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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The purpose of this overview is to describe the significant changes New Mexico proposes in this waiver renewal application:

1. Language and acronyms throughout the DDW application updated for consistency and to align with other 1915(c) HCBS waivers in New Mexico, as appropriate.
2. Removed references to the Supports Intensity Scale (SIS) throughout the application. The SIS was phased out after Waiver Year 1 of the prior waiver cycle.
3. Removal of distinction between adult and children's budgets and children's budget limits. Children, under the age of 21, will move to the clinical review process through the Outside Reviewer (OR).
4. The Community Integrated Employment service definition has been revised and the monthly Employment Maintenance rate has been unbundled into three unit-based rates: Job Development, Job Coaching, and Job Maintenance.
5. The Living Supports service definition has been revised to expand support provided to individuals; include the requirement for living support agencies to have registered or Licensed Dietician or Licensed Nutritionist, on staff or under contact; include the use of remote personal support technology in supported living environments, and move the definition of intensive medical living supports to the Living Supports service.
6. Allowance added to provide Nutritional Counseling services, Occupational Therapy, Physical Therapy, and Speech Language Pathology services remotely through a telehealth model.
7. Removal of Supplemental Dental Care as a covered service.
8. Increased limit on Assistive Technology from $250 to $500.

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Developmental Disabilities Waiver Program

C. Type of Request: renewal

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals*

who are dually eligible for Medicaid and Medicare.)

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NM.0173
Draft ID: NM.019.07.00

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

Regular Waiver

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

07/01/21

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

The Developmental Disabilities Home and Community-Based Services (HCBS) Waiver serves individuals with intellectual disabilities or specific related conditions and developmental disability that occur before the age of 22. New Mexico provides community-based services designed to increase independence and achieve personal goals while providing care and support to enable individuals to live as active members of the community while ensuring health and safety. The purpose of the program is to provide assistance to individuals who require long-term supports and services so that they may remain in the family residence, in their own home, or small community living residences. The program serves as an alternative to an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The waiver offers statutory and ancillary services and sets specific dollar limits of services and supports based on clinical justification and service definitions detailed in Appendix C.

The State has designed and defined a broad range of flexible community-based services that are integrated and support full access of individuals receiving HCBS to the greater community. Waiver services support individuals to engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCBS. Waiver services compliment and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the natural supports that families and communities provide. Through the provision of services and supports identified through the person-centered Individual Service Plan and the operation of a quality assurance and improvement program, the State ensures the health and welfare of the individuals in the program. In addition, the program provides assurances of fiscal integrity and includes participant protections that will be effective and family-friendly.

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

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the

Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

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

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

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

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

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

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

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

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

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

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

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

The State secured public input during the development of the waiver renewal. Input was solicited via: a Developmental Disabilities Waiver (DDW) Renewal Steering Committee, virtual state-wide informational meetings, and a formal public comment process comprised of 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 culminate in a public hearing. Notices were released on November 25, 2020 (Tribal Notification) and December 28, 2020 (General Public). The public hearing was held on January 29, 2021. Public notice distribution included mailings to interested parties, emails, newspaper announcements, and web postings. The public was invited to submit comments via postal mail, email, fax, phone, or in person at the public hearing.

The DDW Renewal Steering Committee met monthly from March through September 2020. The Committee included DDW recipients, family members, consultant agencies, and representatives from constituent groups including the Advisory Council and Quality (ACQ).

In September the Department of Health, Developmental Disabilities and Supports Division (DOH/DDSD) with assistance from the Human Services Department Medical Assistance Division (HSD/MAD) conducted six (6) virtual statewide meetings involving individuals with disabilities, their families, advocates, service providers, and others, to consider and provide input on recommendations for the DDW.

Summary of Public Comments:

Changes made to the waiver application as a result of public comment:

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

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

7. Contact Person(s)

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

Last Name: Roanhorse-Aguilar

First Name: Sharilyn

Title: Bureau Chief, Exempt Services and Programs Bureau

Agency: Human Services Department

Address: 2025 S. Pacheco

Address 2: P.O. Box 2348

City:

Santa Fe

State: **New Mexico**

Zip:

87504-2348

Phone:

(505) 827-1307 **Ext:** ☐ **TTY**

Fax:

(505) 827-7277

E-mail:

sharilyn.roanhorse@state.nm.us

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

Last Name:

Doan

First Name:

Scott

Title:

Deputy Director, Developmental Disabilities Supports Division

Agency:

Department of Health

Address:

1170 N. Solano Suite G

Address 2:

City:

Las Cruces

State: **New Mexico**

Zip:

88001

Phone:

(575) 528-5187 **Ext:** ☐ **TTY**

Fax:

(575) 528-5194

E-mail:

Scott.Doan@state.nm.us

8. Authorizing Signature

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

11/23/2020

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Comeaux

First Name: Nicole

Title: Division Director

Agency: Human Services Department Medical Assistance Division

Address: 1 Plaza la Prensa

Address 2:

City: Santa Fe

State: **New Mexico**

Zip: 87504

Phone: (505) 827-7709 **Ext:** ☐ **TTY**

Fax: (505) 827-3185

E-mail: nicole.comeaux@state.nm.us

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:

Supplemental Dental was utilized one time since 2014. In state fiscal year 2019 there was no utilization of Supplemental Dental. For this reason there are no recipients who will need to transition care. This is not to say that persons with IDD do not have unique and critical dental care needs. However, this service delivery model has not proven successful for individuals on the Developmental Disabilities Waiver (DDW). Individuals on the DDW will continue to receive dental care through the state pan benefit.

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 DD 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) Steering 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.:*

The contracted entities referenced in A-7 refer to the Third-Party Assessor (TPA) contractor and the Outside Review (OR) 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.

DOH-DDSD manages and oversees the following contracted entity and functions: the Outside Reviewer (OR) makes a clinical determination to approve or deny in whole or in part DD Waiver recipients' requested Individual Service Plan (ISP) and proposed budget submissions except for Jackson Class Members.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

The DOH/DDSD is responsible for assessing the performance and compliance of the Outside Reviewer, based on terms of the contract in conducting waiver operational and administrative functions.

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 for Jackson Class members, review, approval and entry of all budgets into the MMIS, and quality assurance and quality improvement activities. 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.

DOH/DDSD assesses the performance of the OR through contract management activities which include:

1.Monthly review of deliverables prior to approving payment

2.Regular formal and informal meetings to review progress and quality of work products

The OR is also required to establish an internal quality management program applicable to all aspects of the work performed under this contract. DOH/DDSD issues Letters of Direction (LODs) as necessary to the OR to provide clarification, guidance and instructions required to be implemented. DOH/DDSD requires monthly and quarterly reporting from the OR to ensure compliance with contract requirements.

DOH/DDSD assesses performance of the related contractors in the same fashion as indicated for the OR. DOH/ DDSD also assesses performance of a contracted entity related to rate setting methodology and analysis through terms of the contract and regular meetings to define specifications of research and analysis required.

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Percentage of DD waiver data reports specified in the OR contract with the Department of Health (DOH) agency that were submitted on time and in the correct format. Numerator: Number of data reports submitted on time and in the correct format. Denominator: Total number reports required to be 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 =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Percentage of DD 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 reports required to be submitted

Data Source (Select one):
Other
If 'Other' is selected, specify:
TPA and OR 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	☒ **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 provider agreements for enrolled providers that adhered to the State's uniform agreement requirements (specific to provider) Numerator: Number of provider agreements in compliance Denominator: Total number of provider agreements

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:

Performance Measure:
Percentage of delegated functions/deliverables specified in the Joint Powers of Agreement

(JPA) with which DOH is compliant Numerator: Number of JPA delegated functions/deliverables that DOH is complaint with on an annual basis Denominator: Total number of JPA delegated functions/deliverables identified by HSD/MAD

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

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:

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 performed the functions listed in the section A-7 chart. HSD/MAD monitors these activities through monthly meetings, review of quarterly and annual reports, and review of actions taken by the operating agency. Formal quality improvement processes are in place, as described in detail in the Developmental Disabilities Services Quality Improvement (DDSQI) Steering Committee description and structure in Appendix H, in which HSD/MAD participates with the operating agency.

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:	☐ **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**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	0		☒
	☒	**Developmental Disability**	0		☒
	☒	**Intellectual Disability**	0		☒
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

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.

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

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	

Waiver Year	Unduplicated Number of Participants
	3400
Year 2	3438
Year 3	3476
Year 4	3514
Year 5	3552

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	3400
Year 2	3438
Year 3	3476
Year 4	3514
Year 5	3552

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

the waiver.

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Individuals are allocated to the waiver on a statewide basis in chronological order by the date of the 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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

☐ **Medically needy without 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)

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 individuals 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:

Monthly for adults; quarterly for children.

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:

○ **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 makes the level of care determination.

The TPA contractor must be a designated Quality Improvement Organization (QIO) or QIO-like entity as described in CFR 475. The current TPA contractor 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 master level, licensed social workers who have medical case management experience for all clinical functions and paraprofessionals educated in areas relating to special needs populations.

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

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

Individuals must be diagnosed with a developmental disability and meet the level of care required in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The ICF/IID Long-Term Care Assessment Abstract (MAD 378) 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.

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

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

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

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

1.The initial level of care (LOC) evaluation occurs after the individual has received an allocation for waiver services and has chosen a case management agency (selected on the 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 determination.

3.The TPA Contractor reviews, evaluates and approves all initial and annual LOC determinations. If the recipient has a change in condition that results in a change in the LOC, the case manager submits the revised MAD 378 and supporting documentation to the TPA Contractor for review.

4.The TPA Contractor is responsible to provide written notification to the case management agency of its determination. The case management agency is responsible for notifying the individual and/or family or legal representative of the LOC determination. If there is a denial of LOC, the denial letter is sent to the individual and/or family or legal representative and includes information on the reconsideration process and fair hearing rights.

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. For re-determinations, the submission shall occur no later than 30 days prior to LOC expiration.

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 recipient and case manager 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.

DDSD Regional Office staff monitors compliance with required timeframes for initial LOC on an individual basis. For annual LOC redeterminations, systems are in place to prevent issuing a prior authorization (PA) for services without a currently approved LOC. This enables DDSD to monitor for expired PA effective dates. DDSD may implement DDSD Contract Management Policy with DD Waiver case management agencies when expired PA's are the result of a case manager's failure obligations to submit LOC packets to the TPA timely.

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 new DD waiver applicants, with whom there is reasonable indication that services may be needed in the future, with an initial completed LOC evaluation. Numerator: Number of initial DD waiver LOC evaluations performed. Denominator: Total number of new DD waiver applicants.

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

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

TPA Contractor		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The 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 DD waiver participants that comply with the processes and instruments specified in the approved waiver Numerator: Number of compliant initial LOC evaluations for participant. Denominator: Total number of initial LOCs evaluations for waiver participants.

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

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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. In addition, the DDSQI Steering Committee routinely collects, aggregates, analyzes, and trends LOC data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

Methods for fixing identified problems include verbal direction, letters of direction, and formal corrective action plans issued by HSD/MAD to the TPA contractor. 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.

Additionally, DOH-DDSD may provide technical assistance to case managers as well as implement DDSD Contract Management Policy with case management agencies related to case manager obligations to submit LOC packets to the TPA contractor for at least annual redetermination. DOH-DDSD is authorized by agreement with HSD to enforce program and service regulations on service providers, and to impose sanctions on providers for failure to perform in accordance with standards applicable under statute, regulation, and contract. DDSD Provider Agreements state that providers shall be subject to sanctions pursuant to DOH- DDSD policy (DIV.DDSD.13.01).

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:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Individuals are allocated to the waiver from the DDSD waitin list. Once DDSD identifies the number of applicants who will receive an allocation, DDSD attempts to contact those applicants to ensure updated contact information is available not only to DDSD personnel, but also for the case management agency that will work with the applicant. Applicants then receive a Letter of Interest along with a Primary Freedom of Choice (PFOC) form. The PFOC provides the options of Home and Community Based Services (HCBS) or institutional services through an ICF/IID) as well as the options to place the allocation on hold or refuse waiver services. When the applicant completes the PFOC and selects HCBS, he or she may choose DD Waiver or Mi Via Self-Directed Waiver and then select from a number of agencies available in the registrant's region to provide case management or consultant services (if the individual selects Mi Via). The PFOC includes the contact information for each case management and consultant agency.

Following receipt of a completed PFOC, DDSD officially notifies the applicant, the HSD/ Income Support Division (ISD), the TPA contractor, and the applicant's selected case management agency of the selection. At this time, the applicant receives an Allocation Letter detailing the next steps in qualifying for DD Waiver services including financial and medical eligibility.

Once the individual is deemed eligible for the DD Waiver, the individual is informed of and given information about the freedom to choose all direct service providers by the case management agency and documents his/her choice on a Secondary Freedom of Choice form. DDSD also offers a Provider Selection Guide, as a useful tool for assisting individuals/families to select the right provider for their support needs. The DOH maintains the Secondary Freedom of Choice form that lists the currently contracted service providers. A Secondary Freedom of Choice of service providers can be revised at any time and is reviewed at least annually by the case manager and individual.

HCBS recipients may transfer between the DD Waiver and the Mi Via Waiver. Interested individuals would contact the DDSD Regional Office personnel who maintain a Waiver Change Form and can provide additional information to assist the individual in making an informed decision.

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

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

Case managers are required to keep all relevant signed Secondary Freedom of Choice forms in the client file as long as the individual is still receiving services from those providers.

Waiver change forms are maintained by DOH and signed copied are stored at DDSD Regional offices statewide.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting

Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Informational materials are available in English and Spanish. Spanish-speaking individuals are available at the HSD/ISD offices and at HSD and DOH statewide toll-free numbers. Statewide disability resource agencies, such as the Governor's Commission on Disabilities, and New Mexicans with Disabilities Information Center, have bi-lingual staff available. All DD Waiver provider agencies are required to communicate in the language that is functionally required by the individual. As indicated in the application, all waiver provider agencies are required to communicate in the language that is functionally required by the individual and informational material will be translated into other languages as determined necessary. This includes Native American languages used in New Mexico.

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Case Management**		
Statutory Service	**Community Integrated Employment**		
Statutory Service	**Customized Community Supports**		
Statutory Service	**Living Supports**		
Statutory Service	**Respite**		
Extended State Plan Service	**Nutritional Counseling**		
Extended State Plan Service	**Occupational Therapy For Adults**		
Extended State Plan Service	**Physical Therapy For Adults**		
Extended State Plan Service	**Speech and Language Therapy For Adults**		
Other Service	**Adult Nursing**		
Other Service	**Assistive Technology**		
Other Service	**Behavioral Support Consultation**		
Other Service	**Crisis Support**		
Other Service	**Customized In-Home Supports**		
Other Service	**Environmental Modifications**		
Other Service	**Independent Living Transition Service**		
Other Service	**Non-Medical Transportation**		
Other Service	**Personal Support Technology**		
Other Service	**Preliminary Risk Screening and Consultation**		
Other Service	**Socialization and Sexuality Education**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Case Management Services assist individuals to gain access to waiver and State Plan services by linking the individual to needed medical, clinical, social, educational and other services from a variety of funding sources, including natural supports and non-disability specific services. Case Management services are intended to enhance, not replace, existing natural supports and other available community resources. Services will emphasize and promote the use of natural and generic supports to address the individual's assessed needs. Case Managers facilitate and assist in assessment, service planning, and monitoring activities.

Case Management services are person-centered and intended to support individuals in pursuing their desired life outcomes while gaining independence and facilitating access to services and supports. Case Management is a set of interrelated activities that are implemented in a collaborative manner involving the active participation of the individual, and/or his/her designated representative/guardian, and the entire Interdisciplinary Team IDT). The Case Manager is an advocate for the person receiving services and is responsible for developing the Individual Service Plan (ISP) and for the ongoing monitoring of the provision of services included in the ISP.

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

Case management for adults, age 18 and over, is a monthly unit with a maximum number of 12 units per ISP year.

A minimum of 4 units is required for children, under the age of 18. When services are provided for children, services must be coordinated with and shall not duplicate other services such as: the Medicaid School Based Services (MSBS) Program, the Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, services offered by the New Mexico State Department of Education, or the Family Infant Toddler (FIT) Program. Each service must be provided in accordance with the corresponding DD Waiver regulations, standards, and applicable DDSD policies.

The essential elements of Case Management include activities related to advocacy, assessment, planning, linking, and monitoring. DD Waiver case managers also play an important role in allocation, annual medical and financial recertification, record keeping, and budget approvals

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License *(specify):*

Licensed social worker as defined by the New Mexico (NM) Board of Social Work Examiners or licensed registered nurse as defined by the NM Board of Nursing (Nursing Practice Act: NMSA. Chapter 61, Article 3 and 16.12.1 New Mexico Administrative Code [NMACJ et seq.) or Bachelor's or Master's degree in social work, psychology, counseling, nursing, special education, or closely related field; or have a minimum of 6 years of direct experience related to the delivery of social services to people with disabilities.

Certificate *(specify):*

Certificate of accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council) on Quality and Leadership (CQL) or applicable waiver of such accreditation approved by DDSD.

Other Standard *(specify):*

Have a current business License issued by the state, county or city government.
Initial and 14 hours of annual ongoing training requirements set forth in DDSD- DD Waiver Standards Training in accordance with DDSD-DDW Service Standards
Quality Improvement (QI) strategies as required per the DD Waiver Standards and DD Waiver Provider Agreement

Have one (1) year clinical experience related to the target population.
Have a working knowledge of health and social resources available within the region.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, within 6-12 months after first year 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:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Community Integrated Employment

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Community Integrated Employment consists of intensive, ongoing services that support individuals to achieve competitive integrated employment or business ownership who, because of their disabilities, might otherwise not be able to succeed without supports to perform in a competitive work setting or own a business.

Services for individuals who wish to work or are working will start with a Person-Centered Assessment. This assessment will include, at a minimum, information about the individual's background and current status, the individual's strengths and interests, conditions for success to integrate into the community, including conditions for job success, and support needs for the individual. A Career Development Plan is required and should be used to in development of the ISP. Community Integrated Employment results in employment alongside non-disabled co-workers within the general workforce and/or in business ownership. Individuals are supported to explore and seek opportunities for career advancement through growth in wages, hours, experience and/or movement from group to individual employment.

Community Integrated Employment activities are designed to increase or maintain the individual's skill and independence, and may include: career exploration; career enhancement; job development; job placement; on the-job training and support; business ownership; job coaching; job site analysis; skills training ; benefits counseling; employer negotiations; co-worker training; vocational assessment; arrangement of transportation; assistance with medication administration ; and nursing support while at the work place; incorporation of reasonable accommodations, which may include therapy and/or behavioral support plans; assistance with the use of assistive devices and medical equipment; and personal care activities.

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

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

Individual Community Integrated Employment may include competitive jobs in the public or private sector, or business ownership (self-employment). The service delivery model for Individual Community Integrated Employment includes the services of a job developer and a job coach.

Individual Community Integrated Employment includes career planning which is a short-term process that is a flexible blend of strategies designed to identify employment options for the job seeker or job holder/business owner. Support needs are specified through career planning that identifies the job or business ownership desired with strategies for development, supports needed in the general workforce or anticipated growth in gross income for business ownership. Career planning is also available to the job seeker or job holder/business owner seeking career advancement or support to make a career change. It is available to all individuals who are interested in exposure to work, career development/advancement or career change.

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

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

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

develop and market any products.

Group Community Integrated Employment is the on-going support needed by an individual to acquire and maintain a paid job as part of a supervised group of workers with disabilities within a community integrated general workforce. This service occurs on a work schedule (days/hours typical for the industry or employer). Individuals have on-going work-related opportunities for inclusion with co-workers without disabilities who are not paid support staff and/or with the general public. Individuals receiving this service are in positions related to personal career planning goals.

Group Community Integrated Employment includes career planning which is a short-term process that is a flexible blend of strategies designed to identify employment options for the job seeker or job holder/business owner.

Services are provided in a manner that conforms with all HCBS settings requirements such that the setting is:
- Is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes individual initiative, autonomy and independence; and
- Facilitates individual choice regarding services and supports.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Group Community Integrated Employment
Agency	Individual Community Integrated Employment

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Integrated Employment

Provider Category:

Agency

Provider Type:

Group Community Integrated Employment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certificate of accreditation from Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Quality and Leadership (CQL) or applicable waiver or such accreditation approved by DDSD.

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.

Training in accordance with DDSD - DDW Service Standards

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Integrated Employment

Provider Category:

Agency

Provider Type:

Individual Community Integrated Employment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certificate of accreditation from Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Quality and Leadership (CQL) or applicable waiver of such accreditation approved by DDSD.

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Training in accordance with DDSD-DDW Service Standards for Direct Support Professional and Internal Service Coordination.
Training in accordance with DDSD-DDW Service Standards. Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Customized Community Supports

HCBS Taxonomy:

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

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

Customized Community Supports services are designed around the preferences and choices of each individual and offers skill training and supports to include: adaptive skill development, adult educational supports, citizenship skills, communication, social skills, socially appropriate behaviors, self-advocacy, informed choice, community integration and relationship building. All services are provided with the focus on community exploration and true community integration.

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

Customized Community Supports services start with, at a minimum, information about the individual's background and current status, the individual's strengths and interests, conditions for success to integrate into the IM community, including conditions for job success, and support needs for the individual. Based on assessed need, providers are also required to coordinate and collaborate with nursing supports to implement personal support, nursing oversight, medication assistance/administration, and integration of strategies in the therapy and healthcare plans into the individual's daily activities. The Customized Community Supports provider will act as a fiscal management agency for the payment of adult education opportunities as determined necessary for the individual.

Customized Community Support providers are required to coordinate and collaborate with behavior support consultants to implement positive behavior support plans and other behavior support plans as outlined in the ISP.

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

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

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

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

Services are provided in a manner that conforms with all HCBS settings requirements such that the setting:
- Is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes individual initiative, autonomy and independence; and
- Facilitates individual choice regarding services and supports.

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

Amount cannot exceed the individual budget allocation per ISP year.
Fiscal Management of Educational Opportunities (FMAEO), is not to exceed $550 annually.(including an administrative processing fee of no more than 10% of the total cost).

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Customized Community Supports Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Customized Community Supports

Provider Category:

Agency

Provider Type:

Customized Community Supports Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certificate of accreditation from CARF or The Council on Quality and Leadership (CQL) or The Council on Quality and Leadership (CQL) or applicable waiver of such accreditation approved by DDSD.

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Training in accordance with DDSD – DD Waiver Service Standards

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Living Supports

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Living Supports is a residential habilitation service that is individually tailored to assist individuals eighteen (18) years or older who are assessed to need daily support and/or supervision with the acquisition, retention, or improvement of skills related to living in the community to prevent institutionalization. Living Supports are intended to increase and promote independence and to support individuals to live as independently as possible in the community in a setting of their own choice.

Living Supports are integrated in and support full access to the greater community. Living supports include training and assistance with activities of daily living, such as bathing, dressing, grooming, oral care, eating, transferring, mobility, and toileting. These services also include training and assistance with instrumental activities of daily living including housework, meal preparation, medication assistance, medication administration and monitoring, and healthcare management.

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

Living Supports includes support to individuals to access: healthcare, dietary, nursing, therapy and behavior supports through telehealth and in person appointments; generic and natural supports, standard utilities including internet services, assistive and remote technology, transportation, employment, and opportunities to establish or maintain meaningful relationships throughout the community. Living Supports providers are also required to coordinate and collaborate with therapists and therapy assistants to implement therapy plans. Living Supports providers are also required to coordinate and collaborate with behavior support consultants to implement behavior support plans.

Living Supports Provider Agencies are required to have a Registered or Licensed Dietician or Licensed Nutritionist, (registered or licensed by the State of New Mexico), on staff or under contract to provide Dietary services for individuals including routine assessment, evaluation, planning, training and monitoring of health, medical and nutritional issues.

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

Family Living: Family Living is intended for individuals who are assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family Living is direct support and assistance to no more than two individuals residing in the home of a natural/consanguinity related or host family member. Family Living Provider Sub-Contractor utilizes substitute care to allow for sick leave and for time off as needed.

Family Living Provider Agencies are required to be an Adult Nursing provider and have a registered nurse (RN) , licensed by the State of New Mexico on staff or under contract who is residing in New Mexico or bordering towns. All family living recipients must receive an annual nursing assessment. If ongoing nursing is needed, it must be budgeted separately through the adult nursing service. LPNs may provide services but must be supervised by an RN. An agency nurse is required to be on call to respond to health related needs or issues. Nurses must respond promptly. They may make an in-person visit or may refer for immediate treatment to an urgent care, Emergency Room (ER) or 911 based on prudent nursing practice.
Any LPN on duty or on-call must have access to their RN supervisor by phone in case consultation is required.

Services may be delivered in person or remotely via phone or telehealth as appropriate. Support for telehealth/telemedicine as needed is a required element of the service.

Supported Living: Supported Living is intended for individuals who are assessed to need residential habilitation to ensure health and safety. Supported Living services are designed to address assessed needs and identified individual outcomes. The service is provided to two (2) to four (4) individuals in a provider operated and controlled community residence. Supported Living providers are responsible for providing an appropriate level of services and supports twenty-four (24) hours per day, seven (7) days per week. Services may be provided as part of on-site response plan with use of Remote Personal Support Technology. Appropriate levels of service may include on site on call and on site response plans developed with individual's use of Remote Personal Support Technology.

Supported Living Services Provider Agencies are required to have a registered nurse (RN), licensed by the State of

New Mexico on staff, or under contract, to provide nursing services including nursing assessments, provide technical assistance to the individual and the Inter-Disciplinary Team (IDT) related to health issues; create, implement, train the direct support professional on the health care plans, and medical emergency response plans, and monitor the implementation of those plans and the persons progress to their goals. . LPNs may provide services but must be supervised by an RN. An agency nurse is required to be on call to respond to emergencies. The provider agency is responsible for providing the level of nursing and nutritional counseling based on assessed need as specified in the in accordance with the waiver service standards. Services may be delivered in person or remotely via phone or telehealth as appropriate. Support for telehealth/telemedicine as needed is a required element of the service .

Intense Medical Living Supports provide community living supports for individuals in a Supported Living environment who require daily direct skilled nursing, in conjunction with community living supports that promote health and assist the individuals to acquire, retain or improve skills necessary to live in the community and prevent institutionalization, consistent with each individual's ISP. No more than four (4) individuals may be served in a single residence at one time. Such residences may include a mixture of individuals receiving Intensive Medical Living Services and Supported Living Services.

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

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

Short-term stay in this model may also be utilized by those individuals who meet the criteria that are living in a family setting when the family needs a substantial break from providing direct service.
In order to accommodate referrals for short-term stays, each approved Intensive Medical Living Supports Provider must maintain at least one (1) bed available for such short-term placements. If the short-term stay bed is occupied, additional requests for short-term stay will be referred to other providers of this service.

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

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

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

This service must arrange transportation or remote access for all medical appointments, household functions and activities, and to and from day services and other meaningful community options

Services may be delivered in person or remotely via phone or telehealth as appropriate. Support for telehealth/telemedicine as needed is a required element of the service.

Living Supports are provided in a manner that conforms with all HCBS settings requirements such that the setting is:
- Is integrated in and supports full access to the greater community,
- Is selected by the individual from among setting options;
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes individual initiative, autonomy and independence; and
- Facilitates individual choice regarding services and supports.

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

Services may be delivered in person or remotely via phone or telehealth as appropriate. Support for telehealth/telemedicine as needed is a required element of the service.

Living Supports are provided in a manner that conforms with all HCBS settings requirements such that the setting is:
- Is integrated in and supports full access to the greater community,
- Is selected by the individual from among setting options;
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes individual initiative, autonomy and independence; and
- Facilitates individual choice regarding services and supports.

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

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

Amount cannot exceed 340 days per ISP year.
Substitute care for Family Living is limited to 750 hours standard/ (1000 Jackson Class Members)
Payment for Living Supports is not made for the cost of room and board, home maintenance or upkeep and improvement of the residence.

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	Supported Living
Agency	Family Living
Agency	Intensive Medical Supports Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Living Supports

Provider Category:

Agency

Provider Type:

Supported Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certificate of accreditation from CARF or The Council on Quality and Leadership (CQL) or applicable waiver of such accreditation approved by DDSD

Other Standard *(specify):*

Have a current business license issued by the state, county or city government. Current CPR and First Aid certification,
Complete training in accordance with DDSD- DD Waiver Service Standards
Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Living Supports

Provider Category:

Agency

Provider Type:

Family Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certificate of accreditation from CARF or The Council on Quality and Leadership (CQL) or applicable waiver of such accreditation approved by DDSD

Other Standard *(specify):*

Have a current business license issued by the state, county or city government. Current CPR and First Aid certification,
Complete training in accordance with DDSD DD Waiver Service Standards .
Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Living Supports

Provider Category:

Agency

Provider Type:

Intensive Medical Supports Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certificate of accreditation from CARF or The Council on Quality and Leadership (CQL) or applicable waiver of such accreditation approved by DDSD

Other Standard *(specify):*

Have a current business license issued by the state, county or city government. Current CPR and First Aid certification.
Training in Accordance with DDSD-DD Waiver Service Standards

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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 more frequently.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

Individuals receiving Family Living, Supported Living, Intensive Medical Living Services or Customized In Home supports (not with a family or friend) may not access respite.

When services are provided to children under the age of 21, services must be coordinated with and shall not duplicate other services such as: the Medicaid School Based Services (MSBS) Program, the Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, services offered by the New Mexico State Department of Education, or the Family Infant Toddler Program.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Respite Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certificate of accreditation from CARF or The Council on Quality and Leadership (CQL) or applicable waiver of such accreditation approved by DDSD

Other Standard *(specify):*

License issued by the state, county or city government. Current CPR and First Aid certification, Complete training in accordance with DDSD- DD Waiver Service Standards
Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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:

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:**

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

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

Service Definition *(Scope):*

Nutritional Counseling services include assessment of the individual's nutritional needs, development and/or revision of the individuals nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan.
Services may be provided in person for assessment, evaluation or monitoring or remotely via telehealth as needed.

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

When services are provided to children under 21, services must be coordinated with and shall not duplicate other services such as: the Medicaid School Based Services (MSBS)Program, the Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, services offered by the New Mexico State Department of Education, or the Family Infant Toddler Program.

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 Practitioner
Agency	Group Practice

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Individual Practitioner

Provider Qualifications

License *(specify):*

Must be registered as a Dietician or Licensed Nutritionist by the Commission on Dietetic Registration of the American Dietetic Association; Nutrition and Dietetics Practice Act 61-7A-1 et seq., NMSA 1978.

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, and 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: Provider Specifications for Service

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

Provider Category:

Agency

Provider Type:

Group Practice

Provider Qualifications

License *(specify):*

Must be registered as a Dietician or Licensed Nutritionist by the Commission on Dietetic Registration of the American Dietetic Association; Nutrition and Dietetics Practice Act 61-7A-1 et seq., NMSA 1978

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, and 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:

Extended State Plan Service

Service Title:

Occupational Therapy For Adults

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

Skilled Direct Treatment may be provided to individuals based upon assessment findings. Skilled Direct Treatment services are used to treat a specific clinical condition or to provide services that require the skill of a licensed therapist. These services are not the role of non-therapists and cannot be delegated. Skilled therapy treatment must always be provided in conjunction with the Collaborative-Consultative Model of service delivery.

Therapists consider fading ongoing direct therapist involvement when implementation of strategies is correct and stable and skilled direct therapy treatment is no longer indicated. Ongoing training and monitoring may also be needed.

Adults on the DD Waiver may access therapy services under the State plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to adults under the DD Waiver are for maintenance and community integration purposes.

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

Initial assessments are limited to 1 per year. After an initial assessment, ongoing provision of this DDW service is limited by need to meet a set of criteria related to new allocation, core, or fading factors as well as various add-ons related to aspiration risk management. A set of established clinical criteria is applied by an Outside Review Contractor. Services approvals depending on individual need may typically span 72 to 280 (15 minute units) under the highest level of licensure. An initial evaluation is conducted at frequency of “each” unit.

This waiver service is only provided to individuals age 21 and over. All medically necessary occupational therapy for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services 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	Provider or group practice, clinics, hospitals
Individual	Licensed Independent Occupational Therapist
Individual	Certified Occupational Therapy Assistant

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Provider or group practice, clinics, hospitals

Provider Qualifications

License *(specify):*

Group Practice Agency that employs licensed occupational therapists in accordance with New Mexico Regulations & Licensing Department.

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Training in Accordance with DDSD DD Waiver Service Standards

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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: Provider Specifications for Service

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

Provider Category:

Individual

Provider Type:

Licensed Independent Occupational Therapist

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Training in Accordance with DDSD-DD Waiver Service Standards

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Certified Occupational Therapy Assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified Occupational Therapy Assistant under the NM Regulation and Licensing Dept; Occupational Therapy Act 61-12A-1 et seq., NMSA 1978

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Training in Accordance with DDSD-DD Waiver Service Standards

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement

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:

Extended State Plan Service

Service Title:

Physical Therapy For Adults

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

Skilled Direct Treatment may be provided to individuals based upon assessment findings. Skilled Direct Treatment services are used to treat a specific clinical condition or to provide services that require the skill of a licensed therapist. These services are not the role of non-therapists and cannot be delegated. Skilled therapy treatment must always be provided in conjunction with the Collaborative-Consultative Model of service delivery.

Therapists consider fading ongoing direct therapist involvement when implementation of strategies is correct and stable and skilled direct therapy treatment is no longer indicated. Ongoing training and monitoring may also be needed.

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

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

Initial assessments are limited to 1 per year. After an initial assessment, ongoing provision of this DDW service is limited by need to meet a set of criteria related to new allocation, core, or fading factors as well as various add-ons related to aspiration risk and management. A set of established clinical criteria is applied by an Outside Review Contractor. Services approvals depending on individual need may typically span 72 to 280 (15-minute units) under the highest level of licensure. An initial evaluation is conducted at frequency of each unit.

This waiver service is only provided to individuals age 21 and over. All medically necessary physical therapy for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services 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
Individual	Physical Therapy Assistant
Individual	Physical Therapist
Agency	Group Practice

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Physical Therapy Assistant

Provider Qualifications

License *(specify):*

Licensed as per NM Regulation and Licensing Dept; Physical Therapy Act 61-12-1.1 et seq., NMSA 1978

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.

Training in Accordance with DDSD-DD Waiver Service Standards

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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: Provider Specifications for Service

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

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Licensed as per NM Regulation and Licensing Dept; Physical Therapy Act 61-12-1.1 et seq., NMSA 1978

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Training in Accordance with DDSD-DD Waiver Service Standards

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, within 6-12 months after first year 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: Provider Specifications for Service

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

Provider Category:

Agency

Provider Type:

Group Practice

Provider Qualifications

License *(specify):*

Group Practice Agency that employs licensed physical therapists in accordance with New Mexico Regulations & Licensing Department.

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, and 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:

Extended State Plan Service

Service Title:

Speech and Language Therapy For Adults

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

Skilled Direct Treatment may be provided to individuals based upon assessment findings. Skilled Direct Treatment services are used to treat a specific clinical condition or to provide services that require the skill of a licensed therapist. These services are not the role of non-therapists and cannot be delegated. Skilled therapy treatment must always be provided in conjunction with the Collaborative-Consultative Model of service delivery.

Therapists consider fading ongoing direct therapist involvement when implementation of strategies is correct and stable and skilled direct therapy treatment is no longer indicated. Ongoing training and monitoring may also be needed.

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

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

Initial assessments are limited to I per year. After an initial assessment, ongoing provision of this DOW service is limited by need to meet a set of criteria related to new allocation, core, or fading factors as well as various add-ons related to aspiration risk and management and clinically justified services to support function. A set of established clinical criteria is applied by an Outside Review Contractor. Services approvals depending on individual need may typically span 72 to 280 (15-minute units) under the highest level of licensure. An initial evaluation is conducted at frequency of each unit.

This waiver service is only provided to individuals age 21 and over. All medically necessary speech and language therapy for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services 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
Individual	Speech Language Pathologist

Provider Category	Provider Type Title
Individual	Clinical Fellow
Agency	Private or group practice, clinics, and hospitals

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Speech Language Pathologist

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Training in Accordance with DDSD DD Waiver Service Standards

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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: Provider Specifications for Service

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

Provider Category:

Individual

Provider Type:

Clinical Fellow

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

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: Provider Specifications for Service

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

Provider Category:

Agency

Provider Type:

Private or group practice, clinics, and hospitals

Provider Qualifications

License *(specify):*

Agency that employs licensed speech licensed speech language pathologists therapists in accordance with New Mexico Regulations & Licensing Department.

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Training in Accordance with DDSD-DD Waiver Service Standards

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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:

Adult Nursing

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Adult Nursing Services are budgeted and used to provide ongoing nursing supports to persons who receive Family Living Services or who do not receive Living Supports but desire or require nursing services in their lives. Adult Nursing Services are provided based on the needs of the individual and include a review of medical history, a standardized nursing n assessment, healthcare planning (in collaboration with other members of the IDT), training, monitoring health status and healthcare plan implementation; , advice, teaching and consultation; and/or direct nursing intervention, supports or treatment or coordination of services for an acute or chronic medical condition or disability. Such activities shall be based upon assessed support needs and may include medication management/administration; aspiration risk management; precautions; cardio/pulmonary management; nutrition or feeding tube management; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; pain management; health screening; infection control; environmental management for safety; nutrition diabetic or pain management; oxygen management; seizure management and precautions; medical management of behavioral symptoms; health education and self-care assistance. Nursing services may be delivered directly or via remote or telehealth services May also include telehealth, and may also include teaching and monitoring for delegated nursing tasks at nurse discretion.
Nursing Services are bundled into the rates for Supported Living and Intensive Medical Living Services.

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

The Initial/Annual Nursing Assessment and Consultation (up to 12 hours per year) establishes the individual's baseline needs and the amount and type of ongoing services is limited by need to meet a set of criteria related to health care planning and coordination, aspiration risk management, medication administration and coordination of complex conditions. A set of established clinical criteria is applied by an Outside Review Contractor for service approvals depending on individual need for various circumstances which typically shall not exceed 454 hours per year.
This waiver service is only provided to individuals age 21 and over. All medically necessary nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services 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
Individual	Private Duty Nursing Individual
Agency	Private Duty Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Nursing

Provider Category:
Individual
Provider Type:

Private Duty Nursing Individual

Provider Qualifications

License *(specify):*

Must be licensed by the New Mexico State Board of Nursing as a RN or LPN per the Nursing Practice Act: NMSA, Chapter 61, Article 3 and 16.12.1 New Mexico Administrative Code [NMAC] et seq.

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Have a minimum of one-year experience as a licensed nurse
Training in Accordance with DDSD DD Waiver Service Standards

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: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Nursing

Provider Category:

Agency

Provider Type:

Private Duty Nursing Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Have a minimum of one-year experience as a licensed nurse.
Training in Accordance with DDSD DD Waiver Service Standards

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:

Assistive Technology

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Assistive Technology (AT) service is intended to increase the individuals physical and communicative participation in functional activities at home and in the community. Items purchased through the AT service assist the individual to meet outcomes outlined in the ISP, increase functional participation in employment, community activities, activities of daily living, personal interactions, and/ or leisure activities, or increase the individuals safety during participation of the functional activity.

Assistive Technology services allow individuals to purchase needed items to develop low-tech augmentative communication, environmental access, mobility systems and other functional AT, not covered through the individuals State plan benefits.

The focused use of Assistive Technology (AT) benefits individuals on the waiver program to engage more fully in life through increasing communication, independence and community access. Increased communication allows the individual to freely express their wishes and supports socialization. AT also supports individuals in the work setting thereby increasing their earning potential and independence. AT services are cost effective because they enable the person to function more independently, which decrease reliance on direct support staff. Administrative fees are allowable within this service.

Assistive Technology may be accessed through an approved waiver provider acting as a purchasing agent for technology vendors whose products meet definition and needs or directly through an approved Technology Provider who is the director vendor of the service and approved DDW Provider.

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

The maximum funding allowed under AT services is $500 per ISP year. Of the $500 00, no more than $50.00 can be used to purchase batteries.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assistive Technology Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Assistive Technology Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Must demonstrate fiscal solvency and function as a payee of services.
An assistive technology purchasing agent provider and agency must comply with 8.314.5.10 NMAC

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:

Behavioral Support Consultation

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

The BSC supports the person's successful achievement of Vision-driven Desired Outcomes. Behavior Support Consultation services identify behaviors that impact quality of life and provide specific prevention and intervention strategies to manage and lessen the risks these behaviors present. This service is provided by an authorized behavior support consultant and includes a Positive Behavior Supports Assessment and Positive Behavior Support Plan development; interdisciplinary team (IDT) training and technical assistance; and monitoring of an individual's behavioral support services.
A quality foundation for BSC has several components:
1. assessment of the person and his/her environment, including barriers to independent functioning;
2. design and testing of strategies to address concerns and build on strengths and skills for independence; and
3. writing and training plans in a way that the person and Direct Support Personnel (DSP) can understand and implement them.

Behavioral support consultants are licensed mental health professionals who contract with the Department of Health (DOH) to:

1. Guide the person's and the IDT's understanding of contributing factors that currently influence behavior such as: genetic and/or syndromal predispositions, developmental and physiological compromises, traumatic events, co-occurring I/DD and mental illness, communicative intentions, coping strategies, and environmental issues;
2. Enhance the person's and the IDT's competency to predict, prevent, intervene with, and potentially reduce behaviors that interfere with quality of life and pursuit of ISP Desired Outcomes, including recommendations regarding needed adaptations to environments in which the person participates;
3. Be available for timely discussion and revision of assessments, plans, and semi-annual reports per DOH/DDSD Service Plans for people with I/DD living in the community [7.26.5 NMAC];
4. Attend and consult, either in person, conference call, or telehealth, the annual ISP and any other IDT meeting convened for service planning that have behavioral implications for the person and the provision of BSC services;
5. Develop assessments and plans in compliance with required components outlined in the "Beyond the ABCs" training required of new BSCs and to lessen the negative impact of contributing factors to enhance the person's autonomy and self-determination;
6. Support effective ISP implementation through timely completion of the PBSA, PBSP, BCIP, PPMP and semi-annual reporting as applicable;
7. Provide IDT members, including DSP, with training, materials and/or other relevant information needed to successfully implement the PBSP, perform any ongoing data collection or provider reporting required by the PBSP and all other related plans (BCIP, PPMP, or RMP);
8. Train staff, and/or an agency designated trainer;
9. Collaborate with medical personnel, ancillary therapies, and Provider Agencies to promote coherent and coordinated support efforts;
10. Monitor the person's progress at a frequency determined by the BSC in conjunction with the IDT, in various settings through direct observation, staff interviews and/or data collection;
11. Attend an HRC meeting, either in person or by conference call, to answer questions that the HRC may have:
a. At the initial presentation of any plan (PBSP, BCIP, PPMP or RMP) containing interventions requiring review;
b. At the annual review of any plan(s), if the restriction(s) is (are) applicable; and
c. When any substantial changes are made to the restriction(s) that a plan contains;
12. Advocate for supports that assure the person is free from aversive, intrusive measures; chemical, mechanical, and non-emergency physical restraint; isolation; incarceration; and abuse, neglect, or exploitation; and
13. Attend psychiatric appointments when the person:
a. Has a significant change in their psychiatric condition or has a mental health diagnosis not currently well managed;
b. Requires ongoing psychiatric evaluation where specialized data collection and analysis is needed;
c. Is currently in Crisis Supports due to a psychiatric or behavioral issue; or
d. Has been recommended to have a Risk Management Plan because of a Preliminary Risk Screening where psychiatric issues are considered a contributing factor.

The behavior support consultants' scope of service is provided through participation and consultation with interdisciplinary team members to support the individual to achieve desired outcomes listed in the ISP.

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

When services are provided to children under the age of 21, services must be coordinated with and shall not duplicate other services such as: the Medicaid School Based Services (MSBS) Program, the Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, services offered by the New Mexico State Department of Education, or the Family Infant Toddler Program. Each service must be provided in accordance with the corresponding DDW regulations, standards, and applicable DDSD policies.

Initial assessments are limited to 1 per year, unless there is a change in BSC provider. After an initial assessment, ongoing provision of this DDW service is limited by need to meet a set of criteria related to core, fading or complexity factors as well as various add-ons related to completion of an initial budget year, crisis and/or risk management. A set of established clinical criteria is applied by an OR Contractor. Services approvals depending on individual may typically span 18 to 148 hours with applicable add-ons when justified.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Consultation

Provider Category:

Individual

Provider Type:

Individual Behavioral Support Consultation Provider

Provider Qualifications

License *(specify):*

Licensed, psychologist, psychologist associate, independent social worker, master social worker, clinical mental health counselor, professional counselor, marriage and family therapist, professional art therapist, or other related licenses and qualifications may be considered with DOH’s prior written approval.

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government. Minimum of one year of clinical or personal experience with persons with I/DD.
Must employ or subcontract with at least one professional with an independent practice license.
Complete mandatory training requirements as specified by DDSD.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, and 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: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Consultation

Provider Category:

Agency

Provider Type:

Behavioral Support Consultation Provider Agency

Provider Qualifications

License *(specify):*

Licensed, psychologist, psychologist associate, independent social worker, master social worker, clinical mental health counselor, professional counselor, marriage and family therapist, professional art therapist, or other related licenses and qualifications may be considered with DOH's prior written approval.

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government. Minimum of one year of clinical or personal experience with persons with I/DD mandatory
Training in Accordance with DDSD DD Waiver Service Standards

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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:

Crisis Support

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Crisis Supports are designed to provide intensive supports by appropriately trained staff to an individual experiencing a behavioral or medical crisis. Crisis Supports help the person and his/her support network to stabilize the crisis. Crisis Supports may be provided within the person's home or in an alternate residential setting.

The Crisis Supports provider is required to do the following:
1. provide trained Crisis Response Staff (CRS) to assist in supporting and stabilizing the person's medical or behavioral condition;
2. provide training and mentoring for staff, family members, IDT members and other natural supports to remediate the crisis and minimize or prevent recurrence;
3. arrange, if necessary, for an alternative residential setting and provision of CRS to support the person in that residential setting;
4. deliver Crisis Supports in a way that maintains the person's normal routine to the maximum extent possible;
5. deliver Crisis Supports in a way that maintains the person's human rights to the maximum extent possible;
6. present and receive approval from an HRC for a short-term restriction in the case of a severe health and safety risk;
7. assist in stabilizing and preparing the person to return to his/her original residence or to move into a new permanent residence because of an amendment to the ISP;
8. consult with IDT members, DSP, and other relevant personnel needed to ensure the implementation of the person's ISP.

Crisis Supports are provided via one of the following models:

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

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

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

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

Crisis Supports must be prior authorized by the Developmental Disabilities Supports Division (DDSD) Office of Behavioral Supports. Crisis Supports may be authorized in fourteen (14) to thirty (30) calendar day increments, typically not to exceed ninety (90) calendar days. In situations requiring crisis supports in excess of ninety (90) calendar days, the DDSD Director must approve such authorization upon submittal of a written plan to transition the individual from crisis supports to typical menu of DD Waiver services. Crisis Supports in the Individual's Residence is a 15 min unit increment that may be authorized within the span as outlined above. Crisis Supports in an Alternate Residential Setting may be authorized as a day unit as outlined above.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Crisis Support Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Support

Provider Category:

Agency

Provider Type:

Crisis Support Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by state, county or city government.
Training in accordance with DDSD training policy Training in Accordance with DDSD DD Waiver Service Standards and enhanced crisis support training in accordance with DDSD BBS Crisis

Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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:

Customized In-Home Supports

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

Services are delivered by a direct support professional in the individuals own home or family home in the community. Services may be provided as part of on-site response plan with use of Remote Personal Support Technology.

This service may not be provided in conjunction with respite. Individuals using this service may also receive customized community supports and community integrated employment.

Services are provided in a manner that conforms with all HCBS settings requirements such that the setting is:
- Is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes individual initiative, autonomy and independence; and
- Facilitates individual choice regarding services and supports.

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 In-Home Supports Provider Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Customized In-Home Supports Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certificate of accreditation from CARF or The Council on Quality and Leadership (CQL) or applicable waiver of such accreditation approved by DDSD

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Current CPR and First Aid certification.
Quality Improvement (QI) strategies as required per the DDW Standards and DDW Provider Agreement.

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:

Environmental Modifications

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*

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 individuals residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

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

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

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

Environmental Modifications are limited to $5,000 every five (5) years.

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	Environmental Modifications Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Environmental Modifications Agency

Provider Qualifications

License *(specify):*

GB-2 Class Construction
License as per NM Regulation and Licensing Department, NMSA 1978, Section 60-13-3.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, and 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:

Independent Living Transition Service

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Living Transition Provider Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Independent Living Transition Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
The provider must demonstrate fiscal solvency and function as the payee of the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, and 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:

Non-Medical Transportation

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

This service includes:
1. Mileage Reimbursement for eligible driver: This is not intended to provide for hourly payment to drivers. Drivers must be planned using natural and/or other paid supports who meet driver eligibility requirements. Eligible drivers are an approved waiver provider or other who has a valid New Mexico driver's license, is free of physical or mental impairment that would adversely affect driving performance, do not have any Driving Under the Influence convictions, or chargeable (at fault) accidents within the previous two (2) years, has a current CPR and First Aid certification, and has current annual training in Abuse Neglect and Exploitation.
2. Reimbursement for public transportation passes or eligible ride share programs identified through the ISP

Non-Medical Transportation may be accessed through an approved waiver provider acting as a purchasing agent for passes or mileage reimbursement. Mileage reimbursement may not be provided when the transportation is part of another DD Waiver service scope.

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

Billable per mile with a maximum of $810 or billable per dollar for pass/ticket with a maximum of $460 per 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	Non-Medical Transportation Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Non-Medical Transportation Agency

Provider Qualifications

License *(specify):*

Business license
Valid NM drivers license

Certificate *(specify):*

Other Standard *(specify):*

Compliance the Caregivers Criminal History Screening (CCHS) Requirements (7.1.9 NMAC).

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:

Personal Support Technology

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Remote Personal Support Technology is an electronic device or monitoring system that supports individuals to be independent in the community or in their place of residence with limited assistance or supervision of paid staff. This service provides up to twenty-four (24) hour alert, monitoring or remote personal emergency response capability, remote prompting or in-home reminders, or environmental controls for independence through the use of technologies. The service is intended to promote independence and quality of life, to offer opportunity to live safely and as independently as possible in one's home, and to ensure the health and safety of the individual in services.

Remote Personal Support Technology is available to individuals who may want to live independently in their own homes, may have a demonstrated need for timely response due to health or safety concerns, or may be afforded increased independence from staff supervision in residential services. The use of technology should ease life activities for individuals and their families.

Remote Personal Support Technology includes development of individualized response plans with the installation of the electronic device or sensors, monthly maintenance, rental or subscription fees. This service is not intended to provide for paid, in-person on-site response. On-site response must be planned through response plans that are developed using natural and/or other paid supports for on-site response.
Remote Personal Support Technology may be accessed through an approved waiver provider acting as a purchasing agent for technology vendors whose products meet definition and needs or directly through an approved Technology Provider who is the director vendor of the service and approved DDW Provider.

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

Up to $5000 per year

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Support Technology

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Support Technology

Provider Category:

Agency

Provider Type:

Personal Support Technology

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Comply with all laws, rules, and regulations from the Federal Communications Commission for telecommunications.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, and 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:

Preliminary Risk Screening and Consultation

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Preliminary Risk Screening & Consultation (PRSC) is designed to assess continued risk of sexually inappropriate and/or offending behavior in persons who exhibit or have a history of exhibiting risk factors for these types of behaviors. This service is part of a continuum of behavior support services (including BSC and Socialization & Sexuality Education) that promotes community safety and reduces the impact of interfering behaviors that compromise the person's quality of life. PRSC is provided by a licensed mental health professional who has been trained and approved as a Risk Evaluator by the BBS.

1. The PRSC service provides, through a structured risk screening process:
a. Identification of individual level and type of risk for inappropriate sexual behavior;
b. Strategies for risk management under the least restrictive supervision conditions, including recommending reduction in supervision when warranted;
c. Technical assistance related to the identification of the management of risk level; and
d. Consultation notes and/or preliminary risk screening report.

2. Individuals may not receive BSC services from the Risk Evaluator.
3. The Risk Evaluator is required to:
a. Engage in activities necessary to collect information to complete a preliminary risk screening report, revised report, and/or consultation notes per the BBS-approved templates including recommendations regarding measurable goals and a system of implementation; and
b. Interface with BBS following completion of a screening or periodic case review in the following ways:
i. Provide reports and/or consultation notes to BBS and the referring team within 30 calendar days of the preliminary risk screening meeting; and
ii. Participate in any mandated BBS-sponsored trainings and meetings.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Preliminary Risk Screening Provider
Agency	Preliminary Risk Screening Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Preliminary Risk Screening and Consultation

Provider Category:

Individual

Provider Type:

Preliminary Risk Screening Provider

Provider Qualifications

License *(specify):*

A PRSC provider agency must subcontract with or employ the Risk Evaluator who is trained and authorized by DDSD BBS and holds a current, independent practice license, through a Board of the New Mexico Regulation and Licensing Department, in a counseling or counseling-related field (e.g., Counseling and Therapy Practice, Psychologist Examiners, Social Work Examiners).

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
A masters or doctoral degree in a counseling or counseling-related field from an accredited college or university.
Training as specified by DDSD.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, within 6-12 months after first year 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: Provider Specifications for Service

Service Type: Other Service
Service Name: Preliminary Risk Screening and Consultation

Provider Category:

Agency

Provider Type:

Preliminary Risk Screening Provider Agency

Provider Qualifications

License *(specify):*

A PRSC provider agency must subcontract with or employ the Risk Evaluator who is trained and authorized by DDSD BBS and holds a current independent practice license, through a Board of the New Mexico Regulation and Licensing Department, in a counseling or counseling-related field (e.g., Counseling and Therapy Practice, Psychologist Examiners, Social Work Examiners).

Certificate *(specify):*

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
A masters or doctoral degree in a counseling or counseling-related field from an accredited college or university.
Training as specified by DDSD.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, and 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:

Socialization and Sexuality Education

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Socialization & Sexuality Education in the form of the Friends & Relationships Course (FRC) provides concrete, interactive instruction that teaches people the social and sexuality skills needed to form relationships. Another important aspect of the classes helps people to make the strongest connection possible between individual personal values and informed choices about relationships and sexuality. The FRC involves the person's network of support (natural supports, paid supports, teachers, nurses, family members, guardians, friends, advocates, and/or other professionals) teaching them to support the social and sexual lives of persons with I/DD, through participation in classes, and by using trained and paid self-advocates as role models and peer mentors in classes.
The IDT provides services and supports to FRC students in such a way that the skills the person is learning in the FRC are being practiced, reinforced, and expanded in all settings. The IDT is required to integrate these skills and supports into the person's Desired Outcomes and TSS where and when appropriate.

The scope of Socialization and Sexuality Education (SSE) includes, but is not limited to:
1. Providing adult education, using the FRC curriculum, about the social skills and sexual knowledge needed to develop and maintain meaningful relationships, including romantic relationships;
2. Collaborating with members of the person's IDT to:
a. Secure a support person to attend classes with the student, and to continue support for skills learned in class outside of the classroom; and
b. Integrate classroom goals and learning objectives into the individual student's ISP and PBSP, if person has a PBSP;
3. Recruiting people who have attended classes and demonstrated leadership skills to be trained and hired as self-advocate peer mentors; and
4. Emphasizing course content on how to assert participants' rights to be free from aversive, intrusive measures; chemical, mechanical, and programmatic physical restraint; isolation; incarceration; and ANE.

Agencies authorized by the Department to provide this service will:
1. Coordinate with DOHIDDSD/Bureau of Behavioral Supports (BBS) on administrative duties related to assuring classes are held (i.e., logistics, student and teacher eligibility, teacher training, preparation and hiring of self-advocate peer mentors);
2. Teach classes, utilizing BBS approved teacher(s), student teacher(s) and self-advocate peer mentor(s);
3. Collaborate with interdisciplinary teams, and others to assure that the student attends classes, and is supported to use learned skills across all settings; and, if applicable;
4. Provide education to individuals, behavior support consultants, parents, guardians, and other team members regarding individualized socialization and sexuality education

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

1. Authorization for per class rate shall not exceed twenty-four (24) classes (total of 48 hours) per student per ISP year

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	Socialization and Sexuality Provider
Agency	Socialization and Sexuality Provider Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Socialization and Sexuality Provider

Provider Qualifications

License *(specify):*

Bachelor’s or Master's degree in Psychology, Counseling, Special Education, Social Work, or related field; or Registered Nurse (RN) or Licensed Practical Nurse (LPN); or Bachelor’s degree in Special Education; or other related licenses and qualifications may be considered with DOH’s prior written approval.

Certificate *(specify):*

Certification in Special Education
New Mexico level three recreational therapy instructional support provider certification

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Bachelor’s or Master's degree or higher in Psychology, Counseling, Special Education, Social Work or related field or Registered Nurse (RN) or Licensed Practical Nurse (LPN). Training requirements as specified by DDSD.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, within 6-12 months after first year 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: Provider Specifications for Service

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

Provider Category:

Agency

Provider Type:

Socialization and Sexuality Provider Agency

Provider Qualifications

License *(specify):*

A master's degree or higher in psychology, counseling, special education, social work, a bachelor's degree in special education, or a Registered Nurse or Licensed Practical Nurse

Certificate *(specify):*

Certification in Special Education

Other Standard *(specify):*

Have a current business license issued by the state, county or city government.
Master's degree or higher in Psychology, Counseling, Special Education, Social Work or related field.
Training requirements as specified by DDSD.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH/DDSD

Frequency of Verification:

Prior to the approval of the initial provider agreement, within 6-12 months after first year 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: 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):

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

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

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

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

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

○ **No. The state does not conduct abuse registry screening.**

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

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

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

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

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

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

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

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

Appendix C: Participant Services

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

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

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

☐ **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.

Relatives/legal guardians, who are qualified to provide services as specified in Appendix C-3, may be paid for providing waiver services. Payment to relatives/legal guardians are allowed under the following circumstances:
Legal guardians who are also natural or adoptive family members who meet the DOH/DDSD requirements and are approved to provide Family Living services may be paid for providing services.
Legal guardians who are also natural or adoptive family members, relatives, or natural family members that meet the DOH/DDSD requirements and are approved to provide Customized In-Home Supports may be paid for providing services.

All waiver services are determined with the individual and the Interdisciplinary Team (IDT) and are documented in the ISP, which includes provision of services provided by a legal guardian.

The case manager is responsible for monitoring the implementation of services on a monthly basis.

Payment is only made for services that are identified in the ISP and the provider agency is responsible for verifying that services have been rendered in accordance with the ISP

The DOH/Division of Health Improvement (DHI) conducts provider surveys to ensure services are provided in accordance with the DOH/DDSD DD Waiver Service Standards.

○ **Other policy.**

Specify:

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

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of enrolled licensed/certified providers who meet licensure/certification requirements prior to furnishing waiver services Numerator: Number of newly enrolled providers that meet licensure/certification requirements prior to furnishing waiver services. Denominator: Total number of newly enrolled providers.

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

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):*

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:
Percentage of non-licensed/non-certified providers who initially meet waiver requirements. Numerator: Number of non-licensed/non-certified providers that initially meet waiver requirements. Denominator: Total number of new non-licensed/non-certified providers

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of non-licensed/non-certified providers that continue to meet waiver requirements. Numerator: Number of non-licensed/non-certified providers that continue to meet waiver requirements. Denominator: Total number of non-licensed/non-certified providers.

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

Responsible Party for data collection/generation	**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:	☒ **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:

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:
Percentage of agency staff, reviewed annually , who are in compliance with training requirements as specified in the DD Waiver policies and procedures. Numerator: Number of agency staff that meet training requirements specified in the DD Waiver policies and procedures. Denominator: Total number of agency staff that are required to meet the training requirements.

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

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 qualified providers are identified by the State, processes are in place to ensure that appropriate and timely action is taken. In addition, the DDSQI Steering Committee routinely collects, aggregates, analyzes, and trends provider qualification data, as described in Append ix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

Assistance with individual problems occurs through the DDSD regional offices. Regional Office Request for Assistance Forms (RORAs) are routed to the appropriate staff and are tracked and trended for system improvement. Regional Office Directors are authorized to provide administrative actions and technical assistance.

Additionally, DOH has an Internal Review Committee (IRC) that meets monthly to address provider compliance issues. If remediation and improvements are not made in accordance with the corrective action plan and other remediation activities, civil monetary penalties may be assessed against a provider, including and up to termination of the provider agreement.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

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

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

In addition to any service parameters addressing any applicable limits on amount, frequency or duration of a service described in Appendix C-3, each DD Waiver service is limited by need to meet a set of criteria that is applied by an Outside Review Contractor when services are requested.

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.

Please refer to Main, Attachment #2.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Service Plan (ISP)

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

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

- ☐ **Social Worker**
  Specify qualifications:

- ☐ **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

During the initial steps in the development of the Individual Service Plan (ISP), the case manager engages and supports the individual and/or family or legal representative, as appropriate, in developing the ISP. The case manager meets with the individual prior to service planning meetings to explain the waiver process, provide information, and encourage his/her leadership and full participation in the service plan meetings.

The case manager:
1.Explains the supports and services available through the DD Waiver to obtain the individual's vision and outcomes;

2.Explains the risk associated with the outcomes and services identified and possible options to mitigate the risks;

3.Provides information and linkage for enhancing natural supports and exploring non disability specific, publicly funded programs and community resources available to all citizens within the individual's community;

4.Explains the rights and responsibilities of the individual, guardian, family, and other team members;

5.Provides a list of the specific service providers available in the individual's area from which the individual may select his/her providers, updated and made available through the secondary freedom of choice process

6.Explains the team process and composition of the team;

7.Encourages the individual and/or family or legal representative to include others of his/her choice as team members;

8.Supports the individual to lead the team meeting;

9.Advocates for the individual on an ongoing basis; and

10.Assists with obtaining and reviewing assessments that can inform the person-centered planning process. Assessments may include those required by DD Waiver and others relevant to the individual.

The participant or their guardian determines what providers they would like to work with by service type through a secondary freedom of choice process. The secondary freedom of choice of providers is reviewed annually. Once a participant chooses a provider, they are considered part of the interdisciplinary team (IDT). The plan is developed by participant with support of IDT and anyone else the participant chooses.

Working together, the case manager, individual, and/or family or legal representative, as appropriate, identify the individual's strengths, and assist the individual in identifying his/her vision, outcomes, and preferences for plan development.

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):

ISPs are written by the case manager and developed by the participant with support from their IDT, typically consisting of selected DD Waiver providers and any other individuals (guardian, family) or natural supports that the individual would like to have present.

The Developmental Disabilities Supports Division (DDSD) also utilizes the following types of assessments:

A. The initial or annual level of care assessment
B. Client Individual Assessment
C. The Electronic Health Assessment Tool (ECHAT), documents and tracks health conditions and informs planning.
D. Medication Administration Assessment Tool (MAAT) clarifies the level and type of assistance needed with the delivery of medications.
E. Assessment and evaluation tools for speech, occupational and physical therapies.
F. Aspiration Risk Screening Tool, a screening for aspiration risk, supports informed decision making on the part of the individual and their guardian, collaborative development of a Comprehensive Aspiration Risk Management Plan (CARMP), training and monitoring.
G. Person Centered Assessments and career development plans
H. Positive Behavior Supports Assessments and Positive Behavior Support Plans
I. Preliminary Risk Screening and Consultation related to Inappropriate Sexual Behavior -/Risk Management Plan
J. Other assessments from non HCBS providers as relevant to the individual

These assessments assist in the development of an accurate and functional plan. The Comprehensive Individual Assessment is conducted in preparation for the LOC determination process which addresses the following needs of a person: medical (including current medications), adaptive behavior skills, nutritional, functional, and community/social factors. Assessments occur on an annual basis, or as needed, during significant changes in circumstance.
In developing the service plan, the case manager explains the individual's rights and responsibilities and the services available through the waiver and other resources. The case manager meets with the individual to arrange a team meeting to develop the Individual Service Plan (ISP). The ISP is based on relevant clinical information and other individualized assessments, as needed.

In developing the service plan, the case manager explains the individual's rights and responsibilities and the services available through the waiver and other resources. The case manager meets with the individual to arrange a team meeting to develop the Individual Service Plan (ISP). The ISP is based on relevant clinical information and other individualized assessments, as needed.

For children, the child’s Level of Care (LOC) assessment and other assessments as relevant to the child are also used to assist the family and team in person centered planning and identifying the DD Waiver services and supports that may help the child achieve ISP outcomes.

An individualized plan is completed when the team has identified:

1.The individual's interests and preferences;
2.The needed support and service areas and activities;
3.The settings the individual is most likely to be in, as well as the activities in which the individual will participate;
4.The specific support functions which will address the identified support needs;
5.Natural supports available for the person;
6.Valued personal outcomes; and
7.Mechanism to monitor the provision and effectiveness of the support and services provided.

The team develops an ISP prior to expiration of the current plan and within timelines established by DDSD to process the submission of ISP and budget for approval and entry into Medicaid Management Information System (MMIS) or as needed based upon the individual’s needs, interests and preferences. At the meeting, the case manager supports the individual to express his/her outcomes for services and supports, preferences, current actions steps necessary to achieve those outcomes. The ISP outcomes, actions steps and activities to accomplish outcomes, services, and amount, frequency and duration of waiver services, services through other resources, and natural supports are developed based on the individual's preferences, assessed needs, and desired outcomes. The ISP addresses the individual’s needed waiver services and includes reference to services and supports that are not waiver funded.

Waiver and other services are coordinated through ongoing communication between the case manager, service providers, the state plan Managed Care Organization care coordinators and the individual and/or family or legal representative as appropriate. DDSD and HSD routinely update and educate DD Waiver case managers and the MCOs related to better overall care coordination. The ISP delineates the roles and responsibilities of each service provider related to the implementation of the plan. Pursuant to the waiver service standards, the case manager is responsible for monitoring implementation of the plan on a monthly or quarterly basis, or more frequently as needed.

The ISP must be updated annually, when requested by the individual, or when the individual experiences one of the following circumstances:

1.Major medical changes;
2.Risk of significant harm;
3.Loss of primary caregiver or other significant person;
4.Serious accident, illness, injury or hospitalization that disrupts the implementation the ISP;
5.Serious or sudden change in behavior;
6.Change in living situation;
7.Changes to or completion of ISP outcomes or vision;
8.Loss of job;
9.Proposed change in services or providers;
10.Abuse, neglect or exploitation is substantiated;
11.Criminal justice system involvement;
12.Any team member requests a meeting;
13.Individual and case manager have not been able to resolve issues and barriers, concerns or proposed changes; or
14.Request by DOH/DDSD.

The State does not use temporary, interim service plans to initiate services while a more detailed service plan can be finalized.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

In order to adequately assess and mitigate risks, the individual, family or legal representative, and others who provide supports must be involved throughout the service plan development process. The process begins with the case manager's completion of the Level of Care (LOC) packet. Based on the LOC packet, the case manager then works with the individual and/or family or legal representative, as applicable, to identify the individual's health and safety needs. The provider completes assessments as needed to more clearly identify the individual's potential risk factors within the service delivery environment.

A discussion among the team members occurs about the identified potential risks, benefits, consequences of various courses of action, and the conditions under which the individual is willing and able to assume responsibility for the risks.

The team discussion regarding risks is documented in the ISP. Depending on assessed need various plans are incorporated by reference into the ISP to address individual risk. These include Health Care Plans, Medical Emergency Response Plans, Comprehensive Aspiration Risk Management Plans, PRN Psychotropic Medication Plans, Behavior Crisis Intervention Plans. Plans are incorporated by reference in the ISP.

Approved waiver providers are also required to have back-up plans and an on-call systems in the event staff should call in sick or are unable to work. This back-up plan must also address what to do in an emergency, as well as more anticipated events such as inclement weather, illness, or if day services are closed.

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.

Once eligibility is determined, the case manager assists the individual and his/her family/guardian in an exploration of service options and provides the individual with relevant Secondary Freedom of Choice Forms. The Secondary Freedom of Choice lists eligible providers in the individual's county for the anticipated services. Individuals/guardians and families are encouraged to research and visit service providers before making selections and to ask providers to describe their programs. Once the individual makes a provider selection, he/she indicates the selection and signs the Secondary Freedom of Choice Form. DDSD provides tools including provider information and sample questions to ask providers in an effort to assists individuals with choice of providers, and a web-based list of currently approved and qualified waiver providers by service type, region and county. Current tools to assist in provider selection are updated as appropriate and are posted on the DDSD website. DDSD has staff available to provide technical assistance to case managers, providers, individuals and guardians regarding the freedom of choice and person-centered planning process as outlined in the waiver standards and regulations.

At the initial team meeting, the ISP document is developed. The ISP describes the waiver services that the individual needs and the service providers selected to provide these services. Individuals may elect to change service providers at any time. Secondary Freedom of Choice Forms are provided to the individual by the case manager and completed by the individual and/or guardian whenever there is a change in providers. DOH/DDSD maintains the Secondary Freedom of Choice Forms through the Provider Enrollment Unit.

Participants or their guardians are also free to select a different case management agency at any time. To mitigate any conflict of interest, this is facilitated by the DDSD Regional Office. Primary Freedom of Choice Forms are provided to the individual and/or guardian by DDSD.

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):

DOH/DDSD contracts with the Outside Reviewer (OR). The OR will make a clinical determination and approve or deny in whole or in part a DD Waiver recipient's requested Individual Service Plan (ISP) and budget in writing. The OR's clinical determination will include the reasons for any denial of requested services. The State may agree to overturn a decision to deny services at an agency review conference. An agency review conference means an optional conference offered by the State to provide an opportunity to informally resolve a dispute over the denial, suspension, reduction, termination or modification of benefits or services. Once the OR makes a written clinical determination on whether the requested services and service amounts are needed, the information is provided to HSD/MAD's Third-Party Assessor (TPA) Contractor who reviews and enters the approved budget into the Medicaid Management Information System (MMIS).

HSD/MAD contracts with a TPA Contractor for utilization review and approval of DD Waiver individual service plans (ISPs) for Jackson Class members. The TPA Contractor approves each participant individual's ISP as submitted by a case manager for Jackson Class Members annually, or more often, according to the circumstances listed in D-1 d.. Upon approval of the ISP, the TPA contractor enters the approved budget into the MMIS. 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

TPA Contractor
Outside Reviewer

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The case manager conducts routine monitoring through visits with the individual, reviews of incident reports, telephone contacts, reviews of regularly required reports from therapists and providers and/or reviews of HSD/MAD Prior Authorization reports. Face to face visits are required monthly at a minimum for adults and at least quarterly for children under the age of 21. Jackson Class Members require two face to face visits per month.

During the monitoring, the case manager is responsible for assuring that:
1. Individuals have access to waiver services as identified in the service plan;
2. Individuals have access to non-waiver services as identified in the service plan, including access to health services;
3. Services meet the needs and preferences of the individual and are chosen from among non-disability specific options;
4. Individuals exercise free and informed choice of qualified and locally available providers of Waiver services;
5. Plans are effective;
6. Individual health and welfare are assured; and
7. Waiver Services are furnished in accordance with the service plan.

The site visits for adults may occur in the home, day habilitation program, community employment site or during therapy sessions. At least every other month, this visit takes place in the individual's home. If monitoring occurs by phone, the case manager must reflect the issues discussed and follow-up needed in case notes in the file. Follow-up must be completed by the case manager within a timely manner and a team meeting must be convened. If a case manager is unable to address issues identified through required monitoring activities, the case manager or any team member may also fill out a "Request for Regional Office Assistance" form to report persistent issues to regional offices and to obtain assistance. DDSD has the authority to provide technical assistance or directly impose administrative actions, civil monetary penalty (CMP), and sanctions on community based provider agencies for non-compliance with or violations of regulations, service standards, policies, procedures, and/or provider agreement requirements which includes requirements related to implementation of an ISP.

The HSD/MAD MMIS contractor supplies providers and case managers with Prior Authorization Reports, and weekly updates of prior authorization and utilization of service units. Case managers and providers are responsible for tracking and monitoring utilization to ensure services are being provided in accordance with the ISP. The provider is responsible for requesting additional service units through the case manager.

Additional monitoring activities are conducted by DOH Division of Health Improvement (DHI) which conducts periodic compliance reviews of provider agencies and their adherence to standards, regulations, policies and procedures through their Quality Management Bureau. Problems are identified by reviewing files, incident reports and complaints, interviewing staff and waiver individuals, and through direct observations.

DHI approves a plan of correction required to be developed by the with providers when crucial items are missing or incomplete. Plans of Correction (POC) are forwarded to DOH/DDSD. DOH/DHI is responsible to track and follow-up with agencies to ensure that the POCs are completed successfully or referred to the appropriate entity for further administrative action or sanctions.

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):
Other
If 'Other' is selected, specify:
TPA and OR reports submitted to HSD/MAD

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

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):
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**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 individuals receiving services consistent with their service plan in type, scope, amount, duration and frequency of services. Numerator: Number of individuals who receive 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:
MMIS

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

Data Aggregation and Analysis:

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

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 DD Waiver participants who are afforded choice between waiver services or institutional care. Numerator: Number of records reviewed which contained Primary Freedom of Choice forms. Denominator: Total number of record reviews for individuals on the DD Waiver.

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

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

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5% margin of error and a 95% confidence level
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: at allocation	

Data Aggregation and Analysis:

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

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

Performance Measure:
Percentage of DD Waiver participants afforded the choice between/among waiver services and providers Numerator: Number of records reviewed which contained current Secondary Freedom of Choice forms for all services being received. Denominator: Total number of record reviews for individuals on the DD Waiver.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 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.

Assistance with individual problems occurs through the DDSD regional offices. Regional Office Request for Assistance Forms (RORAIs) are routed to the appropriate staff and are tracked and trended for system improvement. Regional Office Directors are authorized to provide administrative actions and technical assistance.

Through contract management DDSD is authorized, by agreement with the HSD, to enforce DD Waiver Service Standards and service regulations with DD Waiver Provider Agencies and to impose sanctions on Provider Agencies for failure to perform in accordance with standards applicable under statute, regulation, and contract.

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

ii. Remediation Data Aggregation

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

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

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

1.Verbal information provided by case managers upon entrance to the DD Waiver;
2.Written Notice of Rights in Addendum A to the Individual Service Plan (ISP), provided annually to participants and guardians and made part of the official participant record;
3.Website postings (see current information here: https://nmhealth.org/about/ddsd/lafh/fahr/
4.Hard copy informational documents distributed by DOH/DDSD and Office of Constituent Affairs at regular stakeholder meetings and public forums;
5.Written notice of rights accompany the DD Waiver application provided to the applicant, guardian and authorized representative at the start of the application process; and
6.Verbal explanation provided by DDSD Fair Hearings Unit as requested

Various agencies including HSD's Third-Party Assessor (TPA) and the DOH/DDSD Outside Review (OR) Contractor are responsible for providing the waiver participant with the review determination in writing, including reasons for any denial of requested services or level of care. The participant or their authorized representative is informed by the appropriate agency, in writing, of the opportunity to request a Fair Hearing. The letter providing notice of the adverse action explains the participant's right to continue to receive services during the Hearing process. The HSD Fair Hearings Bureau is responsible for maintaining documentation regarding all aspects of the hearing. Benefits are continued consistent with the due process standards set out in Goldberg v Kelly 397 US 254 (1970) and information on the automatic continuation of benefits is included in the notice.

The agencies responsible for giving notice to individuals or their authorized representatives of their rights to Fair Hearings are responsible for maintaining documentation of the notification.

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.

DOH/DDSD operates two additional dispute resolution processes:

1.The Agency Review Conference (ARC), offered after a Fair Hearing is requested, and
2.Team Facilitation Process

To assist individuals and families through the hearing process, DOH/DDSD created a unit to centralize matters related to waiver- related Fair Hearings. The DDSD Fair Hearings Unit receives all hearing acknowledgements from HSD Fair Hearings Bureau and compiles the Summary of Evidence (SOE) for the Parties and the Administrative Law Judge. 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 before the Fair Hearing. The DOH/DDSD Fair Hearings Unit works with all interested Parties to schedule and conduct an Agency Review Conference (ARC) in the hopes of resolving issues outside of the hearing. Instructions on how to request an ARC are included in the notice of the adverse action. The ARC process includes:

a. Contacting individuals who have requested a Fair Hearing to ask if the individual is interested in participating in an agency conference, and
b. Providing assistance to individuals, families, guardians, case managers and providers in order to efficiently resolve issues outside of the formal hearing.

Frequently, Fair Hearing cases are resolved through action items discussed and acted upon via the Agency Review Conference process. However, participating in an ARC does not replace or impact the individual's right to a Fair Hearing. The DOH/DDSD Fair Hearings Unit verbally explains this to the individual or the individual's representative in addition to the written notice.

The DOH/DDSD Office of Constituent Support (OCS) operates an additional statewide due process (Team Facilitation Process) for all recipients of services within the DDSD, which includes the Developmental Disabilities Medicaid Waiver. The Team Facilitation Process (TFP) consists of OCS outreach, which informs the individual that the Team Facilitation Process is not a prerequisite or substitute for a fair hearing when the individual is informed that the dispute has been accepted and a mediator has been assigned.

The TFP was established to allow all individuals and their team members to have a voluntary means to present and address their concerns or issues in the presence of a neutral third party (trained mediator). The role of the mediator is to provide strategies to facilitate communication, act as a resource, and provide technical assistance to the team. Issues or conflicts that can be disputed apply to the individual's service plan (ISP) when an individual or team believes the ISP is not being implemented appropriately. Conflict resolution consensus is developed with the team and implemented by the interdisciplinary team. This process is offered in addition to the Medicaid fair hearing process.

The process includes the following:

1. Requestor contacts the Manager of the Office of Constituent Supports (OCS)OCS Unit either by telephone, email, in writing, by fax, or in person to request team facilitation.
2. OCS Manager reviews and determines to accept or deny the request per criteria (has five (5) working days to review).
3. If accepted, the case is assigned to a trained mediator.
4. If not accepted, a letter is sent to the requestor stating the reason for denial within ten (10) working days.
5. If accepted, the mediator has thirty (30) days to complete the team facilitation.

During the thirty (30) days, the Mediator:

a. Speaks to the requestor and other pertinent parties;
b. Collects necessary documents;
c. Schedules a meeting with the requestor and other pertinent parties;
d. Facilitates the meeting and has team participants sign an agreement to approve the mediation;
e. Documents, in writing, at the meeting the resolution(s) on an agreement sheet that is signed by all team participants; and
f. Hands out the agreement sheet(s) to all team participants (agreements amend the service plans, and therefore, are

binding.)

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Both HSD/MAD and DOH/DDSD is responsible for the operation of the grievance/complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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.

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 two reporting systems for critical events or incidents involving individuals receiving DD Waiver services: (1) the Division of Health Improvement (DHI)/Incident Management Bureau (IMB) protocols for incidents of abuse, neglect, exploitation, suspicious injury, environmental hazard and deaths, and (2) the DDSD General Events Reporting (GER) system for significant events experienced by adults of the DD Waiver program, which do not meet criteria for reportable incidents listed in (1) but which may pose a risk to individuals served.

DOH/DHI/IMB REPORTING PROTOCOLS:

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

Abuse
Neglect
Exploitation
Suspicious Injury
Environmental Hazard
Death

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

The DDSD GENERAL EVENTS REPORTING SYSTEM:

The DDSD General Events Reporting (GER) is a system to report, track and analyze events, including significant events experienced by adults of the DD Waiver program, which do not meet criteria for reportable incidents listed above but may pose a risk to individuals served. Types of significant events include:

1. Utilization of emergency services;
2. Hospitalization;
3. Urgent Care
4. Law enforcement intervention that results in the arrest or detention of a participant;
5. Falls;
6. PRN Medication;
7. Elopement;
8. Suicide/Attempt/Ideations/Threat
9. Use of Emergency Physical Restraint or Seclusion and
10. Medication Errors

Approved DD Waiver Provider agencies are required to report specified events through the GER System according to timelines specified in the DDW standards (i.e. within 2 business days of occurrence or knowledge of occurrence)

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.

Information on reporting critical incidents is provided through case managers. This information is disseminated to participants and/or family members or legal representatives at the initial enrollment meetings, and during the annual plan renewal meetings.

This information is reinforced by the case managers and community providers, who work with participants during the planning and monitoring process. DOH/DHI posts materials online.

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, investigates incidents and works collaboratively with other state agencies the Children Youth and Families Department Child Protective Services (CYFD-CPS) and the Aging and Long Term Service Division Adult Protective Services (ALTSD- APS)that accept abuse, neglect and exploitation reports concerning any children or adults in New Mexico. The DOH/DHI/IMB's entire intake process must be completed by close of business the day following the date of receipt of a report. Upon receipt of the Incident Report, DOH intake staff determine if IMB has the jurisdiction and authority to investigate. Additional information is obtained from the community-based service provider within the 24-hour timeline, however, the IMB has an extended intake process that can be requested by the intake specialist in order to receive appropriate documents. The process includes:

1. Search for and print a history from the database of prior reported incidents (past 12 months) on the participant;

2. Verify or attain the funding source; and

3. 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 (I) working day of receipt, however, the IMB does have an extended intake process that can be requested by the intake specialist in order to receive appropriate documents.

A. FOR REPORTABLE INCIDENTS

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

i. Abuse;
ii. Neglect;
iii. Exploitation;
iv. Environmental Hazard;
v. Suspicious Injury; and
vi. Death.

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

1. Review Participant History: Identify possible trends.

2. Determine Severity and Priority: Medical Triggers that receive priority are aspiration, fractures, dehydration, and a history of multiple emergency room (ER) visits (in a short period of time). In addition, priority is described as:

a)Emergency case: Reports of very serious cases of Abuse, Neglect, or Exploitation resulting in physical harm, including sexual abuse, or mental anguish which leave affected consumers at continued risk for injury or harm. Due to the severity of the case, the investigator will respond within (3) hours.
b)Priority I Case: Reports of urgent cases of Abuse, Neglect or Exploitation. Due to the severity of the case, the investigator will respond within twenty-four (24) hours but does not require more immediate action.
c)Priority 2 Case: Reports of cases of Abuse, Neglect, or Exploitation. Due to the severity of the case, the investigation will be initiated within five (5) calendar days.

3.Assign Investigator using the following considerations about the report:

a)Region of the incident occurrence: DHI/IMB has divided the State into five (5) regions (consistent with DOH/Developmental Disabilities Support Division (DDSD) Regional designations). DHI investigators are located in each region.
b)Participant specific: Investigator with an existing case involving the participant or with the most knowledge of the participant. Cultural or language needs of the participant are also given consideration.
c)Provider specific: Investigator with an existing case involving the responsible provider.
d)Caseload based: Cases will be assigned with a caseload maximum.
e)Level of urgency: Cases may be assigned based on the most available investigator.
f) Deaths: All deaths are assigned to the DHI Clinical Team for investigation.

g) ALTSD/Adult Protective Services (APS) or CFYD/Child Protective Services (CPS) Status: If DOH/DHI also has jurisdiction, the investigation is a collaborative process.

4.Intake staff documents the Triage decisions.

5.Database Entries are made as appropriate. See also Append ix F: Incident Management Database User’s Manual.

6. Notifications are made to the following entities, as appropriate:

a) DOH-Office of the General Counsel (OGC),
b)DOH-DDSD ALTSD (APS)
c)ALTSD-Elderly and Disability Services Division (EDSD)
d)CYFD (CPS)
e)DOH/DHI and DDSD Director's Office
f)Law Enforcement
g)Human Services Department (HSD)-Medical Assistance Division (MAD),
h)Medicaid Fraud Control Unit,
i)NM Attorney General's Office
j)DOH, Office of Internal Audit (OIA).
k)Responsible Provider in cases of late reporting or failure to report

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

8. Support staff files the entire packet in the appropriate file and make a file folder for cases closed during the Intake process. Closure notifications will be sent at this time for each case completed during Intake to case managers, participants (who are over the age of 18 and are their own guardians), guardians and the provider.

B. FOR NON-REPORTABLE INCIDENTS AND NON-JURISDICITIONAL INCIDENTS (NRI/NJI):

1.Data Entry of information into the separate NRI/NJI Database.

2. As appropriate notifications should be made to the following entities:

a. DOH, Office of the General Counsel (OGC),
b. DOH/DDSD
c. ALTSD (APS)
d. ALTSD (EDSD)
e. CYFD (CPS)
f. DOH/DHI and DDSD Director's Office
g. Law Enforcement
h. HSD/MAD
i. Medicaid Fraud Control Unit,
j. NM Attorney General 's Office, and
k. DOH OIA

NOTIFICATION TO THE PARTICIPANT:

In each situation that critical incident investigations are completed by ALTSD APS, CYFD/CPS, or DOH/DHI, the DD Waiver participant or the participant's guardian receives a letter stating the results of the investigation. The investigator has up to forty-five (45) days to complete the investigation and up to seven (7) days for writing the investigation report. Therefore, informing the participant or guardian and other relevant parties of the investigation results occurs no more than fifty-two (52) days following DOH/DH l/JMB's receipt of the investigation report. Under extenuating circumstances, i.e., necessary documentary evidence is not yet available, a thirty (30) day extension to the forty-five (45)-day timeline may be granted by the investigator's supervisor. With the extension, relevant parties may be notified up to eighty-two (82) days following the incident report. Regulations are found in NMSA 1978, Sections 27-7-14 through 27-7-31 (Adult Protective Services Act) and in NMSA1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect

Act).

DDSD General Events Reporting System includes, but is not limited to:

i. Utilization of emergency services;
ii. Out of Home Placement;
iii. Law enforcement intervention that results in the arrest or detention of a participant are reportable in a designated; iv. Use of Emergency Physical Restraints;
iv. Medication Administration Errors,

Along with DDSD and the Developmental Disabilities Services Quality Improvement (DDSQI) Steering committee, community agency providers review incidents at least quarterly. Individual case managers are required to log into the GER system to review reports and consult with providers regarding the need to convene an interdisciplinary team meeting to address any pattern that emerges regarding multiple events for an individual. All cases involving the use of law enforcement initiated by a community-based waiver service agency in the course of services to a DD Waiver participant will be reported via the GER system. DOH/DDSD Bureau of Behavioral Support (BBS) staff review GERs reported for the use of Law Enforcement services. Those incidents of Law Enforcement involvement that are suspected to include possible abuse, neglect or exploitation are also reported to DOH/DHI for investigation. Investigations are assigned priority and must be completed within a forty-five (45) day timeline. If problems are identified and not corrected within the course of the investigation, the follow-up process will begin to assure the health and safety of the participant and the correction of identified issues. Case closure letters are sent to the participant, and/or his/her guardian, case manager and, if appropriate the provider. Detail about more immediate follow-up action required in incidents of use of emergency physical restraint, and medication errors is detailed in Appendix G-2 and G -3.

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 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. 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. Quality assurance and quality improvement action plans are developed as needed, based on identified trends and other identified issues in order to prevent reoccurrence.

Technical assistance for individual specific critical incident follow-ups and/or identification and remediation of health and safety challenges is available through the DOH as requested by the case manager. Issues brought to the DOH/DDSD by concerned case managers will be addressed in terms of options or resources for the participant to pursue in mitigating their risks. The DOH may consult with knowledgeable professionals within other State Departments or other relevant community resources to explore potential options.

The State has a system to monitor, track, and investigate critical incidents for DD Waiver recipients. DOH/DHI investigates and follows-up regarding providers and critical incidents.

Appendix G: Participant Safeguards

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

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

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

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this

oversight is conducted and its frequency:

◉ **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).

Personal restraints are defined as emergency physical restraints: the use of personal, manual physical force to limit, prohibit or preclude imminently dangerous behavior by restricting movement through specified and allowed sustained physical contact or holding procedures. Use of any emergency physical restraints must be written into a Behavioral Crisis Intervention Plan and approved by a Human Rights Committee prior to its use. Personal restraints (i.e. emergency physical restraints) are used as a last resort, only when other less intrusive alternatives have failed and under limited circumstances that include protecting an individual or others from imminent, serious physical harm, or to prevent or minimize any physical and/or emotional harm to the individual. Staff must be trained in both nonphysical and physical interventions.

Any aversive interventions which result in physical pain, may cause tissue damage or injury, and are ethically unacceptable for people who are not disabled, are prohibited. Providers supporting participants with behaviors that pose a threat of serious physical harm to self and/or others, or result in extreme property damage are required to develop policies regarding use of emergency physical restraints, Providers are to establish methods for evaluating risk of harm versus benefits of harm reduction with use of emergency physical restraints and must document its use including an internal incident report process, post incident analysis and report to the interdisciplinary team and DDSD Bureau of Behavioral Support via the General Events Reporting (GER) system in Therap. When abuse, neglect or exploitation is suspected, the report also goes to the DOH/DHI Incident Management Bureau. DD

Drugs used as restraints are defined as chemical restraints: Chemical restraint is defined as the administration of medication at a dose and/or frequency to intentionally and exclusively preclude behavior without identifying an underlying anxiety, fear or severe emotional distress or other symptoms of psychiatric/emotional disturbance to be eased, managed and/or treated. The administration may be regularly scheduled or on an “as needed” PRN basis. The use of chemical restraints is prohibited. The administration of PRN medication is allowed when prescribed in advance by the prescribing professional. A Human Rights Committee must approve use of PRN Psychotropic medication.

Mechanical restraints are defined as the use of a physical device to restrict the individual’s capacity for desired or intended movement including movement or normal function of a portion of his or her body. The use of mechanical restraints is prohibited.

Any individual for whom the use of emergency physical restraints or PRN Psychotropic medications is allowed is required to have a Positive Behavioral Supports Assessment, Positive Behavior Support Plan, and a Behavioral Crisis Intervention Plan or PRN Psychotropic Medication Plan completed by a Behavior Support Consultant in conjunction with the individual’s Interdisciplinary Team.

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:

DOH/DDSD and DOH/DHI both have oversight responsibility. DOH/DDSD Bureau of Behavior Supports (BBS) provides oversight through the periodic review of provider emergency physical restraint policies and provider reports on prolonged or repeated use of emergency physical restraints, and review of Positive Behavior Support Plans (including Behavioral Crisis Intervention Plans) BBS also offers training and technical assistance to providers, teams and Human Rights Committees when problems are identified that impact the health and safety of the participants. Complex ethical, medical and/or behavioral concerns, which may include use of live or recorded video monitoring/observational systems, cost response systems, restitution systems and resolution of plans contested on the individual team or provider agency level in local Human Rights Committees are heard and resolved in a statewide and state-coordinated Human Rights Committee.

DOH/DHI conducts periodic compliance reviews of provider agencies and their adherence to standards, regulations, policies and procedures through their Quality Management Bureau. During provider compliance reviews DOH/DHI monitors use of emergency physical restraints, other restrictive practices such as the use of live and video monitoring of participants and seclusion to ensure safeguards of their use, when allowable, are followed and to detect unauthorized use of these practices. DOH/DHI also conducts investigations when there are incidents of abuse, neglect and exploitation. The data is collected by DOH/DHI and entered into a database through their Incident Management Bureau. Reports are generated from the database and are reviewed to identify trends. The reports can be aggregated in different ways as requested by the Developmental Disabilities System Quality Improvement (DDSQI) Steering Committee (i.e. by provider, by finding, by type of incident). DOH/DDSQI Steering Committee review the data and determine if any action is necessary. The DDSQI Steering Committee meets monthly. HSD/MAD participates on the Steering Committee

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:

◉ **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.

Restrictive Interventions are defined as interventions that limit an individual's movement; a person's access to other individuals, locations, or activities, or restrict participant rights (From the CMS Technical Guidance document). This does not include restraints or seclusion which are both addressed in other areas of this section (i.e., G-2-a and G-2-c).

Use of Restrictive Interventions must be documented in the individual's Positive Behavior Support Plan and/or Behavioral Crisis Intervention Plan and/or Risk Management Plan and must be reviewed by the Human Rights Committee prior to implementation.

Certain specific interventions are considered ethically unacceptable for application and, as such, are unequivocally prohibited. Interventions that are prohibited include but are not limited to: (a) contingent electrical aversion procedures; (b) forced exercise; (c) withholding food, water, or sleep; (d) public or private humiliation; (e) application of water mist; (f) application of noxious taste, smell, or skin agents; (g) interventions causing or resulting in physical pain; (h) interventions which cause or may potentially cause tissue damage, physical illness or injury, or require the involvement of medical personnel; and (i) the use of police presence and emergency rooms as a principal strategy of behavioral support.

In situations involving documented patterns of risk (i.e., behavioral risk such as conditions that might cause harm to the person or others) certain activities, items, locations, and access to other persons may be limited and are considered a Restrictive Intervention.

The definition of risk above is from the CMS Technical Guidance glossary

Any individual for whom the use of Restrictive Interventions is allowed is required to have a Positive Behavior Supports Assessment, Positive Behavior Supports Plan, and, if warranted, a Behavioral Crisis Intervention Plan completed by a Behavior Support Consultant in conjunction with the individual's Interdisciplinary Team. The Positive Behavior Supports Assessment focuses on a holistic person-centered conceptualization with a focus on possible environmental, skill-based, and/or communicative contributors to behavioral expression. When Restrictive Interventions are proposed, the Positive Behavior Supports Assessment clearly outlines the topography of behavioral patterns that constitute risk. The Positive Behavior Supports Plan addresses person centered, positive behavioral supports and approaches to teach functional skills and to mediate behavior that interferes with the individual's quality of life and community integration. The Positive Behavior Supports Plan is intended to teach strategies to enhance the individual's skills and capacities, including skills to substitute for problem behavior. The provision of behavioral supports is based on principles of planning built on strengths, choices in the planning process, planning that maintains the individual's self-esteem and dignity, and planning that is focused on desired outcomes that arise from the individual's vision. Direct Support Professionals are required to be trained in each individual's Positive Behavior Supports Plan and Behavioral Crisis Intervention Plan.

In certain situations, involving sexually inappropriate or offending behavior with evidence and/or history of offense against others, the Behavior Support Consultant may write a Risk Management Plan. As outlined in DD Waiver Standards the Risk Management Plan is part of a comprehensive integrated system of sexuality services to assure that effective supports are provided in these conditions. This multicomponent system provides services to address the socialization and sexuality skills and supports needed for individuals with I/DD to live safely in the community and to obtain and keep jobs and form relationships, including intimate ones. Risk Management Plans are derived in conjunction with Preliminary Risk Screening – a consultative interview of an individual who has a recent incident or history of engaging in sexually inappropriate and/or offending behavior. The screening is used to identify and assess risk factors for re-offending behaviors, to determine whether further assessment is warranted and to identify educational and risk management strategies. A Risk Management Plan is a supplement to the Positive Behavior Supports Plan that describes a supportive set of interventions designed to increase manageability of risk via specific strategies and supervision. Specifically, Risk Management Plans may contain recommendations for limitations on certain activities or locations in the community, security measures in residences (e.g., door alarms), staff ratios and proximity of supports, and prohibitions on certain materials (e.g., pornography, images of children, unmonitored internet access). All direct support professionals must be trained on the Risk Management Plan. The Bureau of Behavioral Support oversees these processes and reviews the management of risk. Agency Human Rights Committees must approve the components of a Risk Management Plan prior to instigation.

In other cases, Restrictive Practices (e.g., response cost, restitution, limits on access to items or activities) may be recommended or enacted for other types of risk patterns (e.g., physical harm to self or others; severe property destruction). Again, these interventions must be clearly outlined in the related documentation (i.e., Positive Behavior Support Plan, Behavioral Crisis Intervention Plan) and approved by the provider agency Human Rights Committee prior to implementation. The Bureau of Behavioral Support provides guidance via trainings and written materials (i.e., BBS Response Cost Guidelines; BBS Restitution Guidelines) regarding the necessary components when including these types of interventions. The focus of this guidance is to ensure that efforts toward skill development, communication, and community integration remain primary and consequently the team remains focused on increasing skills/activities/integration in desired community settings rather than solely on decreasing a behavior seen as challenging.

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:

DOH/DDSD and DOH/DHI both have oversight responsibility. DOH/DDSD Bureau of Behavior Supports (BBS) provides oversight through the periodic review of provider policies and provider use of restrictive practices, review of Positive Behavior Support Plans, including Behavioral Crisis Intervention Plans, training provided to providers, teams and Human Rights Committees, and the provision of technical assistance to providers, teams, and Human Rights Committees when problems are identified that impact the health and safety of the participants. Complex ethical, medical and/or behavioral concerns, use of live or recorded video monitoring/observational systems, and resolution of plans contested on the individual team or provider agency level in local Human Rights Committees are heard and resolved in a statewide and state coordinated Human Rights Committee.

DOH/DHI conducts periodic compliance reviews of provider agencies and their adherence to standards, regulations, policies and procedures through their Quality Management Bureau. During provider compliance reviews DOH/DHI monitors restraints, restrictive practices and seclusion to ensure safeguards of their use when allowed are followed and to detect unauthorized use of these practices. DOH/DHI also conducts investigations when there are incidents of abuse, neglect, exploitation. The data is collected by DOH/DHI and entered into a database through their Incident Management Bureau. Reports are generated from the database and are reviewed to identify trends. The reports can be aggregated in different ways as requested by the Developmental Disabilities Services Quality Indicators (DDSQI) Steering Committee (i.e. by provider, by finding, by type of incident). DOH/DDSQI Steering Committee review the data and determine if any action is necessary. The DDSQI Steering Committee meets monthly and as needed. HSD/MAD participates on the Steering Committee.

Appendix G: Participant Safeguards

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

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

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

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

The use of seclusion is prohibited pursuant to the DD Waiver Standards.

DOH/DDSD and DOH/DHI both have oversight responsibility. DOH/DDSD Bureau of Behavior Supports (BBS) provides oversight through the periodic review of provider policies and provider practices, review of Positive Behavior Support Plans, including Behavioral Crisis Intervention Plans, training provided to providers, teams and Human Rights Committees, and the provision of technical assistance to providers, teams, and Human Rights Committees when problems are identified that impact the health and safety of the participants. Complex ethical, medical and/or behavioral concerns, use of live or recorded video monitoring/observational systems, and resolution of plans contested on the individual team or provider agency level in local Human Rights Committees are heard and resolved in a statewide and state-run Human Rights Committee

DOH/DHI conducts periodic compliance reviews of provider agencies and their adherence to standards, regulations, policies and procedures through their Quality Management Bureau. During provider compliance reviews DOH/DHI monitors restraints, restrictive practices and seclusion to ensure safeguards of their use when allowed are followed and to detect unauthorized use of these practices. DOH/DHI also conducts investigations when there are incidents of abuse, neglect, exploitation. The data is collected by DOH/DHI and entered into a database through their Incident Management Bureau. Reports are generated from the database and are reviewed to identify trends. The reports can be aggregated in different ways as requested by the Developmental Disabilities Services Quality Indicators (DDSDQI) Steering Committee (i.e. by provider, by finding, by type of incident). DOH/DDS QI Steering Committee review the data and determine if any action is necessary. The DDSQI Steering Committee meets monthly and as needed. HSD/MAD participates on the Steering Committee.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

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

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant

medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

For individuals who receive any type of customized in-home supports, family living or supported living, the relevant provider has primary responsibility for monitoring participant medication regimens. However, customized community supports providers or community integrated employment providers are responsible for providing assistance with medication delivery needs as outlined in the Individual Service Plan during the time the individual is participating in those services.

The DD Waiver Provider agency nurse is responsible for medication management oversight and collaborates with agency management in tracking and reporting all adverse medication events and/or medication errors as part of the agency's required Continuous Quality Improvement program. Monitoring of the medication record for individuals occurs by the agency nurse at a minimum on a monthly basis. Secondarily, the case manager is also responsible for monitoring for any concerns regarding an individual’s health and safety and the implementation of the Individual Services Plan which includes health and safety.

Second-line monitoring is the responsibility of the DOH/DDSD Regional Offices and the DOH Division of Health Improvement (DHI). These state agency responsibilities are detailed in section G-3c iv.

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

The Division of Health Improvement (DHI)/Quality Management Bureau (QMB) oversees the provider agency's medication management monitoring through periodic routine agency compliance surveys. During a routine survey QMB reviews medication management policies, procedures, and practices to identify compliance with regulation and to identify potentially harmful practices. DHI/QMB reviews medication administration documentation for consumers in the review sample in addition to data collected by the provider agency on medication management to identify areas noncompliance including harmful practices.

Compliance with requirements related to "Assisting With Medication Delivery" (AWMD) training are reviewed during the survey to determine whether all staff who assist with the administration of medication delivery have successfully completed this class initially and annually.

QMB determines through interview, observation and record review if the individuals in the sample are receiving medications as prescribed. The survey team determines what medications the individual is currently taking and what medication allergies the individual has. QMB then compares this information with the actual medications in the home, the medications listed on the Medication Administration Record (MAR) and the official Physician orders from the prescriber to determine the accuracy and consistency of the information.

The actual medications in Supported Living and Family Living, if receiving nursing medication oversight services, are examined in order to ascertain whether:

1. The ordered medications are available and stored correctly;

2. Medications have been administered as prescribed (i.e. correct dose, time, amount, form, route, etc.); each medication is labeled correctly; and

3. Each medication is documented correctly in the MAR.

This is review process is performed for all routinely administered medications and PRN medications. Additionally, medications are reviewed for individuals receiving inclusion services if the medication is administered during the time the individual is receiving the inclusion service.

Each provider agency receives a routine survey between one (1) and three (3) years, based upon compliance history from previous survey. Every agency receives a survey at least every three (3) years. New DDW provider agencies are receive an initial compliance survey within 6 – 12 moths of providing services to Individuals participating in waiver programs. Agencies may also be monitored at any time as a result of a request for a focused survey, based upon complaints or concerns raised by DDSD or DHI staff or other stakeholders. Request for focused surveys must be presented through the Internal Review Committee process. If systemic issues are identified, the DDSQI Steering Committee ensures an action plan is developed and implemented to improve quality

The Human Services Department (HSD), Medical Assistance Division (MAD) is provided oversight results in three ways:

1) DHI/QMB provides a copy of all QMB provider survey reports to HSD/MAD;

2) An HSD/MAD staff member is a voting member of the IRC; and

3) Staff from HSD/MAD are members of the DDSQI Steering Committee.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

○ **Not applicable.** *(do not complete the remaining items)*

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

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

The DDW Service Standards regarding self-administration of medications apply to all provider agencies living supports, customized community supports, community integrated employment, intense medical living supports.

The Service Standards identifies the role of the agency nurse, including responsibilities for annual and event-driven medication assessments, and training and procedures for delivery of PRN medication.

The standards outline the requirements regarding the assessment of an individual's ability and/or needs regarding medication delivery. Additionally, the standards outline criteria for self-administration of medications, physical assistance by staff when needed, assistance with medication delivery by staff, and criteria for medication administration by licensed nurses or certified personnel. When medication is administered by licensed nurses or certified personnel the requirements set forth in the New Mexico Nursing Practice Act, 1978 NMAC 16.12.1 et seq. must be complied with.

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

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

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

DHI and DDSD collaborated to create a General Events Reporting Guide that clearly identifies the proper reporting process for all types of medication errors. An electronic General Events Report (GER) is available in Therap, the DDSD electronic records system. All providers have access to this system for reporting and as a data source for internal QI.

In situations where a medication error results in: 1) the need for medical treatment or the agency nurse determines the need to consult with a physician/CNP/PA, pharmacist or poison control; or 2) the individual misses multiple dose over a period equal to or greater than 48 hours; or 3) a prescribed medication is delivered to the wrong person, this error must be reported immediately using the DHI Abuse, Neglect or Exploitation (ANE) report system and toll-free number. Provider agencies may opt to use the GER to track this level of event only after the DHI- ANE report has been filed.

DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to DHI-IMB. They must be entered in GER on at least a monthly basis.

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

Providers are required to record all levels of medication errors including documentation errors, administering medication to the wrong person/patient or at the wrong time, missed doses, dosage errors, delivery errors, and medication reactions/interactions.

DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to DHI-IMB. They must be entered in GER on at least a monthly basis.

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

Providers are required to record all medication errors including documentation errors, administering medications to the wrong person/patient or at the wrong time, missed doses, dosage errors and delivery errors.

DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to DHI-IMB. They must be entered in GER on at least a monthly basis.

○ **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.

DDSD has authority to provide technical assistance or directly impose administrative actions, civil monetary penalty (CMP), and sanctions on community-based provider agencies for non-compliance with or violations of regulations, service standards, policies, procedures, and/or Provider Agreement requirements which includes requirements related to medication administration.

DHI/Incident Management Bureau (IMB) investigates when adverse medication events occur that involve possible abuse, neglect, and exploitation. When abuse, neglect or exploitation is confirmed, the provider is required to take preventative/corrective action and report that action to the investigator. Failure to take adequate actions may result in a referral to the Internal Review Committee (IRC). The IRC is comprised of voting members from the Developmental Disabilities Supports Division (DDSD), the Division of Health Improvement (DHI), and the Human Services Department (HSD). The purpose of the committee is to review performance issues identified by any bureau or responsible party within DDSD, DHI, or HSD, and to apply sanctions, if necessary, to ensure compliance. The IMB reviews data monthly and quarterly to identify any problematic trends or harmful practices within an agency, concerning an individual, or within the region. The trends are discussed at monthly and quarterly Regional Quality Management Meetings with additional information provided by participants, as applicable. Meeting participants develop and implement actions plans to resolve correct or prevent harmful practices, as needed. The Regional Quality Management Meetings include participants from DHI/IMB, DHI/Quality Management Bureau (QMB) and DDSD Regional Offices.

The DHI/Quality Management Bureau (QMB) also conducts periodic agency compliance surveys during which they check for the presence of adequate agency policies, procedures and practices relative to medication management. QMB also monitors for evidence of the agency's implementation of these policies, procedures and practices. During these surveys, DHI/QMB reviews medication administration records for individuals in the review sample in addition to data collected by the provider agency on medication management to identify areas of non-compliance including harmful practices. Each provider agency receives a routine survey between one and three years, based upon compliance history from previous surveys. Every agency receives a survey at least every three years. New DDW provider agencies receive an initial compliance survey within six (6) to twelve (12) to eighteen (18) months following the award of their contract. New DDW provider agencies receive an initial compliance survey within six (6) to twelve (12) months of providing services to Individuals participating in waiver programs. Agencies may also be monitored at any time as a result of a request for a focused survey, based upon complaints or concerns raised by DDSD or DHI staff or other stakeholders. Request for focused surveys must be presented through the Internal Review Committee process.

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 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 DD waiver individuals

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **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 agencies who are compliant with ANE training requirements.
Numerator: Number of agencies compliant with ANE training requirements.
Denominator: Total number of agencies that are required to meet training requirments.

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**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify: DHI	
	☐ **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):
Other
If 'Other' is selected, specify:
DOH data base

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: reported to DDSQI Steering Committee every six (6) months

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):
Other
If 'Other' is selected, specify:
DHI Tracking 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: 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:

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 DD waiver participants without confirmed reports of restrictive interventions(including restraints and seclusion) outside of specified use. Numerator: Number of DD waiver participants without confirmed reports or restrictive interventions. Denominator: Total number of DD participants.

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Other** Specify: reported to DDSQI Steering Committee every six (6) months

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

Performance Measures

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

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

Performance Measure:
Percentage of waiver individuals who received physical exams in accordance with the state waiver policies. Numerator: Number of waiver individuals with completed history and physical. Denominator: Total number of waiver individuals with a completed LOC.

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 95% confidence interval
☒ **Other** Specify: TPA Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

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

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.

Assistance with individual problems occurs through the DDSD regional offices. Regional Office Request for Assistance Forms (RORAs) are routed to the appropriate staff and are tracked and trended for system improvement. Regional Office Directors are authorized to provide administrative actions and technical assistance.

1. Data is also collected by DHI and entered into a database. Reports are generated from the database and are reviewed to identify trends. DHI and DDSQI Steering Committee review the data and determine if any action is necessary. The Steering Committee meets monthly.

The Regional Office or any Bureau within DDSD and HSD/MAD may also refer providers to the Internal Review Committee. Based on the severity of deficiencies identified, the IRC has the authority to take administrative action, including directed corrective action, moratorium on new admissions, or civil monetary penalty. The IRC may also recommend high level sanctions including withholding payment, transition of individuals in service, placing the provider under the supervision of a monitor, or reduction of a contract term, amount, or scope.

ii. Remediation Data Aggregation

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

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

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

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) Executive Committee (comprised of HSD/MAD, DOH/DDSD, and DOH/DHI) 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 Steering Committee where data are reviewed and actions are discussed and reported back to the program for implementation and remediation as required by CMS. Action plans must include an evaluative component to determine the effectiveness of actions once implemented.

• Processes: The role of the DDSQI Committee is to ensure continuous quality improvement. The DDSQI Steering Committee is responsible for making systemic improvements to the DD Waiver based on compliance monitoring. This committee has regularly scheduled meetings and an annual schedule by which it reviews data collected from various waiver programs, develops and implements quality improvement strategies which are reported back to the DDSQI Committee.

Performance data is reviewed through the DDSQI.

Recommendations made by the DDSQI Committee for system design changes are forwarded to senior management of HSD and DOH for consideration and implementation. When a system design change is approved by HSD and DOH senior management and implemented, the DDSQI Committee 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 Committee 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 Committee'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**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Other** Specify: Every other month and additional monitoring/analysis will be done, as necessary.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The DDSQI 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 DD Waiver sign a Provider Agreement at the time of entry and renewal periods in which they agree that if they receive State or Federal funds from the Department of Health (DOH), they shall comply, if applicable, with auditing requirements under the Single Audit Act (31 U.S.C. §7501, et seq.) and the New Mexico State Auditor's rules and regulations. If the Provider is determined to be a sub recipient and not a vendor under the Federal Single Audit Act, the provider shall comply with the audit requirements of the Single Audit Act. If the provider receives more than $250,000 under this agreement or more than $250,000 in any single fiscal year, from the Human Services Department (Medicaid), the provider shall prepare annual financial statements and obtain an audit of, or an opinion on, the financial statements from an external Certified Public Accountant. 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 DD waiver provider billing for Living Supports, Customized In Home Supports, Customized Community Supports, Community Integrated Employment, and case management to verify whether services are being rendered according to the state's rules and regulations. Post-payment review methods are discussed below.

The DOH/QMB creates an annual review schedule that is based on the contract terms of provider agreements. 100% of DDW providers being reviewed and who received payment for claims in Case Management, Customized Community Supports, Community Integrated Employment, Living Supports, and Customized In Home Supports services three months of paid claims, are reviewed based on the date of the survey. Claims data is taken from the MMIS system. Within that provider sample, 100% of paid claims for each provider are reviewed and validated for: 1) correct service codes; 2) correct billed units; 3) supporting documentation for services rendered. All reviews are conducted on-site. The agency is required to correct all deficiencies cited during the Plan of Correction Process and the Plan of Correction process is not closed until all deficiencies have been corrected. All QMB reports are shared with the Human Services Department and the Department of Health Office of Internal Audit who can make the determination whether or not to complete a more comprehensive financial review.

When deficiencies are found in billing, the agency is afforded the opportunity to submit a void/adjust claim to the Medicaid agency and must complete a plan of correction addressing systemic issues to ensure improvement in billing practices. If an agency does not submit a void/adjust claim at that time then when they receive their report of findings, they are required to complete a plan of correction, including evidence of document if not found during survey or a void/adjust claim or remit the identified overpayment to the Medicaid agency.

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

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.

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:
Percentage of paid waiver services claims reviewed during post-payment audits for which the service units specified in the participant's approved ISP were rendered. Numerator: Number of paid waiver claims reviewed for which the service and service units 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:

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:* *FMA, MMIS*	☒ ***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:* *FMA*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Percentage of claims coded in accordance with the reimbursement codes and rates approved by Medicaid. Numerator: Number of claims coded in accordance with the reimbursement codes and rates approved by Medicaid. Denominator: Total number of claims coded.

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

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

☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise.*	

Data Aggregation and Analysis:

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

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

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

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

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 throughout the five year waiver cycle. Denominator: Total number of rates.

Data Source *(Select one):*
Other

If 'Other' is selected, specify:
DDW Fee Schedule

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

Data Aggregation and Analysis:

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

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

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 financial accountability are identified by HSD/MAD, processes are in place to ensure that appropriate and timely action is taken. In addition, the HSD and DOH DDSQI Steering Committee aggregates, analyzes, and trends financial data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *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 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's Developmental Disabilities Supports Division (DDSD) and the Human Services Department (HSD). The State can increase rates based on Legislative appropriation, however, HSD must approve all rates and any changes to these rates. Most waiver services are reimbursed on a prospective, fee-for-service basis, with the exceptions noted below for items that are reimbursed based on cost. Rates do not vary by provider type.

In addition to cost assumptions, the rate models incorporate programmatic assumptions, such as staffing ratios.

Constructing the rate models involved a number of tasks, including several opportunities for public input and periodic review:

- *Service definitions and policies were reviewed in order to ensure that the rate models reflect these requirements.*

- *A provider advisory group was convened several times during the rate-setting process to serve as a 'sounding board' to discuss project goals and materials. The group included a diverse mix of providers in terms of services provided, size, and areas served.*

- *All providers were invited to complete a survey related to the services they provide and their costs.*

- *Benchmark data was identified and researched, such as the Bureau of Labor Statistics' cross-industry wage and benefit data.*

- *'Tiered' rates for Supported Living, Customized Community Support-Group, and Community Integrated Employment-Group recognize the need for more intensive staffing and/or hours of bundled nursing and nutritional counseling when applicable to the service scope for individuals with more significant needs. In accordance with CMS guiding rules for rate setting methodology for 1915 (c) waivers DOH/DDSD conducted a rate study in FY 2019. The contract was awarded through a competitive RFP process to the Public Consulting Group (PCG), a professional organization specializing in economics, statistics and actuaries with experience in health care financing and financial modeling specific to HCBS waiver programs. PCG conducted an independent rate study including rate analysis, rate setting, research and business analysis, and recommended reimbursement rates for the provision of an array of services for individuals with intellectual and developmental disabilities receiving services through the DD waiver program.*

This rate study assessed the delivery of BSC, OT, PT, SLP, PTA, COTA, and PRSC delivered in incentive and non-incentive counties as a part of the 60 service rates it was contracted to assess. PCG developed the rate models for incentive counties using the same approach for other services. The difference between the standard and incentive counties relates to an assumption that a greater number of miles are traveled while delivering the service and a commensurately larger productivity adjustment for travel time. These assumptions recognize the more rural nature and lower population density of the incentive counties. Proposed rate models outlining specific cost assumptions were developed for each service. There was no information gathered for SSE although there was an original intention to do so, since no classes were conducted during the time study period.

PCG presented market salary research for the BLS Southwest Region and an alternative Southwest Region identified through the Family Infant Toddler (FIT) rate study. The State and ACQ Subcommittee decided to use the alternative Southwest Region average salaries from the states of Texas, Arizona, Colorado, and New Mexico.

Some of the HCBS disciplines did not match directly to job titles in the BLS data. For these disciplines, the stakeholder group helped determine the most appropriate job title from the BLS data to use as a proxy. (p. 14-15, HCBS Rate Study | Rate Recommendations Report)

After comparing the reported personnel salaries to the market salary research, PCG, DDSD, and the subcommittee decided to use the market salary research as the base of the rates because it better reflected the market for specific disciplines. Market salary research was based on BLS data for the SW region.

Many HCBS providers have a business model that works with subcontractors versus employees.

Using the data provided through personnel rosters and cost reports, costs attributable to contractor costs were added to

the rate build up. This step resulted in a rate that more accurately reflected how the HCBS providers operate, using a subcontractor model. Adding the subcontractor cost factor resulted in a higher rate proposal than would have been proposed using just an employee personnel cost factor model.

Administrative and program support expenses were based on non- personnel related costs identified through cost report data submitted by HCBS providers. Administrative and program support expenses reported was 28.1% of cost data. This percentage was ultimately raised to 30%-33% to account for the fact that cost report data were reported from a previous fiscal year, and there were some limitations to data collection. The increase was reviewed and vetted in provider subcommittee.

Each service with tiered rates was denoted in the time study tools as a different service activity (e.g. Supported Living Category 1, Supported Living Category 2, Supported Living Category 3). Rates per tier (category) were adjusted using to the same rate methodology and build up as other services, e.g. employee cost, admin and program support, fringe etc. Services with tiers also by definition bundle in a specified number of hours of nutritional counseling or nursing that were factored into the rate per tier. An individual must meet specific clinical criteria to receive the service defined at a specific tier or category.

The Rate Study performed by the Public Consulting Group (PCG) can be found in its entirety at: https://nmhealth.org/publication/view/report/5025/

Rate increases are implemented based on legislative appropriation.

An additional Targeted Rate Study Conducted in January to June 2020:

1.Obtained more focused data from a greater number of Behavioral (BSC) and Therapy (OT, PT, SLP, PTA, and COTA) providers, including services and rates approved by CMS in the current DD Waiver. This study reviewed all current service codes including those based on billable 15 minute units of service. This was intended to inform base and incentive rates for all targeted services.

2.Analyzed and informed the use of telemedicine as an appropriate and cost-effective modality for the following services: nursing; Behavioral (BSC) and Therapy (OT, PT, SLP, PTA, and COTA), and Behavior Support Consultation (BSC) for the DD This objective included recommending language to include in the waiver service definition to ensure the use of telemedicine as a modality in upcoming renewals.

3.Provided comparison and recommendations to the delivery of Crisis Services through the Bureau of Behavioral Supports as compared to other states.

4.Reviewed and evaluated the DDW tiered rates to determine if the number of tiers, and amount of nursing, on call coverage expectations, nutritional counseling, and staffing ratios required for each tier are funded at appropriate levels;

a.Proposed a methodology and criteria to apply tiered rates based on the acuity of individuals and intensity of support required;

b.Made programmatic recommendations that leveraged or incentivized use of remote technology to increase independence and decrease staffing hours in the on-call reimbursement;

c.Recommended ways to monitor and hold providers accountable to providing the level of support included in each tier; and

d.Evaluated the pros and cons of eliminating the use of tiered rates.

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 DOH and HSD/MAD. Retrospective audits include verification that the services were provided as billed.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***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:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- (●) ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*
- ( ) ***Applicable***

Check each that applies:

- [ ] ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

Check each that applies:

- [ ] ***Health care-related taxes or fees***
- [ ] ***Provider-related donations***
- [ ] ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

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

The waiver cost study specifically excluded the cost of room and board in setting rates for residential services. Rates are based on the provision of direct care services and do not include payment for room and board. Pursuant to DOH/DDSD Waiver Service Standards, providers are prohibited from using Medicaid payment for room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii*

through I-7-a-iv):

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	93396.73	7733.45	101130.18	119764.27	6349.53	126113.80	24983.62
2	94204.75	7919.06	102123.81	122638.62	6501.92	129140.54	27016.73
3	94183.26	8109.11	102292.37	125581.94	6657.97	132239.91	29947.54
4	94120.85	8303.73	102424.58	128595.91	6817.76	135413.67	32989.09
5	94210.66	8503.02	102713.68	131682.21	6981.38	138663.59	35949.91

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	3400	3400
Year 2	3438	3438
Year 3	3476	3476
Year 4	3514	3514
Year 5	3552	3552

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 325 days, the level based on actual expenditures for waiver services provided to DDW participants who were in the waiver 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:*

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 DDW participants who were in the waiver FFY 2020. Where noted, the Market Basket Index (MBI) growth rate is based on forecasted FY2021 Q3 Skilled Nursing Facility of 2.4%.
NUMBER OF USERS
The number of users was calculated from the actual number of waiver participants in FFY 2020. There were 3242 participants who accessed services in FFY 2020. This number was trended forward through WY1-5.
Estimate for the UDR was projected using the following methodology:
- *The State estimates attrition due to death of 72 per year*
- *The State estimates 190 new allocations per year*
- *The State estimates transitions from DDW to the Mi Via Waiver (NM.0448) at 90 participants per year, with transitions from the Mi Via Waiver to the DDW per year estimated to be 10 per year.*

NUMBER OF UNITS
Average units per users were derived from utilization data in FFY 2020 and held constant through WY 1-5.

AVERAGE COST PER UNIT
Average cost per unit is the actual rate paid to providers as noted in the DDW Fee Schedule and held constant through W1-5. Average cost per unit for environmental modifications is estimated to be the maximum rate available at $5000.00 every five years.

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	
Community Integrated Employment	
Customized Community Supports	
Living Supports	
Respite	
Nutritional Counseling	
Occupational Therapy For Adults	
Physical Therapy For Adults	
Speech and Language Therapy For Adults	
Adult Nursing	
Assistive Technology	
Behavioral Support Consultation	
Crisis Support	
Customized In-Home Supports	
Environmental Modifications	
Independent Living Transition Service	
Non-Medical Transportation	
Personal Support Technology	
Preliminary Risk Screening and Consultation	
Socialization and Sexuality Education	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**10233098.42**
Case Management, On-going	Month	3356	9.70	314.35	**10233098.42**	
Community Integrated Employment Total:						**6420868.19**
Community Integrated Employment, Intensive	hour	77	152.91	56.42	**664293.03**	
				GRAND TOTAL:		**317548872.03**
				Total Estimated Unduplicated Participants:		**3400**
				Factor D (Divide total by number of participants):		**93396.73**
				Average Length of Stay on the Waiver:		325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integrated Employment, Job Aide	hour	15	104.05	34.44	53752.23	
Community Integrated Employment, Group, Category 1	15 minutes	113	2702.44	2.22	677934.10	
Community Integrated Employment, Group, Category 2 Extensive Support	15 minutes	17	2145.54	3.69	134589.72	
Community Integrated Employment, Job Maintenance	month	541	9.24	951.66	4757196.07	
Community Integrated Employment, Job Development	15 minutes	1	0.01	11.46	0.11	
Community Integrated Employment, Job Coaching	15 minutes	1	0.01	11.46	0.11	
Community Integrated Employement, Self-Employment	15 minutes	19	457.87	15.30	133102.81	
Customized Community Supports Total:						56996134.97
Community Inclusion Aide	hour	10	316.12	18.03	56996.44	
Customized Community Support, Individual	15 minutes	1807	2596.71	7.18	33690390.68	
Customized Community Support, Individual Intensive Behavioral Support	15 minutes	182	3453.85	8.20	5154525.74	
Customized Community Support, Group, Category 1	15 minutes	743	2745.42	2.68	5466790.12	
Customized Community Support, Group, Category 2 Extensive Support	15 minutes	627	2515.53	5.21	8217406.39	
Customized Community Support, Small Group	15 minutes	370	2067.88	5.73	4384112.39	
Customized Community Support, Group, JCM	15 minutes	1	0.01	5.97	0.06	
Fiscal Management					25913.16	

GRAND TOTAL:	317548872.03
Total Estimated Unduplicated Participants:	3400
Factor D (Divide total by number of participants):	93396.73
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
of Adult Education Oppurtunities	each	52	498.33	1.00		
Living Supports Total:						**207479934.16**
Supported Living, Category 1 Basic	day	44	253.98	210.35	**2350686.49**	
Supported Living, Category 2 Moderate Support	day	308	273.20	258.69	**21767625.26**	
Supported Living, Category 3 Extensive Support	day	482	249.62	339.09	**40798237.28**	
Supported Living, Non-Ambulatory Stipend	day	31	187.83	61.93	**360601.67**	
Supported Living, Category 4 Extraordinary Medical/Behavioral Support	day	632	281.03	435.81	**77404632.48**	
Family Living	day	1458	340.12	119.48	**59249529.82**	
Family Living, Jackson Class Only	day	31	365.81	129.47	**1468204.04**	
Intensive Medical Living	day	36	242.19	468.00	**4080417.12**	
Respite Total:						**166715.74**
Respite	15 minutes	9	3097.08	4.67	**130170.27**	
Respite, Group	15 minutes	9	1237.99	3.28	**36545.46**	
Nutritional Counseling Total:						**11880.57**
Nutritional Counseling	15 minutes	47	11.98	21.10	**11880.57**	
Occupational Therapy For Adults Total:						**4843030.37**
Occupational Therapy, Standard	15 minutes	832	108.53	22.90	**2067800.38**	
Occupational Therapy, Incentive	15 minutes	451	92.33	29.20	**1215912.24**	
Occupational Therapy Assistant, Standard	15 minutes	359	147.11	18.84	**994987.31**	
Occupational Therapy Assistant, Incentive	15 minutes	221	103.34	24.71	**564330.44**	
Physical Therapy For Adults Total:						**5515816.82**
Physical Therapy, Standard	15 minutes	826	125.35	22.90	**2371045.39**	

GRAND TOTAL:	**317548872.03**
Total Estimated Unduplicated Participants:	**3400**
Factor D (Divide total by number of participants):	**93396.73**
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy, Incentive	15 minutes	431	107.74	29.30	1360573.04	
Physical Therapy Assistant, Standard	15 minutes	413	154.87	18.84	1205031.08	
Physical Therapy Assistant, Incentive	15 minutes	187	125.34	24.71	579167.31	
Speech and Language Therapy For Adults Total:						7255029.06
Speech, Language, Pathology, Standard	15 minutes	1029	148.01	22.90	3487722.44	
Speech, Language, Pathology, Incentive	15 minutes	805	160.27	29.20	3767306.62	
Adult Nursing Total:						1845748.00
Adult Nursing Services, RN	15 minutes	289	20.28	19.23	112705.49	
Adult Nursing Services, LPN	15 minutes	1598	77.91	13.92	1733042.51	
Assistive Technology Total:						176366.96
Assistive Technology	each	616	286.31	1.00	176366.96	
Behavioral Support Consultation Total:						6906097.78
Behavioral Support Consultation, Standard	15 minutes	1585	187.46	18.34	5449255.99	
Behavioral Support Consultation, Incentive	15 minutes	426	144.54	23.66	1456841.79	
Crisis Support Total:						166002.70
Crisis Support, Alternative Residential	day	8	36.74	465.90	136937.33	
Crisis Support, Individual's Residence	15 minutes	3	998.81	9.70	29065.37	
Customized In-Home Supports Total:						8925965.66
Customized In-Home Supports	15 minutes	385	3374.72	6.87	8925965.66	
Environmental Modifications Total:						390000.00
Environmental Modifications	each	78	1.00	5000.00	390000.00	
Independent Living Transition Service Total:						0.01
Independent Living Transition (New)					0.01	

GRAND TOTAL:	317548872.03
Total Estimated Unduplicated Participants:	3400
Factor D (Divide total by number of participants):	93396.73
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	each	1	0.01	1.00		
Non-Medical Transportation Total:						**71996.38**
Non-Medical Transportation Pass	item	157	357.47	1.00	**56122.79**	
Non-Medical Transportation Per Mile	per mile	52	744.54	0.41	**15873.59**	
Personal Support Technology Total:						**47175.46**
Personal Support Technology, Monthly Maintenance	day	12	91.05	5.48	**5987.45**	
Personal Support Technology, Installation	each	19	2167.79	1.00	**41188.01**	
Preliminary Risk Screening and Consultation Total:						**0.61**
Preliminary Risk Screening and Consultation for Inappropriate Sexual Behavior, Standard	15 minutes	1	0.01	26.54	**0.27**	
Preliminary Risk Screening and Consultation for Inappropriate Sexual Behavior, Incentive	15 minutes	1	0.01	34.51	**0.35**	
Socialization and Sexuality Education Total:						**97010.16**
Socialization and Sexuality Education, Standard	each	62	3.14	354.00	**68916.72**	
Socialization and Sexuality Education, Incentive	each	62	0.64	708.00	**28093.44**	

GRAND TOTAL:	**317548872.03**
Total Estimated Unduplicated Participants:	**3400**
Factor D (Divide total by number of participants):	**93396.73**
Average Length of Stay on the Waiver:	325

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:						**10345918.63**
Case Management, On-going	Month	3393	9.70	314.35	**10345918.64**	
Community Integrated Employment Total:						**6485627.06**
Community Integrated Employment, Intensive	hour	77	152.91	56.42	**664293.03**	
Community Integrated Employment, Job Aide	hour	15	104.05	34.44	**53752.23**	
Community Integrated Employment, Group, Category 1	15 min	115	2702.44	2.22	**689932.93**	
Community Integrated Employment, Group, Category 2 Extensive Support	15 minutes	17	2145.54	3.69	**134589.72**	
Community Integrated Employment, Job Maintenance	month	547	9.24	951.66	**4809956.10**	
Community Integrated Employment, Job Development	15 minutes	1	0.01	11.46	**0.11**	
Community Integrated Employment, Job Coaching	15 minutes	1	0.01	11.46	**0.11**	
Community Integrated Employement, Self-Employment	15 minutes	19	457.87	15.30	**133102.81**	
Customized Community Supports Total:						**57658184.21**
Community Inclusion Aide	hour	11	316.12	18.03	**62696.08**	
Customized Community Support, Individual	15 minutes	1827	2596.71	7.18	**34063278.24**	
Customized Community Support, Individual Intensive Behavioral Support	15 minutes	185	3453.85	8.20	**5239490.45**	
Customized Community Support, Group, Category 1	15 minutes	751	2745.42	2.68	**5525651.93**	
Customized Community Support, Group,	15 minutes	634	2515.53	5.21	**8309147.76**	

GRAND TOTAL:	**323875945.85**
Total Estimated Unduplicated Participants:	**3438**
Factor D (Divide total by number of participants):	**94204.75**
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Category 2 Extensive Support						
Customized Community Support, Small Group	15 minutes	374	2067.88	5.73	4431508.20	
Customized Community Support, Group, JCM	15 minutes	1	0.01	5.97	0.06	
Fiscal Management of Adult Education Oppurtunities	each	53	498.33	1.00	26411.49	
Living Supports Total:						209890441.28
Supported Living, Category 1 Basic	day	45	253.98	210.35	2404111.18	
Supported Living, Category 2 Moderate Support	day	312	273.20	258.69	22050321.70	
Supported Living, Category 3 Extensive Support	day	488	249.62	339.09	41306099.15	
Supported Living, Non-Ambulatory Stipend	day	32	187.83	61.93	372233.98	
Supported Living, Category 4 Extraordinary Medical/Behavioral Support	day	639	281.03	435.81	78261962.27	
Family Living	day	1474	340.12	119.48	59899730.42	
Family Living, Jackson Class Only	day	32	365.81	129.47	1515565.46	
Intensive Medical Living	day	36	242.19	468.00	4080417.12	
Respite Total:						2846498.61
Respite	15 minutes	194	3097.08	4.67	2805892.54	
Respite, Group	15 minutes	10	1237.99	3.28	40606.07	
Nutritional Counseling Total:						12133.34
Nutritional Counseling	15 minutes	48	11.98	21.10	12133.34	
Occupational Therapy For Adults Total:						4897625.39
Occupational Therapy, Standard	15 minutes	841	108.53	22.90	2090168.42	
Occupational Therapy, Incentive	15 minutes	456	92.33	29.20	1229392.42	

GRAND TOTAL:	323875945.85
Total Estimated Unduplicated Participants:	3438
Factor D (Divide total by number of participants):	94204.75
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy Assistant, Standard	15 minutes	363	147.11	18.84	1006073.52	
Occupational Therapy Assistant, Incentive	15 minutes	224	103.34	24.71	571991.03	
Physical Therapy For Adults Total:						5576391.48
Physical Therapy, Standard	15 minutes	836	125.35	22.90	2399750.54	
Physical Therapy, Incentive	15 minutes	436	107.74	29.20	1371659.49	
Physical Therapy Assistant, Standard	15 minutes	418	154.87	18.84	1219619.83	
Physical Therapy Assistant, Incentive	15 minutes	189	125.34	24.71	585361.61	
Speech and Language Therapy For Adults Total:						7334431.74
Speech, Language, Pathology, Standard	15 minutes	1040	148.01	22.90	3525006.16	
Speech, Language, Pathology, Incentive	15 minutes	814	160.27	29.20	3809425.58	
Adult Nursing Total:						1866829.06
Adult Nursing Services, RN	15 minutes	293	20.28	19.23	114265.43	
Adult Nursing Services, LPN	15 minutes	1616	77.91	13.92	1752563.64	
Assistive Technology Total:						178084.82
Assistive Technology	each	622	286.31	1.00	178084.82	
Behavioral Support Consultation Total:						6995322.41
Behavioral Support Consultation, Standard	15 minutes	1602	187.46	18.34	5507702.27	
Behavioral Support Consultation, Incentive	15 minutes	435	144.54	23.66	1487620.13	
Crisis Support Total:						165882.19
Crisis Support, Alternative Residential	day	8	36.74	465.49	136816.82	
Crisis Support, Individual's Residence	15 minutes	3	998.81	9.70	29065.37	
Customized In-Home Supports Total:						9018702.97
Customized In-					9018702.97	

GRAND TOTAL:	323875945.85
Total Estimated Unduplicated Participants:	3438
Factor D (Divide total by number of participants):	94204.75
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Supports	15 minutes	389	3374.72	6.87		
Environmental Modifications Total:						**390000.00**
Environmental Modifications	each	78	1.00	5000.00	**390000.00**	
Independent Living Transition Service Total:						**0.01**
Independent Living Transition (New)	each	1	0.01	1.00	**0.01**	
Non-Medical Transportation Total:						**73016.58**
Non-Medical Transportation Pass	item	159	357.47	1.00	**56837.73**	
Non-Medical Transportation Per Mile	per mile	53	744.54	0.41	**16178.85**	
Personal Support Technology Total:						**42280.61**
Personal Support Technology, Monthly Maintenance	day	12	91.05	1.00	**1092.60**	
Personal Support Technology, Installation	each	19	2167.79	1.00	**41188.01**	
Preliminary Risk Screening and Consultation Total:						**0.61**
Preliminary Risk Screening and Consultation for Inappropriate Sexual Behavior, Standard	15 minutes	1	0.01	26.94	**0.27**	
Preliminary Risk Screening and Consultation for Inappropriate Sexual Behavior, Incentive	15 minutes	1	0.01	34.51	**0.35**	
Socialization and Sexuality Education Total:						**98574.84**
Socialization and Sexuality Education, Standard	each	63	3.14	354.00	**70028.28**	
Socialization and Sexuality Education, Incentive	each	63	0.64	708.00	**28546.56**	

GRAND TOTAL:	**323875945.85**
Total Estimated Unduplicated Participants:	**3438**
Factor D (Divide total by number of participants):	**94204.75**
Average Length of Stay on the Waiver:	325

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:						***10461788.04***
Case Management, On-going	*month*	*3431*	*9.70*	*314.35*	***10461788.04***	
Community Integrated Employment Total:						***6553013.69***
Community Integrated Employment, Intensive	*hour*	*78*	*152.91*	*56.42*	***672920.21***	
Community Integrated Employment, Job Aide	*hour*	*15*	*104.05*	*34.44*	***53752.23***	
Community Integrated Employment, Group, Category 1	*15 minutes*	*116*	*2702.44*	*2.22*	***695932.35***	
Community Integrated Employment, Group, Category 2 Extensive Support	*15 minutes*	*17*	*2145.54*	*3.69*	***134589.72***	
Community Integrated Employment, Job Maintenance	*month*	*553*	*9.24*	*951.66*	***4862716.14***	
Community Integrated Employment, Job Development	*15 minutes*	*1*	*0.01*	*11.46*	***0.11***	
Community Integrated Employment, Job Coaching	*15 minutes*	*1*	*0.01*	*11.46*	***0.11***	
Community Integrated Employement, Self-Employment	*15 minutes*	*19*	*457.87*	*15.30*	***133102.81***	
Customized Community Supports Total:						***58286212.23***
Community Inclusion Aide	*hour*	*11*	*316.12*	*18.03*	***62696.08***	
Customized Community Support, Individual	*15 minutes*	*1847*	*2596.71*	*7.18*	***34436165.80***	
Customized Community	*15 minutes*				***5296133.59***	

GRAND TOTAL:	***327381000.84***
Total Estimated Unduplicated Participants:	***3476***
Factor D (Divide total by number of participants):	***94183.26***
Average Length of Stay on the Waiver:	*325*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support, Individual Intensive Behavioral Support		187	3453.85	8.20		
Customized Community Support, Group, Category 1	15 minutes	759	2745.42	2.68	5584513.73	
Customized Community Support, Group, Category 2 Extensive Support	15 minutes	641	2515.53	5.21	8400889.14	
Customized Community Support, Small Group	15 minutes	378	2067.88	5.73	4478904.01	
Customized Community Support, Group, JCM	15 minutes	1	0.01	5.97	0.06	
Fiscal Management of Adult Education Oppurtunities	each	54	498.33	1.00	26909.82	
Living Supports Total:						212155687.91
Supported Living, Category 1 Basic	day	45	253.98	210.35	2404111.18	
Supported Living, Category 2 Moderate Support	day	315	273.20	258.69	22262344.02	
Supported Living, Category 3 Extensive Support	day	493	249.62	339.09	41729317.38	
Supported Living, Non-Ambulatory Stipend	day	32	187.83	61.93	372233.98	
Supported Living, Category 4 Extraordinary Medical/Behavioral Support	day	647	281.03	435.81	79241767.74	
Family Living	day	1490	340.12	119.48	60549931.02	
Family Living, Jackson Class Only	day	32	365.81	129.47	1515565.46	
Intensive Medical Living	day	36	242.19	468.00	4080417.12	
Respite Total:						2875425.34
Respite	15 minutes	196	3097.08	4.67	2834819.27	
Respite, Group	15 minutes	10	1237.99	3.28	40606.07	
Nutritional Counseling Total:						12133.34
Nutritional					12133.34	

GRAND TOTAL:	327381000.84
Total Estimated Unduplicated Participants:	3476
Factor D (Divide total by number of participants):	94183.26
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Counseling	15 minutes	48	11.98	21.10		
Occupational Therapy For Adults Total:						**4949666.87**
Occupational Therapy, Standard	15 minutes	850	108.53	22.90	**2112536.45**	
Occupational Therapy, Incentive	15 minutes	461	92.33	29.20	**1242872.60**	
Occupational Therapy Assistant, Standard	15 minutes	367	147.11	18.84	**1017159.73**	
Occupational Therapy Assistant, Incentive	15 minutes	226	103.34	24.71	**577098.10**	
Physical Therapy For Adults Total:						**5635821.46**
Physical Therapy, Standard	15 minutes	845	125.35	22.90	**2425585.18**	
Physical Therapy, Incentive	15 minutes	441	107.74	29.20	**1387389.53**	
Physical Therapy Assistant, Standard	15 minutes	422	154.87	18.84	**1231290.84**	
Physical Therapy Assistant, Incentive	15 minutes	191	125.34	24.71	**591555.92**	
Speech and Language Therapy For Adults Total:						**7417223.84**
Speech, Language, Pathology, Standard	15 minutes	1052	148.01	22.90	**3565679.31**	
Speech, Language, Pathology, Incentive	15 minutes	823	160.27	29.20	**3851544.53**	
Adult Nursing Total:						**1887520.15**
Adult Nursing Services, RN	15 minutes	296	20.28	19.23	**115435.38**	
Adult Nursing Services, LPN	15 minutes	1634	77.91	13.92	**1772084.76**	
Assistive Technology Total:						**180088.99**
Assistive Technology	each	629	286.31	1.00	**180088.99**	
Behavioral Support Consultation Total:						**7057206.70**
Behavioral Support Consultation, Standard	15 minutes	1620	187.46	18.34	**5569586.57**	
Behavioral Support Consultation, Incentive	15 minutes	435	144.54	23.66	**1487620.13**	
Crisis Support Total:						**182984.29**

GRAND TOTAL:	**327381000.84**
Total Estimated Unduplicated Participants:	**3476**
Factor D (Divide total by number of participants):	**94183.26**
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Crisis Support, Alternative Residential	day	9	36.74	465.49	153918.92	
Crisis Support, Individual's Residence	15 minutes	3	998.81	9.70	29065.37	
Customized In-Home Supports Total:						9111440.28
Customized In-Home Supports	15 minutes	393	3374.72	6.87	9111440.28	
Environmental Modifications Total:						395000.00
Environmental Modifications	each	79	1.00	5000.00	395000.00	
Independent Living Transition Service Total:						0.01
Independent Living Transition (New)	each	1	0.01	1.00	0.01	
Non-Medical Transportation Total:						74036.79
Non-Medical Transportation Pass	item	161	357.47	1.00	57552.67	
Non-Medical Transportation Per Mile	per mile	54	744.54	0.41	16484.12	
Personal Support Technology Total:						47175.46
Personal Support Technology, Monthly Maintenance	day	12	91.05	5.48	5987.45	
Personal Support Technology, Installation	each	19	2167.79	1.00	41188.01	
Preliminary Risk Screening and Consultation Total:						0.61
Preliminary Risk Screening and Consultation for Inappropriate Sexual Behavior, Standard	15 minutes	1	0.01	26.94	0.27	
Preliminary Risk Screening and Consultation for Inappropriate Sexual Behavior, Incentive	15 minutes	1	0.01	34.51	0.35	
Socialization and Sexuality Education Total:						98574.84
Socialization and Sexuality Education, Standard	each	63	3.14	354.00	70028.28	

GRAND TOTAL:	327381000.84
Total Estimated Unduplicated Participants:	3476
Factor D (Divide total by number of participants):	94183.26
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Socialization and Sexuality Education, Incentive	each	63	0.64	708.00	28546.56	
				GRAND TOTAL:		327381000.84
				Total Estimated Unduplicated Participants:		3476
				Factor D (Divide total by number of participants):		94183.26
				Average Length of Stay on the Waiver:		325

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:						10574608.26
Case Management, On-going	month	3468	9.70	314.35	10574608.26	
Community Integrated Employment Total:						6627405.73
Community Integrated Employment, Intensive	hour	79	152.91	56.42	681547.39	
Community Integrated Employment, Job Aide	hour	15	104.05	34.44	53752.23	
Community Integrated Employment, Group, Category 1	15 minutes	117	2702.44	2.22	701931.77	
Community Integrated Employment, Group, Category 2 Extensive Support	15 minutes	17	2145.54	3.69	134589.72	
Community Integrated Employment, Job Maintenance	month	559	9.24	951.66	4915476.17	
Community Integrated Employment, Job Development	15 minutes	1	0.01	11.46	0.11	
Community Integrated					0.11	
				GRAND TOTAL:		330740671.32
				Total Estimated Unduplicated Participants:		3514
				Factor D (Divide total by number of participants):		94120.85
				Average Length of Stay on the Waiver:		325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment, Job Coaching	15 minutes	1	0.01	11.46		
Community Integrated Employement, Self-Employment	15 minutes	20	457.87	15.30	140108.22	
Customized Community Supports Total:						58944235.25
Community Inclusion Aide	hour	11	316.12	18.03	62696.08	
Customized Community Support, Individual	15 minutes	1868	2596.71	7.18	34827697.73	
Customized Community Support, Individual Intensive Behavioral Support	15 minutes	189	3453.85	8.20	5352776.73	
Customized Community Support, Group, Category 1	15 minutes	767	2745.42	2.68	5643375.54	
Customized Community Support, Group, Category 2 Extensive Support	15 minutes	648	2515.53	5.21	8492630.52	
Customized Community Support, Small Group	15 minutes	383	2067.88	5.73	4538148.77	
Customized Community Support, Group, JCM	15 minute	1	0.01	5.97	0.06	
Fiscal Management of Adult Education Oppurtunities	each	54	498.33	1.00	26909.82	
Living Supports Total:						214212315.62
Supported Living, Category 1 Basic	day	46	253.98	210.35	2457535.88	
Supported Living, Category 2 Moderate Support	day	319	273.20	258.69	22545040.45	
Supported Living, Category 3 Extensive Support	day	493	249.62	339.09	41729317.38	
Supported Living, Non-Ambulatory Stipend	day	33	187.83	61.93	383866.29	
Supported Living, Category 4 Extraordinary Medical/Behavioral Support	day	654	281.03	435.81	80099097.53	
Family Living	day				61240769.16	

GRAND TOTAL:	330740671.32
Total Estimated Unduplicated Participants:	3514
Factor D (Divide total by number of participants):	94120.85
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1507	340.12	119.48		
Family Living, Jackson Class Only	day	33	365.81	129.47	1562926.88	
Intensive Medical Living	day	37	242.19	468.00	4193762.04	
Respite Total:						2910484.28
Respite	15 minutes	198	3097.08	4.68	2869878.21	
Respite, Group	15 minutes	10	1237.99	3.28	40606.07	
Nutritional Counseling Total:						12386.12
Nutritional Counseling	15 minutes	49	11.98	21.10	12386.12	
Occupational Therapy For Adults Total:						5006510.58
Occupational Therapy, Standard	15 minutes	860	108.53	22.90	2137389.82	
Occupational Therapy, Incentive	15 minutes	466	92.33	29.20	1256352.78	
Occupational Therapy Assistant, Standard	15 minutes	371	147.11	18.84	1028245.94	
Occupational Therapy Assistant, Incentive	15 minutes	229	103.34	24.70	584522.04	
Physical Therapy For Adults Total:						5695023.18
Physical Therapy, Standard	15 minutes	854	125.35	22.90	2451419.81	
Physical Therapy, Incentive	15 minutes	445	107.74	29.20	1399973.56	
Physical Therapy Assistant, Standard	15 minutes	427	154.87	18.84	1245879.59	
Physical Therapy Assistant, Incentive	15 minutes	193	125.34	24.71	597750.22	
Speech and Language Therapy For Adults Total:						7496626.51
Speech, Language, Pathology, Standard	15 minutes	1063	148.01	22.90	3602963.03	
Speech, Language, Pathology, Incentive	15 minutes	832	160.27	29.20	3893663.49	
Adult Nursing Total:						1908211.23
Adult Nursing Services, RN	15 minutes	299	20.28	19.23	116605.34	

GRAND TOTAL:	330740671.32
Total Estimated Unduplicated Participants:	3514
Factor D (Divide total by number of participants):	94120.85
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Nursing Services, LPN	15 minutes	1652	77.91	13.92	1791605.89	
Assistive Technology Total:						182093.16
Assistive Technology	each	636	286.31	1.00	182093.16	
Behavioral Support Consultation Total:						7136190.08
Behavioral Support Consultation, Standard	15 minutes	1638	187.46	18.34	5631470.86	
Behavioral Support Consultation, Incentive	15 minutes	440	144.54	23.66	1504719.22	
Crisis Support Total:						182984.29
Crisis Support, Alternative Residential	day	9	36.74	465.49	153918.92	
Crisis Support, Individual's Residence	15 minutes	3	998.81	9.70	29065.37	
Customized In-Home Supports Total:						9227361.91
Customized In-Home Supports	15 minutes	398	3374.72	6.87	9227361.91	
Environmental Modifications Total:						400000.00
Environmental Modifications	each	80	1.00	5000.00	400000.00	
Independent Living Transition Service Total:						0.01
Independent Living Transition (New)	each	1	0.01	1.00	0.01	
Non-Medical Transportation Total:						74751.73
Non-Medical Transportation Pass	item	163	357.47	1.00	58267.61	
Non-Medical Transportation Per Mile	per mile	54	744.54	0.41	16484.12	
Personal Support Technology Total:						49343.25
Personal Support Technology, Monthly Maintenance	day	12	91.05	5.48	5987.45	
Personal Support Technology, Installation	each	20	2167.79	1.00	43355.80	
Preliminary Risk Screening and Consultation Total:						0.61

GRAND TOTAL:	330740671.32
Total Estimated Unduplicated Participants:	3514
Factor D (Divide total by number of participants):	94120.85
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Preliminary Risk Screening and Consultation for Inappropriate Sexual Behavior, Standard	15 minutes	1	0.01	26.94	0.27	
Preliminary Risk Screening and Consultation for Inappropriate Sexual Behavior, Incentive	15 minutes	1	0.01	34.51	0.35	
Socialization and Sexuality Education Total:						100139.52
Socialization and Sexuality Education, Standard	each	64	3.14	354.00	71139.84	
Socialization and Sexuality Education, Incentive	each	64	0.64	708.00	28999.68	
				GRAND TOTAL:		330740671.32
				Total Estimated Unduplicated Participants:		3514
				Factor D (Divide total by number of participants):		94120.85
				Average Length of Stay on the Waiver:		325

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:						10690477.67
Case Management, On-going	month	3506	9.70	314.35	10690477.67	
Community Integrated Employment Total:						6702709.40
Community Integrated Employment, Intensive	hour	80	152.91	56.42	690174.58	
Community Integrated Employment, Job Aide	hour	15	104.05	34.44	53752.23	
				GRAND TOTAL:		334636280.78
				Total Estimated Unduplicated Participants:		3552
				Factor D (Divide total by number of participants):		94210.66
				Average Length of Stay on the Waiver:		325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integrated Employment, Group, Category 1	15 min	118	2702.44	2.22	707931.18	
Community Integrated Employment, Group, Category 2 Extensive Support	15 minutes	18	2145.54	3.69	142506.77	
Community Integrated Employment, Job Maintenance	month	565	9.24	951.66	4968236.20	
Community Integrated Employment, Job Development	15 minutes	1	0.01	11.46	0.11	
Community Integrated Employment, Job Coaching	15 minutes	1	0.01	11.46	0.11	
Community Integrated Employement, Self-Employment	15 minutes	20	457.87	15.30	140108.22	
Customized Community Supports Total:						59579620.99
Community Inclusion Aide	hour	11	316.12	18.03	62696.08	
Customized Community Support, Individual	15 minutes	1888	2596.71	7.18	35200585.29	
Customized Community Support, Individual Intensive Behavioral Support	15 minutes	191	3453.85	8.20	5409419.87	
Customized Community Support, Group, Category 1	15 minutes	776	2745.42	2.68	5709595.07	
Customized Community Support, Group, Category 2 Extensive Support	15 minutes	655	2515.53	5.21	8584371.90	
Customized Community Support, Small Group	15 minutes	387	2067.88	5.73	4585544.58	
Customized Community Support, Group, JCM	15 minutes	1	0.01	5.97	0.06	
Fiscal Management of Adult Education Oppurtunities	each	55	498.33	1.00	27408.15	
Living Supports Total:						216862948.44

GRAND TOTAL:	334636280.78
Total Estimated Unduplicated Participants:	3552
Factor D (Divide total by number of participants):	94210.66
Average Length of Stay on the Waiver:	325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Living, Category 1 Basic	day	46	253.98	210.35	2457535.88	
Supported Living, Category 2 Moderate Support	day	322	273.20	258.69	22757062.78	
Supported Living, Category 3 Extensive Support	day	504	249.62	339.09	42660397.48	
Supported Living, Non-Ambulatory Stipend	day	33	187.83	61.93	383866.29	
Supported Living, Category 4 Extraordinary Medical/Behavioral Support	day	661	281.03	435.81	80956427.32	
Family Living	day	1523	340.12	119.48	61890969.76	
Family Living, Jackson Class Only	day	33	365.81	129.47	1562926.88	
Intensive Medical Living	day	37	242.19	468.00	4193762.04	
Respite Total:						2933278.79
Respite	15 minutes	200	3097.08	4.67	2892672.72	
Respite, Group	15 minutes	10	1237.99	3.28	40606.07	
Nutritional Counseling Total:						12386.12
Nutritional Counseling	15 minutes	49	11.98	21.10	12386.12	
Occupational Therapy For Adults Total:						5058788.71
Occupational Therapy, Standard	15 minutes	869	108.53	22.90	2159757.85	
Occupational Therapy, Incentive	15 minutes	471	92.33	29.20	1269832.96	
Occupational Therapy Assistant, Standard	15 minutes	375	147.11	18.84	1039332.15	
Occupational Therapy Assistant, Incentive	15 minutes	231	103.34	24.71	589865.75	
Physical Therapy For Adults Total:						5757370.91
Physical Therapy, Standard	15 minutes	863	125.35	22.90	2477254.44	
Physical Therapy, Incentive	15 minutes	450	107.74	29.20	1415703.60	
Physical Therapy Assistant, Standard	15 minutes				1260468.35	

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Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		432	154.87	18.84		
Physical Therapy Assistant, Incentive	15 minutes	195	125.34	24.71	603944.52	
Speech and Language Therapy For Adults Total:						7579418.62
Speech, Language, Pathology, Standard	15 minutes	1075	148.01	22.90	3643636.18	
Speech, Language, Pathology, Incentive	15 minutes	841	160.27	29.20	3935782.44	
Adult Nursing Total:						1928902.31
Adult Nursing Services, RN	15 minutes	302	20.28	19.23	117775.29	
Adult Nursing Services, LPN	15 minutes	1670	77.91	13.92	1811127.02	
Assistive Technology Total:						184097.33
Assistive Technology	each	643	286.31	1.00	184097.33	
Behavioral Support Consultation Total:						7211735.44
Behavioral Support Consultation, Standard	15 minutes	1655	187.46	18.34	5689917.14	
Behavioral Support Consultation, Incentive	15 minutes	445	144.54	23.66	1521818.30	
Crisis Support Total:						182984.29
Crisis Support, Alternative Residential	day	9	36.74	465.49	153918.92	
Crisis Support, Individual's Residence	15 minutes	3	998.81	9.70	29065.37	
Customized In-Home Supports Total:						9320099.21
Customized In-Home Supports	15 minutes	402	3374.72	6.87	9320099.21	
Environmental Modifications Total:						405000.00
Environmental Modifications	each	81	1.00	5000.00	405000.00	
Independent Living Transition Service Total:						0.01
Independent Living Transition (New)	each	1	0.01	1.00	0.01	
Non-Medical Transportation Total:						75414.46

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Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-Medical Transportation Pass	item	164	357.47	1.00	58625.08	
Non-Medical Transportation Per Mile	per mile	55	744.54	0.41	16789.38	
Personal Support Technology Total:						49343.25
Personal Support Technology, Monthly Maintenance	day	12	91.05	5.48	5987.45	
Personal Support Technology, Installation	each	20	2167.79	1.00	43355.80	
Preliminary Risk Screening and Consultation Total:						0.61
Preliminary Risk Screening and Consultation for Inappropriate Sexual Behavior, Standard	15 minutes	1	0.01	26.94	0.27	
Preliminary Risk Screening and Consultation for Inappropriate Sexual Behavior, Incentive	15 minutes	1	0.01	34.51	0.35	
Socialization and Sexuality Education Total:						101704.20
Socialization and Sexuality Education, Standard	each	65	3.14	354.00	72251.40	
Socialization and Sexuality Education, Incentive	each	65	0.64	708.00	29452.80	

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