The SCI worker asks a series of questions (demographics of each participant) and records the issues and concerns of abuse or neglect. The SCI worker then enters the information into the FACTS system. A Structured Decision-Making Tool in the FACTS system is done on each report. This assists the worker to determine a priority status for each report ranging from an emergency (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; 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; 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.

- Screened-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 CYFD SCI for 18 months and then archived.

NOTIFICATION TO THE PARTICIPANT

In each situation that critical incident investigations are completed by APS, CYFD/CPS, or DOH/DHI, the participant or the participant's guardian receives a letter stating the results of the investigation.
Regulations are found in NMSA 1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect Act).

The DOH/DHI has 45 days to complete an investigation. Once completed, the investigator has ten (10) ten days to complete a report. This report is submitted to a supervisor who has three (3) days to approve the closure of the investigation. If there is no further action is needed at that time, a letter of findings is sent to the CM, participant, and guardian.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DOH/DDSD and DOH/DHI are jointly responsible for trending, remediation and oversight of critical incidents and management in collaboration with HSD/MAD. Oversight of critical incidents and events is part of the Quality Improvement Strategy. As with all components of the Quality Improvement Strategy, DOH/DDSD and DOH/DHI work together to analyze aggregated data and identify trends. Quality assurance and quality improvement action plans can be developed as needed, based on identified trends and other identified issues in order to prevent re-occurrence. The aggregated data and identified trends are then reported to the (DDSQI) for review. Trending and analysis of the data are used to prioritize improvements of the quality management system.

The operating agency, DOH, reviews incidents quarterly through the “Quarterly Quality Management Meetings” that DDSD and DHI attend to identify/review trends and any areas of necessary remediation. The Mortality Review Committee meets monthly. It is facilitated through the DOH/DDSD/Clinical Services Bureau and includes HSD. If the Bureau has issues/concerns they follow up with the MFW Unit to address any issues/concerns who then follows up with the CM and informs HSD.

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of restraints**

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

DOH monitors safeguards against the use of restraints/restrictive interventions/seclusion through the Case Manager, during home visits, who 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 restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

◉ **The state does not permit or prohibits the use of restrictive interventions**

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

DOH monitors safeguards against the use of restraints/restrictive interventions/seclusion through the Case Manager, during home visits, who inquires if there are any issues or concerns regarding service delivery. The MFW program does not authorize the use of restrictive interventions.

For participants with behavioral support needs seeking support through the MFW 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-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

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

restraints.)

◉ **The state does not permit or prohibits the use of seclusion**

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

DOH monitors safeguards against the use of restraints/restrictive interventions/seclusion through the Case Manager, during home visits, who inquires if there are any issues or concerns regarding service delivery. The MFW program does not authorize the use of restrictive interventions.

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

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

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

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices

(e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

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

iii. Medication Error Reporting. *Select one of the following:*

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

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

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

  (c) Specify the types of medication errors that providers must *report* to the state:

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Percentage of substantiated abuse, neglect and exploitation (ANE), and unexplained death investigations resulting in a corrective action plan (CAP) initiated by the DHI. Numerator: Number of CAP's developed as a result of substantiated ANE and unexplained death investigations Denominator: Number of substantiated ANE and unexplained death investigations involving individuals served on the MFW.

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

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

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DOH/DDSD/Mortality Review Committee	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DOH/DHI/IMB DDSQI Steering Committee	☒ **Annually**

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Percentage of waiver participants' critical incident reports that were initiated within required timeframes. Numerator: The number of critical incident reports initiated within required timeframes Denominator: The total number of critical incident reports initiated during the reporting period.

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

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

☒ **Other** Specify: DHI	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of waiver participants' critical incident reports that were reviewed and completed within required timeframes. Numerator: The number of critical incident reports reviewed and completed within required timeframes. Denominator: The number of critical incident reports reviewed and completed during the reporting period

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

Performance Measure:
Percentage of MFW participants without confirmed reports of restrictive interventions including restraints and seclusion. Numerator: Number of MFW participants without confirmed reports of restrictive interventions. Denominator: Total number of MFW participants.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DOH?DHI	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

Performance Measure:
Percentage of MFW participants who received a completed history and physical exams in accordance with state waiver policies. Numerator: Number of MFW participants with a completed history and physical. Denominator: Total number of MFW 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Formal quality improvement processes are in place, as described in detail in the DDSQI Committee description and structure in Appendix H.
DOH monitors and reports to HSD on a quarterly basis: 1) case timeliness and 2) completion of ANE trainings which all home and community-based Medicaid waiver service providers are required to take. The state maintains a data base of ANE reporting, substantiation, and remediation and requires a correction and preventative action plan of every substantiated finding. In addition, HSD reviews DOH reporting to ensure compliance and continuous quality improvement with this performance measure and discuss recommendations for system improvements with the Developmental Disabilities Systems Quality Improvement (DDSQI) committee

b. Methods for Remediation/Fixing Individual Problems

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

Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement related to 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*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise.

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

waiver's critical processes, structures and operational features in order to meet these assurances.

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

The primary goals for the waiver's Quality Improvement Strategy (QIS) are to administer and evaluate a quality improvement system that:
•Supports participants in exercising greater choice and control over the types of services and supports;
•Serves the most people possible within available resources;
•Identifies opportunities for improvement and ensures action, when indicated; and
•Ensures that the State meets each of its statutorily required assurances to CMS.

The Developmental Disabilities System Quality Improvement (DDSQI) Committee is comprised of HSD/MAD, DOH/DDSD, and DOH/DHI. DDSQI utilizes the following measures and processes to ensure that DD Waiver program is meeting its QIS goals:
•Performance Measures: Performance measures are specific to each of the Waiver assurances and are described in Appendices A, B, C, D, G, and I. The Waiver assurance workgroups report to the DDSQI 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 is to ensure continuous quality improvement. The DDSQI is responsible for making systemic improvements to the DD Waiver based on compliance monitoring. DDSQI has regularly scheduled meetings, typically monthly, and an annual schedule by which it reviews data collected from various waiver programs, develops and implements quality improvement strategies.

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

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

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

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Other** Specify: Quarterly with 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 has regularly scheduled meetings to review the performance data collected. The DDSQI meet to develop and implement quality improvement strategies related to the performance data collected. As part of its ongoing review of data collected, the DDSQI Committee considers the findings related to system design changes and incorporates them into the DOH/DDSD program planning process.

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

The DDSQI has an extended scope of work which includes an ongoing evaluation of the effectiveness of both the assurance workgroup strategies in improving the functions of the Waiver and an evaluation of the effectiveness of the DDSQI oversight of the strategies. The DDSQI continuously reviews information about current remediation activities and projections of future quality management plans -- all related to how well the functions of the Waiver are operating and to ensure that the DD Waiver QIS supports participants in selection of services and qualified providers, identifies opportunities for improvement, and ensures that the State meets each of the required assurances to the Centers for Medicare and Medicaid Services (CMS). The DOH/DDSD and DOH-DHI Senior Management receives regularly scheduled updates when trends and/or issues are identified as requiring higher level Departmental intervention.

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

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

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Providers are required to have an annual financial statement audit. Providers for the MF Waiver sign a Provider Agreement at the time of entry and renewal periods in which they agree that if they receive State or Federal funds from the Department of Health (DOH), they shall comply, if applicable, with auditing requirements under the Single Audit Act (31 U.S.C. §7501, et seq.) and the New Mexico State Auditor's rules and regulations. If the Provider is determined to be a sub recipient and not a vendor under the Federal Single Audit Act, the provider shall comply with the audit requirements of the Single Audit Act. If the provider receives more than $100,000 under this agreement or more than $100,000 in any single fiscal year, from the Human Services Department (Medicaid), the provider shall prepare annual financial statements and obtain an audit of, or an opinion on, the financial statements from an external Certified Public Accountant. HSD's Administrative Services Division, Financial Accounting Bureau, receives and reviews the audits. The annual audits are submitted to DOH for further review.

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

In addition to the MMIS, the DOH Quality Management Bureau conducts post-payment reviews of MFW provider billing to verify whether services are being rendered according to the state's rules and regulations. Post-payment review methods are discussed below.

Additionally, the DOH Quality Management Bureau (QMB) conducts post-payment reviews of all MFW providers who provide Home Health Aide, Respite Home Health Aide, Private Duty Nursing (RN and LPN), Respite Private Duty Nursing (RN and LPN). Providers receive a post-payment review at a minimum of once per contract term; usually once every three years. A provider may be audited more frequently, if there are issues. The DOH/QMB creates an annual review schedule that is based on the contract terms of provider agreements. 100% of MFW providers, who received payment for claims in the above services during the previous quarter, three months of paid claims, are reviewed. Claims data is taken from the MMIS system. Within that provider sample, 100% of paid claims for each provider are reviewed and validated for: 1) correct service codes; 2) correct billed units; 3) supporting documentation for services rendered. All reviews are conducted on-site. The agency is required to correct all deficiencies cited during the Plan of Correction Process and the Plan of Correction process is not closed until all deficiencies have been corrected. All QMB reports are shared with the Human Services Department and the Department of Health Office of Internal Audit who can make the determination whether or not to complete a more comprehensive financial review.

In addition, the HSD or DOH may refer providers for audit to the Medicaid Fraud Control Unit of the State Attorney General's Office.

Independent auditors conduct the Human Services Department audit in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General, and in accordance with the Single Audit Act.

The State is preparing for implementation of the 21st Century Cures Act by 2023 for the Medically Fragile Waiver home health aide services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
The percentage of MF waiver claims coded correctly in accordance with the reimbursement codes and rates approved by Medicaid. Numerator: The number of MF waiver claims coded correctly in accordance with reimbursement codes and rates approved by Medicaid. Denominator: Total number of MF waiver claims submitted

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

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☒ ***Other*** *Specify:* *MMIS*	☐ ***Annually***
	☐ ***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.*

Performance Measure:
Percentage of MF waiver claims paid in accordance with Medicaid claims payment requirements. Numerator: The number of claims paid in accordance with MF waiver claims payment requirements. Denominator: Total number of MF waiver claims paid.

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☒ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

Performance Measure:
Percentage of paid waiver services claims reviewed during post-payment audits that were for services specified in the participant's ISP were rendered. Numerator: Number of paid waiver claims reviewed for which the service was specified in the participants approved ISP were rendered. Denominator: Total number of waiver service claims reviewed.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Additional data collection, analysis, aggregation will be done, as necessary, to address unusual or urgent issues that may arise.*

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

Performance Measures

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

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

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

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
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):*
☒ ***State Medicaid***	☐ ***Weekly***	☒ ***100% Review***

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement are identified by the State related to financial accountability, processes are in place to ensure that appropriate and timely action is taken. In addition, the DDSQI routinely collects, aggregates, analyzes, and trends financial data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☒ ***Other*** *Specify:* *DDSQI Steering Committee*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***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 between the Department of Health (DOH) and the Human Services Department (HSD). The State can increase rates based on Legislative appropriation. However, HSD must approve all rates and any changes to these rates.

In July 2018, New Mexico Department of Health, Developmental Disabilities Supports Division (DDSD), contracted with Public Consulting Group, Inc. (PCG) to perform a study to recommend reimbursement rates for individuals with intellectual and developmental disabilities receiving services through three 1915(c) Medicaid home- and community-based (HCBS) waiver programs. This included the following waivers: Developmental Disabilities (DD), Medically Fragile (MF) and Mi Via (MV). In January 2020, DDSD contracted with PCG to conduct additional evaluation on specific services to recommend rates. The report was an add-on rate study tailored specifically towards the following providers to collect further data and develop new rate recommendations with the additional information. The following services were included:

- *Behavioral Supports Consultation (BSC)*
- *Physical Therapy (PT)*
- *Physical Therapy Assistant (PTA)*
- *Occupational Therapy (OT)*
- *Certified Occupational Therapy Assistant (COTA)*
- *Speech-Language Pathology*

Only providers of these services in the Developmental Disabilities Waiver and the Medically Fragile waiver would be eligible for participation.

Annual Utilization Changes and Fiscal Year Choice
PCG reviewed historical claims data, but yielded no discernable service growth or contraction. Trends varied greatly over time. For this reason, PCG used the most recent complete one year's worth of service units to reprice these units under the new rate recommendations. No inflationary or growth trend has been applied to the numbers above as recent years have seen reduction, small growth, and exponential increases varied by year and service. Additionally, with service changes due to the current Covid-19 pandemic, inflation or deflation are unknown at this point. As the State is currently negotiating the waiver renewals, PCG did not apply the inflationary costs as the rates are expected to be applied sooner than one year from now.

Medically Fragile Fiscal Impact Expenditures
PCG's fiscal impact methodology for the MF Waiver deviated from the DD waiver due to the new rates implemented on July 1, 2020. In lieu of using actual expenditures as the baseline for comparison, PCG repriced the units from April 1, 2019 to March 31, 2020 using the new rates to set the baseline for expected expenditures.

Medically Fragile Therapy Services
PCG's review, along with DDSD secondary confirmation showed no Physical Therapy, Occupational Therapy, or Speech-Language Pathology services were delivered to Medically Fragile waiver clients during the time-frame in question. After consulting DDSD staff, it was determined this is not unexpected due to the low number of adults on the waiver and low provider participation due to current rates. If the latter element is a correct assessment, DDSD should be prepared to see a small increase in the fiscal impact for the Medically Fragile waiver.

Payment rates for waiver services are uniform for every provider of a waiver service and are as follows:

Behavior Support Consultation 15 minute unit $24.39
Case Management Ongoing monthly unit $581.91
Customized Community Group Supports 15 minutes unit $5.63
Environmental Modifications Item, Every 5 years $5,000
Home Health Aide hourly unit $30.46
Individual Directed Goods and Services each $1.00
Nutritional Counseling –Adults hourly unit $84.40
Occupational Therapy 15 minute unit $34.93
Physical Therapy 15 minute unit $34.938

Private Duty Nursing— RN 15 minute unit $24.36
Private Duty Nursing LPN 15 minute unit $16.59
Respite, Home Health Aide hourly unit $30.46
Respite, RN 15 minute unit $24.36
Respite, LPN 15 minute unit $16.59
Respite Daily $468.00
Specialized Medical Equipment Item $1.00
Specialized Therapies- Massage session $100.00
Vehicle Modifications Item , Every 5 years $5000

Constructing the rate models involved a number of tasks, including:
- *Service definitions and policies were reviewed in order to ensure that the rate models reflect these requirements.*
- *Benchmark data was identified and researched, such as the Bureau of Labor Statistics' cross-industry wage and benefit data.*

Other assumptions associated with each individual cost factors taken into consideration. These factors include:
- *Wage proxies based on estimates on staffing levels*
- *Wages paid to direct service staff*
- *Fringe benefits for direct service staff*
- *Program support costs (e.g., supervision, program development, quality assurance, etc.)*
- *Administrative costs (e.g., executive management, finance, human resources, etc.)*
- *Other estimates of incurred costs such as service-specific costs such as mileage costs for traveling to a client location, building and supply costs.*

Although the rate models include specific assumptions for each cost factor, these assumptions are not prescriptive. That is, providers must manage to the bottom-line rate, but do not, for example, have to pay the wages or offer the benefits assumed in the rate models. This flexibility allows providers to respond to local market conditions, create individually-tailored programs, etc. Periodic adjustments have been made based on cost of living appropriations from the NM State Legislature.

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.

Rates for massage therapy and vehicle modifications in the Medically Fragile Waiver program were established by comparison to New Mexico's HCBS Mi Via Waiver (NM.0448) and Supports Waiver (NM.1726). The Mi Via waiver is New Mexico's self-directed waiver that also serves the medically fragile population. Rates were compared among same these services between the three waivers and established rates bring equity among these services.

The waiver rates can be accessed through HSD's website at http://www.hsd.state.nm.us/providers/fee-for-service.aspx. Individuals may also request a copy of the fee schedule from their case manager, DOH-DDSD, or HSD.

AMENDMENT NM.017.06.01
In May 2022, New Mexico submitted amendment NM.017.06.01, to implement a tiered economic recovery payment for Medically Fragile Waiver providers through funding available through the American Rescue Plan Act (ARPA) of 2021, Section 9817. The economic recovery payments were phased over a period of 3 years at increments of 15%, 10%, and 5%. Amendment NM.017.06.01, implemented the 10% and 5% increase to provider rates respectively over waiver years 2 and 3. An Appendix K was submitted to CMS in February 2022 to implement 15% increase to provider rates for waiver year 1 of the waiver

RATES FOR WAIVER YEAR 1 (15% APRA ECONOMIC RECOVERY PAYMENT) are follows:
Behavior Support Consultation $28.01/ 15 minute unit
Case Management Ongoing $669.23/monthly unit
Customized Community Group Supports $6.47/15 minutes unit
Environmental Modifications Item, Every 5 years $5,000
Home Health Aide $35.03/hourly unit

Individual Directed Goods and Services each $1.00
Nutritional Counseling –Adults $97.06/hourly unit
Occupational Therapy $40.16/15 minute unit
Physical Therapy $40.16/15 minute unit
Speech Language Therapy $40.16/15 minute
Private Duty Nursing— RN $28.01/15 minute unit
Private Duty Nursing LPN $19.08/15 minute unit
Respite, Home Health Aide $35.03/hourly unit
Respite, RN $28.01/15 minute unit
Respite, LPN $19.08/15 minute unit
Respite $538.20/Daily
Specialized Medical Equipment Item $1.00
Specialized Therapies- Massage session $100.00
Vehicle Modifications Item , Every 5 years $5000

RATES FOR WAIVER YEAR 2 (10% APRA ECONOMIC RECOVERY PAYMENT) are follows:
Behavior Support Consultation $26.79/ 15 minute unit
Case Management Ongoing $640.13/monthly unit
Customized Community Group Supports $6.19/15 minutes unit
Environmental Modifications Item, Every 5 years $6,000
Home Health Aide $33.51/hourly unit
Individual Directed Goods and Services each $1.00
Nutritional Counseling –Adults $92.84/hourly unit
Occupational Therapy $38.42/15 minute unit
Physical Therapy $38.42/15 minute unit
Speech Language Therapy $38.42/15 minute
Private Duty Nursing— RN $26.80/15 minute unit
Private Duty Nursing LPN $18.25/15 minute unit
Respite, Home Health Aide $33.51/hourly unit
Respite, RN $26.80/15 minute unit
Respite, LPN $18.25/15 minute unit
Respite $514.80/Daily
Specialized Medical Equipment Item $1.00
Specialized Therapies- Massage session $100.00
Vehicle Modifications Item , Every 5 years $5000

RATES FOR WAIVER YEAR 3 (5% APRA ECONOMIC RECOVERY PAYMENT) are follows:
Behavior Support Consultation $25.54/ 15 minute unit
Case Management Ongoing $611.04/monthly unit
Customized Community Group Supports $65.91/15 minutes unit
Environmental Modifications Item, Every 5 years $6,000
Home Health Aide $33.51/hourly unit
Individual Directed Goods and Services each $1.00
Nutritional Counseling –Adults $88.62/hourly unit
Occupational Therapy $36.62/15 minute unit
Physical Therapy $36.62/15 minute unit
Speech Language Therapy $36.62/15 minute unit
Private Duty Nursing— RN $25.58/15 minute unit
Private Duty Nursing LPN $17.42/15 minute unit
Respite, Home Health Aide $31.98/hourly unit
Respite, RN $25.58/15 minute unit
Respite, LPN $17.42/15 minute unit
Respite $491.40/Daily
Specialized Medical Equipment Item $1.00
Specialized Therapies- Massage session $100.00

Vehicle Modifications Item , Every 5 years $5000

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:*

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

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:

The limited fiscal agent supports ordering and payment for specialized medical equipment, massage therapy and individual goods and services. The Department of Health contracts with an entity outside of Case Management to serve as a limited fiscal agent. Case Managers do not act as limited fiscal agents. The Department of Health contracted limited fiscal agent is Parents Reaching Out (PRO).

Participants select services and qualified providers during the ISP planning. Case managers assist with the collection of required documents. The items and services are approved through the budget process and reviewed per waiver service standards within the case management review. Families notify the case manager if items regarding the receipt of items. The fiscal agent orders and files a claim to the Medicaid Management Information System (MMIS).

SME claims are periodically reviewed as to items ordered and expenditures. The limited fiscal agent submits reports with DOH. Issues identified by case management are included in the quarterly QIC meeting.

The fiscal agent follows The Medically Fragile Waiver Fee Schedule posted on the HSD website and is subject to billing requirements as stated in NMAC 8.314.3.11.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☐ ***Appropriation of State Tax Revenues to the State Medicaid agency***
- ☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-

c:

The source of funds utilized to provide the non-federal share of costs associated with the MFW 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 DOH/DDSD monthly 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:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

  Check each that applies:

  - ☐ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

- ◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

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

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	16749.48	16452.48	33201.96	119262.21	4443.14	123705.35	90503.39
2	14039.00	16847.34	30886.34	122124.50	4549.77	126674.27	95787.93
3	13509.57	17251.68	30761.25	125055.49	4658.07	129713.56	98952.31
4	12998.87	17665.72	30664.59	128056.82	4770.78	132827.60	102163.01
5	13062.42	18089.69	31152.11	131130.18	4885.28	136015.46	104863.35

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	210	210
Year 2	210	210
Year 3	210	210
Year 4	210	210
Year 5	210	210

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average length of stay has been held constant at 285 days, the level derived from utilization data in FFY 2020 . Since this is a mature waiver, it is assumed that the yearly turnover and length of waiver experience will be fairly stable.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Waiver services remain constant through the waiver period:

Average cost per unit is the actual rate paid to providers as noted in the MFW Fee Schedule. The range of rates do not change from waiver year to waiver year; the average cost per unit is held constant through WY1-5.

The average units per users were derived from utilization data in FFY 2020 and held constant through WY 1-5. The State estimates that the units per user are held constant with variable in costs due to annual changes to UDRs.

The number of users, Factor C, is held constant at 210 participants in waivers year 1 through 5 to reflect the Factor C estimates for WY5 of the currently approved waiver, NM.0223.R05.03. The estimate for Factor C allows for estimated increases or decreases due to transitions from other 1915(c) waivers, allocation trending, and attrition.

The methodology used to estimate Factor D and the basis for the state's cost estimate is based on actual expenditures for waiver services provided to Medically Fragile Waiver participants who were in the waiver FFY 2020.

Individual Directed Goods, Services and Specialized Therapies are estimated to be used by 50% of all participants in waiver in WY1 and with an additional 50% of all new allocants, 10 users per year, in WY2-WY5. Vehicle Modifications is a new service. The state estimates that in WY1, 50% of all waiver participants will use the service (105). In WY2-WY5, the state estimates that 50% of new allocants will use this service. Since it is estimated that 20 new allocants will enroll each year, the state estimates 10 participants will use the service each year for WY2-WY5. The State estimates that 100% of participants who are over 21 will access Customized Community Group Supports. Environmental modifications are estimated to be used by 50% of new allocants at 10 users per year.

Average units per users for Customized Community Group Supports was derived from data reported on NM.0448 Mi Via waiver FFY2017 CMS372. The Mi Via waiver was used to derive these estimates because: 1) Mi Via Waiver offers these same services; 2) Mi Via waiver serves both a developmental disabilities population and a medically fragile population; and 3) Proposed MFW budget caps and Mi Via Individual Budgetary Allotments are equitable in amounts by age group. The units used under the NM.0448 Mi Via waiver was used as estimates for units of the above services under MFW as their budget dictates similar services. The average units per uses was held constant through WY 1-5.

This availability of a facility to provide Respite Services in a facility is new to the waiver with the inclusion of Intensive Medical Living Supports provider agency as qualified providers of this service. Units for use of this service is unknown and there is not a similar service in other NM HCBS waivers for which to make projections.

The State will complete a utilization review after WY1.

The average cost per unit, rate, for Customized Community Group Supports is derived from the 2019 rate study for NM.0173 Developmental Disabilities Waiver (DDW). Rate study methodology is outlined in Appendix I-2-a. For Environmental Modifications and Vehicle Modifications, the State estimates that users will use the full $5,000.00.
For Individual Directed Goods and Services and Specialized Medical Equipment and Supplies, the State estimates that users will use the full $1200.00 per year.

AMENDMENT NM.017.06.01
In May 2022, New Mexico submitted amendment NM.017.06.01, to implement a tiered economic recovery payment for Supports Waiver providers through funding available through the American Rescue Plan Act (ARPA) of 2021, Section 9817. The economic recovery payments were phased over a period of 3 years at increments of 15%, 10%, and 5%. Amendment NM.025.00.01, implemented the 10% and 5% increase to provider rates respectively over waiver years 2 and 3. An Appendix K was submitted to CMS in February 2022 to implement

15% increase to provider rates for waiver year 1 of the Medically Fragile waiver.
In addition, Environmental Modification limits were increased from $5000 to $6000, once every five (5) years in waivers years 2 and 3.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is the estimated annual average per capita Medicaid costs for all services that are furnished in addition to waiver services while the individual is in the waiver. Factor D' estimates accounts for managed care capitations and all fee for service claims and acute expenditures that are not waiver services. The State did not use pre-Medicare Part D expenditure data in its estimate for Factor D', so it was not necessary to adjust for this factor.

Factor D' is based on the actual Factor D' derived from utilization data in FFY 2020, trended forward at the Medicare PPS (MBI) of 2.40%.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is based on the Factor G derived from utilization data in FFY 2020, trended forward at the Medicare PPS MBI of 2.40%.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is based on the actual Factor G' derived from utilization data in FFY 2020, trended forward at the Medicare PPS Market Basket Index of 2.40%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Case Management	
Customized Community Group Supports	
Home Health Aide	
Respite	
Nutritional Counseling	
Skilled Therapy for Adults	
Behavior Support Consultation	
Environmental Modifications	
Individual Directed Goods and Services	
Private Duty Nursing	
Specialized Medical Equipment and Supplies	
Specialized Therapies	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Case Management Total:						***1398690.70***
Case Management	*month*	*209*	*10.00*	*669.23*	***1398690.70***	
Customized Community Group Supports Total:						***72899.43***
Customized Community Group Supports	*15 minutes*	*11*	*1024.30*	*6.47*	***72899.43***	
Home Health Aide Total:						***385432.99***
Home Health Aide	*hour*	*13*	*846.38*	*35.03*	***385432.99***	
Respite Total:						***338893.84***
Respite, LPN	*15 minutes*	*7*	*556.59*	*19.08*	***74338.16***	
Respite, HHA	*hour*	*34*	*102.12*	*35.03*	***121626.96***	
Respite, RN	*15 minutes*	*18*	*282.42*	*28.01*	***142390.52***	
Respite, Facility	*daily*	*1*	*1.00*	*538.20*	***538.20***	
Nutritional Counseling Total:						***3199.10***
Nutritional Counseling	*hour*	*16*	*2.06*	*97.06*	***3199.10***	
Skilled Therapy for Adults Total:						***120.48***
Speech Therapy	*15 minutes*	*1*	*1.00*	*40.16*	***40.16***	
Physical Therapy	*15 minutes*	*1*	*1.00*	*40.16*	***40.16***	
Occcupational Therapy	*15 minutes*	*1*	*1.00*	*40.16*	***40.16***	
Behavior Support Consultation Total:						***61862.05***
Behavior Support Consultation	*15 minutes*	*39*	*56.63*	*28.01*	***61862.05***	
Environmental Modifications Total:						***50000.00***
Environmental					***50000.00***	

GRAND TOTAL:	***3517391.05***
Total Estimated Unduplicated Participants:	***210***
Factor D (Divide total by number of participants):	***16749.48***
Average Length of Stay on the Waiver:	*285*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modifications	item	10	1.00	5000.00		
Individual Directed Goods and Services Total:						**126000.00**
Individual Directed Goods and Services	each	105	1.00	1200.00	**126000.00**	
Private Duty Nursing Total:						**438168.35**
Private Duty Nursing, LPN	15 minutes	2	1440.77	19.08	**54979.78**	
Private Duty Nursing, RN	15 minutes	13	1052.34	28.01	**383188.56**	
Specialized Medical Equipment and Supplies Total:						**106624.12**
Specialized Medical Equipment and Supplies	item	127	839.56	1.00	**106624.12**	
Specialized Therapies Total:						**10500.00**
Massage Therapy	session	105	1.00	100.00	**10500.00**	
Vehicle Modifications Total:						**525000.00**
Vehicle Modifications	item	105	1.00	5000.00	**525000.00**	

GRAND TOTAL:	**3517391.05**
Total Estimated Unduplicated Participants:	**210**
Factor D (Divide total by number of participants):	**16749.48**
Average Length of Stay on the Waiver:	285

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**1337871.70**
Case Management	month	209	10.00	640.13	**1337871.70**	
Customized Community						**69744.59**

GRAND TOTAL:	**2948190.17**
Total Estimated Unduplicated Participants:	**210**
Factor D (Divide total by number of participants):	**14039.00**
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Supports Total:						
Customized Community Group Supports	15 minutes	11	1024.30	6.19	**69744.59**	
Home Health Aide Total:						**368708.52**
Home Health Aide	hour	13	846.38	33.51	**368708.52**	
Respite Total:						**324207.98**
Respite, LPN	15 minutes	7	556.59	18.25	**71104.37**	
Respite, HHA	Hour	34	102.12	33.51	**116349.40**	
Respite, RN	15 minutes	18	282.42	26.80	**136239.41**	
Respite, Facility	daily	1	1.00	514.80	**514.80**	
Nutritional Counseling Total:						**3027.05**
Nutritional Counseling	hour	16	2.06	91.84	**3027.05**	
Skilled Therapy for Adults Total:						**115.26**
Speech Therapy	15 minutes	1	1.00	38.42	**38.42**	
Physical Therapy	15 minutes	1	1.00	38.42	**38.42**	
Occcupational Therapy	15 minutes	1	1.00	38.42	**38.42**	
Behavior Support Consultation Total:						**59167.59**
Behavior Support Consultation	15 minutes	39	56.63	26.79	**59167.59**	
Environmental Modifications Total:						**60000.00**
Environmental Modifications	item	10	1.00	6000.00	**60000.00**	
Individual Directed Goods and Services Total:						**138000.00**
Individual Directed Goods and Services	each	115	1.00	1200.00	**138000.00**	
Private Duty Nursing Total:						**419223.36**
Private Duty Nursing, LPN	15 minutes	2	1440.77	18.25	**52588.10**	
Private Duty Nursing, RN	15 minutes	13	1052.34	26.80	**366635.26**	

GRAND TOTAL:		**2948190.17**
Total Estimated Unduplicated Participants:		**210**
Factor D (Divide total by number of participants):		**14039.00**
Average Length of Stay on the Waiver:	285	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:						**106624.12**
Specialized Medical Equipment and Supplies	item	127	839.56	1.00	**106624.12**	
Specialized Therapies Total:						**11500.00**
Massage Therapy	session	115	1.00	100.00	**11500.00**	
Vehicle Modifications Total:						**50000.00**
Vehicle Modifications	item	10	1.00	5000.00	**50000.00**	

GRAND TOTAL:	**2948190.17**
Total Estimated Unduplicated Participants:	**210**
Factor D (Divide total by number of participants):	**14039.00**
Average Length of Stay on the Waiver:	285

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**1277073.60**
Case Management	month	209	10.00	611.04	**1277073.60**	
Customized Community Group Supports Total:						**66589.74**
Customized Community Group Supports	15 minutes	11	1024.30	5.91	**66589.74**	
Home Health Aide Total:						**351874.02**
Home Health Aide	hour	13	846.38	31.98	**351874.02**	
Respite Total:						**304524.83**
Respite, LPN	15 minutes	7	559.59	17.42	**68236.40**	
Respite, HHA	hour				**105759.56**	

GRAND TOTAL:	**2837009.11**
Total Estimated Unduplicated Participants:	**210**
Factor D (Divide total by number of participants):	**13509.57**
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		34	102.12	30.46		
Respite, RN	15 minutes	18	282.42	25.58	130037.46	
Respite, Facility	daily	1	1.00	491.40	491.40	
Nutritional Counseling Total:						1054.06
Nutritional Counseling	hour	16	2.06	31.98	1054.06	
Skilled Therapy for Adults Total:						109.86
Speech Therapy	15 minutes	1	1.00	36.62	36.62	
Physical Therapy	15 minutes	1	1.00	36.62	36.62	
Occcupational Therapy	15 minutes	1	1.00	36.62	36.62	
Behavior Support Consultation Total:						56517.31
Behavior Support Consultation	15 minutes	39	56.63	25.59	56517.31	
Environmental Modifications Total:						60000.00
Environmental Modifications	item	10	1.00	6000.00	60000.00	
Individual Directed Goods and Services Total:						150000.00
Individual Directed Goods and Services	each	125	1.00	1200.00	150000.00	
Private Duty Nursing Total:						400141.57
Private Duty Nursing, LPN	15 minutes	2	1440.77	17.42	50196.43	
Private Duty Nursing, RN	15 minutes	13	1052.34	25.58	349945.14	
Specialized Medical Equipment and Supplies Total:						106624.12
Specialized Medical Equipment and Supplies	item	127	839.56	1.00	106624.12	
Specialized Therapies Total:						12500.00
Massage Therapy	session	125	1.00	100.00	12500.00	
Vehicle Modifications Total:						50000.00
Vehicle Modifications					50000.00	

GRAND TOTAL:	2837009.11
Total Estimated Unduplicated Participants:	210
Factor D (Divide total by number of participants):	13509.57
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	item	10	1.00	5000.00		
			GRAND TOTAL:			2837009.11
			Total Estimated Unduplicated Participants:			210
			Factor D (Divide total by number of participants):			13509.57
			Average Length of Stay on the Waiver:			285

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**1216191.90**
Case Management	month	209	10.00	581.91	**1216191.90**	
Customized Community Group Supports Total:						**63434.90**
Customized Community Group Supports	15 minutes	11	1024.30	5.63	**63434.90**	
Home Health Aide Total:						**335149.55**
Home Health Aide	hour	13	846.38	30.46	**335149.55**	
Respite Total:						**295048.27**
Respite, LPN	15 minutes	7	559.59	16.59	**64985.19**	
Respite, HHA	hour	34	102.12	30.46	**105759.56**	
Respite, RN	15 minutes	18	282.42	24.36	**123835.52**	
Respite, Facility	daily	1	1.00	468.00	**468.00**	
Nutritional Counseling Total:						**2781.82**
Nutritional Counseling	hour	16	2.06	84.40	**2781.82**	
Skilled Therapy for Adults Total:						**104.79**
Speech Therapy					**34.93**	
			GRAND TOTAL:			2729762.15
			Total Estimated Unduplicated Participants:			210
			Factor D (Divide total by number of participants):			12998.87
			Average Length of Stay on the Waiver:			285

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minutes	1	1.00	34.93		
Physical Therapy	15 minutes	1	1.00	34.93	34.93	
Occcupational Therapy	15 minutes	1	1.00	34.93	34.93	
Behavior Support Consultation Total:						53867.02
Behavior Support Consultation	15 minutes	39	56.63	24.39	53867.02	
Environmental Modifications Total:						50000.00
Environmental Modifications	Item	10	1.00	5000.00	50000.00	
Individual Directed Goods and Services Total:						162000.00
Individual Directed Goods and Services	each	135	1.00	1200.00	162000.00	
Private Duty Nursing Total:						381059.78
Private Duty Nursing, LPN	15 minutes	2	1440.77	16.59	47804.75	
Private Duty Nursing, RN	15 minutes	13	1052.34	24.36	333255.03	
Specialized Medical Equipment and Supplies Total:						106624.12
Specialized Medical Equipment and Supplies	item	127	839.56	1.00	106624.12	
Specialized Therapies Total:						13500.00
Massage Therapy	session	135	1.00	100.00	13500.00	
Vehicle Modifications Total:						50000.00
Vehicle Modifications	item	10	1.00	5000.00	50000.00	

GRAND TOTAL:	2729762.15
Total Estimated Unduplicated Participants:	210
Factor D (Divide total by number of participants):	12998.87
Average Length of Stay on the Waiver:	285

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**1216191.90**
Case Management	month	209	10.00	581.91	**1216191.90**	
Customized Community Group Supports Total:						**63434.90**
Customized Community Group Supports	15 minutes	11	1024.30	5.63	**63434.90**	
Home Health Aide Total:						**335149.55**
Home Health Aide	hour	13	846.38	30.46	**335149.55**	
Respite Total:						**295048.27**
Respite, LPN	15 minutes	7	559.59	16.59	**64985.19**	
Respite, HHA	hour	34	102.12	30.46	**105759.56**	
Respite, RN	15 minutes	18	282.42	24.36	**123835.52**	
Respite, Facility	daily	1	1.00	468.00	**468.00**	
Nutritional Counseling Total:						**3129.55**
Nutritional Counseling	hour	18	2.06	84.40	**3129.55**	
Skilled Therapy for Adults Total:						**104.79**
Speech Therapy	15 minutes	1	1.00	34.93	**34.93**	
Physical Therapy	15 minutes	1	1.00	34.93	**34.93**	
Occcupational Therapy	15 minutes	1	1.00	34.93	**34.93**	
Behavior Support Consultation Total:						**53867.02**
Behavior Support Consultation	15 minutes	39	56.63	24.39	**53867.02**	
Environmental Modifications Total:						**50000.00**
Environmental Modifications	item	10	1.00	5000.00	**50000.00**	
Individual Directed Goods and Services Total:						**174000.00**
Individual Directed Goods and Services	each	145	1.00	1200.00	**174000.00**	
Private Duty Nursing Total:						**381058.12**

GRAND TOTAL:	**2743108.22**
Total Estimated Unduplicated Participants:	**210**
Factor D (Divide total by number of participants):	**13062.42**
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Private Duty Nursing, LPN	15 minutes	2	1440.72	16.59	47803.09	
Private Duty Nursing, RN	15 minutes	13	1052.34	24.36	333255.03	
Specialized Medical Equipment and Supplies Total:						106624.12
Specialized Medical Equipment and Supplies	item	127	839.56	1.00	106624.12	
Specialized Therapies Total:						14500.00
Massage Therapy	session	145	1.00	100.00	14500.00	
Vehicle Modifications Total:						50000.00
Vehicle Modifications	item	10	1.00	5000.00	50000.00	

GRAND TOTAL:	2743108.22
Total Estimated Unduplicated Participants:	210
Factor D (Divide total by number of participants):	13062.42
Average Length of Stay on the Waiver:	285