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

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

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

1. Major Changes

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

The key components included in the waiver renewal application are as follows:

1. Throughout the document, language was removed related to the Joint Powers Agreement as it is no longer relevant due to the creation of the Health Care Authority (HCA) which encompasses both the Medical Assistance Division, and the Developmental Disabilities Supports Division. This change includes removal of all references of the Department of Health (DOH) and Human Services Department (HSD). The HCA is both the administering and operating agency for the waiver
2. Throughout the document, the terms “Case Management Agency” and “University of New Mexico Center for Developmental Disabilities Nurse Case Management” were updated to “Nurse Case Management Agency.” In addition, all references to “Case Manager” were updated to “Nurse Case Manager.”
3. Appendix A: Language differentiating between the roles and responsibilities of the administrative and operational agencies was removed due to the creation of the Health Care Authority. The performance measure tracking the percentage of delegated functions/deliverables specified in the Joint Powers of Agreement (JPA) with which DOH is compliant was eliminated.
4. Appendix B and J: Projections for unduplicated recipient counts were updated in tables B-3a and J-2-a.
5. Appendix C1/C3: Acupuncture, Biofeedback, Chiropractic, Cognitive Rehabilitation Therapy, Hippotherapy, Naprapathy, Play Therapy, and Music Therapy were added as covered services.
6. Appendix C: Annual capped dollar amounts were increased to align with updated provider rates and ensure participants continue to have adequate access to needed services.
7. Appendix C and I: Language was removed related to temporary additional funding previously available through the American Rescue Plan Act (ARPA) of 2021, as this funding is no longer available to states.
8. Appendix C1/C3: For congruency among services and waivers, language was updated under all services in the section of Other Standards, Entity Responsible for Verification, and Frequency of Verification.
9. Appendix C-2. a: Language regarding criminal history and/or background investigations was updated.
10. Appendix D: Language related to service plan development process, implementation and monitoring was updated.
11. Appendix F: Language related to additional dispute resolution and a grievance complaint system was updated.
12. Appendix G: Language was updated to clarify responsibility for reviewing and responding to critical events or incidents, as well as reporting and follow up requirements, in alignment with the creation of the HCA which encompasses both the Medical Assistance Division, and the Developmental Disabilities Supports Division.
13. Appendix H: Language was updated to describe how New Mexico identifies trends, prioritizes emerging issues, and incorporates them into system implementation
14. Appendix I: Language was updated to reflect the current financial integrity and accountability process, and current rate methodologies.

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 section 1915(c) of the Social Security Act (the Act).

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

Medically Fragile Waiver

C. Type of Request: 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.0223
Draft ID: NM.017.07.00

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

Regular Waiver

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

07/01/26

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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 section 1915(a)(1)(a) of the Act and described in Appendix I**

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

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

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

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

☐ **section 1915(b)(2) (central broker)**

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

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

☐ **A program operated under section 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 section 1915(i) of the Act.**

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

☐ **A program authorized under section 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 MFW is a Medicaid Home and Community-Based Services (HCBS) waiver program that has operated since 1984. The MFW serves individuals of all ages who have a medically fragile condition and a developmental disability, or who are developmentally delayed or at risk for developmental delay, and who meet ICF/IID level of care prior to their 22nd birthday. The waiver is designed to support medically fragile individuals who require frequent and ongoing medical supervision to remain safely in their homes and communities rather than in institutional settings. The MFW operates under the federal cost-effectiveness requirement, meaning the total cost of waiver services cannot exceed the cost of institutional care. Waiver services are combined with natural supports from family, friends, community programs, and other funding sources to help manage costs. Each participant's budget is based on a capped dollar amount (CDA) tied to their assessed level of care. The State establishes specific service dollar limits based on the individual's age and level of support need.

The MFW has three primary goals: maintain and supports participants in a safe and comfortable home and community environment, maximize each participant's level of functioning, and ensure timely and consistent delivery of waiver services. Each participant receives services according to an Individual Service Plan (ISP), which is developed through a person-centered planning process and overseen by the case management agency. This waiver program uses traditional service delivery methods. 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 New Mexico Medically Fragile Waiver (MFW) is administered by the Health Care Authority (HCA) through the Developmental Disabilities Supports Division (DDSD) with assistance from and the Medical Assistance Division (MAD) and Division of Health Improvement (DHI).

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 section 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 section 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 section 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 section 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 section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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 of New Mexico secured public input for the development of the Medically Fragile Waiver renewal through a variety of committees and methods. Beginning in June 2025 through August 2025, meetings were held throughout the state to provide information about the waiver renewal and gather feedback from participants, families, and stakeholders. Participants, families, and stakeholders had the opportunity to provide additional feedback by sending the information directly to DDSD through an online portal.

In January 2026, the state implemented a formal public comment process for the waiver renewal. This included a sixty (60) day Tribal Notification period; and a thirty (30) day general public comment period, both of which culminated in a public hearing. Notices were released on January 21, 2026 for Tribal Notification and February 20, 2026 (General Public). Public notice distribution includes mailings to interested parties, emails, newspaper announcements in the Las Cruces Sun and Albuquerque Journal, and web postings. The public was invited to submit comments via postal mail, email, fax, phone or in person at the public hearing. The public hearing was held was held live, via conference call, and Teams on March 23, 2026.

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: Zwally

First Name: Jennifer

Title: Director

Agency: Health Care Authority, Developmental Disabilities Supports Division

Address: 2540 Camino Edward Ortiz

Address 2:

City: Santa Fe

State: **New Mexico**

Zip: 87507

Phone:

(505) 670-2407 **Ext:** ☐ **TTY**

Fax:

E-mail: jennifer.zwally@hca.nm.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **New Mexico**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature:

01/21/2026

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **New Mexico**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

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.

Developmental Disabilities Supports Division (DDSD)

(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:

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:

The Health Care Authority (HCA) through the Developmental Disabilities Supports Division (DDSD) is responsible for the overall administration of the Medically Fragile Waiver including recipient enrollment; expenditure monitoring; provider enrollment and agreement oversight; rate methodology; standards development, rule promulgation; quality assurance and quality improvement (QA/QI) activities; and stakeholder engagement. Oversight of the waiver is conducted by DDSD waiver program staff through the following methods:

• Monitoring and oversight of the operations of the waiver program to ensure compliance with Medicaid and Center for Medicare and Medicaid (CMS) requirements; review oversight findings and develop strategies for improvement as determined necessary;
•Participation in the Developmental Disabilities Services Quality Improvement (DDSQI) Committee as described in Appendix H of this application. DDSQI follows a comprehensive quality improvement strategy (QIS) which addresses compliance with waiver assurances among other quality improvement strategies and performance measures designed to help the MFW service system achieve better outcomes for people receiving services, their communities, and the New Mexico public at large.

•Ad hoc and regular waiver specific and cross-division workgroups related to promulgation of state regulations and the development and implementation of standards, policies and procedures in alignment with all state and federal authorities related to home and community-based services (HCBS) waivers.

If DDSD identifies any issues that are inconsistent with CMS requirements at any time, DDSD corrects the problem through program improvement activities and contract management.

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:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

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 Health Care Authority (HCA) contracts with entities to perform operational and/or administrative functions.

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

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

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the**

Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

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

- (●) **Not applicable**
- ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

The Health Care Authority (HCA) contracts with the Third Party Assessor (TPA) Contractor and is responsible for assessing the TPA's performance and compliance in conducting its respective waiver operational and administrative functions based on the terms of its contract.

Appendix A: Waiver Administration and Operation

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

The Health Care Authority (HCA) uses various methods to assess the performance of contracted entities to ensure that they are performing assigned waiver operational and administrative functions in accordance with waiver requirements:

- HCA uses monthly Third-Party Assessor (TPA) reports and specific monthly audits to monitor level of care performance and functions and to ensure the Contractor is compliant with the terms of the contract for the performance and operation of level of care and Individual Service Plan (ISP)/budget reviews.

- The Contractor is required to attend monthly meetings with HCA TPA contract manager whereby any waiver-related contract compliance issues may be identified and monitored through resolution. Issues and corrective action plans (CAPS) will be monitored through resolution.

- On an annual basis, HCA reviews and approves the Contractor's quality improvement/quality management work plan, evaluation, and results to ensure compliance with quality management activities related to the waiver.

- HCA also utilizes customer service complaints, grievances, and fair hearing data, along with input from the quarterly case management meetings to assess the contractor's performance.

- Performance assessments of contracted entities are conducted by the HCA. If any problems are identified, HCA may require a state-directed corrective action plan (CAP). HCA monitors the implementation and completion of TPA’s corrective action plan. The TPA may also impose their own internal corrective action plan, or performance improvement plan, prior to implementation of a state-directed CAP.

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☒
Level of care waiver eligibility evaluation	☒	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☐
Execution of Medicaid provider agreements	☒	☐

Function	Medicaid Agency	Contracted Entity
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Percentage of MF waiver data reports specified in the TPA contract with the Medicaid agency that were submitted on time and in the correct format. Numerator: Number of data reports submitted on time and in the correct format. Denominator: Total number of data reports required to be submitted.

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

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: 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: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

Performance Measure:
Percentage of case management provider agreements that adhered to the State's uniform agreement requirements. Numerator: Number of case management provider agreements in compliance Denominator: Total number of provider agreements.

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

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

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

Data Aggregation and Analysis:

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

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

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.

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, DDSD meets regularly in person and by phone with contactors and Medical Assistance Division (MAD) as necessary. 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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement are identified by Health Care Authority (HCA), processes are in place to ensure that appropriate and timely action is taken whether the situation is in regard to people receiving services, providers, or contractors. Methods for remediating identified problems by HCA include contract management activities.

Documentation is kept on all actions taken. In some instances, policy and/or regulatory changes may be required in all cases, if HCA identifies any issues that are inconsistent with CMS requirements at any time, HCA will ensure that it corrects the identified problems or issues and that compliance with the Assurance is met.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: 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 Sub Group	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**	0		☒
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

In addition to the target group indicated in B-1.a above, the individual must:
1) have a medically fragile condition that meets the definition below, and may have, or is at risk for an intellectual or developmental delay as defined below; and
2) meet the level of care provided in an intermediate care facility for individuals with intellectual disabilities (ICF/IID); and
3) meet all other applicable financial and non-financial eligibility requirements.
An individual must meet all four (3) criteria to be eligible for this waiver.

The definition for medically fragile individuals is as follows:

Medically fragile individuals are those who have been diagnosed with a medically fragile condition before reaching age 22 and who also have a developmental disability, a developmental delay, or are at risk for developmental delay. A medically fragile condition is defined as a chronic physical condition that results in prolonged dependence on medical care requiring daily skilled nursing intervention. This condition is characterized by one or more of the following:

• A life threatening condition with reasonably frequent periods of acute exacerbation that requires ongoing medical supervision and/or physician consultation, and which—without such supervision—would likely require hospitalization.

• The frequent and time consuming administration of medically necessary specialized treatments.

• Dependence on medical technology to maintain a reasonable level of health, such that the absence of this technology would compromise the individual's well being. Examples of such medical technologies include, but are not limited to, ventilators, dialysis machines, enteral or parenteral nutrition support, and continuous oxygen.

The definition for intellectual and developmental disability (IDD) is as follows:

Developmental disabilities are limited to intellectual disability (ID) or a related condition as determined by 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.

An individual is considered to have an intellectual disability if they have 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 groups. Deficits in Adaptive Behavior are defined as two standard deviations below mean (≤70).
d. The developmental period is defined as the period between birth and the 18th birthday.

An individual is considered to have a related condition if they have a severe, chronic disability that meets all 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 like 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	350
Year 2	350
Year 3	350
Year 4	350
Year 5	350

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

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **Section 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)

- [ ] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [ ] **Pregnant Women (42 CFR § 435.116)**
- [ ] **Infants and Children under Age 19 (42 CFR § 435.118)**
- [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 section 1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 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, 2027 (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 section 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 section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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 section 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 period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required

by law).

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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

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

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

  Specify formula:

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

  Specify:

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

Select one:

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

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

The Third-Party Assessor (TPA) conducts the level of care (LOC) evaluation. The Health Care Authority (HCA) through the Medical Assistance Division (MAD) contracts and oversees TPA to assure compliance with all policies and regulations. MAD makes the final decision for level of care through the review and recommendations of the contracted TPA. The HCA retains the authority to exercise administrative discretion and issues policies, rules and regulations for waiver operations.

- ( ) **Other**

Specify:

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

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

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

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

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

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

Areas of health evaluated in the Long-Term Care Assessment Abstract are as follows:

a. Physical Development and Health: healthcare supervision, medication management, and medication supervision
b. Nutritional Status: eating skills and diet supervision
c. Sensorimotor Development: mobility, toileting, hygienic, and dressing
d. Affective Development
e. Speech and Language Development: expressive and receptive
f. Auditory Function
g. Cognitive development: reasoning, problem solving; skills transfer
h. Social development: interpersonal skills and social participation
i. Independent living: home skills and community skills
j. Adaptive behaviors: harmful, disruptive, socially unacceptable or stereotypical behavior; or uncooperative behavior

After the level of care is determined with the LTCAA, other documents are used to further substantiate the level of care. The Comprehensive Individual Assessment & Family Centered Review delineates medical, functional, social and developmental information; the Medically Fragile Parameters determine level of medical fragility and the history and physical are reviewed for any inaccuracies that may dispel the level of care determined in the Long-Term Care Assessment Abstract.

The New Mexico administrative code criteria for level of care are set forth at 8.290.400 NMAC.

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

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

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

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

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

The initial LOC evaluation occurs after the individual has been offered and accepted waiver services and has chosen a nurse case management agency via the Primary Freedom of Choice (PFOC) form. The nurse case manager contacts the individual immediately and assists the individual in completing the eligibility process.

The nurse case manager obtains the Long-Term Care Medical Assessment Abstract (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 Third-Party Assessor (TPA) Contractor for LOC evaluation. The TPA reviews, evaluates, and completes all initial LOC determinations. All participants are re-evaluated on an annual basis. The TPA reviews, evaluates, and completes all annual LOC redeterminations.

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

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

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

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

The Third-Party Assessor (TPA) uses a report tracking system to ensure that Level of Care (LOC) reevaluations are completed on an annual or other basis and according to the timeliness requirements. Report tracking is done via a database system. The TPA enters all pertinent dates into the database and applies to any date specific requirement. This system triggers when notifications are to be sent out as well as the date the notification is sent out to ensure timely notifications. The TPA Contractor notifies the participant and nurse 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.

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

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

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

The Third-Party Assessor (TPA) contractor and participant’s nurse 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 state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
TPA Contractor reports on LOC reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: TPA	☒ **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: Additional data collection, analysis, and aggregation will be done, if necessary, to address unusual issues that may arise.

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Percentage of initial LOC evaluations for MF waiver participants that comply with the processes and instruments specified in the approved waiver. Numerator: Number of initial LOC evaluations for MFW waiver participants that comply with the processes and instruments specified in the approved waiver. Denominator: Total number of initial LOC evaluations for waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
TPA Contractor reports on LOC reevaluation reviews

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

Data Aggregation and Analysis:

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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 level of care (LOC) are identified by Health Care Authority(HCA), processes are in place to ensure that appropriate and timely action is taken. This applies to both current participants and new waiver applicants with a reasonable indication that services may be needed. Methods for correcting identified problems include providing education, verbal direction, letters of direction, and formal corrective action plans; documentation is kept on all actions taken. In some instances, policy and/or regulatory changes are required. In all cases, if HCA identifies at any time any issues that are inconsistent with Medicaid requirements related to LOC, HCA ensures that the problem is corrected and that compliance with the Assurance is met.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

As part of the offer of waiver services, the individual is offered freedom of choice at the initial point of contact. The HCA sends a Letter of Interest that includes the Primary Freedom of Choice (PFOC) form for the individual to complete and return. The PFOC informs the individual of their right to choose between Home and Community Based Services (HCBS) and institutional services, specifically Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). It also explains that, if HCBS is selected, the individual may choose between the Medically Fragile Waiver (MFW) and the Mi Via Self Directed Waiver. The individual is also provided with information about the services available under each option to support an informed decision.

The eligible participant or participant's representative meets with the nurse case manager, who provides oral and written explanations of the available MFW services and other alternatives to support an informed choice. The participant or representative also receives a Family Handbook containing information about MFW services, all other waiver programs, and ICF/IID placement options.

Upon selecting the requested services and before the Interdisciplinary Team (IDT) meeting, the participant or participant representative is encouraged to contact agencies and interview potential service providers. After choosing the desired waiver services and providers, the participant or representative signs a Secondary Freedom of Choice (SFOC) form for each selected service. The SFOC form informs the participant of their right to freely choose providers and lists only the approved MFW provider agencies for each service.

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

Freedom of choice records are maintained by the Developmental Disabilities Supports Division (DDSD) Medically Fragile Waiver Unit. In addition, these records are maintained by the nurse case management agency for a period of ten (10) years, or for seven (7) years after the person reaches the age of maturity (21), whichever period of time is greater.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Informational materials are available in English and Spanish. Spanish-speaking individuals are available at the Health Care Authority (HCA) Income Support Division (ISD) offices and at HCA statewide toll-free numbers. Statewide disability resource agencies, such as Aging and Long-Term Services Department (ALTSD) Resource Center, Governor's Commission on Disabilities (GDC), and New Mexicans with Disabilities Information Center (NMDIC), Independent Living Resource Centers (ILRC), have bi-lingual staff available.

The HCA Developmental Disabilities Supports Division (DDSD) can arrange for variety of translators for planning meetings upon participant requests. Translated documents can also be arranged through the HCA/DDSD upon participant request. The nurse case management, provider agencies, and TPA are required to communicate in the language that is functionally required by the participant and have "language lines" available for participants who speak a language other than Spanish or English.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Case Management**		
Statutory Service	**Customized Community Group Supports**		
Statutory Service	**Home Health Aide**		
Statutory Service	**Respite**		
Extended State Plan Service	**Nutritional Counseling**		
Extended State Plan Service	**Skilled Therapy for Adults**		
Other Service	**Behavior Support Consultation**		
Other Service	**Environmental Modifications**		
Other Service	**Individual Directed Goods and Services**		
Other Service	**Private Duty Nursing**		
Other Service	**Specialized Medical Equipment and Supplies**		
Other Service	**Specialized Therapies**		
Other Service	**Vehicle Modifications**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
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 is a comprehensive, person-centered function responsible for supporting waiver participants to gain access to needed waiver and non-waiver services, coordinate care, and ensure health and welfare. Under the Medically Fragile (MF) Waiver, case managers are registered nurses. Nurse Case Management (NCM) services are intended to enhance, not replace, existing natural supports and other available community resources. NCM includes assessment, service planning, monitoring, and ongoing advocacy to help individuals live safely and successfully in the community.

Assessment and Information Gathering
- Assists the participant with completing required Level of Care assessments and documentation.
- Reviews assessments to identify the participant's strengths, needs, preferences, risks, and desired outcomes.
- Gathers information from the participant, guardian, providers, medical professionals, and other relevant sources.
- Ensures assessments are updated when the participant needs change and at minimum annually.

Person Centered Service Planning
- Facilitates a person centered planning process that empowers the participant to lead service planning to the greatest extent possible, including the coordination of Interdisciplinary Team (IDT) meetings
- Develops the Individual Service Plan (ISP) based on assessed needs, goals, and preferences of the participant.
- Ensures the ISP includes all required elements: outcomes, services, providers, frequency, duration, risk mitigation strategies, and backup plans.
- Provides information about available waiver and non-waiver services and supports the participant's freedom of choice when deciding on providers.

Coordination of Services
- Coordinates waiver and non-waiver services, including medical, behavioral health and community supports.
- Ensures services do not duplicate or conflict with Medicaid State Plan benefits.

- Facilitates communication among providers, state agencies, and the participant's support network.

Monitoring and Follow Up
- Monitors the implementation of the ISP to ensure services are delivered as planned and meet the participant's needs and wants.
- Conducts monthly face to face and regular electronic contacts to evaluate health, safety, satisfaction, and progress toward outcomes.
- Reviews incident reports, provider documentation, and utilization data to identify concerns or gaps in service engagement and delivery.
- Ensures compliance with HCBS settings requirements under 42 CFR 441.301(c)(4)–(5).

Risk Assessment and Mitigation
- Identifies potential risks to health and safety through assessments and team discussions.
- Incorporates risk mitigation strategies and individualized backup plans into the ISP.
- Monitors the effectiveness of risk strategies and updates plans as needed.

Advocacy and Support
- Supports the participant in exercising their rights, making informed decisions, and accessing community resources.
- Assists with resolving service issues, provider conflicts, or barriers to care.
- Ensures the participant's voice is central in all planning and decision making.

Documentation and Compliance
- Maintains accurate and timely documentation of assessments, planning activities, monitoring of contacts, and follow up actions.
- Ensures the ISP meets CMS requirements and state standards before submission for approval.
- Participates in quality assurance activities and responds to corrective actions when required.

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

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 MF Waiver regulations, standards, and applicable DDSD policies.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License *(specify):*

Agency licensed by the State of New Mexico; nurses licensed by the New Mexico State Board of Nursing as a registered nurse (RN).
Licensure requirement for Nurse Case Management Agency as per NMAC 8.314.5.10, C. and D.

Certificate *(specify):*

Other Standard *(specify):*

- Nurse case managers (NCM) must be RNs as defined by the NM State Board of Nursing and have a minimum of two (2) years of supervised experience with the target population in one or more areas of pediatrics, critical care or public health.

Providers must:
- Have a current business license issued by the state, county or city government.
- Be financially solvent.
- Complete initial and annual training requirements set forth in DDSD Policy and periodic training updates and supplemental requirements as issued by DDSD.
- Adhere to Quality Improvement (QI) strategies as required per the waiver service standards and DDSD Waiver Provider Agreement.
- Must have proof of records being maintained in accordance with waiver standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement, and at least every three (3) years upon renewal. Providers under HCA 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:

Day Habilitation

Alternate Service Title (if any):

Customized Community Group Supports

HCBS Taxonomy:

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

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

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

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 (CCS) provide meaningful, person centered assistance that helps individuals to acquire, maintain, and improve opportunities for independence, community membership, and increase independence in the most integrated settings possible.

CCS may include participation in community day programs or centers that offer meaningful activities to build or maintain self help, social, and adaptive skills. CCS may include Day Habilitation and other day support models and must not duplicate nurse case management, home health aide services, respite, or any other waiver service.

Services are available four or more hours per day, one or more days per week, as specified in the ISP. The state does not limit the maximum number of hours per day or days per week this service may be used. CCS are provided only through a provider agency and do not duplicate community direct support services or other waiver services.

CCS can occur in community settings, classrooms, or site based locations, and must always promote community participation, growth, and integration. Remote supports may be used to help individuals explore community activities and online resources.

Services are provided in a manner that:
• 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.
• Facilitates individual choice regarding services and supports.

The use of telehealth and remote assistive technology is permitted only in accordance with waiver service standards and CMS requirements.

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**
- ☒ **Remote/via Telehealth**

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

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Customized Community Group Supports Provider

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Customized Community Group Supports Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must:
- Have a current business license issued by the state, county or city government.
- Be financially solvent.
- Complete initial and annual training requirements set forth in DDSD Policy and periodic training updates and supplemental requirements as issued by DDSD.
- Adhere to Quality Improvement (QI) strategies as required per the waiver service standards and DDSD Waiver Provider Agreement.
- Must have proof of records being maintained in accordance with waiver standards.

Providers, whether an agency staff or an individual provider must meet the following qualifications: (i) must be at least 18 years of age; (ii) pass criminal background check and abuse registry screen; (iii) demonstrate capacity to perform required tasks; (iv) complete training on critical incident, abuse, neglect, and exploitation reporting; and (v) have the ability to successfully communicate with the eligible recipient.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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:

Home Health Aide

Alternate Service Title (if any):

HCBS Taxonomy:

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

Home Health Aide (HHA) services provide total care or assist a person in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampoo (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake.

The HHA services assist the participant in a manner that promotes an improved quality of life and a safe environment for the person. HHA's perform an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulation and exercise, household services essential to health care at home, assisting with medications that are normally self-administered, reporting changes in patient conditions and needs, and completing appropriate records.

HHA services are:

- Available to be provided outside the person's home.
- Provided hourly, for people who need this service on a long-term basis.
- Provide basic non-invasive nursing assistant skills within the scope of their practice.

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

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

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency, Rural Health Clinic or Federally Qualified Health Center (42 CFR 484.36; 7.28.2.30 NMAC)
Licensure as per NMAC 8.314.5.10, E, F

Certificate *(specify):*

(HHA) or certified nursing assistants (CNA), must have successfully completed a Home Health Aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a Home Health Aide training program described in the New Mexico Regulations governing Home Health Agencies, 7.28.2.30 NMAC.

Other Standard *(specify):*

Providers must:
- Have a current business license issued by the state, county or city government.
- Be financially solvent.
- Complete initial and annual training requirements set forth in DDSD Policy and periodic training updates and supplemental requirements as issued by DDSD.
- Adhere to Quality Improvement (QI) strategies as required per the waiver service standards and DDSD Waiver Provider Agreement.
- Must have proof of records being maintained in accordance with waiver standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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:

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 their duties.

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

Respite may be provided in the following settings: participant's home or private place of residence, the private residence of a respite care provider.
The person and/or representative has the option and gives final approval of where the respite services are provided. The agency(s) are required to coordinate all services with the participant and/or the participant representative.

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

Respite services are furnished up to a maximum of thirty-one (31) days or seven hundred and twenty (750) hours per annualized budget.

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 (FIT).

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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	Specialized Foster Care
Agency	Home Health Agency
Agency	Intensive Medical Living Supports Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Specialized Foster Care

Provider Qualifications

License *(specify):*

Licensed Home Health Agency, Licensed Rural Health Clinic or Licensed Federally Qualified Health Center. Licensure requirements as per NMAC 8.314.5.10, I.

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

Certificate *(specify):*

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

The (HHA) or certified nursing assistants (CNA), must have successfully completed a Home Health Aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a Home Health Aide training program described in the New Mexico Regulations governing Home Health Agencies, 7.28.2.30.

Other Standard *(specify):*

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

Providers must:
- Have a current business license issued by the state, county or city government.
- Be financially solvent.
- Complete initial and annual training requirements set forth in DDSD Policy and periodic training updates and supplemental requirements as issued by DDSD.
- Adhere to Quality Improvement (QI) strategies as required per the waiver service standards and DDSD Waiver Provider Agreement.
- Must have proof of records being maintained in accordance with waiver standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Licensed Home Health Agency, Licensed Rural Health Clinic or Licensed Federally Qualified Health Center. Respite provider agencies must hold a current business license, and meet financial solvency, training, records management and quality assurance rules and requirements.

Certificate *(specify):*

Other Standard *(specify):*

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

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

The Home Health Aide

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Initially and annually or up to every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Intensive Medical Living Supports Provider

Provider Qualifications

License *(specify):*

An intensive medical living services provider must have a current business license, proof of financial solvency, proof of compliance with training and personnel qualification standards, quality assurance policies and procedures and proof of records being maintained in accordance with MF Waiver standards.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Nutritional Counseling

HCBS Taxonomy:

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

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

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

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

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 includes specialized assessment, guidance, and intervention to address the unique food and nutrition needs of individuals with developmental disabilities and/or chronic medical conditions who are eligible for the Medically Fragile (MF) Waiver. Services include evaluating nutritional status, developing or revising a nutritional plan, providing counseling, education and nutritional intervention, observation, and technical assistance to support implementation of nutritional plans. Services help individuals achieve appropriate nutritional intake by integrating assessment findings with information about food, nutrient sources, and meal preparation practices that align with the person's cultural background and socioeconomic circumstances. The goal is to help the individual achieve appropriate nutritional intake and maintain or improve health.

This service is available to individuals who require nutritional support due to conditions such as failure to thrive, gastroesophageal reflux, esophageal or gastric dysmotility, the need for specialized formulas, or reliance on tube feedings or parenteral nutrition. Nutritional Counseling may be delivered in the home.

The use of telehealth and remote assistive technology is permitted only in accordance with waiver service standards and CMS requirements.

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 (FIT).

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**
- ☒ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nutritional Counseling Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Nutritional Counseling Agency

Provider Qualifications

License *(specify):*

Must be registered as a 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):*

Providers must:
- Have a current business license issued by the state, county or city government.
- Be financially solvent.
- Complete initial and annual training requirements set forth in DDSD Policy and periodic training updates and supplemental requirements as issued by DDSD.
- Adhere to Quality Improvement (QI) strategies as required per the waiver service standards and DDSD Waiver Provider Agreement.
- Must have proof of records being maintained in accordance with waiver standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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:

Skilled Therapy for Adults

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*

Skilled therapy services include Physical Therapy, Occupational Therapy or Speech and Language Therapy. Adults access therapy services under the State Plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Waiver services are provided when the limits of State Plan skilled therapy services are exhausted. The scope and nature of these services do not otherwise differ from the services furnished under the State Plan.

A therapist in the MFW may use a variety of modality to deliver this service, including but limited to music, art and animal therapy.

Skilled Maintenance Therapy services specifically include:

PHYSICAL THERAPY
Physical Therapy services promote gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include: professional assessment(s), evaluation(s) and monitoring for therapeutic purposes; physical therapy treatments and interventions; training regarding physical therapy activities, use of equipment and technologies or any other aspect of the persons physical therapy services; designing, modifying or monitoring use of related environmental modifications; designing, modifying, and monitoring use of related activities supportive to the ISP goals and objectives; and consulting or collaborating with other service providers or family members, as directed by the participant.

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

SPEECH LANGUAGE THERAPY
Speech Language Therapy services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology, and/or prevent progressive disabilities. Specific services may include: identification of communicative or oropharyngeal disorders and delays in the development of communication skills; prevention of communicative or oropharyngeal disorders and delays in the development of communication skills; development of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the participants environment to meet their needs; training regarding speech language therapy activities; and consulting or collaborating.

The use of telehealth and remote assistive technology is permitted only in accordance with waiver service standards and CMS requirements.

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

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

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

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

☒ **Provider managed**

☒ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Group Practice/Home Health Agency

Provider Qualifications

License *(specify):*

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

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

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

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

Licensed Home Health Agency that employs licensed therapist(s)

Certificate *(specify):*

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

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

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

Other Standard *(specify):*

Providers must:
- Have a current business license issued by the state, county or city government.
- Be financially solvent.
- Complete initial and annual training requirements set forth in DDSD Policy and periodic training updates and supplemental requirements as issued by DDSD.
- Adhere to Quality Improvement (QI) strategies as required per the waiver service standards and DDSD Waiver Provider Agreement.
- Must have proof of records being maintained in accordance with waiver standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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: Skilled Therapy for Adults

Provider Category:

Individual

Provider Type:

Individual Therapy Practitioner

Provider Qualifications

License *(specify):*

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

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

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Initially and annually or up to every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Support Consultation

HCBS Taxonomy:

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

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 primary purpose of Behavior Support Consultation (BSC) is to assess the person's behavioral needs, develop an appropriate support plan, and provide consultation to those responsible for implementing the strategies. The service helps the participant, family, and providers understand contributing factors to behavior; implement strategies that enhance functional abilities; prevent and respond to interfering behaviors; and adapt supports as needed to ensure services are delivered in the least restrictive manner.

BSC services provides assessment, treatment planning, evaluation, and follow up services to assist the participant, family members, and primary caregivers in developing effective coping and support strategies that promote stability in the home and community. The service includes:

- Completion of a Positive Behavior Supports Assessment (PBSA) Behavior Crisis Intervention Plans (BCIPs), PRN Psychotropic Medication Plans (PPMPs), and Risk Management Plans (RMPs).
- Development of a Positive Behavior Support Plan (PBSP)
- Training and technical assistance for the interdisciplinary team (IDT)
- Ongoing monitoring of behavioral support strategies and outcomes
- Assessment of the person and their environment, including barriers to independent functioning

- Design and testing of strategies that address concerns and build on strengths and skills
- Development and training of plans in a manner that the person and Direct Support Personnel (DSP) can understand and implement

Services are delivered in integrated/natural settings or clinical settings, as determined by the participant's Individual Support Plan (ISP).

The use of telehealth and remote assistive technology is permitted only in accordance with waiver service standards and CMS requirements.

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**

☒ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavioral Support Consultant Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support Consultation

Provider Category:

Agency

Provider Type:

Behavioral Support Consultant Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Providers must:
- Have a current business license issued by the state, county or city government.
- Be financially solvent.
- Complete initial and annual training requirements set forth in DDSD Policy and periodic training updates and supplemental requirements as issued by DDSD.

- Adhere to Quality Improvement (QI) strategies as required per the waiver service standards and DDSD Waiver Provider Agreement.
- Must have proof of records being maintained in accordance with waiver standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 physical adaptations to an individual's residence that are necessary to ensure the individual's health, welfare, and safety, or to enhance the individual's

level of independence. Allowable adaptations include, but are not limited to:

- Widening of doorways and hallways
- Construction of entrance ramps
- Installation of specialized electrical or plumbing systems to support medical equipment and supplies
- Lifts and elevators
- Bathroom modifications (roll-in showers, sink, bathtub, and toilet modifications; water-faucet controls; floor urinals; bidet adaptations; plumbing adjustments)
- Turnaround space adaptations
- Specialized accessibility or safety adaptations
- Ceiling-mounted trapeze or mobility tracks
- Automatic door openers and doorbells
- Voice-activated, light-activated, motion-activated, and other electronic devices
- Fire-safety adaptations
- Air-filtering devices
- Heating and cooling adaptations
- Glass substitutes for windows or doors
- Modified switches, outlets, or environmental controls for the home
- Alarm, alert, or signaling systems

All services must be provided in accordance with applicable federal, state, and local building codes.

Environmental modification providers must ensure that appropriate design criteria are addressed during planning and design; secure licensed contractors or approved vendors to complete construction or remodeling; provide administrative and technical oversight of the project; consult with family members, waiver providers, and contractors; and inspect the completed work to ensure it meets the approved plan.

Environmental Modifications are managed by professional staff who provide technical assistance and oversight throughout the project.

Excluded from this service are adaptations or home improvements that are of general utility and not of direct medical or remedial benefit to the individual. Additions that increase the total square footage of the home are not covered, except when necessary to complete an approved adaptation (e.g., improving entrance/egress or configuring a bathroom to accommodate a wheelchair).

All environmental modification must be authorized based on assessed need.
Repeat or replacement modifications may only be approved when the individual's needs have changed, the existing adaptation is no longer functional, or the modification is required to maintain health and safety.

Modifications must be the most cost effective option that meets the individual's assessed needs.

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.

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

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

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	GB-2 Class Construction

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

GB-2 Class Construction

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Providers must:
- Have a current business license issued by the state, county or city government.
- Be financially solvent.
- Complete initial and annual training requirements set forth in DDSD Policy and periodic training updates and supplemental requirements as issued by DDSD.
- Adhere to Quality Improvement (QI) strategies as required per the waiver service standards and DDSD Waiver Provider Agreement.
- Must have proof of records being maintained in accordance with waiver standards.
- 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:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

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

Individual Directed Goods and Services (IDGS) are equipment, supplies, or services that are not otherwise available through the Medically Fragile Waiver Specialized Medical Equipment and Supplies Service, the Medicaid State Plan, or Medicare. IDGS must directly relate to the individual's qualifying condition or disability and must address a clinical, functional, medical, or habilitative need identified in the Individual Support Plan (ISP).

To be approved, IDGS must meet all of the following requirements:

- Support the individual to remain in the community and reduce the risk of institutionalization
- Promote personal safety and health and provide an accommodation that increases independence
- Decrease the need for other Medicaid services
- Assist the individual in managing their household or performing activities of daily living

IDGS may be purchased only when the individual does not have the personal funds to obtain the item or service and when it is not available through any other funding source. Items are purchased from the individual's approved budget. Experimental or prohibited treatments, goods, or services are not allowed.

IDGS is an optional waiver benefit available to individuals of all ages. It is not age restricted and may only be used for goods and services that are not otherwise covered under any other Medicaid program, waiver service, or third-party funding source.

Requested IDGS are subject to review and approval by the Third-Party Assessor (TPA) to ensure medical necessity, alignment with ISP goals, and compliance with waiver requirements.

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

Limit is $1200 per ISP year.

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:

Agency

Provider Type:

Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Vendors for individual directed goods and services are retail stores, community health centers, or medical supply stores and must 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:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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:

Private Duty 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):*

Private Duty Nursing (PDN) is the provision of continuous or full-time nursing services, as defined in 42 CFR 440.80, and delivered by licensed nurses acting within the scope of State law. PDN is provided in the individual's home and consists of ongoing nursing activities, procedures, and treatments required to address a physical condition, physical illness, or chronic disability.

PDN services may include:

- medication management
- medication administration and teaching
- aspiration precautions
- feeding tube management
- gastrostomy and jejunostomy care
- skin care
- weight management
- urinary catheter management
- bowel and bladder care
- wound care
- health education
- health screening
- infection control
- environmental safety management

- nutrition management
- oxygen management
- seizure management and precautions
- anxiety-reduction interventions
- supervision of direct support personnel for delegated tasks
- behavioral and self-care assistance within the nurse's scope of practice

PDN ensures that individuals with medically fragile conditions receive the level of skilled nursing care necessary to maintain health, safety, and stability in the home environment.

The use of telehealth and remote assistive technology is permitted only in accordance with waiver service standards and CMS requirements.

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

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

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

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

☒ **Provider managed**

☒ **Remote/via Telehealth**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Home Health Agency/ Rural Health Clinic/ FQHC

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:

Agency

Provider Type:

Licensed Home Health Agency/ Rural Health Clinic/ FQHC

Provider Qualifications

License *(specify):*

Licensed Home Health Agency (7 NMAC 28.2 et seq.)
Licensed Rural Health Clinic (7 NMAC 11.2 et seq.)
Licensure requirements for Federally Qualified Health Centers as per: NMAC 8.26.4.18,E,F.

RNs and LPNs must be licensed by the New Mexico State Board of Nursing as a RN or LPN per the Nursing Practice Act: NMSA, Chapter 61, Article 3 and 16.12.1 and have a minimum of one year of supervised nursing experience; nursing experience preferably with individuals with developmental disabilities or who are medically fragile.

Certificate *(specify):*

Other Standard *(specify):*

Providers must:
- Have a current business license issued by the state, county or city government.
- Be financially solvent.
- Complete initial and annual training requirements set forth in DDSD Policy and periodic training updates and supplemental requirements as issued by DDSD.
- Adhere to Quality Improvement (QI) strategies as required per the waiver service standards and DDSD Waiver Provider Agreement.
- Must have proof of records being maintained in accordance with waiver standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

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

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

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

Service Definition *(Scope):*

Specialized Medical Equipment and Supplies include:

(a) Devices, controls, or appliances specified in the individual's plan of care that enable the individual to increase their ability to perform activities of daily living.
(b) Devices, controls, or appliances that enable the individual to perceive, control, or communicate with their environment.
(c) Items necessary for life support or to address physical conditions, along with ancillary supplies and equipment required for proper functioning of such items.
(d) Durable and non durable medical equipment not available under the Medicaid State Plan that is necessary to address the individual's functional limitations.
(e) Necessary medical supplies not available under the Medicaid State Plan.

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude items that are not of direct medical or remedial benefit to the individual. The cost of maintenance and upkeep of equipment is included in the cost of equipment and supplies. All items must meet applicable standards for manufacture, design, and installation. Medical equipment and supplies covered under the State Plan are not included in this service. Nutritional or dietary supplements are not covered.

Specialized Medical Equipment and Supplies may be utilized by individuals of all ages and is not age restricted. This benefit may only be used for durable medical equipment or medical supplies that are not available under the Medicaid State Plan.

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

Limited to $1200 per ISP year

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendor

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Vendor must:

- Have a current business license issued by the state, county or city government.
- Have a tax ID for state and federal government reporting
- Be financially solvent.
- Have proof of use of approved accounting principles
- Meet bond requirements as established by HCA
- Comply with timeliness standards for this service

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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:

Specialized Therapies

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):*

Specialized Therapies are non-experimental massage therapies or techniques that have been proven effective for certain conditions.
Persons may include specialized therapies in their MFW services and Individual Support Plan (ISP) when the services enhance opportunities to achieve inclusion in community activities and avoid institutionalization. Services must be related to the person's disability or condition, ensure the person's health and welfare in the community, supplement rather than replace the person's natural supports and other community services for which the person may be eligible, and prevent the person's admission to institutional services. Experimental or investigational procedures, technologies or therapies and those services covered as a Medicaid State Plan benefit are excluded.

Services in this category include:

ACUPUNCTURE:
Acupuncture is a distinct system of primary health care with the goal of prevention, cure, or correction of any disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits.

BIOFEEDBACK
Biofeedback uses visual, auditory or other monitors to feed back to participants physiological information of which they are normally unaware. This technique enables a participant to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health and performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

CHIROPRACTIC
Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis, for the purpose of restoring and maintaining health for treatment of human disease primarily by, but not limited to, adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion, and lead to improved general health.

COGNITIVE REHABILITATION THERAPY
Cognitive rehabilitation therapy services are designed to improve cognitive functioning by reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome specific cognitive problems.

Hippotherapy:
Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for participants with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the participant use cognitive functioning, especially for sequencing and memory. Participants with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic

activities, therapeutic activities, sensory integration activities, and for individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production.

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

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

Naprapathy:
Naprapathy is the evaluation of persons with connective tissue disorders through the use of connective tissue manipulation. It is a system for restoring functionality and reducing pain in muscles and joints. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function.

Play Therapy:
Play therapy is a variety of play and creative arts techniques (the 'Play Therapy Tool-Kit') utilized to alleviate chronic, mild and moderate psychological and emotional conditions in eligible recipients that are causing behavioral problems and/or are preventing eligible recipients from realizing their potential. The Play Therapist works interactively using a wide range of play and creative arts techniques, mostly responding to the eligible recipient's wishes.

Music Therapy:
Music Therapy is the clinical & evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapy interventions can address a variety of healthcare & educational goals:

- Promote Wellness
- Manage Stress
- Alleviate Pain
- Express Feelings
- Enhance Memory
- Improve Communication
- Promote Physical Rehabilitation
- and more

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

$2000 per budget year

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

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

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Group practice/vendor

Provider Category	Provider Type Title
Individual	Individual Practioner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Therapies

Provider Category:

Agency

Provider Type:

Group practice/vendor

Provider Qualifications

License *(specify):*

A current NM State license as applicable:

Qualifications: Acupuncture and Oriental Medicine license

Qualifications: Biofeedback - license in a health care profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision.

Qualifications: Chiropractic Physician license

Qualifications: Cognitive rehabilitation therapy - license in a health care profession whose scope of practice includes cognitive rehabilitation therapy, and appropriate specialized training and clinical experience and supervision.

Qualifications: Hippotherapy - a health care professional licensed in physical therapy, occupational therapy, speech language therapy, whose scope of practice includes hippotherapy, and appropriate specialized training and experience.

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

Qualifications: Naprapathic Physician license

Qualifications: Play therapy - license in a mental or behavioral health profession whose scope of practice includes play therapy, a masters degree or higher mental or behavioral health degree, and specialized play therapy training and clinical experience and supervision.

Qualifications: Music Therapist: Music therapists must hold a bachelor’s degree or higher in music therapy from an American Music Therapy Association (AMTA) approved program and credentialed as an music therapist-board certified (MT-BC).

Certificate *(specify):*

Other Standard *(specify):*

Providers must:
- Have a current business license issued by the state, county or city government.
- Be financially solvent.
- Complete initial and annual training requirements set forth in DDSD Policy and periodic training updates and supplemental requirements as issued by DDSD.
- Adhere to Quality Improvement (QI) strategies as required per the waiver service standards and DDSD Waiver Provider Agreement.
- Must have proof of records being maintained in accordance with waiver standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)

HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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: Specialized Therapies

Provider Category:

Individual

Provider Type:

Individual Practioner

Provider Qualifications

License *(specify):*

A current NM State license as applicable:

Qualifications: Acupuncture and Oriental Medicine license

Qualifications: Biofeedback - license in a health care profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision.

Qualifications: Chiropractic Physician license

Qualifications: Cognitive rehabilitation therapy - license in a health care profession whose scope of practice includes cognitive rehabilitation therapy, and appropriate specialized training and clinical experience and supervision.

Qualifications: Hippotherapy - a health care professional licensed in physical therapy, occupational therapy, speech language therapy, whose scope of practice includes hippotherapy, and appropriate specialized training and experience.

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

Qualifications: Naprapathic Physician license

Qualifications: Play therapy - license in a mental or behavioral health profession whose scope of practice includes play therapy, a masters degree or higher mental or behavioral health degree, and specialized play therapy training and clinical experience and supervision.

Qualifications: Music Therapist: Music therapists must hold a bachelor’s degree or higher in music therapy from an American Music Therapy Association (AMTA) approved program and credentialed as an music therapist-board certified (MT-BC).

Certificate *(specify):*

Other Standard *(specify):*

Providers must:
- Have a current business license issued by the state, county or city government.
- Be financially solvent.
- Complete initial and annual training requirements set forth in DDSD Policy and periodic training updates and supplemental requirements as issued by DDSD.
- Adhere to Quality Improvement (QI) strategies as required per the waiver service standards and DDSD Waiver Provider Agreement.
- Must have proof of records being maintained in accordance with waiver standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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:

Vehicle 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):*

Vehicle Modifications include adaptations or alterations to an automobile or van that is the individual's primary means of transportation, when such modifications are necessary to accommodate the individual's special needs. These adaptations must be identified in the individual's service plan as necessary to support the individual's health, welfare, and safety, and enable the individual to access the community and participate more fully in daily life.

Allowable modifications may include installation, repair, maintenance, training on the use of the modifications, and extended warranties related to the approved adaptations.

The vehicle being modified may be owned by the individual, a family member with whom the individual lives or has ongoing and consistent contact, or a non-relative who provides primary long-term support to the individual and is not a paid service provider.

The following are not covered under Vehicle Modifications:
1. Adaptations or improvements to the vehicle that are of general utility and not of direct medical or remedial benefit to the individual.
2. Purchase or lease of a vehicle.
3. Routine vehicle maintenance or repair, except for upkeep and maintenance directly related to the approved modifications.

All modifications must meet applicable federal, state, and local safety and manufacturing standards.

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Individual

Provider Type:

Individual or company

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

OTHER STANDARD

- Have a current business license issued by the state, county or city government.
- Financially solvent.
- 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:

Health Care Authority (HCA)/Developmental Disabilities and Supports Division (DDSD)
HCA/Division of Health Improvement (DHI)

Frequency of Verification:

Prior to the approval of the initial provider agreement and at least every three (3) years upon renewal. Providers under Health Care Authority (HCA) 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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under section 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.*

☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Customized Community Group Supports
Nutritional Counseling
Skilled Therapy for Adults
Behavior Support Consultation
Private Duty Nursing

1. Will any in-person visits be required?

- (●) **Yes.**
- ( ) **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☒ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. *Explain:***

All waiver services provided remotely or through telehealth will be delivered in a manner that fully upholds the individual's privacy and personal rights. This includes ensuring strict privacy during activities such as toileting, dressing, or any other situation that occurs in a bedroom, bathroom, or other private area of the individual's home. Participants are entitled to dignity and privacy within their residence, and remote service delivery will be structured to protect those rights at all times.

☒ **How the telehealth service delivery will facilitate community integration. *Explain:***

Telehealth is designed to enhance, not replace, in person service delivery. By offering a flexible blend of remote and in person options, telehealth expands the individual's ability to participate in assessments and planning activities that inform their Individual Service Plan (ISP). These assessments support the development of Behavior Supports, Risk Screening, and Community Inclusion strategies that help the participant identify, prepare for, and access services and opportunities within their community. Telehealth also strengthens Person Centered Planning by allowing the individual and their support team to collaborate more frequently and conveniently, promoting safety, engagement, and meaningful participation in community life.

☒ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. *Explain:***

The Developmental Disabilities and Supports Division (DDSD) supports the successful delivery of services for individuals who require hands on or physical assistance by ensuring that the participant and their Interdisciplinary Team (IDT) are actively involved in all service planning decisions. The participant plays a central role in determining what supports are appropriate and how they are delivered within the Individual Service Plan (ISP). Through team discussions, the feasibility and safety of using telehealth are carefully evaluated, including whether services can be provided without someone physically present. Telehealth is only used when the team determines that it aligns with the participant's needs, supports their goals, and maintains the integrity and effectiveness of the required services.

☒ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. *Explain:***

DDSD supports individuals who need assistance with telehealth technology by using a person centered approach that ensures equitable access to enabling technology for all waiver participants. As part of service planning, the Case Manager and Interdisciplinary Team (IDT) assess and document the individual's technology needs, comfort level, and required supports. Therapists who recommend specific technology are responsible for training the participant, their family, and direct support professionals to ensure the equipment is used safely and effectively. Through this coordinated approach, individuals receive the support necessary to participate in telehealth services with confidence and independence.

☒ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

Telehealth is implemented in a manner that safeguards the individual's health and safety. The Interdisciplinary Team evaluates whether telehealth can meet the participant's needs, identifies any risks, and determines what supports must be in place to ensure safe and effective service delivery. Telehealth is only used when it aligns with the participant's goals, maintains service integrity, and ensures that the individual can participate safely with the appropriate level of support.

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 State of New Mexico requires criminal history and background investigations for all positions whose employment or contractual duties include direct care or routine, unsupervised physical or financial access to any care recipient served under Medicaid or Medicaid waiver programs, including the Medically Waiver (MF) Waiver. Covered positions include residential, habilitation, and respite service care providers, as well as any other direct support personnel reimbursed in whole or in part with state or Medicaid funds. This requirement does not apply to independent licensed or Medicaid-certified health care professionals in good standing who are not employees or operators of the provider agency and who only deliver medical treatment or consultation.

Under the Caregivers Criminal History Screening (CCHS) Act (8.370.5 NMAC; NMSA 1978, Section 29 17 5), all covered care providers must undergo both statewide and nationwide criminal history background investigations. These screenings are conducted through fingerprint-based checks reviewed by the New Mexico Department of Public Safety and submitted to the Federal Bureau of Investigation. The investigation includes arrests, indictments, formal charges, and all resulting dispositions such as convictions, dismissals, acquittals, sentencing, and correctional supervision. Individuals with a disqualifying conviction who receive a final determination of disqualification may not be hired or continue employment.

Provider agencies are responsible for initiating the required nationwide criminal history screening and must ensure that each new employee or contractor submits fingerprints within 20 calendar days of the first day of employment or the start of the contractual relationship. Until clearance is received, the employee may work only under direct supervision and may not provide services independently.

The Health Care Authority (HCA), Division of Health Improvement (DHI) oversees compliance with all criminal history screening requirements. The DHI Quality Management Bureau (QMB) conducts reviews of 100% of agency personnel records to verify completion of required background checks. Deficiencies require a formal Plan of Correction (POC), which must be fully implemented and verified before closure. HCA regional staff monitor POC completion, and audit findings are forwarded to the HCA Provider Enrollment Unit for inclusion in each provider's master file, where they may influence future provider agreement terms. Additionally, HCA/DHI conducts on site compliance reviews at least every three years, and may conduct verification reviews to confirm that corrective actions have been implemented and that the provider is in full compliance with CCHS requirements.

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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 Health Care Authority (HCA) maintains the statewide electronic Employee Abuse Registry in accordance with the Employee Abuse Registry Act (NMSA 1978, Sections 27-7A-1 through 27-7A-8) and 8.370.8 NMAC. The registry includes all unlicensed direct care providers who have been found to have engaged in a substantiated incident of abuse, neglect, or exploitation that meets the statutory severity standard.

Abuse registry screenings are required for all unlicensed employees or contractors who provide face-to-face services or have routine, unsupervised physical or financial access to individuals receiving Medicaid or Medicaid waiver services. Providers must check the registry prior to hiring any unlicensed direct care worker and must maintain documentation of the screening in the employee's personnel file. Substantiated incidents involving licensed health care professionals are reported directly to the appropriate licensing board for investigation and action.

The HCA Division of Health Improvement (DHI) ensures compliance by conducting provider reviews at least every three years to verify that mandatory screenings have been completed and properly documented. When deficiencies are identified, providers must submit and implement a Corrective Action Plan (CAP), with immediate correction of any identified risk of harm. DHI may conduct verification reviews to confirm compliance. If a direct care worker is added to the abuse registry, the provider must immediately remove the individual from service, and a transition meeting is held to ensure continuity of care and communication among the Interdisciplinary Team (IDT).

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

A Legally Responsible Individual (LRI) is a person who has a duty under state law to care for another person. This includes: the parent (biological, legal, or adoptive) of a minor participant, a guardian who must provide care to an eligible recipient under 18 years of age, or the spouse of an eligible recipient.
For these purposes an LRI does not include the parent of an adult participant even if the parent is a legal guardian. A spouse is an individual who is legally married to another individual, married by common law, or their relationship is otherwise acknowledged in some legal manner such as a domestic partnership established in jurisdictions where those unions are legally permitted.

LRIs cannot be paid for personal care unless they fall under extraordinary care circumstances. Personal care provides support for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Personal care is included within the scope of a variety of waiver services such as Home Health Aide and Respite. Extraordinary care means care exceeding the range of activities that an LRI would ordinarily perform in the household on behalf of a person without a disability or a chronic illness of the same age, and which are necessary to assure the health and safety of the individual and avoid institutionalization.
Payment to LRIs, relatives and legal guardians is allowed for the following services: Home Health Aide, Respite, and Private Duty Nursing,
Professional or corporate guardians may not be paid for providing any waiver services. When an LRI, relative, or legal guardian is chosen to provide services, the planning process must protect against self-referral by demonstrating that the LRI, relative or legal guardian is selected as the best fit.
This may include explanations such as: Direct support professionals (DSP) are not available to serve the individual or the selected agency provider is unable to hire or maintain DSP. Language is a factor in service delivery and the agency-based provider selected is unable to find DSP who can communicate in the language of the individual. There are other extraordinary circumstances in the individual's situation, e.g., the unique ability of the relative or legal guardian to meet the needs of the cultural or care needs of individual. Hiring the LRI, relative or legal guardian is the preference of the individual in services.

The following must be documented in the individual's Individual Service Plan (ISP):
- Best fit information identified through the person-centered planning process.
- How the individual was included in the decision to hire an LRI, relative or legal guardian.
- There must be a backup plan in place to ensure continuity of care.
- The number of units per service requested to be provided by the LRI, relative or legal guardian, must address participant preferences and needs. Units may not be determined to maximize payment to LRIs, relatives and legal guardians at the cost of removing other needed services on the budget.

Specifically, when an LRI provides a service that includes an element of personal care in the scope, LRIs can only be paid for what is considered extraordinary care. DDSD must be made aware of the LRI providing care and the extraordinary care circumstances at least annually, using a form that includes: The participant, LRI, and the service(s) being provided. The extraordinary care circumstances. Signature that attests to understanding that more than forty (40) hours of services in a seven (7)-day period may not be provided as an LRI due to the existing duty of care responsibilities.
One LRI, relative or legal guardian may provide more than one service type if they are qualified for each service and the overall planning for support and services does not routinely rely on a single LRI, relative or legal guardian. (Family Living providers are the exception. Family Living providers cannot be paid for a second service because they are already paid for daily, 24/7 residential service.)
All other service standards including training requirements, background checks and monitoring found in these standards that apply to non – related Direct Support Professionals (DSP) also apply to LRIs, relatives and legal guardians.

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be

made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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.

Legally responsible individuals (LRIs) may be paid for providing waiver services only when they meet all Health Care Authority (HCA) Developmental Disabilities and Supports (DDSD) provider qualifications and are approved to deliver the specific service as outlined in Appendix C 3. All services, including those delivered by a legally responsible individual, must be authorized through the Individual Service Plan (ISP) developed by the participant and the Interdisciplinary Team (IDT).

To ensure payment is made only for services rendered, multiple controls are in place. The nurse case manager (NCM) monitors service implementation monthly, and payment is limited to services documented in the Individual Service Plan (ISP). Provider agencies are responsible for verifying and maintaining documentation that services were delivered as authorized. The HCA Division of Health Improvement (DHI) conducts routine provider surveys to confirm compliance with waiver standards and verify that billed services were actually rendered.

○ **Other policy.**

Specify:

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

The Health Care Authority (HCA) ensures that willing and qualified providers have the opportunity to enroll as waiver providers.

Provider enrollment is a continuous, open enrollment, overseen by the Developmental Disabilities Supports Division (DDSD) Provider Enrollment and Relations Unit (PERU). The PERU releases Call for Providers announcements through DDSD bimonthly document distribution and HCA social media accounts. Call for Provider announcement highlights a specific service, provider requirements and responsibilities.
The PERU contact information published on the Call for Providers and the HCA DDSD website. Information is readily available to answer interested providers regarding enrollment requirements, procedures, and established timeframes. Applications for enrollment are available on the HCA website.

PERU 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.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify

whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- (●) **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ( ) **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - [ ] **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - [ ] **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - [ ] **The HCBS must be identified in the individual's person-centered service plan; and**
  - [ ] **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCA/DDSD/Provider Enrollment and Relations Unit (PERU) database

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

Data Aggregation and Analysis:

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

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

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

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

		100% of providers selected based on provider agreement dates. For details see text box C-QIS-c-ii
	☒ **Other** Specify: Annually up to every 3 years, depending upon compliance history and trends data for complaints and incidents.	

Data Aggregation and Analysis:

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

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

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

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

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

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

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

	☒ **Other** Specify: Annually up to every 3 years, depending upon compliance history and trends data for complaints and incidents.	

Data Aggregation and Analysis:

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

Performance Measure:
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-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: 100% of providers selected based on provider agreement dates. For details see text box C-QIS-c-ii.
	☒ **Other** Specify: Annually up to every 3 years, depending upon compliance history and trends data for complaints and incidents.	

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
The percentage of agency staff reviewed annually, who are in compliance with training requirements as specified in the MF Waiver service standards. Numerator: Number of compliant agency staff. Denominator: Total number of agency staff.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: 100% of providers selected based on provider agreement dates. For details see text box C-QIS-c-ii
	☒ **Other** Specify: Annually up to every 3 years, depending upon compliance history and trends data for complaints and incidents.	

Data Aggregation and Analysis:

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

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

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

Formal quality improvement processes are in place, as described in detail Appendix H.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

Methods for addressing and correcting identified problems include verbal direction, letters of direction, formal corrective action plans; documentation is kept on all actions taken. In some instances, policy and/or regulatory changes are required. In all cases, if Health Care Authority (HCA) identifies at any time any issues that are inconsistent with Medicaid requirements related to provider qualifications. In addition, the Developmental Disabilities Supports Division Quality Improvement (DDSQI) Steering Committee routinely collects, analyzes, and trends provider qualification 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.

In addition, the HCA 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.

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**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Additional data collection, analysis, and aggregation will be done as necessary to address unusual or urgent issues that may arise.

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

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

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

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

AGE: 21 years of age and over
Level I $145,000.00
Level II $130,000.00
Level III $115.000.00

AGE: Under 21 years of age
Level I $60,000.000
Level II $60,000.000
Level III $60,000.000

Because persons under age 21 receive the bulk of their services through the State Plan, there is a single budget cap for that age group. An additional $5000 is available to each person every five years for the purpose of Environmental Modifications.

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

Safeguards for persons whose needs exceed that which can be provided within the budget caps above include:
1) a carefully planned and managed annual MF Waiver budget;
2) the NCM coordinates with the State Plan to request and obtain additional support services when MF Waiver services have been exhausted and there is a demonstrated need for more services;
3) people may choose to transition to another waiver that offers residential services, if offered an allocation to these waivers;
4) as a last resort, the person may transition to an ICF/IID when the caregiver(s) is no longer able to support the person at home.

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

Participants of Medically Fragile (MF) Waiver receive services in the setting of their choice to include the following:

Residential Habilitation Settings: Services provided at personal residences to include owned or rented homes.

Non-Residential and Community Settings: Services may be provided at the participants' non-residential home, place of employment, non-paid activities and experiences, agency operated facilities and adult education locations.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

The Health Care Authority (HCA) ensures that all waiver settings meet federal Home and Community Based Services (HCBS) Settings requirements at the time of this submission and on an ongoing basis through a coordinated set of oversight, enrollment, monitoring, and quality assurance activities. These activities apply to all residential and non-residential settings in which waiver services are delivered.

PROVIDER ENROLLMENT

- The HCA Developmental Disabilities and Supports Division (DDSD) Provider Enrollment and Relations Unit (PERU) ensures that only qualified providers are authorized to deliver waiver services. PERU conducts comprehensive reviews of new and renewal applications, verifies licensure and insurance, processes accreditation waivers, and manages amendments, expirations, and terminations of provider agreements. PERU maintains current information on all enrolled Provider Agencies across all thirty-three counties, including service availability by county and service type. This ensures that only settings operated by approved providers may serve waiver participants.
- Provider Agency Monitoring Duties: All waiver provider agencies must ensure that every setting in which they deliver services complies with federal HCBS Settings requirements. Providers must continuously monitor their settings for compliance, ensure participants receive meaningful choices, and uphold participant rights consistent with person centered planning principles.

STATE OVERSIGHT

- Human Rights Committees (HRCs) safeguard participant rights by reviewing any proposed rights restrictions based on documented, severe health or safety concerns. HRCs also monitor the implementation of time limited restrictive interventions to ensure they are justified, least restrictive, and appropriately monitored.
- Case Management Monitoring: All waiver participants receive Case Management services. Case Managers (CMs) conduct structured, ongoing monitoring to evaluate the quality, effectiveness, and appropriateness of services and supports identified in the Individualized Service Plan (ISP).
  - o CMs conduct monthly face to face visits with each participant.
  - o At least one quarterly visit occurs in the participant's home.
  - o For individuals receiving day services in agency operated facilities, CMs conduct at least one quarterly visit at the day program.
  - o During these visits, CMs assess health and safety, verify that the environment is free from abuse, neglect, and exploitation, and confirm that the setting continues to meet HCBS requirements.

ONGOING MONITORING

- Continuous Compliance Verification: HCA uses a combination of provider self attestations, case management observations, incident management data, and targeted reviews to ensure ongoing compliance with HCBS Settings requirements.
- Annual and Periodic Reviews: Provider Agencies are subject to periodic reviews that may include desk audits, on site assessments, participant interviews, and review of policies and procedures to confirm that settings remain integrated, support autonomy, and uphold participant rights. Annual/periodic or targeted reviews in conjunction with case management observations, and incident management data are used to ensure ongoing compliance with HCBS Settings requirements.
- Remediation and Corrective Action: When noncompliance is identified, the HCA requires corrective action plans, increased monitoring, state-imposed moratorium, or if necessary, termination of the provider agreement.
- System Level Quality Assurance: HCA analyzes trends across settings, providers, and regions to identify systemic issues and implement statewide improvements to maintain long term compliance with federal HCBS Settings standards.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☒ **Facilitates individual choice regarding services and supports, and who provides them.**

☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

◉ **No, the waiver does not include provider-owned or controlled settings.**

○ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☐ **Each individual has privacy in their sleeping or living unit:**

☐ **Units have entrance doors lockable by the individual.**

☐ **Only appropriate staff have keys to unit entrance doors.**

☐ **Individuals sharing units have a choice of roommates in that setting.**

☐ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☐ **Individuals have the freedom and support to control their own schedules and activities.**

☐ **Individuals have access to food at any time.**

☐ **Individuals are able to have visitors of their choosing at any time.**

☐ **The setting is physically accessible to the individual.**

☐ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(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. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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 stages of developing the Individual Service Plan (ISP), the nurse case manager (NCM) provides the participant and when appropriate, the family or legal representative, with the information, guidance, and support needed to direct and actively engage in the person-centered planning process. The NCM meets with the individual prior to formal service planning to explain the waiver process, provide essential information, and encourage the participant's leadership and full participation in the planning process. Together, the NCM and the individual, and/or family or legal representative, explore the person's strengths, preferences, vision, and desired outcomes for services.

To ensure the participant can meaningfully direct the development of the ISP, the NCM:

- Explains available supports and services under the Medically Fragile (MF) Waiver that can help the individual achieve their identified vision and outcomes.
- Reviews rights and responsibilities of the individual, guardian, family members, and other Interdisciplinary Team (IDT) participants.
- Provides information and links to strengthen natural supports and connect the individual with non disability–specific, publicly funded programs and community resources available to all residents.
- Discusses risks associated with identified outcomes and services, along with strategies to mitigate those risks.
- Provides an updated list of service providers available in the individual's area to support informed choice through the Secondary Freedom of Choice (SFOC) process.
- Explains the IDT process, including team roles and composition.
- Encourages the individual or guardian to invite others of their choosing to participate as IDT members.
- Supports the individual in leading the IDT meeting, promoting self direction and empowerment.
- Advocates for the individual on an ongoing basis.
- Assists with obtaining and reviewing assessments required by the MF Waiver or otherwise relevant to person centered planning.

The participant, or their guardian when applicable, has full authority to determine who is included in the service planning process. This includes:

- Selecting service providers by service type through the Secondary Freedom of Choice (SFOC) process, reviewed annually. Once selected, providers become members of the IDT.
- Determining and inviting additional individuals of their choosing such as family members, friends, or other supporters to participate as IDT members.

The ISP is developed by the participant with support from the IDT and any other individuals the participant chooses to involve. Working collaboratively, the NCM and participant, and/or family or legal representative, as appropriate) identify the participant's strengths, vision, outcomes, and preferences to guide the development of a person-centered plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the

participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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):

The Medically Fragile (MF) Waiver uses a comprehensive, person-centered planning process to develop the Individual Service Plan (ISP). The process ensures that the participant directs planning to the maximum extent possible and that the ISP reflects the participant's goals, preferences, needs, and desired outcomes.

INITIAL ISP DEVELOPMENT TIMELINE
An initial Individual Service Plan (ISP) must be completed within ninety (90) days of the participant's receipt of the allocation letter from the Medically Fragile (MF) Waiver program.

PERSON-CENTERED PLANNING AND IDT MEETINGS
Interdisciplinary Team (IDT) meetings are held to develop the person-centered ISP. The ISP is written by the Nurse Case Manager (NCM) and developed by the individual with support from their IDT. The IDT typically includes MF Waiver providers selected by the individual, as well as any other persons the individual, guardian, or family chooses to include (e.g., natural supports, friends, or other professionals). Planning meetings occur at least annually and additionally as needed when there is a change in the individual's condition or circumstances. Meetings are scheduled at times and locations convenient to the individual.

INFORMATION GATHERING FOR ISP DEVELOPMENT
To support person centered planning, the NCM gathers information about the individual's strengths, capacities, preferences, desired outcomes, and barriers. This information is obtained through:

- Review of the Level of Care (LOC) assessment
- Interviews with the individual and/or guardian
- Ongoing person-centered planning discussions

ASSESSMENTS USED IN ISP DEVELOPMENT
The Developmental Disabilities Supports Division (DDSD) utilizes multiple assessments prior to the IDT meeting, including:

- Initial or annual Level of Care assessment, Long Term Care Medical Assessment Abstract (LTCAA)
- Personal history and physical (H&P) completed by the primary care physician (PCP)
- Review of pertinent medical history and documentation
- LOC determination
- Therapy assessments (speech, occupational, physical)
- Positive Behavior Supports Assessments and Positive Behavior Support Plans
- Assessments from non-Home and Community Based Services (HCBS) providers, including those related to Individuals with Disabilities Education Act (IDEA), the Rehabilitation Act as amended and Workforce Innovation and Opportunity Act (WIOA).

These assessments support the development of an accurate and functional ISP. Assessments occur annually or as needed during significant changes in circumstance. The NCM makes assessment results available to the individual and/or guardian, and the ISP must address all identified needs, risks, and concerns.

PRE-PLANNIG ACTIVITIES
Preplanning includes informal calls and in person visits used to prepare for the IDT meeting. During pre-planning, the NCM reviews available waiver services with the participant and/or guardian, the participant's rights and responsibilities, and other available resources. The NCM documents the services selected for discussion at the IDT meeting.

INTERDISCIPLINARY TEAM (IDT) MEETING PROCESS
The participant and/or guardian select the date and time of the IDT meeting. The NCM supports the participant in planning and, to the extent possible, leading the meeting. The IDT includes the individual and/or guardian, the NCM, MF Waiver providers, external providers, and the PCP when available. The individual's managed care organization (MCO) care coordinator is invited to participate in person or by phone. All required team members must attend or provide input prior to the meeting.

During the IDT meeting, the individual's ISP is developed with input from all team members. The ISP may be revised throughout the year to address medical, behavioral, or social changes. The ISP must address:

- Activities of daily living
- Assistance needs
- Health care needs
- Equipment needs
- Home and community relationships
- Anticipated or known transitions
- Personal safety
- Available providers

The NCM ensures that the ISP addresses the participant's goals, health and safety needs, and concerns identified through assessments. Providers develop activities and strategies to support the outcomes identified by the team.

An individualized plan is considered complete when the IDT has identified:

- The individual's interests and preferences
- Needed support and service areas
- Settings and activities
- Specific support functions to meet identified needs
- Natural supports available
- Valued personal outcomes
- A mechanism for monitoring service provision and effectiveness
- Needed waiver services and references to non-waiver services

BUDGET REVIEW AND SUBMISSION
The NCM ensures the budget is within the participant's authorized level before submitting it to the Third Party Assessor (TPA). The NCM verifies that:

- The plan addresses the participant's needs and personal goals, including medical supports
- Services selected align with assessment findings
- Health and safety considerations are incorporated
- Services do not duplicate Medicaid State Plan or other public programs
- Services are not duplicated across service codes
- Responsible parties are clearly identified
- Back up plans are complete
- Waiver and non waiver services are appropriately referenced

The ISP is submitted to the Third-Party Assessor (TPA) in accordance with MF Waiver NMAC and Service Standards. Implementation begins once the ISP and budget are approved and provider service plans are received by the NCM and the individual and/or guardian. Temporary interim service plans are not used.

CCORDINATION OF SERVICES
Waiver and other services are coordinated through ongoing communication between the NCM, service providers, MCO care coordinators, and the participant and/or guardian. HCA/DDSD provides ongoing training and updates to MF Waiver case managers and MCOs to support effective care coordination. The ISP outlines the roles and responsibilities of each service provider. The NCM monitors implementation monthly or quarterly, or more frequently as needed.

ISP REVISION REQUIREMENTS
The ISP must be updated annually, upon request by the participant, or when any of the following occur:

1. Major medical changes
2. Risk of significant harm
3. Loss of primary caregiver or significant support
4. Serious accident, illness, injury, or hospitalization disrupting ISP implementation
5. Serious or sudden behavioral change
6. Change in living situation

7. Changes to or completion of outcomes or vision
8. Loss of employment
9. Proposed change in services or providers
10. Substantiated abuse, neglect, or exploitation
11. Criminal justice involvement
12. Request by any IDT member
13. Unresolved issues or barriers between the individual and NCM
14. Request by Health Care Authority (HCA) or DDSD

The NCM contacts the participant and/or guardian to initiate budget revisions and schedules IDT meetings in compliance with MF Waiver Service Standards.

MONITORING
The NCM monitors the ISP pre planning and development process and conducts ongoing quality improvement activities. The ISP is monitored monthly through phone, electronic, and face to face contact. The ISP is reviewed with IDT members at least every six (6) months for the initial ISP and at least annually thereafter. Ongoing review ensures that:

- Services and supports are delivered as identified
- Goals and objectives remain appropriate and achievable
- Adjustments are made when needed

PARTICIPANT ENGAGEMENT AND DIRECTING THE PERSON-CENTERED PLANNING PROCESS
The participant directs the planning process to the maximum extent possible. The participant and/or guardian:

- Selects the date, time, and location of the IDT meeting
- Chooses who participates in the IDT
- Identifies goals, preferences, and desired outcomes
- Leads the IDT meeting to the extent they choose
- Selects MF Waiver providers

The NCM supports the participant's leadership, provides information in accessible formats, and ensures the participant's voice drives all decisions.

CONSENT OF THE PERSON-CENTERED SERVICE PLAN
The participant or their legal representative provides documented consent for the ISP through required signatures on the finalized plan. The NCM ensures that the participant receives the completed ISP. Consent is required before implementation of the ISP and any subsequent revisions.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☒ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☒ **A specific and individualized assessed need for the modification.**
- ☒ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☒ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☒ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☒ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☒ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☒ **Informed consent of the individual.**

☒ **An assurance that interventions and supports will cause no harm to the individual.**

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.

Potential risks to the participant are assessed throughout the person-centered service plan development process. Risk identification begins with the nurse case manager's (NCM) completion and review of the Level of Care (LOC) packet, which includes the Long-Term Care Medical Assessment Abstract (LTCAA), the health and physical (H&P), and other relevant medical documentation. Using this information, the NCM works with the participant and/or guardian to identify health and safety needs and any potential risk factors in the service environment. Providers complete additional assessments as needed to further clarify risks related to medical conditions, behavioral needs, functional limitations, and environmental factors.

The interdisciplinary team (IDT), which includes the participant, guardian, NCM, providers, and other professionals such as physicians, therapists, and private duty nurses review identified risks and discusses the benefits, consequences, and participant preferences related to different courses of action. The team also considers the extent to which the participant is willing and able to assume responsibility for certain risks. This collaborative process ensures that risk mitigation strategies included in the ISP reflect the participant's needs, choices, and desired level of independence.

Risk mitigation strategies are incorporated directly into the ISP. These may include specific supports, monitoring approaches, health related interventions, or environmental modifications. The assessment process also informs the development of a required backup plan. Each participant has a backup plan tailored to their circumstances, addressing how essential services will continue during emergencies or disruptions. Backup plans may include substitute staffing arrangements, access to physician or emergency services, and procedures for anticipated events such as illness, inclement weather, or provider agency closures. Primary caregivers must also have a documented backup plan. All waiver providers are required to develop backup plans in collaboration with the participant.

The NCM monitors the use and effectiveness of these risk mitigation strategies and back up plans during monthly contacts and updates them as needed to address emerging risks or equipment needs. Provider agencies are required to complete Abuse, Neglect, and Exploitation (ANE) training to further support participant safety.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The nurse case manager (NCM) is required to provide information to each person regarding choices for each service entered on the Medically Fragile (MF) Waiver budget. The Secondary Freedom of Choice (SFOC) form 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/guardian makes a provider selection, they indicate the selection and sign the SFOC Form. The Health Care Authority (HCA) Developmental Disabilities Supports Division (DDSD) provides tools including provider information and sample questions to assist individuals and/or guardians with making an informed choice for selecting service providers. HCA/DDSD also provides a web-based list of currently approved and qualified waiver providers by service type, region and county. HCA/DSDD staff are available to provide technical assistance to case managers, providers, individuals and guardians regarding informed decision making and the person-centered planning process as outlined in the waiver standards and regulations.

At the initial team meeting, the Individual Service Plan (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. SFOC 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. HCA/DDSD maintains the SFOC through the Provider Enrollment and Relations Unit (PERU).

Individuals 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. Case Management Agency Change 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):

The Health Care Authority (HCA) Medical Assistance Division (MAD) contracts with a Third-Party Assessor (TPA) to review and approve all Developmental Disabilities (DD) Waiver Individual Service Plans (ISPs). After completing an internal review, the case manager (CM) submits the ISP and budget to the TPA. The TPA reviews 100% of initial ISPs, annual ISPs, and ISP revisions and issues a written clinical determination approving or denying the requested services in whole or in part. Any denial includes the specific reasons for the decision.

Participants may request an Agency Review Conference (ARC), an optional informal process through HCA, to resolve adverse determinations. Additional appeal rights are described in Appendix F. Once the TPA approves the ISP and budget, the approved budget is entered into the Medicaid Management Information System (MMIS).

HCA monitors the accuracy and compliance of TPA decisions through monthly quality assurance reviews and quarterly reporting. HCA also contracts with a nurse auditor who conducts monthly retrospective reviews of a sample of approved ISPs to ensure they meet Medicaid requirements and protect participant health and welfare. If HCA identifies issues, it requires the TPA to correct them through measures such as letters of direction, corrective action plans, or contract sanctions. This full review and approval process ensures that every service plan is subject to HCA agency oversight.

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, when the individual's circumstances or needs change significantly, or at the request of the individual, 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:

Third Party Assessor (TPA) Contractor

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The nurse case manager (NCM) is the primary entity responsible for monitoring implementation of the Individual Service Plan (ISP), the participant's health and welfare, and adherence to HCBS settings requirements. The NCM works directly with the participant and/or guardian through face-to-face, electronic, and telephone contact to assess, plan, implement, and evaluate services.

Additional monitoring is conducted by the Health Care Authority's (HCA) Division of Health Improvement (DHI), Quality Management Bureau (QMB), and by the HCA MF Waiver program manager.
The NCM uses multiple methods to monitor service delivery and participant well-being, including:

- Routine face to face, electronic, and telephone contact with the participant
- Review of all services identified in the ISP to ensure they are delivered as planned
- Regular communication with waiver providers, non-waiver providers, and state agencies
- Follow up with provider agencies when concerns arise
- Participation in problem resolution when service issues occur
- Review of training needs through the Individual Specific Training (IST) section of the ISP
- Verification that backup plans are in place and implemented when needed

During monitoring, the NCM ensures that:

1. Individuals have access to all waiver services identified in the ISP
2. Individuals have access to non waiver services, including health services
3. Services meet the participant's needs and preferences and are chosen from non disability specific options
4. Participants exercise free and informed choice of qualified, locally available providers
5. Plans are effective in achieving desired outcomes
6. Participant health and welfare are assured
7. Waiver services are delivered according to the ISP and Home and Community-Based Services (HCBS) settings rules

HCA's Division of Health Improvement (DHI) conducts compliance surveys of provider agencies. These surveys review:

- Whether services match the ISP
- Whether backup plans are in place
- Whether health and welfare are protected
- Whether the participant has access to all waiver services in the ISP
- Whether the participant has received information on reporting abuse, neglect, and exploitation

Findings are based on record reviews, observations, and interviews. Providers must submit a Plan of Correction (POC) within 10 business days and correct deficiencies within 45 working days. Failure to comply may result in referral to the Internal Review Committee (IRC), DDSD, or other administrative action.

Non-compliance is identified through record reviews, observations, and interviews. Providers must submit a Plan of Correction (POC) within 10 business days and correct deficiencies within 45 working days.

The HCA MF Waiver program manager reviews monitoring results and conducts additional audits to ensure participants have access to both waiver and non-waiver services.

NCM agencies also conduct quarterly internal quality reviews and report findings to the State.
Monitoring occurs on a regular schedule:

- NCM face-to-face contact: at least every other month
- NCM telephone or electronic contact: monthly

- ISP review by NCM: at least annually, or more often if needed
- DHI/QMB provider compliance surveys: every 12–36 months, depending on provider compliance history

(no provider exceeds a 3-year cycle; surveys may occur more frequently if needed)

- HCA MF Waiver program manager audits: at least twice per year
- NCM agency internal quality reviews: quarterly

These combined activities ensure ongoing oversight of ISP implementation, participant health and welfare, and compliance with HCBS settings requirements.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

	☒ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

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: 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 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):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

		Sample Confidence Interval =
☒ **Other** Specify: Nurse Case Management Agency data	☒ **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):*
	Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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 Health Care Authority (HCA), processes are in place to ensure that appropriate and timely action is taken. In addition, the DDSQI Steering Committee routinely collects, aggregates, analyzes, and trends service plan data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

Methods for fixing identified problems include verbal direction, letters of direction, formal corrective action plans; documentation is kept on all actions taken. In some instances, policy and/or regulatory changes are required. In all cases, if HCA identifies at any time any issues that are inconsistent with Medicaid requirements related to service plans, HCA 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: DDSDQI Steering Committee	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

c. 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.

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.

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

State laws, regulations, policies and notices referenced are available to CMS upon request through the Health Care Authority (HCA). New Mexico Administrative Code (NMAC) 8.100.970, 8.200.430, 8.352.2. and 8.354.2, provide that the State must grant an opportunity for an administrative hearing pursuant to state statute Annotated 1978: 27-3-3 & 27-7A and Code of Federal Regulations 42 CFR §§ 431.205-245 and 45 CFR 205.10. Individuals are afforded the opportunity to request a Fair Hearing in all instances when they are denied the service(s) or provider(s) of their choice and denial, reduction, suspension or termination of service.

To ensure that a participant is fully informed of rights to a Fair Hearing, the Health Care Authority (HCA) 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:

- Verbal information provided by case manager (CM) upon entrance to the Developmental Disabilities (DD) Waiver.
- Written notice in the Individual Service Plan (ISP) via the Client's Rights Client Rights, Grievance Process and ANE Reporting Acknowledgement Form provided annually to individuals and/or guardians annually and made part of the official participant record.
- Website postings: Office of Fair Hearings – New Mexico Health Care Authority https://www.hca.nm.gov/about_the_department/fair_hearings_bureau/
- Verbal explanation provided by HCA 's Office of Fair Hearings (OFH) as requested
- 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
- Written notice through the s Bill of Rights for Adults Who Have a Guardian, available on the Office of the Courts website: https://adultguardianship.nmcourts.gov/wp-content/uploads/sites/36/2025/04/Bill-of-Rights.Feb2025.pdf

HCA Medical Assistance Division (MAD) contracted Third-Party Assessor (TPA) is responsible for providing the waiver recipient with the review determination in writing, including reasons for any denial of requested services or level of care. The individual and/or guardian 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 HCA's Office of Fair Hearings (OFH) 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.

The case manager may address questions or aid an individual who requests assistance with the fair hearing process. The Developmental Disabilities Supports Division (DDSD) Bureau of Individual Safety and Advocacy (BISA) and OFH are also available to answer questions regarding the Fair Hearing process and provide assistance as needed.

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

- **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.

Two additional dispute resolution processes are available to individuals:

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

AGENCY REVIEW CONFERENCE
Prior to the Fair Hearing, the entity who issued the adverse action or the Disabilities Supports Division (DDSD) Fair Hearing Unit (FHU) will offer the claimant an Agency Review Conference (ARC). An ARC is not required and may be declined by the claimant. The claimant has the right to skip the ARC and go straight to a Fair Hearing.

The ARC provided an opportunity for the eligible recipient to meet and discuss the fair hearing issues to attempt clarification and possible resolution before the Fair Hearing.

Instructions on how to request an ARC are included in the notices of the adverse action. The ARC process includes:

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

Frequently, Fair Hearing cases are resolved through action items discussed and acted upon via the ARC process. However, participating in an ARC does not replace or impact the individual's right to a Fair Hearing. The Health Care Authority (HCA) HCA/ Office of Fair Hearings (OHF) verbally explains this to the individual or the individual's representative in addition to the written notice.

TEAM FACILIATION
The HCA Developmental Disabilities Supports Division (DDSD) 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 DD Waiver. OCS informs the individual that the TFP 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 or 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 any interdisciplinary team issues as it relates to the DD Waiver, or 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:
Requestor contacts the Manager of the OCS either by telephone, email, in writing, or in person to request team facilitation.
1. OCS Manager reviews and decides to accept or deny the request per criteria (has five (5) working days to review).
2. If accepted, the case is assigned to a trained mediator.
3. If not accepted, a letter or email is sent to the requestor stating the reason for denial within ten (10) working days.
4. If accepted, the mediator has thirty (30) days to complete the team facilitation.

During the thirty (30) days, the Mediator:
1. Speaks to the requestor and other pertinent parties;
2. Collects necessary documents;
3. Schedules a meeting with the requestor and other pertinent parties;
4. Facilitates the meeting;
5. Documents, in writing, at the meeting or after the meeting the resolution(s) on an agreement sheet that is signed by all team participants; and

Agreements that amend the service plans 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**

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

Both the Health Care Authority (HCA) Office of the Secretary (OOS) and Developmental Disabilities Supports Division (DDSD) are responsible for the operation of the grievance/complaint system. The DDSD Office of Constituent Supports (OCS) monitors and resolves complaints and grievances received by DDSD directly or through OOS. Individuals, family, and/or legal representative may register a complaint or grievance about any issue with which they are dissatisfied. Individuals, family, and/or legal representatives may also register complaints with HCA/OOS or DDSD OCS via email, phone, online, or standard mail. The individual, family, or legal representative is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing.

• **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 Health Care Authority (HCA) Developmental Disabilities Supports Division (DDSD) Office of Constituent Support (OCS) monitors and resolves complaints received by the HCA. The individual and/or family or legal representative may register complaints about any issue with which they are dissatisfied with as it relates to the DD Waiver. Complaints can be filed directly with the HCA/DDSD via email, phone, online, or standard mail, or with the HCA/OOS via email, phone, online, or standard mail. Complaints or grievances received by the HCA Office of the Secretary (OOS) are sent via email to the HCA/DDSD OCS.

For all complaints, whether the complaint is sent to the HCA/OOS or to the HCA/DDSD, the HCA/DDSD OCS follows up within two (2) business days from the date the complaint/grievance is received and informs the individual that the complaint has been received. A database is used to track and monitor the requests and actions taken. The person that files the complaint may contact the HCA/DDSD OCS at any time via phone, email, online, or standard mail after they have filed their complaint to add information to the complaint.

Complaints sent to the HCA/DDSD from the HCA/OOS must be resolved within two (2) business days. The HCA/DDSD OCS will contact the HCA/OOS if an extension is needed for an HCA/OOS complaint. Complaints are resolved using state policies and procedures or other mechanisms as appropriate to the program. Complaints sent directly to the HCA/DDSD must be resolved by the HCA/DDSD OCS within fifteen (15) business days. If the complaint or grievance is not resolved within fifteen (15) business 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 Developmental Disabilities Supports Division (DDSD)operates a reporting system for critical events or incidents involving individuals receiving MFW services through the Division of Health Improvement (DHI)/Incident Management Bureau (IMB) protocols for incidents of abuse, neglect, exploitation, suspicious injury, environmental hazard and deaths.

REPORTING PROTOCOLS:

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

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

Trained nurse case managers (NCM) and home health agency staff provide direction and support to the person and their informal caregivers in recognizing and reporting critical incidents. Initially and annually, the NCM meets with the individual and reviews the who, what, when, and how to report any instances of abuse, neglect and exploitation (ANE).

Health Care Authority (HCA) Division of Health Improvement (DHI) posts materials on the HCA website at https://www.hca.nm.gov/report-abuse-neglect-expoitation/

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 Health Care Authority (HCA) Division of Health Improvement (DHI) Incident Management Bureau (IMB) receives reports, investigates incidents and works collaboratively with other state agencies the Children Youth and Families Department (CYFD) Child Protective Services (CPS) and the Aging and Long-Term Service Department (ALTSD) Adult Protective Services (APS) that accept abuse, neglect and exploitation reports concerning any children or adults in New Mexico. Upon receipt of the Incident Report, HCA/IMB intake staff determine if they have the jurisdiction and authority to investigate. The HCA/DHI/IMB prioritizes allegations of ANE based on the seriousness of the allegation. The HCA/DHI/IMB must initiate an investigation within three hours if the allegation is determined to be an Emergency, within twenty-four (24) hours if the allegation is determined to be a Priority One and within five days if the allegation is determined to be a Priority Two. HCA/DHI has 45 days for the completion of the case investigation regardless of the priority assignment.

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 a review of prior reported incidents (past 12 months) on the individual consumer and verification of the funding source to determine if they have the proper jurisdiction or if the incident should be transferred to another jurisdiction. Once HCA/DHI has determined jurisdiction, they assign severity and priority.

Triage/Intake Investigation is the decision process utilized by Intake staff to determine priority, severity and assignment of the case. Intake staff will triage the case within one working day of receipt; the IMB does have an extended intake process that can be requested by the intake specialist in order to receive appropriate documentation.

A. 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, and the authority to investigate. 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:

• Emergency case: Reports of serious cases of Abuse, Neglect, or Exploitation resulting in physical harm, including sexual abuse, or mental anguish which affected individuals at continued risk for injury or harm. Due to the severity of the case, the investigator will initiate investigation within (3) hours. Emergency (1-3 hour response time) requires face-to-face contact; staffed with a Supervisor who has the discretion of lowering or raising the status on any report. The report is generated electronically and submitted to the Supervisor for review to insure all the information is correct and the allegations match the narrative. The Supervisor then processes and assigns the report to the county where the family resides. The report is called out telephonically and an electronic report is created in the FACTS system, accessible by the particular county.

• Priority One Case: Reports of urgent cases of Abuse, Neglect or Exploitation. Due to the severity of the case, the investigator will initiate investigation within twenty-four (24) hours but does not require more immediate action.

• Priority Two 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:

- Region of the incident occurrence: DHI/IMB has divided the State into five (5) regions (consistent with HCA/Developmental Disabilities Support Division (DDSD) Regional offices. DHI investigators are located in each region.
- Participant specific: Investigator with an existing case involving the individual or the investigator is next due on rotation to receive a case.
- Level of urgency: Cases may be assigned based on the most available investigator.

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. Appropriate referrals, when necessary, are made to outside agencies:

a) HCA-Office of the General Counsel (OGC)
b) HCA-DDSD
c) HCA-DHI
d) ALTSD- Adult Protective Services (APS)
e) CYFD/CPS
f) Law Enforcement
g) HCA -Medical Assistance Division (MAD)
h) Medicaid Fraud Control Unit (MFCU)
i) New Mexico M Attorney General's Office
j) HCA Office of Internal Audit (OIA)
k) Responsible Provider in cases of late reporting or failure to report

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

1. Data Entry of information into the separate closure Database.

2. Appropriate referrals, when necessary, are made to outside agencies

NOTIFICATION TO THE PARTICIPANT:

In each situation that critical incident investigations are completed by ALTSD/APS, CYFD/CPS, or HCA/DHI, the waiver participant and/or guardian receives a letter stating the results of the investigation. The investigator has up to forty-five (45) calendar days to complete the investigation, ten (10) calendar days to write the report and seven (7) calendar days for supervisor review of the case. Incident Management Bureau (IMB) Investigators are required to initiate an assigned ANE investigation within three hours for an Emergency case assignment, 24 hours for a Priority One case assignment and within 5 calendar days for a Priority Two case assignment. Under extenuating circumstances, i.e., necessary documentary evidence is not yet available, an extension may be granted by the investigator's supervisor, pursuant to 8.370.10 of the New Mexico Administrative Code (NMAC).

REPORTS AND TRENDS

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

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

If a report of abuse or neglect of a child (person under age 18) is being made to CYFD/CPS, the call comes into the toll-free number. The SCI worker asks a series of questions (demographics of each participant) and records the issues and concerns of abuse or neglect. The SCI worker then enters the information into the FACTS system. A Structured Decision-Making Tool in the FACTS system is done on each report. This assists the worker to determine a priority status for each report ranging from an emergency (1 to 3-hour response time for face-to-face contact), P-1 (face to face contact within 24 hours), P-2 (1-5 calendar days to respond with face-to-face contact) or Screen-Out (no investigation).

• Emergency (1-3 hour response time) requires face-to-face contact; staffed with a Supervisor who has the discretion of lowering or raising the status on any report. The report is generated electronically and submitted to the Supervisor for review to insure all the information is correct and the allegations match the narrative. The Supervisor then processes and assigns the report to the county where the family resides. The report is called out telephonically and an electronic report is created in the FACTS system, accessible by the particular county.

• P-1 (face-to-face contact within 24 hours) requires face-to-face contact; staffed with a Supervisor who has the discretion of lowering or raising the status on any report. The report is generated electronically and submitted to the Supervisor for review to insure all the information is correct and the allegations match the narrative. The Supervisor then processes and assigns the report to the county where the family resides. The report is called out telephonically and an electronic report is created in the FACTS system, accessible by the particular county.

• P-2 (1-5 calendar days to respond with face-to-face) - The report IS NOT called out but is sent to the county as soon as it is processed.

• Screened-Out which requires no investigation – These reports are faxed to law enforcement and the New Mexico Regulation & Licensing Department (as needed). Hard copies are kept at CYFD SCI for 18 months and then archived.

NOTIFICATION TO THE PARTICIPANT

In each situation that critical incident investigations are completed by APS, CYFD/CPS, or HCA/DHI, the participant or the participant's guardian receives a letter stating the results of the investigation.
Regulations are found in NMSA 1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect Act). The HCA/DHI has 45 days to complete an investigation. Once completed, the investigator has ten (10) ten days to complete a report. This report is submitted to a supervisor who has three (3) days to approve the closure of the investigation. If there is no further action is needed at that time, a letter of findings is sent to the NCM, participant, and guardian.

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

The Health Care Authority (HCA) Developmental Disabilities Supports Division (DDSD) and the Division of Health Improvement (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 (QIS). As with all components of the Quality Improvement Strategy, HCA/DDSD and DHI work together to analyze aggregated data and identify trends. 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.

The Mortality Review Committee meets monthly, facilitated through the HCA/DDSD Clinical Services Bureau (CSB). If the CSB has issues/concerns they follow up with the Developmental Disabilities (DD) Waiver Unit to address any issues/concerns with the appropriate entities such as case managers.

Technical assistance for individual specific critical incident follow-ups and/or identification and remediation of health and safety challenges is available through the HCA as requested by the nurse case manager (NCM). Issues brought to the HCA/DDSD by concerned NCM will be addressed in terms of options or resources for the participant to pursue in mitigating their risks. The HCA 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 Medically Fragile Waiver recipients. HCA/DHI investigates and follows-up regarding providers and critical incidents. HCA Incident Management Bureau (IMB) has a database that allows information input. From this database, investigative reports and notifications are created. There are various reports pulled from the Intake database which allows IMB to review such information as substantiated cases, multiple allegations on a particular individual, obtain provider information, and quarterly and yearly statistics such as the total number of allegations called into the IMB hotline. The database allows IMB to determine how many reported critical incidents are assigned for investigation. IMB also uses provider information to refer to the IRC if a particular agency has repeated and egregious substantiations.

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:

HCA monitors safeguards against the use of restraints/restrictive interventions/seclusion through the Nurse Case Manager (NCM), during home visits, who inquires if there are any issues or concerns regarding service delivery. The Medically Fragile (MF) Waiver program does not authorize the use of restrictive interventions.

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

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

HCA monitors safeguards against the use of restraints/restrictive interventions/seclusion through the Nurse Case Manager (NCM), during home visits, who inquires if there are any issues or concerns regarding service delivery. The Medically Fragile (MF) Waiver program does not authorize the use of restrictive interventions.

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-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:

HCA monitors safeguards against the use of restraints/restrictive interventions/seclusion through the Nurse Case Manager (NCM), during home visits, who inquires if there are any issues or concerns regarding service delivery. The Medically Fragile (MF) Waiver program does not authorize the use of restrictive interventions.

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

○ **The use of 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)*

- **Medication Management and Follow-Up**

Do not complete this section

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

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

• **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).

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

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

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

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

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

Responsible Party for data collection/generation *(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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
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 reviewed and completed within required timeframes. Numerator: The number of critical incident reports reviewed and completed within required timeframes. Denominator: The number of critical incident reports reviewed and completed during the reporting period

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

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

		Interval =
☒ **Other** Specify: 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: DHI	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of waiver participants' critical incident reports that were initiated within

required timeframes. Numerator: The number of critical incident reports initiated within required timeframes Denominator: The total number of critical incident reports initiated during the reporting period.

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

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

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

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: 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: DHI	☒ **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):*

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

Performance Measures

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

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

Performance Measure:
Percentage of MFW participants who received a completed history and physical exams in accordance with state waiver policies. Numerator: Number of MFW participants with a completed history and physical. Denominator: Total number of MFW participants.

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

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 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 (QIS) 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. 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 Health Care Authority (HCA) has implemented a system for trending, prioritizing, and implementing system improvements through the Developmental Disabilities System Quality Improvement (DDSQI) Committee. The committee was established to drive effective management practices at the Developmental Disabilities Supports Division (DDSD) and the Division of Health Improvement (DHI) that lead to sustained improvement in the programs for individuals with intellectual and developmental disabilities (IDD) operated by the HCA. The committee is comprised of the following Health Care Authority (HCA) divisions: Developmental Disabilities Supports Division (DDSD), Medical Assistance Division (MAD), and Division of Health Improvement (DHI).

TRENDING AND PRIORITIZING

DDSQI utilizes the following measures to evaluate areas of improvement, trend and prioritize emerging issues.

1. 1915(c) Home and Community Based Services Waiver (HCBS) Performance Measures: Performance measures are specific to each of the Waiver assurances and are described in Appendices A, B, C, D, G, and I. Waiver assurance data is reported to the DDSQI where the data is 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. In addition to waiver assurances, the HCA DDSD has their own set of performance measures that are reported to the DDSQI.

2. New Mexico Legislative Finance Committee (LFC) Performance Measures: The LFC uses performance measures to evaluate how effectively state agencies are delivering services and meeting goals. These measures are part of a broader accountability framework under the Accountability in Government Act (AGA), which links funding to performance outcomes and HCA Strategic Plan Goals. LFC performance measures tracked the following measures:

- Number of home visits completed annually;
- Number of individuals deemed eligible awaiting services;
- Number of individuals receiving HCBS waiver program services 519004 Quarterly Percent of adults between ages twenty-two and sixty-two years served in a developmental disabilities;
- Percent of adults between ages twenty-two and sixty-two years served in a developmental disabilities waiver program, traditional or mi via, who receive employment support;
- Percent of HCBS waiver program applicants who have a service plan and budget within ninety days of income and clinical eligibility determination;
- Percent of general event reports in compliance with general events timely reporting requirements within the two-day rule;
- Percent of home visits that result in abuse, neglect or exploitation report;
- Percent of people receiving HCBS waiver program services who have received their annual level of care assessment

IMPLEMENTATION

The DDSQI meets every other month; but can meet more often as needed. Members are responsible to bring forth systemic emerging issues as they arise, review findings, and make recommendations for system improvement. When a system change is approved by DDSQI, the DDSQI work with waiver program staff to ensure understanding of action items, plan for completion, and review data for accuracy and completeness. Process is monitored and adjustments made based on data and feedback.

Waiver program staff collaborate to inform families and providers of changes resulting from new system designs. The method and format of communication are determined by the scope and impact of the change on participants and stakeholders. All system design changes are communicated to key stakeholders prior to implementation to ensure transparency and preparedness.
Information may be shared through:
- Formal letters
- Announcements at scheduled meetings
- Website updates
- Statewide meetings and forums

If changes to state regulations are required, the State follows all applicable rulemaking procedures in accordance

with established laws and policies.

The DDSQI also meets with the Advisory Council on Quality Supports for Individuals with Developmental Disabilities (ACQ) to discuss plans for quality improvement in the administration of the intellectual developmental disabilities (IDD) service system. The ACQ is also statutorily required to advise the HCA on policy related to the programs administered by HCA. The ACQ meets regularly and is comprised of waiver stakeholders, which can include individual participants and their families.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: DDSQI Steering Committee	☒ **Other** Specify: Quarterly with additional monitoring/analysis will be done, as necessary.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Developmental Disabilities System Quality Improvement (DDSQI) has regularly scheduled meetings to review the performance data collected. 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 DDSD program planning process.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Developmental Disabilities System Quality Improvement (DDSQI) continues to evaluate data to assess effectiveness of actions and identify further improvements during regularly scheduled meetings. DDSQI continuously reviews information from performance measures and current remediation activities to ensure sustained improvement in the programs for individuals with intellectual and developmental disabilities (IDD). The DDSQI monitors progress on action items using the Plan, Do, Study, Act (PSDA) continuous quality improvement process. Actions and results are reviewed and adjustments made as necessary based on data and feedback. In addition, the DDSQI can establish relevant quality measures to monitor and take action to improve system performance for emerging issues. These may be revised by DDSD, subject to the Division’s interest to track and analyze performance and improvement in certain areas.

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).*

To ensure the integrity of payments made for waiver services, the state employs different financial oversight activities that includes independent audit requirements for provider agencies, a comprehensive state administered financial audit program, and clearly defined agency responsibilities for conducting these reviews.

INDEPENDENT AUDIT REQUIREMENTS FOR PROVIDER AGENCIES
All providers participating in the Medically Fragile (MF) Waiver are required to obtain an annual financial statement audit. At initial enrollment and at each renewal period, providers must sign a Provider Agreement affirming that, if they receive State or Federal funds through the Health Care Authority (HCA), they will comply with all applicable auditing requirements under the Single Audit Act (31 U.S.C. § 7501 et seq.) and the New Mexico State Auditor's rules and regulations. The HCA Administrative Services Division (ASD), Financial Accounting Bureau, receives and reviews all required audits to ensure compliance.

STATE FINANCIAL AUDIT PROGREM FOR MEDICAID WAIVER PAYMENTS
The state conducts several complementary activities to ensure the accuracy and integrity of provider billings for Medicaid waiver services:

6. Explanation of Medical Benefits (EOMB) Verification: The Medicaid Management Information System (MMIS) generates monthly EOMB letters to a statistically selected percentage of participants. These letters serve as a quality control mechanism to confirm that billed services were actually received. Participant and date of service selection is random and based on claims payment dates.

7. Post Payment Reviews Conducted by the Quality Management Bureau (QMB): The HCA Division of Health Improvement (DHI), Quality Management Bureau (QMB), conduct systematic post payment reviews of DD Waiver provider billing. These reviews verify that services were delivered in accordance with state rules, regulations, and service standards.

Scope and Frequency:
o Providers receive a post payment review at least once per contract term, typically every three years, with more frequent reviews conducted when concerns arise.
o QMB develops an annual review schedule based on provider contract terms.
o For each selected provider, QMB reviews 100% of paid claims for a three month period
o Each claim is validated for correct service codes, accurate billed units, and adequate supporting documentation confirming service delivery.
Methods:
o All reviews are conducted on site by QMB.
o Providers must correct all deficiencies through the Plan of Correction (POC) process. QMB does not close a POC until all deficiencies have been fully resolved.
o QMB shares all review reports with the HCA Office of Internal Audit, which may initiate a more comprehensive financial review if warranted.
Corrective Actions:
o When billing deficiencies are identified, providers must void or adjust claims complete a POC addressing systemic issues.
o If a provider does not submit corrections during the review, they must do so upon receipt of the final report or remit any identified overpayment.
8. Additional Oversight: The HCA may refer providers to the Medicaid Fraud Control Unit (MFCU) of the State Attorney General's Office or to the Office of Inspector General (OIG) for further investigation when appropriate.
9. Independent Audits of HCA: Independent auditors conduct audits of the HCA in accordance with generally accepted auditing standards in the United States, Government Auditing Standards issued by the Comptroller General, and the Single Audit Act.
10. Electronic Visit Verification (EVV)
In compliance with the 21st Century CURES Act, the state requires providers of personal care services (PCS) and home health services to use Electronic Visit Verification. Providers must document service delivery using the state approved EVV system as a condition of payment integrity and program compliance.

AGENCIES RESPONSIBLE FOR CONDUCTING FINANCIAL AUDITS

The following agencies are responsible for financial oversight and audit activities related to waiver services:
• Quality Management Bureau (QMB), Division of Health Improvement (DHI): Conducts on site post payment reviews, issues POC and ensures remediation of deficiencies.

- *HCA Administrative Services Division (ASD), Financial Accounting Bureau: Receives and reviews provider independent audits.*
- *HCA Office of Internal Audit: Reviews QMB findings and may initiate expanded financial audits.*
- *Medicaid Fraud Control Unit (MFCU) and Office of Inspector General (OIG): Receive referrals for suspected fraud, waste, or abuse.*

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

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

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

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

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

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

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

☒ ***Other*** *Specify:* *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, MMIS*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

Data Source *(Select one):*

Other
If 'Other' is selected, specify:
Fiscal Intermediary Reports

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

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

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

Data Source *(Select one):*
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:*

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

Performance Measures

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

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

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

consistent with the rate methodology. Denominator: Total number of rates.

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

Remediation and improvement strategies vary, based on the findings. When problems and areas for improvement are identified by the State related to financial accountability, processes as outlined in section I-1 are in place to ensure that appropriate and timely action is taken. In addition, the Developmental Disabilities Supports Division (DDSD) Developmental Disabilities Supports Quality Improvement (DDSQI) committee routinely collects, analyzes, and trends financial data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☐ ***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 Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Developmental Disabilities Supports Division (DDSD) is the state agency that is responsible for rate setting and engages vendors to conduct rate rebasing activities and related data collection. HCA can increase rates based on Legislative appropriation In 2023, state law required DDSD, to conduct biennial rate studies for the purpose of recommending reimbursement rates for service providers. Rate increases are implemented through waiver amendments when the necessary funding is received through legislative appropriation. Generated rates are reflected on DDSD-approved rate sheets found at the HCA website: https://www.hca.nm.gov/providers/fee-schedules

Most waiver services are reimbursed on a prospective, fee-for-service basis, with exceptions for items or services that are reimbursed based on cost.

In July 2025, DDSD, contracted with Health Management Associates (HMA) to perform a study to recommend reimbursement rates for individuals with intellectual and developmental disabilities receiving services throughout the three 1915(c) Medicaid home- and community- based services (HCBS) waiver programs. This included the Medically Fragile (MF) Waiver. All services and reimbursement were reviewed.

Rate model specific assumptions:

- New Mexico wage data published by the Bureau of Labor Statistics (BLS) was used as the starting point for establishing market-based wage assumptions
- BLS wage data inflated to January 2027
- A wage floor was established to account for local minimum wages
- For each service, BLS occupations were chosen to represent staff qualifications
- Direct Support Professional (DSP) wages were based on a composite of standard occupational classifications (SOCs)
- Payroll, fringe benefits and productivity were taken into account
- When combined with administration, the rate models included an average of nearly 28 percent for overhead costs not including Gross Receipts Tax

Rate increases are implemented via waiver amendments. DDSD follows the process of Tribal Notification and public comment to inform the public of rate determinations and seek public input through a variety of means including mailings, emails, newspaper announcements, web postings, and public hearings.

ACCESS RULE INTEGRATION
To comply with the federal Access Rule at 42 CFR §447.203, the state incorporates access to care considerations into all rate setting and rate review activities. The DDSD evaluates whether reimbursement rates support adequate provider participation and beneficiary access to waiver services. The biennial rate studies required under state law serve as a primary mechanism for assessing whether rates reflect the reasonable and necessary costs of delivering services, including direct support professional wages, staffing requirements, administrative overhead, and regional labor market conditions.

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 Medicaid Management Information System (MMIS) 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 HCA 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 Medicaid Management Information System (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 the Health Care Authority (HCA) Medical Assistance Division (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 HCA/MAD. Retrospective audits include verification that the services were provided as billed. Additionally, HCA Division of Health Improvement (DHI) verifies that the services were provided as billed during case manager and provider on-site compliance monitoring reviews.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The limited fiscal agent supports ordering and payment for specialized medical equipment, massage therapy and individual goods and services. The Health Care Authority (HCA) contracts with an entity outside of Case Management to serve as a limited fiscal agent. Case Managers (CM) do not act as limited fiscal agents.

Participants select services and qualified providers during the Individual Service Plan (ISP) planning. Case managers assist with the collection of required documents. The items and services are approved through the budget process and reviewed per waiver service standards within the case management review. Families notify the case manager if items regarding the receipt of items. The fiscal agent orders and files a claim to the Medicaid Management Information System (MMIS).

Specialized Medical Equipment (SME) claims are periodically reviewed as to items ordered and expenditures. The limited fiscal agent submits reports with HCA. Issues identified by case management are included in the quarterly QIC meeting.

The fiscal agent follows The Medically Fragile Waiver Fee Schedule posted on the HCA website and is subject to billing requirements as stated in NMAC 8.314.3.11.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 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 text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 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 section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching

arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

Check each that applies:

- [ ] ***Health care-related taxes or fees***
- [ ] ***Provider-related donations***
- [ ] ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

- (●) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ( ) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

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

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

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	12110.83	18346.90	30457.73	142820.82	5321.37	148142.19	117684.46
2		18934.00	18934.00	147391.09	5491.65	152882.74	133948.74
3	11773.78	19539.88	31313.66	152107.60	5667.38	157774.98	126461.32
4		20165.16	20165.16	156975.05	5848.74	162823.79	142658.63
5	11607.16	20810.45	32417.61	161988.25	6035.90	168024.15	135606.54

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	350	350
Year 2	350	350

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 3	*350*	*350*
Year 4	*350*	*350*
Year 5	*350*	*350*

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 276 days, the level derived from utilization data in FFY 2024. 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, with the exception of number users, and the basis for the state's cost estimate is based on actual expenditures for waiver services provided to Medically Fragile (MF) Waiver participants who were in the waiver State Fiscal Year (SFY) 2024.

NUMBER OF USERS
The number of users, Factor C, for WY1-5, or the unduplicated receipt counts, were set using assumptions about rising waiver demand and declining attrition resulting from improved participant health.

NUMBER OF USERS PER SERVICE
The number of users per service was estimated by using the percentage of users per each service in SFY2024 and applying the percentage to the UDR by service through WY 1-5. For new services: Acupuncture, Biofeedback, Chiropractic, Cognitive Rehabilitation Therapy, Hippotherapy, Naprapathy, and Play Therapy, the estimates assume a minimum of one user per service. Utilization data will be reviewed regularly, and the projected user counts will be adjusted if needed.

NUMBER OF UNITS
Average units per users were derived from utilization data in SFY2024 and held constant through WY 1-5. For new services: Acupuncture, Biofeedback, Chiropractic, Cognitive Rehabilitation Therapy, Hippotherapy, Naprapathy, and Play Therapy, the estimates assume a minimum of one user per service. Utilization data will be reviewed regularly, and the projected user counts will be adjusted if needed.

AVERAGE COST PER UNIT
Average cost per unit is the actual rate paid to providers as noted in the Medically Fragile Fee Schedule and held constant through W1-5.

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 State Fiscal Year (SFY) 2024. Factor D' is projected to increase at the Center for Medicare and Medicaid (CMS) 2026 four quarter average market basket index (MBI) rate of 3.2%.

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 State Fiscal Year (SFY) 2024 and is projected to increase at the Center for Medicare and Medicaid (CMS) 2026 four quarter average market basket index (MBI) rate of 3.2%.

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 State Fiscal Year (SFY) 2024 and is projected to increase at the Center for Medicare and Medicaid (CMS) 2026 four quarter average market basket index (MBI) rate of 3.2%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Case Management	
Customized Community Group Supports	
Home Health Aide	
Respite	
Nutritional Counseling	
Skilled Therapy for Adults	
Behavior Support Consultation	
Environmental Modifications	
Individual Directed Goods and Services	
Private Duty Nursing	
Specialized Medical Equipment and Supplies	
Specialized Therapies	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg.*

Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**2204400.00**
Case Management	month	330	10.00	668.00	**2204400.00**	
Customized Community Group Supports Total:						**0.06**
Customized Community Group Supports	15 minutes	1	0.01	5.93	**0.06**	
Home Health Aide Total:						**497662.98**
Home Health Aide	hour	13	846.38	45.23	**497662.98**	
Respite Total:						**1012439.31**
Respite, HHA	hour	62	102.12	45.23	**286371.03**	
Respite, RN	15 minutes	45	282.42	29.76	**378216.86**	
Respite, Facility	daily	1	0.01	492.90	**4.93**	
Respite, LPN	15 minutes	21	556.59	29.76	**347846.49**	
Nutritional Counseling Total:						**8240.10**
Nutritional Counseling	hour	45	2.06	88.89	**8240.10**	
Skilled Therapy for Adults Total:						**3.98**
Speech Therapy	15 minutes	1	0.01	48.93	**0.49**	
Physical Therapy	15 minutes	1	0.01	49.66	**0.50**	
Occcupational Therapy	15 minutes	6	0.01	40.83	**2.45**	
Physical Therapy Assistant	15 minutes	1	0.01	27.80	**0.28**	
Occupational Therapy Assistant	15 minutes	1	0.01	27.05	**0.27**	
Behavior Support Consultation Total:						**30515.64**
Behavior Support Consultation	15 minutes	21	56.63	25.66	**30515.64**	

GRAND TOTAL: ***4238790.47***

Total Estimated Unduplicated Participants: ***350***

Factor D (Divide total by number of participants): ***12110.83***

Average Length of Stay on the Waiver: 276

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications Total:						**65000.00**
Environmental Modifications	item	13	1.00	5000.00	**65000.00**	
Individual Directed Goods and Services Total:						**1200.00**
Individual Directed Goods and Services	each	1	1.00	1200.00	**1200.00**	
Private Duty Nursing Total:						**213959.65**
Private Duty Nursing, RN	15 minutes	5	1052.34	29.76	**156588.19**	
Private Duty Nursing, LPN	15 minutes	2	1440.77	19.91	**57371.46**	
Specialized Medical Equipment and Supplies Total:						**199815.28**
Specialized Medical Equipment and Supplies	item	238	839.56	1.00	**199815.28**	
Specialized Therapies Total:						**553.46**
Massage Therapy	session	1	1.00	105.32	**105.32**	
Play Therapy	15 minutes	1	1.00	26.33	**26.33**	
Biofeedback	session	1	1.00	105.32	**105.32**	
Chiropractic	visit	1	1.00	105.32	**105.32**	
Hippotherapy	session	1	1.00	105.32	**105.32**	
Acupuncture	15 minutes	1	0.01	26.33	**0.26**	
Cognitive Rehabilitation Therapy	15 minutes	1	0.01	26.33	**0.26**	
Naprapathy	visit	1	1.00	105.32	**105.32**	
Vehicle Modifications Total:						**5000.00**
Vehicle Modifications	item	1	1.00	5000.00	**5000.00**	

GRAND TOTAL: 4238790.47

Total Estimated Unduplicated Participants: 350

Factor D (Divide total by number of participants): 12110.83

Average Length of Stay on the Waiver: 276

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:						***2204400.00***
Case Management	*month*	*330*	*10.00*	*668.00*	***2204400.00***	
Customized Community Group Supports Total:						***0.06***
Customized Community Group Supports	*15 minutes*	*1*	*0.01*	*5.93*	***0.06***	
Home Health Aide Total:						***497662.98***
Home Health Aide	*hour*	*13*	*846.38*	*45.23*	***497662.98***	
Respite Total:						***897425.55***
Respite, HHA	*Hour*	*62*	*102.12*	*45.23*	***286371.03***	
Respite, RN	*15 minutes*	*45*	*282.42*	*29.76*	***378216.86***	
Respite, Facility	*daily*	*1*	*0.01*	*492.90*	***4.93***	
Respite, LPN	*15 minutes*	*21*	*556.59*	*19.92*	***232832.73***	
Nutritional Counseling Total:						***8240.10***
Nutritional Counseling	*hour*	*45*	*2.06*	*88.89*	***8240.10***	
Skilled Therapy for Adults Total:						
Speech Therapy	*15 minutes*	*1*	*0.01*	*48.93*	***0.49***	
Physical Therapy	*15 minutes*	*1*	*0.01*	*49.66*	***0.50***	
Occcupational Therapy	*15 minutes*	*6*	*0.01*	*40.83*	***2.45***	
Physical Therapy Assistant	*15 minutes*	*1*	*0.01*	*27.80*	***0.28***	
Occupational Therapy Assistant	*15 minutes*			*27.05*		
Behavior Support Consultation Total:						***30515.64***
Behavior Support Consultation	*15 minutes*				***30515.64***	

GRAND TOTAL:

Total Estimated Unduplicated Participants: *350*

Factor D (Divide total by number of participants):

Average Length of Stay on the Waiver: *276*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		21	56.63	25.66		
Environmental Modifications Total:						**5000.00**
Environmental Modifications	item	1	1.00	5000.00	**5000.00**	
Individual Directed Goods and Services Total:						**1200.00**
Individual Directed Goods and Services	each	1	1.00	1200.00	**1200.00**	
Private Duty Nursing Total:						**213988.47**
Private Duty Nursing, RN	15 minutes	5	1052.34	29.76	**156588.19**	
Private Duty Nursing, LPN	15 minutes	2	1440.77	19.92	**57400.28**	
Specialized Medical Equipment and Supplies Total:						**199815.28**
Specialized Medical Equipment and Supplies	item	238	839.56	1.00	**199815.28**	
Specialized Therapies Total:						**527.39**
Massage Therapy	session	1	1.00	105.32	**105.32**	
Play Therapy	15 minutes	1	0.01	26.33	**0.26**	
Biofeedback	session	1	1.00	105.32	**105.32**	
Chiropractic	visit	1	1.00	105.32	**105.32**	
Hippotherapy	session	1	1.00	105.32	**105.32**	
Acupuncture	15 minutes	1	0.01	26.33	**0.26**	
Cognitive Rehabilitation Therapy	15 minutes	1	0.01	26.33	**0.26**	
Naprapathy	visit	1	1.00	105.32	**105.32**	
Vehicle Modifications Total:						**5000.00**
Vehicle Modifications	item	1	1.00	5000.00	**5000.00**	

GRAND TOTAL:

Total Estimated Unduplicated Participants: 350

Factor D (Divide total by number of participants):

Average Length of Stay on the Waiver: 276

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:						***2204499.00***
Case Management	*month*	*330*	*10.00*	*668.03*	***2204499.00***	
Customized Community Group Supports Total:						***0.06***
Customized Community Group Supports	*15 minutes*	*1*	*0.01*	*5.93*	***0.06***	
Home Health Aide Total:						***497662.98***
Home Health Aide	*hour*	*13*	*846.38*	*45.23*	***497662.98***	
Respite Total:						***898680.51***
Respite, HHA	*hour*	*62*	*102.12*	*45.23*	***286371.03***	
Respite, RN	*15 minutes*	*45*	*282.42*	*29.76*	***378216.86***	
Respite, Facility	*daily*	*1*	*0.01*	*492.90*	***4.93***	
Respite, LPN	*15 minutes*	*21*	*559.59*	*19.92*	***234087.69***	
Nutritional Counseling Total:						***5127.18***
Nutritional Counseling	*hour*	*28*	*2.06*	*88.89*	***5127.18***	
Skilled Therapy for Adults Total:						***3.98***
Speech Therapy	*15 minutes*	*1*	*0.01*	*48.93*	***0.49***	
Physical Therapy	*15 minutes*	*1*	*0.01*	*49.33*	***0.49***	
Occcupational Therapy	*15 minutes*	*6*	*0.01*	*40.83*	***2.45***	
Physical Therapy Assistant	*15 minutes*	*1*	*0.01*	*27.80*	***0.28***	
Occupational Therapy Assistant	*15 minutes*	*1*	*0.01*	*27.05*	***0.27***	
Behavior Support Consultation Total:						***30515.64***

GRAND TOTAL: 4120821.49

Total Estimated Unduplicated Participants: 350

Factor D (Divide total by number of participants): 11773.78

Average Length of Stay on the Waiver: *276*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavior Support Consultation	15 minutes	21	56.63	25.66	30515.64	
Environmental Modifications Total:						65000.00
Environmental Modifications	item	13	1.00	5000.00	65000.00	
Individual Directed Goods and Services Total:						1.00
Individual Directed Goods and Services	each	1	1.00	1.00	1.00	
Private Duty Nursing Total:						213988.47
Private Duty Nursing, RN	15 minutes	5	1052.34	29.76	156588.19	
Private Duty Nursing, LPN	15 minutes	2	1440.77	19.92	57400.28	
Specialized Medical Equipment and Supplies Total:						199815.28
Specialized Medical Equipment and Supplies	item	238	839.56	1.00	199815.28	
Specialized Therapies Total:						527.39
Massage Therapy	session	1	1.00	105.32	105.32	
Play Therapy	15 minutes	1	0.01	26.33	0.26	
Biofeedback	session	1	1.00	105.32	105.32	
Chiropractic	visit	1	1.00	105.32	105.32	
Hippotherapy	session	1	1.00	105.32	105.32	
Acupuncture	15 minutes	1	0.01	26.33	0.26	
Cognitive Rehabilitation Therapy	15 minutes	1	0.01	26.33	0.26	
Naprapathy	visit	1	1.00	105.32	105.32	
Vehicle Modifications Total:						5000.00
Vehicle Modifications	item	1	1.00	5000.00	5000.00	

GRAND TOTAL: 4120821.49

Total Estimated Unduplicated Participants: 350

Factor D (Divide total by number of participants): 11773.78

Average Length of Stay on the Waiver: 276

Appendix J: Cost Neutrality Demonstration

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:						***2204499.00***
Case Management	*month*	*330*	*10.00*	*668.03*	***2204499.00***	
Customized Community Group Supports Total:						***0.06***
Customized Community Group Supports	*15 minutes*	*1*	*0.01*	*5.93*	***0.06***	
Home Health Aide Total:						***497662.98***
Home Health Aide	*hour*	*13*	*846.38*	*45.23*	***497662.98***	
Respite Total:						***899168.48***
Respite, HHA	*hour*	*62*	*102.12*	*45.23*	***286371.03***	
Respite, RN	*15 minutes*	*45*	*282.42*	*29.76*	***378216.86***	
Respite, Facility	*daily*	*1*	*1.00*	*492.90*	***492.90***	
Respite, LPN	*15 minutes*	*21*	*559.59*	*19.92*	***234087.69***	
Nutritional Counseling Total:						***2929.81***
Nutritional Counseling	*hour*	*16*	*2.06*	*88.89*	***2929.81***	
Skilled Therapy for Adults Total:						***3.98***
Speech Therapy	*15 minutes*	*1*	*0.01*	*48.93*	***0.49***	
Physical Therapy	*15 minutes*	*1*	*0.01*	*49.66*	***0.50***	
Occcupational Therapy	*15 minutes*	*6*	*0.01*	*40.83*	***2.45***	
Physical Therapy Assistant	*15 minutes*	*1*	*0.01*	*27.80*	***0.28***	
Occupational Therapy Assistant	*15 minutes*		*0.01*	*27.05*	***0.27***	

GRAND TOTAL:

Total Estimated Unduplicated Participants: 350

Factor D (Divide total by number of participants):

Average Length of Stay on the Waiver: *276*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1				
Behavior Support Consultation Total:						**30515.64**
Behavior Support Consultation	15 minutes	21	56.63	25.66	**30515.64**	
Environmental Modifications Total:						**5000.00**
Environmental Modifications	Item	1	1.00	5000.00	**5000.00**	
Individual Directed Goods and Services Total:						**1200.00**
Individual Directed Goods and Services	each	1	1.00	1200.00	**1200.00**	
Private Duty Nursing Total:						**213988.47**
Private Duty Nursing, RN	15 minutes	5	1052.34	29.76	**156588.19**	
Private Duty Nursing, LPN	15 minutes	2	1440.77	19.92	**57400.28**	
Specialized Medical Equipment and Supplies Total:						**199815.28**
Specialized Medical Equipment and Supplies	item	238	839.56	1.00	**199815.28**	
Specialized Therapies Total:						
Massage Therapy	session	1	1.00	105.32	**105.32**	
Play Therapy	15 minutes	1	0.01	26.33	**0.26**	
Biofeedback	session	1	1.00	105.32	**105.32**	
Chiropractic	visit	1	1.00	105.32	**105.32**	
Hippotherapy	session	1	1.00	105.32	**105.32**	
Acupuncture	15 minutes	1	0.01	26.33	**0.26**	
Cognitive Rehabilitation Therapy	15 minutes	1	0.01	26.33	**0.26**	
Naprapathy	visit					
Vehicle Modifications Total:						**5000.00**
Vehicle Modifications	item	1	1.00	5000.00	**5000.00**	

GRAND TOTAL:

Total Estimated Unduplicated Participants: 350

Factor D (Divide total by number of participants):

Average Length of Stay on the Waiver: 276

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:						***2204499.00***
Case Management	*month*	*330*	*10.00*	*668.03*	***2204499.00***	
Customized Community Group Supports Total:						***0.06***
Customized Community Group Supports	*15 minutes*	*1*	*0.01*	*5.93*	***0.06***	
Home Health Aide Total:						***497662.98***
Home Health Aide	*hour*	*13*	*846.38*	*45.23*	***497662.98***	
Respite Total:						***899168.48***
Respite, HHA	*hour*	*62*	*102.12*	*45.23*	***286371.03***	
Respite, RN	*15 minutes*	*45*	*282.42*	*29.76*	***378216.86***	
Respite, Facility	*daily*	*1*	*1.00*	*492.90*	***492.90***	
Respite, LPN	*15 minutes*	*21*	*559.59*	*19.92*	***234087.69***	
Nutritional Counseling Total:						***5127.18***
Nutritional Counseling	*hour*	*28*	*2.06*	*88.89*	***5127.18***	
Skilled Therapy for Adults Total:						***3.98***
Speech Therapy	*15 minutes*	*1*	*0.01*	*48.93*	***0.49***	
Physical Therapy	*15 minutes*	*1*	*0.01*	*49.66*	***0.50***	
Occcupational Therapy	*15 minutes*	*6*	*0.01*	*40.83*	***2.45***	
Physical Therapy Assistant	*15 minutes*	*1*	*0.01*	*27.80*	***0.28***	

GRAND TOTAL: 4062506.47

Total Estimated Unduplicated Participants: 350

Factor D (Divide total by number of participants): 11607.16

Average Length of Stay on the Waiver: *276*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy Assistant	15 minutes	1	0.01	27.05	0.27	
Behavior Support Consultation Total:						30515.64
Behavior Support Consultation	15 minutes	21	56.63	25.66	30515.64	
Environmental Modifications Total:						5000.00
Environmental Modifications	item	1	1.00	5000.00	5000.00	
Individual Directed Goods and Services Total:						1200.00
Individual Directed Goods and Services	each	1	1.00	1200.00	1200.00	
Private Duty Nursing Total:						213986.48
Private Duty Nursing, RN	15 minutes	5	1052.34	29.76	156588.19	
Private Duty Nursing, LPN	15 minutes	2	1440.72	19.92	57398.28	
Specialized Medical Equipment and Supplies Total:						199815.28
Specialized Medical Equipment and Supplies	item	238	839.56	1.00	199815.28	
Specialized Therapies Total:						527.39
Massage Therapy	session	1	1.00	105.32	105.32	
Play Therapy	15 minutes	1	0.01	26.33	0.26	
Biofeedback	session	1	1.00	105.32	105.32	
Chiropractic	visit	1	1.00	105.32	105.32	
Hippotherapy	session	1	1.00	105.32	105.32	
Acupuncture	15 minutes	1	0.01	26.33	0.26	
Cognitive Rehabilitation Therapy	15 minutes	1	0.01	26.33	0.26	
Naprapathy	visit	1	1.00	105.32	105.32	
Vehicle Modifications Total:						5000.00
Vehicle Modifications					5000.00	

GRAND TOTAL: 4062506.47

Total Estimated Unduplicated Participants: 350

Factor D (Divide total by number of participants): 11607.16

Average Length of Stay on the Waiver: 276

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	item	1	1.00	5000.00		

GRAND TOTAL: 4062506.47

Total Estimated Unduplicated Participants: 350

Factor D (Divide total by number of participants): 11607.16

Average Length of Stay on the Waiver: 276