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

1. Request Information

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

B. Program Title:
Mi Via - ICF/IDD Waiver

C. Waiver Number:NM.0448
Original Base Waiver Number: NM.0448.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
01/01/27
Approved Effective Date of Waiver being Amended: 10/01/25

2. Purpose(s) of Amendment

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

The purpose of the amendment is to implement the following services in the Mi Via Waiver:

1. Addition of Support Broker Services as a service. Supports Broker Services are being added to ensure that Mi Via participants who do not have a guardian, family member, or other natural support available to assist with employer-related functions have access to the support necessary to successfully direct and maintain their waiver services. (Appendix C1/3, E1, E2, I-2, J2)
2. The term "Employer of Record" was updated to "Supports Broker (voluntary or paid service)" to more accurately reflect the role of the individual assisting the participant with employer-related functions and align with the new Support Broker Services. (Appendix C 1/3, E1, E2, I-2, J2)

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A - Waiver Administration and Operation	
☐ Appendix B - Participant Access and Eligibility	
☑ Appendix C - Participant Services	C1/C3
☐ Appendix D - Participant Centered Service Planning and Delivery	
☑ Appendix E - Participant Direction of Services	E1. E1-e, E2-b-v
☐ Appendix F - Participant Rights	
☐ Appendix G - Participant Safeguards	
☐ Appendix H	
☑ Appendix I - Financial Accountability	I2-a
☑ Appendix J - Cost-Neutrality Demonstration	J2-b,d

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☑ **Add/delete services**

☑ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

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*):

Mi Via - ICF/IDD Waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NM.0448
Draft ID: NM.015.04.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/25
Approved Effective Date of Waiver being Amended: 10/01/25

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.

New Mexico's program called Mi Via, which means my path, my way, or my road, is the State's Medicaid Self-Directed Home and Community-Based Services (HCBS) Waiver program. The goal of Mi Via is to provide a community-based alternative to institutional care that facilitates greater participant choice, direction and control over services and supports. When participants are minor children or have a legal guardian, the term participants also include parents or other legally authorized decision-maker.

The program is operated and administered by the New Mexico (NM) Health Care Authority (HCA), Developmental Disabilities Supports Division (DDSD).

Mi Via is the result of the efforts of many individuals and groups statewide, starting in 2000, to realize inclusion of self-direction as an option in New Mexico's HCBS Waivers. The Health Care Authority is invested in maintaining the spirit and structure of self- direction by carrying on the program name and concepts of Mi Via even though individuals formerly served by Mi Via are now accessing self-directed program options in Turquoise Care. Mi Via's Guiding Principles state that all participants have value and potential; shall be viewed in terms of their abilities; have the right to participate and be fully included in their communities; and have the right to live, work, learn, and receive all services and supports, appropriate to their individual needs, in the most integrated settings within their communities.

Participants' easy access to information about Mi Via is critical for a successful program. Participants are offered information, tools, training and support, in order to make informed choices and to plan, direct and manage their services and supports. The HCA/DDSD regional offices throughout the state appoint a Mi Via liaison to provide information, promote access to the program and resolve participant issues at a local level.

Mi Via recognizes the essential role of participants in planning and purchasing services and supports. Consultant agencies provide required consultant and support guide services. Consultants, who are well-versed in the philosophy and practice of self-direction, assist participants in understanding Mi Via and in developing and implementing the Service and Support Plan. Mi Via's covered services include those necessary for participants to live at home and in the community as independently as possible. The array of Mi Via services and supports are structured around key life areas: living supports, community membership and health and wellness to allow participants to design their services and supports in a flexible and individualized fashion. Participants utilize qualified employees, traditional waiver service providers, and/or generic resources of their choice. Other participant-delegated supports are also available to enhance outcomes in those key areas and to provide for development of a comprehensive person-centered plan.

The State determines the individual participant's allocated budgetary amount and the state's contractor authorizes the plan and budget. HCA contracts with a Financial Management Agent (FMA), which is well-versed in the philosophy and practice of self-direction. Based on the authorized budget, the FMA sets up individual participant accounts, makes expenditures that follow the approved budget, handles all payroll functions on behalf of participants who hire service providers and other support personnel, provides participants with a monthly report of expenditures and budget status, and provides the State with a quarterly and annual documentation of expenditures. The State contracts with a Third-Party Assessor (TPA) to conduct level of care determinations and utilization review of individual participants' plan and budget.

Quality improvement mechanisms are implemented that reflect the shared roles of the participant, State, consultant agencies, FMA, and TPA, but ultimately the State is accountable for assuring that participants' functional needs are satisfied, approved funds are used appropriately, and the quality of the Mi Via program is continually improving.

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 secured public input during the development of the waiver renewal. Input was solicited via: vendor forums, state-wide informational meetings, mailings, emails, newspaper announcements, web postings, and public hearings. Input was sought from a wide range of stakeholders representing active waiver recipients, families, persons on the Waiting List who are individuals that could be served in the future, advisory and advocacy groups, providers, Tribal leadership, Indian health clinics, university clinics, and hospitals. Individuals were invited to submit comments via postal mail, email, fax, phone, or in person at public hearings.

Vendor forums were held in April through June of 2024. All direct service vendor agencies currently providing services for Mi Via participants were invited to attend the sessions. During the first session in April vendors were asked to identify areas in the waiver for change and improvement related to the waiver renewal. This information was collated and in the second session, held in June, vendors provided recommendations for improvement in the identified areas which included: communication between stakeholders, training opportunities, and revisions to service definitions.

In June through August of 2024 the Health Care Authority, Developmental Disabilities Supports Division (DDSD) with assistance from the Health Care Authority Medical Assistance Division (MAD) conducted seven (7) statewide meetings in key areas throughout the state involving individuals with disabilities, their families, advocates, service providers, and others, to consider what was working in Mi Via, what needed improvement, and to gather input on changes suggested by the Departments for the renewal. Meetings were held in Albuquerque, Santa Fe, Las Cruces, Farmington, and Roswell. Two of the seven meetings were held virtually and open to individuals throughout the state that were unable to join in person. Tribal, Indian Health Service and Urban Indian health programs were invited separately and apprised of the schedule for these public meetings and the proposed changes. DDSD Regional Office Mi Via Liaisons were apprised of the proposed changes to ensure they would also be able to answer questions from the public. Information was also shared with the Mi Via Advisory Committee (MVAC) as well as Mi Via Consultant Agency representatives to solicit input. In addition, the renewal and public meetings were announced at the quarterly MVAC meetings and Mi Via Operations meetings which includes representatives from the Health Care Authority, consultants, Third Party Assessor, and Fiscal Management Agent. The proposed changes to the waiver also include the input received by DDSD and MAD through the MVAC and the Health Care Authority Advisory Council on Quality (ACQ).

Interested parties are identified as the following:
1. Current Mi Via Recipients
2. Individuals on the Central Registry individuals that potentially will access services (300 parties)
3. Mi Via consultants
4. Members of the Mi Via Advisory Committee
5. Members of the Advisory Council on Quality
6. Tribal Leadership, IHS and Tribal health clinics
7. Hospitals, universities, and advocacy groups

Tribes and the public were asked to send comments via email, mail, and voicemail.

AMENDMENT NM.0448.R04.01 (NM.015.04.01)
On July 27, 2026, HSD sent out public notice to inform tribal leaders and tribal healthcare providers, through letters, email, and an HSD website posting of changes to the waiver amendment. A contact name, number and email were provided on the notice for tribal members who had questions or needed more information. The HCA invited the tribes to send comments by close of business on September 25, 2026.

On August 26, 2026, a notice will be sent to all interested parties summarizing the proposed changes to the waiver amendment and notification of the public hearing. Notices were sent via email, mail and HSD website posting. The notice provided the web link to the full waiver application website posting on the HSD webpage. A contact name, number and email were provided on public notice for individuals to provide comment or request additional information. Notices for Public Comment were published in the Las Cruces Sun and the statewide Albuquerque Journal on August 26, 2026. Interested parties were asked to send comments via email, mail, and voicemail by September 25, 2026.

Interested parties are identified as the following:
1. Current Mi Via Recipients
2. Individuals on the Central Registry individuals that potentially will access services (300 parties)
3. Mi Via consultants
4. Members of the Mi Via Advisory Committee

5. Members of the Advisory Council on Quality
6. Tribal Leadership, IHS and Tribal health clinics
7. Hospitals, universities, and advocacy groups

A public hearing will be held on September 25, 2026 in Santa Fe, New Mexico. Interested participants were able to join in person, by phone, or virtually.

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: Rodriguez

First Name: Jennifer

Title: Director

Agency: Developmental Disabilities Supports Division, Health Care Authority

Address: 1190 S. St. Francis Drive

Address 2:

City: Santa Fe

State: **New Mexico**

Zip: 87505

Phone: (505) 670-2407 **Ext:** ☐ **TTY**

Fax: (505) 476-8992

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **New Mexico**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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.

Health Care Authority/Developmental Disabilities Supports Division (HCA/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:

HCA participates and assists in the following operational and administrative functions: participant waiver enrollment; waiver enrollment and expenditures managed against approved limits and levels; qualified provider enrollment of consultants; execution of Medicaid provider agreements for consultants; establishment of a statewide rate methodology; rules, policies, procedures and information development governing the waiver program; and quality assurance and quality improvement activities. HCA also works with stakeholders to obtain input and to assist the State with the on-going evaluation of the waiver program through the Advisory Committee on Quality (ACQ). The ACQ is a statutorily required committee that advises HCA on policy related to programs and supports that assist people with Intellectual/Developmental Disabilities (IDD). The Mi Via Advisory Committee (MVAC)is a standing committee of the ACQ and is charged with reviewing quality issues specific to Mi Via. The MVAC reports on these topics to the ACQ.

In addition, HCA monitors program quality and compliance with program requirements, through participation on the Developmental Disabilities Services Quality Improvement Steering Committee (DDSQI), as described in Appendix H of this application. HCA participates as a member of the HCA/DDSQI Steering Committee.

- The DDSQI Steering Committee as described in Appendix H of this application follows a quality improvement strategy (QIS) which addresses compliance with waiver assurances among other quality improvement strategies and key performance indicators designed to help the waiver service system achieve better outcomes for consumers, their communities, and the New Mexico public at large.

- Ad hoc and regular waiver specific and cross-agency workgroups related to the 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.

- HCA monitors the operating agency's HCA actions on a quarterly basis via a desk audit of Health Care Authority/Developmental Disabilities Service Division (HCA/DDSD)1915c Waivers Administration and Operations deliverables.

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 State utilizes two contracted entities: 1) Third-Party Assessor (TPA) and the Financial Management Agency (FMA).

TPA Contractor: The role of the TPA is to conduct the level of care evaluation (LOC), review participant service plans and budgets, and approve prior authorization of waiver services. The HCA oversees the TPA to assure compliance with all policies and regulations. The Medical Assistance Division makes the final decision for level of care through the review and recommendations of the contracted TPA. 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.

FMA Contractor: The primary role of the FMA is support to the participant regarding employer-related functions for Mi Via participants. This includes: processing employer forms and background checks, processing payment for providers, providing the interface for employees to enter timesheets, and providing the interface for participants to monitor and approve payments to providers for services rendered and monitor their service plan and budget.

○ **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:

HCA contracts with the TPA and FMA Contractor and assesses this contractor's performance in conducting its respective waiver operational and administrative functions based on the contract.

HCA uses monthly TPA reports to ensure the Contractor is compliant with the terms of the contract for the performance and operation of level of care and SSP/budget reviews, and specific monthly audits to monitor level of care performance and functions as outlined in Appendix A-7. The Contractor is also required to attend monthly meetings with HCA TPA contract manager whereby any waiver-related contract compliance issues may be identified and monitored to 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. In addition, HCA utilizes customer service and complaint data, Fair Hearings data, input from the quarterly consultant meetings, and the ACQ and MVAC meetings to assess the Contractor's performance.

HCA uses weekly and monthly FMA reports to assess compliance with the terms of the contract and functions as outlined in Appendix A-7. HCA performs on-going monitoring of the FMA Contractor's claim's payment accuracy and adherence to the terms of the provider agreement and performs web-based and on-site reviews of the claims history, as needed.

Performance assessments of contracted entities are conducted by the HCA.

If any problems are identified, HCA may require a state-directed corrective action plan from the Contactors and monitors its implementation. The Contractors may also impose its own internal corrective action plan, or performance improvement plan, prior to a state-directed Corrective Action Plan (CAP) being placed.

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:

TPA Contractor:

The TPA is responsible for the following waiver operational and administrative functions: level of care evaluation (LOC); review of participant service plans; prior authorization of waiver services; and utilization management, quality assurance and quality improvement activities.

HCA uses monthly TPA reports to ensure the Contractor is compliant with the terms of the contract for the performance and operation of level of care and SSP/budget reviews, and specific monthly audits to monitor level of care performance. The Contractor is also required to attend monthly meetings with HCA TPA contract manager whereby any waiver-related contract compliance issues may be identified and monitored to 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. In addition, HCA utilizes customer service and complaint data, Fair Hearings data, input from the quarterly Mi Via Consultant Meetings, the ACQ, and MVAC meetings to assess the Contractor's performance.

If any problems are identified, HCA may require a state-directed corrective action plan (CAP) from the TPA and monitor its implementation. The TPA may also impose its own internal corrective action plan, or performance improvement plan, prior to a state-directed CAP being placed.

FMA:

The FMA is responsible for the following waiver operational and administrative functions: qualified provider enrollment and background checks; execution of provider agreements; complete payroll functions on behalf of the participant; and process and pay invoices for good and services.
HCA uses weekly and monthly FMA reports to assess compliance with the terms of the contract, processing of payments to providers; and quality assurance and quality improvement activities.

HCA performs on-going monitoring of the FMA Contractor's claims payment accuracy and adherence to the terms of the provider agreement and performs web-based and on-site reviews of the claims history, as needed.

HCA provides HCA with any data, complaints or other information HCA has obtained from any source regarding the FMA's performance.

HCA, reviews oversight findings and implements program improvements or Corrective Action Plans if needed.

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	☑	☑
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 MV waiver data reports specified in the TPA contract with the Medicaid Agency agency that were submitted on time and in the correct format. Numerator: Number of data reports submitted on time and in correct format. Denominator: Total of TPA 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 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.

Performance Measure:
Percentage of Mi Via data reports specified in the Fiscal Management Agent (FMA) 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 FMA reports required 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: FMA	☑ **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 consultant agency provider agreements that adhered to the State's uniform agreement requirements (specific to provider). Numerator: Number of consultant agency provider surveys found in compliance. Denominator: Total number of consultant agency provider surveys required by HCA.

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 Source (Select one):
Trends, remediation actions proposed / taken
If 'Other' is selected, specify:

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

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 HCA administrative authority are identified by HCA, processes are in place to ensure that appropriate and timely action is taken whether the situation is related to participants, providers and vendors of services and supports, contractors, or the State agencies systems. Methods for addressing 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 any issues that are inconsistent with Medicaid requirements at any time, HCA ensures that the problem is corrected and in compliance with the Assurance is met through regularly scheduled joint meetings.

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Data aggregation and analysis will be done more frequently to address specific issues should they arise.

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- ◉ **No**
- ○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	**Included**	**Target Sub Group**	**Minimum Age**	**Maximum Age**	
				Maximum Age Limit	**No Maximum Age Limit**
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	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	0		☑
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

The waiver is limited to persons who want to direct their services.

Developmental disabilities waiver services are intended for eligible recipients who have developmental disabilities limited to intellectual disability (ID) or a related condition as determined by HCA. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated. The eligible recipient must also require the level of care provided in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), in accordance with 8.313.2 NMAC, and meet all other applicable financial and non-financial eligibility requirements.

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

Related Condition
An individual is considered to have a related condition if they have a severe, chronic disability that meets all of the following:
a. Is attributable to a condition, other than mental illness, found to be closely related to ID because this condition results in limitations in general intellectual functioning or adaptive behavior similar to that of persons with ID and requires similar treatment or services
b. Is manifested before the person reaches age twenty-two (22) years of age
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

The definition for Medically Fragile is as follows:

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

The State's proposed changes will not result in current participants losing eligibility or be transferred to another waiver under 1915(c) or another Medicaid authority.

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	4155
Year 2	4570
Year 3	5027
Year 4	5530
Year 5	6083

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Individuals are allocated to the waiver on a statewide basis in chronological order by date of waiver registration. In addition, individuals can be offered an expedited allocation if the DDSD Crisis Referral Review Team determines a crisis situation exists and the individual meets the criteria in the DDSD crisis policy. The DDSD crisis policy states that a person not receiving waiver services may be allocated immediately if they in the following situations: released from incarceration, under court order or homeless. The individual, who meets eligibility criteria, and who is under court order to the Health Care Authority, Developmental Disabilities Supports Division, may be offered an expedited allocation or may be served using other funding resources. The individual has the choice to receive ICF waiver or other available funding.

When funding becomes available based on appropriations from the New Mexico Legislature, a registrant receives a letter of interest. At that time, the individual selects either institutional care or Home and Community-Based Services (HCBS). After an individual selects HCBS, an individual is offered a choice of Mi Via or another HCBS waiver if they choose not to self-direct.

New Mexico will enroll individuals who have an allocation based upon the criteria specified, up to the approved unduplicated users and contingent upon appropriations from the Legislature to cover the costs of services.

If a participant finds that their needs cannot be met in the Mi Via Self-Directed Waiver, they may request to transition to the traditional Developmental Disabilities or Medically Fragile Waivers.

New Mexico will have sufficient funds to serve both transfers from the Developmental Disabilities and Medically Fragile Waivers contingent upon appropriations from the Legislature to cover the costs of services.

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:

Third Party Assessor (TPA)

- ( ) **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 (LOC) for waiver participants include licensed physicians, licensed registered nurses, licensed independent social workers (LISW), licensed master's level social workers and qualified mental health retardation professionals as defined in 42 CFR 483.430.

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

The individual must meet the level of care required in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The State's Long Term Care Assessment Abstract is used to determine ICF/IID level of care. To be eligible for the Mi Vi waiver program, participants must meet both the ICF/IID LOC criteria and either the medically fragile criteria or the developmental disabilities criteria, as applicable to the participant's waiver allocation.

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

After the level of care is determined with the Long-Term Assessment Abstract, other documents are used to further substantiate the level of care. The Comprehensive Individual Assessment and Family Centered Review for individuals allocated for Medically Fragile, further delineates medical, functional, social, and developmental information. The Vineland, a norm referenced, age-appropriate assessment for Developmentally Disabled participants, and history and physical are reviewed for any inaccuracies are used as supportive documentation in the determination of LOC.

The New Mexico admistrative code criteria for level of care are set forth at 8.314.3 and 8.314.6 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:

The Level of Care (LOC) evaluation/reevaluation are completed by the contracted Third Party Assessor (TPA). Consultants do not play a role in conducting LOC assessments, rather they provide assistance to participants during the LOC process.

1. The initial LOC evaluation occurs after the participant has received an allocation letter for waiver services. Upon notification by the State, the selected Consultant Agency contacts the participant and provides information and assistance to the participant in completing the LOC eligibility process.

2. The participant, or participant's physician, submits the LTCAA and the current History and Physical to the TPA. The TPA conducts the in-home assessment using Vineland/norm-referenced adaptive behavior scale tool, or for MF only, the Comprehensive Individual Assessment & Family Centered Review form, to substantiate the LOC. Criteria that are used to evaluate the participant's level of care which addresses
the following factors: medical; cognitive; nutritional; communication/hearing; mood and behavior patterns; psychosocial well-being; and physical, functional, and structural limitations.

3. 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.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are

conducted no less frequently than annually according to the following schedule *(select one)*:

- **Every three months**
- **Every six months**
- **Every twelve months**
- **Other schedule**
  Specify the other schedule:

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

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

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

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

As part of its TPA contract compliance review, 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:

LOC evaluation and reevaluation records are maintained at the offices of the TPA Contractor.

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC assessment documentation; HSD/MAD audits of TPA contractor.

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

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: TPA Contractor	☑ **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 are identified by HCA related to Level of Care (LOC), processes are in place to ensure that appropriate and timely action is taken. This applies to both current and new waiver applicants with a reasonable indication that services may be needed.

Methods for 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 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:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Additional data collection,analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise.

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- ◉ **No**
- ○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Individuals register for waiver services through their local HCA Income Support Division (ISD) office, or their local HCA Developmental Disabilities Supports Division Regional Office (DDSD). Individuals registering for a home and community-based waiver are given the choice of registering for any of the traditional waivers in New Mexico.

When the individual receives an offer for waiver services, also known as an allocation, they begin the medical and financial eligibility processes. The individual is also given information from HCA staff about the freedom to choose home and community-based waiver services or institutional services, informed about alternatives, risks and responsibilities associated with choosing self-direction through Mi Via, asked to select whether they want home and community-based services or institutional care, and to select a consultant agency and assist with implementation of their choice.

The State notifies the Consultant Agency to initiate contact with the individual.

Participants in Mi Via have a high degree of choice among qualified traditional and non-traditional providers, employees, and generic vendors. Participants document their choices on the Service and Support Plan action plan and on the Employee or Agency/Vendor agreements they complete with the employees and/or vendors selected.

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 at the HCA Pre-Service and Intake Bureau.

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 HCA statewide toll-free numbers. Statewide disability resource agencies, such as the ALTSD Resource Center, Independent Living Resource Centers, Governor's Commission on Disabilities, and New Mexicans with Disabilities Information Center, have bi-lingual staff available. The Developmental Disabilities Supports Division can arrange for a variety of translators for planning meetings upon participant request. Translated documents can also be arranged for through the HCA upon participant request. The Consultant Contractor(s), FMA, 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	**Consultant Services**		
Statutory Service	**Customized Community Group Supports**		
Statutory Service	**Employment Supports**		
Statutory Service	**Home Health Aide Services**		
Statutory Service	**Homemaker/Direct Support Services**		
Statutory Service	**Respite**		
Extended State Plan Service	**Skilled Therapy for Adults**		
Supports for Participant Direction	**Personal Plan Facilitation**		
Supports for Participant Direction	**Support Broker Services**		

Service Type	Service		
Other Service	Behavior Support Consultation		
Other Service	Community Direct Support		
Other Service	Emergency Response Services		
Other Service	Environmental Modifications		
Other Service	In-Home Living Supports		
Other Service	Individual Directed Goods and Services		
Other Service	Nutritional Counseling		
Other Service	Private Duty Nursing for Adults		
Other Service	Specialized Therapies		
Other Service	Transportation		

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):

Consultant Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Consultant services are intended to monitor, educate, guide and assist the participant to make informed planning decisions about services and supports. This leads to the development of a service and support plan (SSP), based on the participant's assessed needs. Consultant services help the participant identify supports, services and goods that meet their need for waiver services and are specific to the participant's disability or qualifying condition and help prevent institutionalization. Consultant services provide a level of support to a participant that is unique to their individual needs in order to maximize their ability to self-direct in the Mi Via Program. Consultants are required to have face-to face monthly contact with Mi Via participants as determined by the HCA.

Specific waiver function(s) that consultant agency providers have in the Mi Via include but are not limited to: getting to know the participant well and establishing rapport in order to best support the participant, providing the participant with information, support and assistance during the Medicaid financial and medical eligibility process; developing the Service and Support Plan (SSP) with the participant; revising the SSP as necessary and assisting participants to identify and resolve issues related to the implementation of the SSP and quality assurance activities; serving as an advocate for the participant, as needed, to enhance his/her opportunity to be successful with self-direction; assisting participants with their chosen providers and adherence to Mi Via Service Standards as applicable; providing assistance and support to the Support Broker and/or vendor related to invoices, payments and billing concerns, as requested, providing assistance and support to participants and Support Broker related to service delivery concerns; sharing information with various supports as requested by the participant, assisting participants to transition from and to other waiver programs; providing training initially and annually to participants related to recognizing and reporting critical incidents; maintenance of relevant documentation; and monitoring of SSP implementation, service delivery, coordination of other supports and health and safety assurances as described in the SSP.

Consultant Pre-Eligibility/Enrollment Services are intended to provide information, support, guidance, and/or assistance to individuals during the Medicaid eligibility process, which includes both financial and medical components. The level of support provided is based upon the unique needs of the individual for the sole purpose of helping them navigate the Medicaid eligibility and enrollment processes.
Consultant pre-eligibility/enrollment services are delivered in accordance with the individual's identified needs. Based upon those needs, the consultant provider shall assign a consultant and contact the individual within five (5) working days after receiving the Primary Freedom of Choice (PFOC) to schedule an initial orientation and enrollment meeting. This meeting should be conducted within 30 days of receiving the PFOC.

Enrollment activities include but are not limited to: General program overview including key agencies and contact information; Discuss medical and financial eligibility requirements and offer assistance in completing these requirements as needed; Provide information on Mi Via participant roles and responsibilities, which is documented by participant signing of the rights and responsibilities form; Discussion of support broker including discussion and possible identification of an Support Broker and completion of the Support Broker information form; Review the processes for hiring employees and contractors and required paperwork; Review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees; Discuss the background check and other credentialing requirements for employees and contractors; Discuss training requirements related to recognizing and reporting critical incidents; Referral for accessing training for the Mi Via on-line system and to obtain information on the Financial Management Agency (FMA); and, Provide information on the Service and Support Plan (SSP) including covered, and non-covered, goods and services, planning tools and community resources available.

Pre-eligibility/enrollment assistance provided by consultants are claimed as an administrative expense and not billed as a waiver service as part of the participant's budget.

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

Consultants must meet with the participant face to face twelve (12) times a year where four (4) of the visits must be done in the participants home.

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	Consultant Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Consultant Services

Provider Category:

Agency

Provider Type:

Consultant Agency

Provider Qualifications

License *(specify):*

Hold a current business license issued by the State, county, or city government.

Certificate *(specify):*

Other Standard *(specify):*

A. Consultant providers shall ensure that all individuals providing consultant services meet the criteria specified in this section:

1. Consultant providers shall:

a. Be at least 21 years of age;

b. Possess a minimum of a Bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field;

c. Have one year of supervised experience working with people with disabilities;

d. Complete all required Mi Via orientation and training courses including training on critical incident, abuse, neglect, and exploitation reporting; and

e. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

OR

2. Consultant providers shall:

a. Be at least 21 years of age;

b. Have a minimum of six (6) years of direct experience related to the delivery of social services to people with disabilities ;

c. Complete all required Mi Via orientation and training courses including training on critical incident, abuse, neglect, and exploitation reporting; and

d. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCA assures that the consultant agency meets the provider qualifications.

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

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:**

Service Definition *(Scope):*

This service is to be provided in an integrated community-based setting that supports opportunities for participants to access, as well as actively engage with, their preferred community resources and activities that includes others in their community. Customized Community Supports are expected to be provided in integrated community settings such as community-based day programs and community centers and can take place in non-institutional and non-residential settings including typical integrated community settings as specified in the participant's service and support plan (SSP). Typical integrated community settings include settings that occur naturally in the community such as public libraries, restaurants, classes at community centers, community events such as festivals/organized gatherings which would be accessed by others in the community without disabilities. These settings could also include naturally occurring volunteer settings accessible to all members of the public. These would be settings that would be accessible naturally to all members of the public regardless of disabilities. Customized community group supports are designed to offer the Mi Via participant flexible supports. These supports can include participation in community day programs and centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Customized community group supports may include Day Habilitation (Customized Community Group Supports) and other day support models and does not duplicate waiver case management, community direct support services, employment supports or any other waiver service. Services are available at least four (4) or more hours per day one (1) or more days per week as specified in the participant's SSP. The state does limit the maximum number of hours this service may be used in a day nor does the state limit the maximum number of days per week this service may be provided. Customized Community Group Supports include adult day habilitation and other day support models and do not duplicate community direct support services, employment support services or any other waiver service. Customized Community Group Support services are only provided through a provider agency. Remote based supports may be implemented to assist the individual to explore the community activities, groups, and resources.

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

All activities must be provided outside of the home and in the community.

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 (Day Habilitation) 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 (Day Habilitation) Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Customized Community Group Support Provider Agency must meet requirements including a business license, financial solvency, training requirements, records management, quality assurance policy and processes.

The Customized Community Group Support Agency staff must meet the following requirements:
i. Be at least 18 years of age;
ii. Have at least one year of experience working with people with disabilities;
iii. Be qualified to perform the service and demonstrate capacity to perform required tasks;
iv. Be able to communicate successfully with the participant;
v. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
vi. Complete DOH required training on critical incident, abuse, neglect, and exploitation reporting;
vii. Complete participant specific training; the evaluation of training needs is determined by the participant or his/her legal representative; participant is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Mi Via participant's Authorized Annual Budget (AAB); and
viii. Meet any other service qualifications, as specified in the Mi Via regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Employment Supports

HCBS Taxonomy:

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

Service Definition *(Scope):*

The focus of Mi Via employment supports services is tailored to meet the needs of the individual participant. Employment for individuals with intellectual and developmental disabilities (IDD) is an optional, person-centered choice that respects each individual's goals, preferences, and needs. Employment First initiatives are designed to fully support individuals who choose to pursue work by providing access to inclusive, meaningful employment opportunities, resources, and accommodations. As part of the person-centered planning process, employment is explored as a pathway to independence, community integration, personal fulfillment and offered as a flexible option that aligns with the participant's vision for their future. Working age is defined as 21-62 years of age. The intent of this service is to provide the scope of the service, job coaching and job development, as a service designed to meet the needs of an individual and not a group that result in community employment in jobs which increase economic independence, self-reliance, social connections and the ability to grow within a career.

Employment Support Services are a one-to-one service and are to be individualized to meet the needs of the participant and not the needs of a group. Employment Supports services are geared to place and support individuals with disabilities in employment situations with non-disabled co-workers within the general workforce; or assist the individual in business ownership. Employment Supports include job development and job coaching supports after available vocational rehabilitation supports have been exhausted. Employment Supports include job development and job coaching supports after available vocational rehabilitation supports have been exhausted, including programs funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA).

Job development is a service provided to participants by a skilled individual. The service has several components:
1) Conducting situational and/or Vocational Assessments.
2) Developing and/or identifying community-based job opportunities that are in line with the individual's skills and interests;

3) Supporting the individual in gaining the skills or knowledge to advocate for themselves in the workplace;
4) Promoting career exploration based on interests within various careers through job sampling, job trials or other assessments as needed;
5) Arranging for or providing benefits counseling;
6) Facilitating job accommodations and use of assistive technology such as communication devices;
7) Providing job site analysis (matching workplace needs with those of the individual);
8) Assisting the individual in gaining and/or increasing job seeking skills (interview skills, resume writing, work ethics, etc.).

The job coach provides the following services: skill development; employer consultation specific to the participant; co-worker training; job site analysis; education of the participant and co-workers on rights and responsibilities; assistance with or utilization of community resources to develop a business plan if the participant elects to start their own business; conduct market analysis and establish the infrastructure to support a business; and increase the participants' capacity to engage in meaningful and productive interpersonal interactions with co-workers, supervisors and customers.

Employment Supports will be provided by staff at current or potential work sites. When employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an individual's supported employment program.

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

FFP cannot be claimed to defray expenses associated with starting up or operating a business.

"Employment Support Services should be offered and discussed as a priority service over other day service options for all working age adults. Working age is defined as 21-62 years of age."

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	Job Coach
Individual	Job Developer
Agency	Supported Employment Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Supports

Provider Category:

Individual

Provider Type:

Job Coach

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Job Coach must:
- Be at least 18 years of age;
- Must have the high school diploma or GED;
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
- Complete training on critical incident, abuse, neglect, and exploitation reporting;
- Be qualified to perform the service; experience with providing employment supports, and training methods;
- Knowledgeable about business and employment resources
- Be able to successfully communicate with the participant and with the employer and the participant's coworkers develop/ encourage natural supports on the job.

Additionally, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Supports

Provider Category:

Individual

Provider Type:

Job Developer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Job Developer must:
- Be at least 21 years of age;
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
- Complete training on critical incident, abuse, neglect, and exploitation reporting;
- Experience in developing and using job and task analyses;
- Knowledge of American with Disabilities Act (ADA);

o Knowledge and experience working with the Department of Vocational Rehabilitation (DVR)office; and
o Experiences with or Knowledge of the purposes, functions and general practices of entities such as:
Department of Labor Navigators
One-Stop Career Centers
Business Leadership Network
Chamber of Commerce
Job Accommodation Network
Small Business Development Centers
Retired Executives
Local Businesses
Community Agencies
DDSD Resources

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Supports

Provider Category:

Agency

Provider Type:

Supported Employment Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Supported Employment Provider Agency must meet requirements including a current business license, financial solvency, training requirements, records management, quality assurance policy and processes. The agency must hire job developers and job coaches with the following requirements:
Job Developer must:
o Be at least 21 years of age;
o Must have the high school diploma or GED;;
o Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
o Complete training on critical incident, abuse, neglect, and exploitation reporting;
o Experience in developing and using job and task analyses;
o Knowledge of American with Disabilities Act (ADA);
o Knowledge and experience working with the Department of Vocational Rehabilitation (DVR)office; and
o Experiences with or Knowledge of the purposes, functions and general practices of entities such as:
Department of Labor Navigators
One-Stop Career Centers
Business Leadership Network
Chamber of Commerce
Job Accommodation Network

Small Business Development Centers
Retired Executives
Local Businesses
Community Agencies
DDSD Resources

Job Coach must:
o Be at least 18 years of age;
o Have a high school diploma or GED
o Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
o Be qualified to perform the service; experience with providing employment supports, and training methods;
o Knowledgeable about business and employment resources
o Be able to successfully communicate with the participant and with the employer and the participant's coworkers develop/ encourage natural supports on the job.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Home Health Aide

Alternate Service Title (if any):

Home Health Aide Services

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

Services defined in 42 CFR § 440.70 that are provided in addition to home health aide services furnished under the approved State plan. Home Health Aide services under the waiver differ in nature, scope, supervisory arrangements, or provider type from home health aide services in the State plan. Home health aide services under the waiver provide total care or assist a participant in all activities of daily living in a manner that will promote an improved quality of life and a safe environment to support the participant's independence and health needs in the home and in the community. Home health aide services can be provided on a long-term basis based on the participant's habilitative supports. Whereas, State plan home health aide services address acute conditions; the purpose of which is curative and restorative, with the goal of assisting the participant to return to an optimum level of functioning and to facilitate timely discharge of the participant to the self-care or to care by his/her family. Additionally, home health aide services under the waiver are not duplicative of homemaker services. Home health aides may provide non-invasive nursing assistance skills within the scope of their practice, whereas homemakers do not have the ability to perform such tasks. This service is not to be provided in homes or apartments owned/leased by provider agencies.

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

This waiver service is only provided to individuals age 21 and over. All medically necessary home health aide benefits for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

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/Homemaker Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Health Aide Services

Provider Category:

Agency

Provider Type:

Home Health Agency/Homemaker Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Homemaker agencies must be certified by MAD or its designee. A Home Health Agency must meet requirements including a current business license, financial solvency, training requirements, records management, quality assurance policy and processes.

Home Health Aides must:

Be 18 years of age or older;
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 descibed in the New Mexico Regulations Governing Home Health Agencies, 7.28.2.30 NMAC;
Be supervised by a registered nurse and such supervision, which must occur at least once every sixty (60) days in the participant's home, shall be in accordance with the New Mexico Nurse Practice Act and be specific to the participant's Service and Support Plan;
Complete training on critical incident, abuse, neglect, and exploitation reporting; and
Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

The state regulations require fourteen (14) hours of initial education for the home health aide and following, twelve (12) hours of education are required annually. The State Abuse, Neglect, and Exploitation (ANE) training is required for all persons providing direct service to participants and is provided by the State. Agencies may also use a state certified trainer to give the state approved ANE training.

The Department of Health's web site, https://providersearch.health.state.nm.us/ , may be used to search for home health agencies by county and by city. In addition, many home health providers are listed on the NM Home Care and hospice Association. Mi Via consultant agency often also provide a list of resources personal care agencies and home health care agencies.

A certified home health aide or nursing assistant is a higher designation. There is a registry of CNAs. The information is available at: https://www.nmhealth.org/about/dhi/hflc/prop/nar/

A search of the registry can be performed at: https://registry.prometric.com/publicNM

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

Homemaker/Direct Support Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Homemaker/Direct Support Services are provided on an episodic or continuing basis to assist the participant with activities of daily living, performance of general household tasks, provide companionship to acquire, maintain, or improve social interaction skills in the community, and enable the participant to accomplish tasks they would normally do for themselves if they did not have a disability. Homemaker/Direct Support services are provided in the participant's home and in the community, depending on the participant's needs and choice. The participant identifies the Homemaker/Direct Support Worker's training needs, and, if the participant is unable to do the training on their own, the participant arranges for the needed training. Services are not intended to replace supports available from a primary caregiver. Homemaker services are not duplicative of home health aide services. Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Homemakers do not have this ability to perform such tasks. This service must not to be provided in homes or apartments owned/leased or operated by provider agencies. Homes or apartments are considered provider owned or operated when the participant lives with a person, non-family member, specifically for the purpose of that person providing paid supports to the participant and when the participant would not live in that home if the person were not being paid to provide services.

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

Waiver participants in all living arrangements are assessed individually and service plan development is individualized. The TPA will assess the service plans of participants living in the same residence to determine whether or not there are homemaker services that are common to more than one participant living in the same household in order to determine whether one or more employees may be needed to ensure that individual different cognitive, clinical, and habilitative needs are met. This waiver service is only provided to individuals age 21 and over. All medically necessary homemaker services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit. This service will require the use of Electronic Visit Verification (EVV) system.

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	Homemaker/Direct Support

Provider Category	Provider Type Title
Agency	Home Health Agency/Homemaker Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker/Direct Support Services

Provider Category:

Individual

Provider Type:

Homemaker/Direct Support

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Worker must be:
18 years of age or older;
Demonstrate capacity to perform required tasks;
Be able to communicate successfully with the participant;
Complete training on critical incident, abuse, neglect, and exploitation reporting; and
Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

Additionally, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker/Direct Support Services

Provider Category:

Agency

Provider Type:

Home Health Agency/Homemaker Agency

Provider Qualifications

License *(specify):*

Home Health Agency

Certificate *(specify):*

Other Standard *(specify):*

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

The Homemaker/Direct Support Agency staff must meet the following requirements:
Workers must be 18 years of age or older;
Demonstrate capacity to perform required tasks;
Be able to communicate successfully with the participant;
Complete training on critical incident, abuse, neglect, and exploitation reporting; and
Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Respite is a flexible family support service, the primary purpose of which is to provide intermittent support to the participant and give the unpaid primary caregiver relief from their duties on a short-term basis. Respite is provided on a short-term basis to allow the participants' primary unpaid caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency. Services must only be provided on an intermittent or short-term basis because of the absence or need for relief of those persons normally providing care to the participant. If there is a paid primary caregiver residing with the eligible recipient providing living supports or community membership supports, or both, respite services cannot be utilized.

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

RRespite services are furnished on a short-term, intermittent basis for unpaid primary caregivers and can be provided in the participant's home, the respite provider's home, in a community setting of the family's choice (e.g., community center, swimming pool, and park) or at a center in which other individuals are provided care. Federal Financial Participation (FFP) is not claimed for the cost of room and board as part of respite services. Respite may not be furnished at the same time when other services that include care and supervision are provided.

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

The TPA approves the amount of respite services based on individual need and service definitions. The TPA compares the amount of respite being requested on the Service and Support Plan (SSP)/Budget with the participant's natural supports, clinical, functional, medical, and habilitative needs as outlined in the SSP. The TPA will request more information as applicable to make a determination. This service will require the use of Electronic Visit Verification (EVV) system.

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	Respite Provider
Individual	RN/LPN
Individual	Respite Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Respite Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

The Respite provider staff must meet the following requirements:
Be 18 years of age or older;
Demonstrate capacity to perform required tasks;
Be able to communicate successfully with the participant;
Complete training on critical incident, abuse, neglect, and exploitation reporting;and
Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

RN/LPN

Provider Qualifications

License *(specify):*

Licensed by the NM State Board of Nursing as a RN or LPN

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

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:

Individual

Provider Type:

Respite Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Worker must be:
18 years of age or older;
Demonstrate capacity to perform required tasks;
Be able to communicate successfully with the participant;
Complete training on critical incident, abuse, neglect, and exploitation reporting; and
Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

Additionally, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

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:

Skilled Therapy for Adults

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Extended State Plan Skilled Therapy for Adults services include Physical Therapy, Occupational Therapy or Speech Language Therapy. Extended skilled therapy for adults is available when skilled therapy services under the state plan are exhausted or not a benefit. Adults on the Mi Via Waiver 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. The TPA reviews eligibility of the participant to receive the service and whether the service is covered or already has been exhausted under the state plan or Medicare. Therapy services provided to adults under Mi Via focus on maintenance, community integration, socialization, and exercise, or enhance support and normalization of family relationships.

Physical Therapy is the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy activities do the following: 1) increase, maintain or reduce the loss of functional skills; 2) treat a specific condition clinically related to a participant's developmental disability; 3) support the participant's health and safety needs; and/or 4) identify, implement, and train on therapeutic strategies to support the participant and his/her family/support staff consistent with the participants Service and Support Plan (SSP) desired outcomes and goals.

Occupational Therapy is the diagnosis, assessment, and management of functional limitations intended to assist adults to regain, maintain, develop, and build skills that are important for independence, functioning, and health. Occupational Therapy services typically include: customized treatment programs to improve ones ability to perform daily activities; comprehensive home and job site evaluations with adaptation recommendations; skills assessments and treatment; assistive technology recommendations and usage training; and guidance to family members and caregivers. Occupational Therapy services do the following: 1) increase, maintain, or reduce the loss of functional skills; 2) treat specific conditions clinically related to a participant's developmental disability; 3) support the participant's health and safety needs; and/or 4) identify, implement, and train therapeutic strategies to support the participant and his/her family/support staff consistent with the participants SSP desired outcomes and goals.

Speech and Language Pathology is the diagnosis, counseling and instruction related to the development and disorders of communication including speech fluency, voice, verbal, and written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal, and sensor motor competencies. Speech Language (SL) Pathology is also used when a participant requires the use of an augmentative communication device. Services are intended to improve or maintain the participant's capacity for successful communication or to lessen the effects of the participant's loss of communication skills and/or to improve or maintain the participant's ability to eat foods, drink liquids, and manage oral secretions with minimal risk of aspiration or other potential injuries or illness related to swallowing disorders. Activities include identification, implementation and training of therapeutic strategies to support the participant and his/her family/support staff consistent with the participant's SSP desired outcomes and goals. Based upon therapy goals, services may be delivered in integrated natural setting, clinical setting and/or in a group.
For waiver participants under age 21, skilled therapy services are covered under the Medicaid state plan as expanded EPSDT benefits for waiver participants under age 21.

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

This waiver service is only provided to individuals aged 21 and over. All medically necessary Physical Therapy, Occupational Therapy or Speech Language Therapy benefits for children under the age of 21 are covered in the state plan

pursuant to the EPSDT benefit.

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	Physical Therapist
Individual	Speech and Language Pathologist
Individual	Occupational Therapist
Agency	Group Practice

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:

Physical Therapist

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Certified physical therapy assistants must possess a physical therapy certification from the NM RLD.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

The State of NM verifies the qualifications of all licensed providers annually.

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:

Speech and Language Pathologist

Provider Qualifications

License *(specify):*

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):*

Speech clinical fellows must possess a clinical fellow license from the NM RLD.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

The State of NM verifies the qualifications of all licensed providers annually.

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:

Occupational Therapist

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Certified occupational therapy assistants must possess an occupational therapy assistant certification from the NM RLD.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

The State of NM verifies the qualifications of all licensed providers annually.

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

Provider Qualifications

License *(specify):*

Physical Therapist: Licensed as per NM Regulation and Licensing Dept; Physical Therapy Act, NMSA 1978, Section 61-12-1.1 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):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

The State of NM verifies the qualifications of all licensed providers annually.

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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Personal Plan Facilitation

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Personal Plan Facilitation supports provides planning activities that will result in a holistic person-centered plan that may be used by the Consultant/participant to develop his/her service support plan (SSP) as well as identify other sources of support outside the SSP process. Essential Life Planning (ELP), Circle of Friends, Making Action Plans (MAPS), Planning Alternative Tomorrows with Hope (PATH), Personal Future Planning (PFP), Lifestyle Planning and Personal Profile may be used by the facilitator to produce the plan. This is not a function of the Consultant nor a non-professional support guide staff. This service provides an opportunity for the individual to explore and articulate the vision he/she has for his/her life. This service is provided by trained staff using personal plan facilitation tools. This service is only available to participants one (1) time per budget year.

In the scope of Personal Planning Facilitation, the Personal Plan Facilitator will:

(1) Meet with the participant and his/her family (or guardian, as appropriate) prior to the personal planning session to discuss the process, to determine who the participant wishes to invite, and determine the most convenient date, time and location. This meeting preparation shall include an explanation of the techniques the facilitator is proposing to use or options if the facilitator is trained in multiple techniques. The preparation shall also include a discussion of the role the participant prefers to play at the planning session, which may include co-facilitation of all or part of the session.
(2) Arrange for participation of invitees and location.
(3) Conduct the personal planning session.
(4) Document the results of the personal planning session and provide a copy to the participant, the Consultant and any other parties the participant would like to receive a copy. Elements of this report shall include:
(a) Strengths, gifts, talents, interests and preferences of the participant;
(b) Long term dream(s)/goal(s) the participant wishes to pursue;
(c) Challenges the participant faces (if any) in pursuing his or her dream(s)/goal(s);
(d) Potential resources, especially natural supports within the participants community that can potentially support the participant in pursuing his or her dream(s)/goal(s); and
(e) A list of any follow-up actions to take, including time lines.
(5) Provide session attendees, including the participant, with an opportunity to provide feedback regarding the effectiveness of the session.

The provider of this service documents the results of the personal planning session and provides a copy to the participant, authorized representative, personal representative and/or the consultant and any other parties the participant would like to receive a copy. These parties then utilize the plan to assist the participant with the development of the Service and Support Plan (SSP). Consultants, not the non-professional support guide staff (if utilized), is responsible for the development of the SSP.

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

Limit one personal plan per year up to $650.00.

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	Personal Plan Facilitator (Sole Proprietor)
Agency	Personal Plan Facilitator Agency

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Personal Plan Facilitation

Provider Category:

Individual

Provider Type:

Personal Plan Facilitator (Sole Proprietor)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Personal Plan Facilitator must:
- Be at least 18 years old;
- Be trained/mentored in the planning tool used;
- Complete training on critical incident, abuse, neglect, and exploitation reporting;
- Have at least one year experience in providing the personal plan facilitation service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Personal Plan Facilitation

Provider Category:

Agency

Provider Type:

Personal Plan Facilitator Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Personal Plan Facilitator Agency must meet requirements including a current business license, financial solvency, training requirements, records management, quality assurance policy and processes. The personal plan facilitation agency staff must:
- Be at least 18 years old;
- Be trained/mentored in the planning tool used;
- Complete training on critical incident, abuse, neglect, and exploitation reporting;
- Have at least one year experience in providing the personal plan facilitation service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Support Broker Services

HCBS Taxonomy:

Category 1: 12 Services Supporting Self-Direction

Sub-Category 1:

Category 2:

Sub-Category 2:

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

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

Service Definition *(Scope):*

The Supports Broker service is available to Mi Via participants who do not have a guardian, family member, or other natural support willing and able to serve as a volunteer Supports Broker. The Supports Broker assists the Mi Via participant in successfully self-directing waiver services while ensuring the participant's preferences, goals, and health and safety needs remain central to service delivery. Acting on behalf of the participant, the Supports Broker provides guidance and assistance with arranging, directing, and managing waiver services and supports in accordance with the participant's approved Service and Support Plan (SSP).

Responsibilities of the Supports Broker include assisting the participant with recruiting, interviewing, selecting, orienting, scheduling, supervising, and, when necessary, dismissing service employees and vendors. The Supports Broker helps the participant understand and fulfill employer-related responsibilities, ensures required employment and service documentation is completed and submitted to the Financial Management Agent (FMA), monitors service delivery to ensure services are provided as authorized, and supports implementation of backup plans when necessary to address gaps in services.

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	Support Broker

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Broker Services

Provider Category:

Agency

Provider Type:

Support Broker

Provider Qualifications

License *(specify):*

- Hold a current business license issued by the State, county, or city government.
- Must meet all requirements from a business license including the financial solvency

Certificate *(specify):*

Other Standard *(specify):*

Support Broker Services provider agencies shall ensure that all individuals providing Support Broker services meet the criteria specified in this section:

1. Support Broker providers shall:

a. Be at least 21 years of age;

b. Possess a minimum a minimum of high school diploma or GED

c. Have one year of supervised experience working with people with disabilities;

d. Complete all required Mi Via orientation and training courses including training on critical incident, abuse, neglect, and exploitation reporting; and

e. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCA assures that the Support Broker Services agency meets the provider qualifications.

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Support Consultation

HCBS Taxonomy:

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

Service Definition *(Scope):*

Behavior Support Consultation services consist of functional support assessments, positive behavior support plan/treatment plan development, and training and support coordination for a participant related to behaviors that compromise a participant's quality of life. Behavior Support Consultation: 1) informs and guides the participants service and support employees/vendors toward understanding the contributing factors to the participant's behavior; 2) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the providers competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s); 3) supports effective implementation based on a functional assessment and subsequent Service and Support Plan (SSP); 4) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues, and to limit the need for psychotherapeutic medications; and 5) monitors and adapts support strategies based on the response of the participant and his/her service and support providers. Based on the participants SSP, services are delivered in an integrated/natural setting or in a clinical setting.The State defines a clinical setting as a formal office setting where the BSC, as the clinician, would be providing the service and the participant would go to their location to obtain the service.

The overarching purpose of the service is to assess the participant's behaviors, prepare a plan, and then give consultation to others on how to implement the strategies to address the participant's behavior. This service assists to inform and guide the participant, family, employees and/or vendors toward understanding the contributing factors to the participant's behavior. Furthermore, this service assists to identify and implement support strategies to enhance functional capacities; prevent and respond to interfering behavior and potentially reducing interfering behaviors; and to monitor and adapt support strategies based on the response of the participant and his/her family, employees and/or vendors in order for services to be provided in the least restrictive manner.

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	Behavior Consultation Practice
Individual	Behavior Support Consultant

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:

Behavior Consultation Practice

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:

Psychiatrist; Clinical Psychologist; Independent Social Worker (LISW); Professional Clinical Mental Health Counselor (LPCC); Professional Art Therapist (LPAT); Marriage and Family Therapist (LMFT); Mental Health Counselor (LMHC); Professional Mental Health Counselor (LPC) (Until December 31, 2012); Master Social Worker (LMSW); Psychiatric Nurse; or Psychologist Associate (PA).

Certificate *(specify):*

Other Standard *(specify):*

The Behavior Consultant provider agency shall have a current business license issued by the state, county or city government, if required by any of these government entities. The Behavior Consultant provider agency shall comply with all applicable federal, state, and Waiver regulations and policies and procedures regarding behavior consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

The State of NM verifies the qualifications of all licensed providers annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support Consultation

Provider Category:

Individual

Provider Type:

Behavior Support Consultant

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:

Psychiatrist; Clinical Psychologist; Independent Social Worker (LISW); Professional Clinical Mental Health Counselor (LPCC);Professional Art Therapist (LPAT); Marriage and Family Therapist (LMFT); Mental Health Counselor (LMHC); Professional Mental Health Counselor (LPC) (Until December 31, 2012); Master Social Worker (LMSW); Psychiatric Nurse; or Psychologist Associate (PA).

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

The State of NM verifies the qualifications of all licensed providers annually.

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:

Community Direct Support

HCBS Taxonomy:

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

Service Definition *(Scope):*

Community Direct Support delivers support to the participant to identify, develop, nurture and maintain community connections and to access social, educational, recreational and leisure options. The community direct support provider may be a skilled independent contractor or a hired employee depending on the level of support needed by the participant to access the community. The Community Direct Support provider may instruct and model social behavior necessary to interact with community members or in groups (not as a part of a group of people with disabilities only) and provide assistance in needed ancillary tasks related to community membership, provide attendant care and help the participant schedule, organize and meet expectations related to chosen community activities. Community Direct Support services provide assistance to the participant outside of the individual's residence. In home activities of daily living will not qualify for Community Direct Support Services. Community Direct Support services promote the development of valued social relationships and builds connections within local communities. This service supports the participant in having frequent opportunities to expand meaningful roles in the community to increase and enhance natural supports, networks, friendships and build a sense of belonging. This promotes self-determination, increases interdependence and enhances the individual's ability to interact with and contribute to his or her community.

Community Direct Support services also assist in the development of skills and behaviors that strengthen an individual's connection with their community. The participant is supported to create such community connections individually, not as a part of a group of people with disabilities. The skills to assist someone in a community setting may be different than those for assisting a person at home. The provider will demonstrate knowledge of the local community and resources within that community that are identified by the participant on the service and support plan. The provider will also be aware of the participants barriers to communicating and maintaining health and safety while in the community setting. Community Direct Support does not duplicate waiver case management service as it is a care service provided only outside the participant's residence.

Remote based supports may be implemented to assist the individual to explore the community and online community

activities, groups, and resources. Remote based supports are intended to supplement not supplant community-based services and must not lead to social isolation. Individuals are encouraged to participate in the community to the fullest extent possible in conjuction with the use of remote based supports.

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

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

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **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	Community Direct Support
Agency	Community Access Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Direct Support

Provider Category:

Individual

Provider Type:

Community Direct Support

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Worker must be:
18 years of age or older;
Demonstrate capacity to perform required tasks;
Be able to communicate successfully with the participant;
Complete training on critical incident, abuse, neglect, and exploitation reporting; and
Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.
Additionally, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Direct Support

Provider Category:

Agency

Provider Type:

Community Access Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Community Access Provider Agency must meet requirements including a business license, financial solvency training requirements, records management, quality assurance policy and processes. The agency staff must meet the following qualifications:

Be 18 years of age or older;
Demonstrate capacity to perform required tasks;
Be able to communicate successfully with the participant;
Complete training on critical incident, abuse, neglect, and exploitation reporting; and
Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Emergency Response Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Emergency Response services provide an electronic device that enables a participant to secure help in an emergency at home and avoid institutionalization. The participant may also wear a portable help button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center when a help button is activated. The response center is staffed by trained professionals. Emergency response services include: testing and maintaining equipment; training participants, caregivers and first responders on use of the equipment; twenty-four (24) hour monitoring for alarms; checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.; and, reporting participant emergencies and changes in the participant's condition that may affect service delivery. Emergency Response Services does not include the initial set-up and installation of Emergency Response System devices.

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	Emergency Response Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Emergency Response Services

Provider Category:

Agency

Provider Type:

Emergency Response Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Approved Emergency Response Provider; must comply with all laws, rules and regulations from the Federal Trade Communication Commission for Telecommunications

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modifications

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

All services shall be provided in accordance with applicable federal, state, and local building codes. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction/remodeling services, provide administrative and technical oversight of construction projects, provide consultation to family members, waiver providers and contractors concerning environmental modification projects to the participant's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.
Environmental Modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects.

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

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

Environmental Modifications is delivered through a participant directed model in that participants or their Support Broker can choose the service provider for the environmental modification.

Environmental Modifications are not eligible for Additional Funding.

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: Environmental Modifications

Provider Category:

Individual

Provider Type:

Individual or Company

Provider Qualifications

License *(specify):*

Appropriate plumbing, electrician, contractor license; appropriate technical certification to perform the modification

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Upon initial employee or vendor/provider agreement.

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:

In-Home Living Supports

HCBS Taxonomy:

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

Service Definition *(Scope):*

In-Home Living Supports are individually designed intermittent services and/or supports that are related to the participant's qualifying condition or disability. This enables the participant to live in an apartment or home that is owned or leased by the participant in the community of their choice. This includes homes owned or operated by an agency provider and leased to the participant. Each participant that lives in an agency owned home must have a lease agreement in place that includes protections against eviction. These services and/or supports are provided in the participant's home and are individually designed to instruct or enhance home living skills as well as address health and safety. Services and/or supports provided under In-Home Living supports include assistance with activities of daily living and assistance with the acquisition, restoration, and/or retention of independent living skills. This is not a residential service, but rather an intermittent support service. The service does not provide service coordination, residential placements (a home) or nursing. IHLS providers are not responsible for finding or providing a physical residence for the participant. Nursing services are not provided under this service but may be selected as a separate service on the participant's budget. This service is intended for people who require limited intermittent support throughout the day for a minimum of 4 or more hours per day, one or more days per week. The participant's SSP outlines the specific needs, service hours, and days of service requested. The number of hours of support are based on the needs of the participant(s) and may be up to 24 hours per day. When the SSP identifies that the participant requires intermittent services for 24 hours per day, the SSP must outline how the In-home living support provider will ensure appropriate staff availability to meet this need. In-home living providers must assure 24-hour response capability to address scheduled or unpredictable needs for health, safety or security concerns. When In-home living supports is used the In-home living support agency must be included in the Emergency Back Up Plan to provide back up support staff. Participants receiving in-home living supports may not use homemaker direct support, home health aide services or respite because they duplicate in-home living supports.

This does not duplicate Customized Community Group Supports since Customized Community Group Supports is provided in a community setting. In addition, per state regulation, individuals receiving in-home living services are not eligible to receive homemaker, home health aide, or respite services.

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
Individual	In-home Living Provider/Independent Contractor
Agency	In-Home Living Provider Agency

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

In-home Living Provider/Independent Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Worker must be:

- 18 years of age or older;
- Have one year of experience working with people with disabilities;
- Demonstrate capacity to perform required tasks;
- Complete training on critical incident, abuse, neglect, and exploitation;
- Be able to communicate successfully with the participant; and
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.
- Additionally the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

In-Home Living Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

In-Home Living Provider Agency must meet requirements including a business license, financial solvency training requirements, records management, quality assurance policy and processes. IHLS Provider Agencies must complete all state required and approved trainings at the frequency specified. IHLS Agencies must maintain records that all staff, and sub-contracted individuals, who provide direct service to participants have completed required trainings.

IHLS Provider Agencies must comply with DOH Division of Health Improvement (DHI) provider surveys. When delinquencies are identified IHLS provider agencies must implement corrective action to remediate delinquencies. Failure to remediate delinquencies will result in disqualification of the vendor.

IHLS Provider Agencies must maintain records that ensure all staff, and sub-contracted individuals, who provide direct service to participants meet the minimum provider qualifications listed below:

Worker must be:
- 18 years of age or older;
- Have one year of experience working with people with disabilities;
- Demonstrate capacity to perform required tasks;
- Complete training on critical incident, abuse, neglect, and exploitation;
- Be able to communicate successfully with the participant; and
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.
- Additionally, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

The State of NM verifies the qualifications of all licensed providers annually.

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:**

Service Definition *(Scope):*

Individual Directed Goods and Services are equipment, supplies, or services, not otherwise provided through this Waiver or through the Medicaid State Plan. Individual Directed Goods and Services must address a need identified in the participant's Service and Support Plan (SSP) (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: be responsive to the participant's qualifying condition or disability; and promote personal safety and health; and afford the participant an accommodation for greater independence; and advance the desired outcomes in the participant's SSP; and decrease the need for other Medicaid services; and accommodate the participant in managing this household; and/or facilitate activities of daily living. Individual Directed Goods and Services must be documented in the SSP.
The participant receiving this service does not have the funds to purchase the Individual Directed Goods and Services (s) or the Individual Directed Goods and Services (s) is/are not available through another source. These items are purchased from the participant's individual budget. Experimental or prohibited treatments and goods are excluded. Services and goods that are recreational or diversional in nature are excluded. Recreational and diversional in nature is defined as inherently and characteristically related to activities done for enjoyment. Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of FFP for waiver services. A legally responsible individual may not be paid to provide Individual Directed Goods and Services.

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	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):*

The vendor types for related goods spans retail stores, community health centers, and medical supply stores.

Certificate *(specify):*

Other Standard *(specify):*

Business license and a tax ID for the state and federal government

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nutritional Counseling

HCBS Taxonomy:

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

Service Definition *(Scope):*

Nutritional Counseling services include assessment of the participant's nutritional needs, development and/or revision of the participant's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan.

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

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

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **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	Dietitian
Agency	Group Practice

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Counseling

Provider Category:

Individual

Provider Type:

Dietitian

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

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: Other Service
Service Name: Nutritional Counseling

Provider Category:

Agency

Provider Type:

Group Practice

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Nutritional Counseling Provider Agency may be a group of nutritional counseling group practice or a group practice that employs nutritional counselors. The agency must meet requirements as outlined in a nutritional counseling provider agency application approved by HSD or its designee including a business license, financial solvency training requirements, records management, quality assurance policy and processes.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

The State of NM verifies the qualifications of all licensed providers annually.

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 for Adults

HCBS Taxonomy:

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

Service Definition *(Scope):*

Private Duty Nursing for Adults includes activities, procedures, and treatment for a participant's physical condition, physical

illness or chronic disability. Services include medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance.

Private duty nursing for waiver participants under age 21 are covered under the Medicaid state plan as expanded EPSDT benefits.

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

This waiver service is only provided to individuals age 21 and over. All medically necessary private duty nursing benefits for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

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	RN/LPN
Agency	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 for Adults

Provider Category:

Individual

Provider Type:

RN/LPN

Provider Qualifications

License *(specify):*

Licensed by the NM State Board of Nursing as a RN or LPN

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing for Adults

Provider Category:

Agency

Provider Type:

Home Health Agency/Rural Health Clinic/FQHC

Provider Qualifications

License *(specify):*

Agency licensed by the State of New Mexico; nurses licensed by the New Mexico State Board of Nursing as a RN or LPN.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Therapies

HCBS Taxonomy:

Category 1:	Sub-Category 1:

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

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

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

Service Definition *(Scope):*

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

A participant may include specialized therapies in their Mi Via Service and Support Plan (SSP) when the services enhance opportunities to achieve inclusion in community activities and avoid institutionalization. Services must be related to the participant's disability or condition, ensure the participant's health and welfare in the community, supplement rather than replace the participant's natural supports and other community services for which the participant may be eligible, and prevent the participant'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 in order 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 the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a participant'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.

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.

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
Individual	Specialized Therapist
Agency	Group Practice/Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Therapies

Provider Category:
Individual
Provider Type:
Specialized Therapist

Provider Qualifications

License *(specify):*

A current NM State license as applicable:
Acupuncture and Oriental Medicine license
Biofeedback - license in a health care profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision.
Chiropractic Physician license
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.
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.
Massage Therapist license
Naprapathic Physician license
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.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years for all providers listed

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):*

The vendor type for this service under agency providers are licensed providers in acupuncture and oriental medicine; providers with specialty in biofeedback; licensure in chiropractic medicine; licensure in cognitive rehabilitation therapies, licensure in PT, OT, and SLP with certification in hippo therapy; licensure in massage therapy; licensed mental health professional in play therapy.

Group practice/vendor staff must hold current NM licensure and training in their respective discipline as follows:
Acupuncture and Oriental Medicine license
Biofeedback license in a health care profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision.
Chiropractic Physician license
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.
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.

Massage Therapist license
Naprapathic Physician license
Play therapy license in a mental health profession whose scope of practice includes play therapy, a masters degree or higher mental health degree, and specialized play therapy training and clinical experience and supervision.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years for all providers listed

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:

Transportation

HCBS Taxonomy:

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

Service Definition *(Scope):*

Payment for transportation is limited to the costs of transportation needed to access waiver services included in the participant's service plan or access other activities and resources identified in the service plan. Transportation services are

offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. Transportation services under the waiver are offered in accordance with the participant's service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a), and does not replace them. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the State plan are to transport participants to medically necessary physical and behavioral health services. Non-medical transportation services enable participants to gain access to waiver and non-medical community services, events activities and resources as specified in the participant's service plan related to community resources and services, work, volunteer sites, homes of local family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events. Payment for Mi Via transportation services is made to the participant's individual transportation employee or to a public or private transportation service vendor; payment cannot be directed to the individual participant. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

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
Individual	Driver
Agency	Transportation Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Driver

Provider Qualifications

License *(specify):*

Valid NM drivers license

Certificate *(specify):*

Other Standard *(specify):*

The driver must meet the following qualifications:
1. Be at least 18 years old;
2. Possess a valid New Mexico drivers license;
3. Have a current insurance policy and registration;

4. Complete training on critical incident, abuse, neglect, and exploitation reporting.

All providers must pass a criminal history and background check prior to providing services. The NMAC also specifies that all individual employees, independent providers must pass a nationwide caregiver criminal history screening and employee abuse registry.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Transportation Vendor

Provider Qualifications

License *(specify):*

Valid NM drivers license

Certificate *(specify):*

Other Standard *(specify):*

Provider agencies will have a current business license and tax identification number. Each agency will ensure drivers meet the following qualifications:

1. Be at least 18 years old;
2. Possess a valid New Mexico drivers license;
3. Have a current insurance policy and registration;
4. Complete training on critical incident, abuse, neglect, and exploitation reporting.

Each agency will ensure vehicles have a current basic First Aid kit in the vehicle.

All providers must pass a criminal history and background check prior to providing services. The NMAC also specifies that all individual employees, independent providers must pass a nationwide caregiver criminal history screening and employee abuse registry.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Agent (FMA)

Frequency of Verification:

Initially and every 3 years

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

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:***

Remote services will be delivered in a manner where support is offered without intruding on personal or private activities such as toileting, bathing, or dressing.
1. All remote supports must align with and be documented in the participant's Service and Support Plan (SSP). The use of technology will be tailored to their needs and preferences and must avoid or minimize intrusion during private tasks such as toileting and dressing unless explicitly agreed to and necessary for health and safety.
2. Remote and telehealth service delivery will focus on verbal prompts, coaching, or check-ins rather than visual monitoring during private tasks.
3. Adjust technology use to allow for audio-only support or muting, along with maintaining flexibility to end sessions and reschedule the resumption of a session to avoid unnecessary observation or delay of personal care activities.
4. Individuals have the right to refuse or change how remote support is used. Service plans must be regularly reviewed to ensure support remains necessary and respectful, and individual choice is being honored.
5. Clear boundaries must be established so that cameras or devices are never placed in areas where privacy could be compromised.

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

Telehealth service delivery will facilitate community integration by removing barriers like transportation or provider availability in rural areas or underserved areas of New Mexico. Participants will be able to access virtual groups, community events and organizations. Participant feedback from experiences during the Covid pandemic was largely in favor of continuing to allow remote and telehealth service delivery as a greater way for people to be included, participate from the comforts of their homes, and have the flexibility they desired, while expanding social opportunities in ways they could never before. Remote service delivery broadens access to meaningful connections in ways that were not available before.

☑ **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:***

Telehealth services are designed to complement, not replace, hands-on or physical assistance when it is required for health, safety, or daily living needs. Remote services must be clearly defined in the Service and Support Plan (SSP). The participant and the Circle of Support (family, friends, guardians) will be required to clearly define when telehealth is appropriate and when hands-on support is required. The participant and the Circle of Support must specify staff roles, technology used, and frequency/duration of telehealth versus in-person sessions. Physical needs may require in-person support such as hands-on assistance, where non-physical needs may be appropriate for remote services where verbal prompting, monitoring, or coaching is the support being provided.

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

Under the Individual Directed Goods and Services, an array of services is offered. Mi Via participants can purchase items that are not otherwise covered by state plans, if they are linked to the person's assessed needs, included in the Service and Support Plan (SSP); and necessary for telehealth or remote services. Eligible technology items may include tablets, smartphones, or laptops, internet service (data plans, routers), accessibility tools such as adaptive keyboards, and software needed to access care platforms. Requests for items are reviewed and approved by the Third-Party Assessor (TPA).

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

Telehealth effectively promotes health and safety for individuals receiving waiver services by improving timely access to services, improving oversight, and supporting safe service delivery in tailored and inclusive environments. Telehealth improves waiver participants' convenience and reduces barriers to otherwise being able to easily access healthcare. The Mi Via participant, their Circle of Support, and the Mi Via Consultant, must properly plan and document supports and safeguards within the participant's Service and Support Plan (SSP). The consultant is required to review the SSP monthly with the individual to monitor the health and safety to include monitoring of current health status, recommended appointments and any medical follow up.

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):

HCA Caregivers Criminal History Screening (CCHS) Act requires that persons whose employment or contractual service includes direct care or routine and unsupervised physical or financial access to any care recipient served by that provider, must consent to a nationwide and statewide criminal history screening to ensure to the highest degree possible the prevention of abuse, neglect, or financial exploitation of individuals receiving services. This requirement does not pertain to independent health care professionals, licensed or Medicaid-certified in good standing, who are not otherwise associated with the care provider as an administrator, operator, or employee, and who are involved in the treatment or management of the medical care of a care recipient such as attending or treating physicians or other health care professionals providing consultation or ancillary services.
The Financial Management Agent (FMA) Contractor is responsible for conducting criminal history screenings for all applicable persons, as described above, employed or contracted to provide services to Mi Via waiver participants. The FMA Contractor must ensure that the person has submitted to a nationwide criminal history screening before the person begins employment and every other year thereafter.
This screening collects information concerning a person's arrests, indictments, or other formal criminal charges, and any dispositions arising there from, including convictions, dismissals, acquittals, sentencing, and correctional supervision. If the person's nationwide criminal history record reflects a disqualifying conviction and results in a final determination of disqualification, then this person cannot be hired or continue to be employed.
The FMA submits a monthly report to HCA of mandatory investigations that have been conducted.
HCA/MAD is responsible for monitoring the FMA Contractor's compliance with this provision of the contract. The process for monitoring is outlined in Appendices A-5 and A-6.
The Caregivers Criminal History Screening Act is available for review and can be found in NMSA 1978, Sections 29-17-2 through 29-17-5. Regulations are found at 7.1.9 NMAC.

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):

Based on legislation passed during the New Mexico 2005 Legislature, the Employee Abuse Registry Act went into effect on January 1, 2006. This rule, which implements the Act, requires listing employees with substantiated registry-referred abuse, neglect, or exploitation on the registry, following an opportunity for a hearing. This rule also requires that providers check with the registry and avoid employing an individual on the registry (NMAC 7.1.12).

The HCA has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined to have engaged in a substantiated registry-referred incident of abuse, neglect, or exploitation of a person receiving care or services from a provider.
The FMA Contractor is responsible for ensuring that screening has been completed on applicable providers of services to Mi Via participants. The registry screening applies to persons employed by or on contract with a provider, either directly or through a third-party arrangement to provide direct care. An "employee" does not include a NM licensed health care professional practicing within the scope of the professional's license or a certified nurse aide practicing as a certified nurse aide.
The FMA Contractor, prior to enrolling a provider who a Mi Via participant is employing or contracting with, shall inquire of the registry whether the individual under consideration for direct or contractual employment is listed on the registry. The Mi Via participant may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect, or exploitation of a person receiving care or services from that individual. The FMA Contractor shall maintain documentation in the employee's personnel or employment records that evidences the fact that the Contractor made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the Contractor, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.
The state receives monthly reports of all new employees and providers that have been screened through the nationwide caregiver criminal history screening and employee abuse registry. The FMA also notifies the state when a current employee has been involved in a disqualifying event.
HCA/MAD is responsible for monitoring the FMA Contractor's compliance with this provision of the contract. The process for monitoring is outlined in Appendices A-5 and A-6.
The Employee Abuse Registry Act is available for review and can be found in NMSA 1978, Sections 27-7A-1 through 27-7A-8. Regulations are found at 7.1.12 NMAC and 8.11.6. NMAC.

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.*

Legally responsible individuals may be paid for waiver services under extraordinary circumstances in order to assure the health and welfare of the participant and avoid institutionalization, and provided that the State is eligible to receive federal financial participation. Extraordinary circumstances include the inability of the legally responsible individual to find other qualified, suitable caregivers when the legally responsible individual would otherwise be absent from the home and, thus, must stay at home to ensure the participant's health and safety. Legally responsible individuals may not be paid for any services that they would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness.
Legally responsible individuals who may receive payment for the provision of services through Mi Via include biological or adoptive parents of recipients under eighteen (18) and legal spouses of adult participants. Legally responsible individuals may be paid to provide all Mi Via Waiver services, except for transportation of a minor, consultant services, and customized group supports services, and individual directed goods and services. A spouse may be paid to provide transportation services for adult participants. The person-centered planning process must protect against self-referral by demonstrating that the LRI is selected as the best fit and is documented in the SSP. Additionally the number of units per service requested must address participant preferences and needs, Units may not be determined to maximize payments to LRIs at the cost of removing other needed services on the budget. Consultants routine monthly monitoring visits will include documentation for ongoing best fit, back up planning, and participant satisfaction in the decision to hire LRIs.

The service must:

· Meet the definition of a service or support, as outlined in Appendix C and as approved by CMS;

· Be necessary to avoid institutionalization;

· Be specified in the participant's SSP and budget;

· Be provided by a legally responsible individual who meets the provider qualifications and training standards specified in the waiver for that service;

· Be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and approved by the TPA Contractor;

· Not be services that the legally responsible individual would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness.

The legally responsible individual who is a service provider must be approved by the HCA prior to submission of the SSP and budget to the TPA Contractor and must comply with the following:

· A parent of a minor, a spouse, or other legally responsible individual may not provide more than forty (40) hours of services in a seven (7)-day period.

· Planned work schedules must be identified in the approved SSP and budget, and variations to the schedule must be reported to the participant's consultant and noted and supplied to the FMA when billing;

· Time sheets and other required documentation must be maintained and submitted to the FMA for hours paid;

· Legally married individuals must be offered a choice of providers. If they choose a spouse as their service provider, it must be documented in the SSP.

New Mexico's monitoring requirements include:

· The participant's Consultant monitors implementation and management of the SSP and budget, as described in Appendix D-1:a. This includes the Consultant's quality assurance activities, e.g., ensuring that all applicable procedures related to plan and budget development occur, including the procedures for payment of legally responsible individuals; monitoring implementation of the approved plan; communicating with the FMA to monitor appropriate use of the authorized budget, according to the SSP; supporting the participant in developing and implementing their individual quality assurance plan; and supporting the participant in revising the SSP and budget, as indicated, to meet the participant's changing circumstances and needs.

· The Consultant is required to contact the individual participant at least on a monthly basis and meet face-to-face with the participant at a minimum of twelve (12) times throughout the year, four visits, one per quarter, must be conducted in the participants home.

· The FMA monitors, on a monthly basis, hours billed for services provided by the legally responsible family member and the total amounts billed for all goods and services during the month.

· If the Consultant and FMA have any concerns that the best interests of the participant are at risk or that the approved SSP and budget are not being followed, these concerns must be brought to the attention of the Consultant Agency, FMA and to the State for investigation and follow-up.

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 and legal guardians may receive payment for providing all Mi Via Waiver services except for Consultant Services, Customized Community Group Supports and Individual Directed Goods and Services. Professional or corporate guardians may not be paid for providing any waiver services. The person-centered planning process must protect against self-referral by demonstrating that the relative or legal guardian is selected as the best fit and is documented in the SSP. Additionally the number of units per service requested must address participant preferences and needs, Units may not be determined to maximize payments to relatives and legal guardians at the cost of removing other needed services on the budget. Consultants routine monthly monitoring visits will include documentation for ongoing best fit, back up planning, and participant satisfaction in the decision to hire relatives and or legal guardians.

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

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

- **Other policy.**

  Specify:

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

In their Service and Support Plan, participants will identify needed services and the appropriate providers from which to purchase identified services. Mi Via participants may choose to hire any and all willing and qualified providers. Regional resource lists are maintained by consultant agencies and available to participants. Providers of goods and services that are not currently enrolled as Medicaid-participating providers and want to participate in Mi Via may request to be included in regional resource lists.

Information on becoming a Consultant is readily accessible on the HCA website. Information on applications for becoming a consultant provider is also available on the FMA website. https://providersearch.health.state.nm.us/.

Provider eligibility requirements are specified in Appendix C-3 of the application. The HCA specifies provider enrollment for consultant agencies, timelines, and verifies provider qualifications. The FMA contract specifies provider enrollment procedures and timelines and verifies waiver provider qualifications for all other Mi Via providers.

All Consultant Agency applicants will be reviewed by HCA. If approved by HCA, the provider enrollment and relations unit at HCA will then provide final review of the Consultant provider applications before providing a Medicaid number. HCA will enroll and provide Medicaid numbers within six weeks of their review for qualified applicants.

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:
Number and percent of enrolled licensed/certified providers who continue to meet required licensure and/or certification standards. Numerator: Number of enrolled licensed/certified providers who meet licensure/certification standards. Denominator: Total number of enrolled licensed/certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider reports compiled by the Financial Management Agency (FMA) contractor.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider reports compiled by the Financial Management Agency (FMA) contractor..

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

collection/generation *(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: FMA	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Upon enrollment of providers	

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 Contractor CA Contractor	☑ **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 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:
Number and percent of enrolled non-licensed/non-certified providers who are in compliance with required background checks. Numerator: Number of non-licensed/non-certified providers who are in compliance with required background checks. Denominator: Total number of enrolled non-licensed/non-certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider reports compiled by the Financial Management Agency (FMA) contractor.

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number and percent of employee-providers who are in compliance with training requirements as specified in the service standards, approved waiver, and employee-provider agreements. Numerator: Number of compliant employee-provider agreements that attest provider trainings have been conducted. Denominator: Total number of employee-provider agreements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The employee-vendor agreement provides for the participant or Support Broker to attest that provider trainings have been conducted including information on training requirements.

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

	Specify:	

Data Aggregation and Analysis:

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

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 Consultant providers, processes are in place to ensure that appropriate and timely action is taken.

Methods for addressing and correcting identified problems include contract management activities such as, but not limited to technical assistance,, letters of direction, formal performance improvement plans, review by the HCA Internal Review Committee (IRC) and civil monetary penalties. 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 provider qualifications, 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	☑ **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.

Participants in Mi Via have authority to expend waiver funds for services through an approved Individual Budgetary Allotment (IBA) amount, which applies to all waiver services except Environmental Modification Service, the methodology for which is described in Appendix E. Participants can develop a service plan with services based on assessed need, including health and safety. The participant can determine service duration and frequency, with total cost of their budget not exceeding the IBA. The exception is the Environmental Modification Service which has a dollar limit, as established by the HCA, every 5 years.

The Individual Budgetary Allotment (IBA) amount that is to be expended on a monthly basis. Each participant's annual individual budget is based on the 2007 Developmental Disabilities Waiver (DDW) Annual Resource Allotments (ARA) method. The ARAs allow the individual to utilize a flexible combination of services that are identified in the traditional DDW Individual Service Plan (ISP) up to the maximum available amount.

Adult Budget Methodology

The adult (21 and over) Mi Via budgetary allotment was developed using the ARAs for residential services, deducting the cost for case management services and a 10 percent (10%) discount to the net remaining amount. The ten percent (10%) discount, which reflects administrative/overhead agency costs that are not provided by and included in the reimbursement to self-directed providers, is used to fund the fiscal management role under the self-directed waiver. The State performed this calculation for the remaining adult level of care ARAs. The State then calculated a weighted budget using the new amounts multiplied by the number of participants at the time of calculation in each corresponding level of care category to get a total cost divided by the total number of participants. The weighted residential ARA developed was added to the annual cost of the most flexible and community-oriented Community Living Service in the traditional DDW, Family Living, to derive the Adult Budgetary allotment for Mi Via.

Children's (0 - 20 years) Budget Methodology

The same methodology utilizing the DDW ARAs for children was applied. Generally, in New Mexico, children under 18 have residential options available through the Children, Youth and Families Department rather than through Waiver services. However, under the DDW, young adults ages 18-20 are eligible for Community Living Services. Should a young adult require residential or similar supports, a budgetary amount equal to Intensive Independent Living (IIL) under the DDW would be made available. The Intensive Independent Living rate was chosen as it provides assistance to an individual living at home or in his/her own home for 100 to 300 hours per month. This is equivalent to 8-10 hours per day and should provide sufficient support as these individuals are still receiving school services during the day.

The assigned budgets change as the person ages, at the time of the change or at recertification.

Medically Fragile

The State applies the same methodology to persons on the Medically Fragile Waiver (MFW) that transition to Mi Via, as they also would benefit from services available to other persons with developmental disabilities. The annual Mi Via budget for medically fragile children was calculated by removing case management and the ten percent (10%) discount (as with other Mi Via budget methodologies). The resulting budget, when included in the weighted calculations, is consistent with the weighted average budgets for other children with developmental disabilities. For medically fragile individuals 21 years and over, the rates developed for Adults with Developmental Disabilities will apply including the opportunity to access community living services or enhanced supports.

Safeguards

Additional Funding is available for those participants who have needs that exceed the budget limit and meet one of four categories of criteria. There are four criteria which include:

1. A chronic physical condition;
2. A change in physical health status;

3. Chronic or intermittent behavioral conditions or cognitive difficulties; or
4. A change in natural supports.

Requests for Additional Funding (AF) are requested by the participant and the consultant processes those requests on the SSP/Budget through the contracted Third-Party Assessor (TPA) for review. These four categories of criteria each have corresponding supporting documentation requirements for the TPA to review in rendering a decision to approve, partially approve or deny the request for Additional Funding. A fair hearing process is available for denials rendered by the TPA.

At the enrollment meeting, consultants provide information regarding program rules including information related to the participant's individual budget allotment. This information is also shared during the development of the Service and Support Plan. Additionally, Participants are notified of their individual budget allotment through the contracted Third-Party Assessor upon approval of medical eligibility for Mi Via Waiver services.

The State does not foresee adjusting the participant waiver limit during the waiver cycle. Quarterly and annual review of Mi Via participant waiver expenditures shows that average participant budget expenditure falls below the established IBA. In addition, the process in place that allows participants to request additional funding, provides a mechanism for participants to requests additional funding as needed.

Additional Funding is available for those participants who have needs that exceed the budget limit and meet one of four categories of criteria. There are four criteria which include:

1. A chronic physical condition;
2. A change in physical health status;
3. Chronic or intermittent behavioral conditions or cognitive difficulties; or
4. A change in natural supports.

Requests for Additional Funding are requested by the participant and the consultant processes those requests on the SSP/Budget through the contracted Third Party Assessor (TPA) for review. These four categories of criteria each have corresponding supporting documentation requirements for the TPA to review in rendering a decision to approve, partially approve or deny the request for Additional Funding. A fair hearing process is available for denials rendered by the TPA.

At the enrollment meeting, consultants provide information regarding program rules including information related to the participant's individual budget allotment. This information is also shared during the development of the Service and Support Plan. Additionally, Participants are notified of their individual budget allotment through the contracted Third Party Assessor upon approval of medical eligibility for Mi Via Waiver services.

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

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

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.)*

New Mexico has been at the forefront of self-direction with the implementation of the Mi Via waiver in 2006. This waiver was originally designed and developed with person-centered planning at its core which is reflected in our current 1915 (c) Home and Community-Based Services (NM.0448) waiver, Mi Via Service Standards, and the New Mexico Administrative Code rules. As such, Mi Via service and support plans (SSPs) are developed through the person-centered planning process which guides the participant's selection of services that achieve personally defined outcomes in the most integrated community setting.
Mi Via service and support plans (SSPs) are developed through the person-centered planning process which guides the participant's selection of services that achieve personally defined outcomes in the most integrated community setting. Mi Via services are provided in non-residential/non-institutional settings, primarily in the participant's home and community.

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.)*

Mi Via services are integrated in and support full access of individuals to the greater community, including opportunities to seek employment. The services are selected by the participants where they have the ability to engage in community life and control their own resources. Participants have autonomy in selecting the services, independence in choosing how they engage in community life, their daily activities, physical environment, and with whom they interact. Mi Via participants choose all of their providers and can change providers at any time based on their preference or needs. All Mi Via employees, vendors, providers, and circle of support members are responsible for monitoring for settings compliance with the assurances in section C.5.3. Consultants have the primary responsibility of monthly monitoring with monthly face-to-face tools that prompt review of settings compliance assurances.

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:

Participant Service and Support Plan (SSP)

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:

Consultant -Bachelor's Degree and at least one year's experience in working with people with disabilities or IDD or a minimum of 6 years' experience related to the delivery of social services to people living with disabilities.

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.

Mi Via affords opportunities for individuals to self-direct their services. The participant develops his or her individualized service and support plan (SSP), within the State-assigned budgetary allotment, and directs all services and supports identified in his or her plan. These services and supports must address the participant's qualifying condition or disability and assist the individual to live at home, go to school, work, and integrate into the community as independently as possible. The breadth of services and supports should reflect all aspects of a participant's life, including but not limited to home, community, school, work, and productive activity. Using the person-centered approach, the SSP revolves around the individual participant and reflects his or her chosen lifestyle and culture. Planning should occur where, when and with whom the participant chooses. The participant directs development of the Plan, which serves as the foundation for participation in Mi Via.

The Consultant provides support to the participant prior to the Service and Support Plan (SSP) meeting and assists him or her with SSP planning through orientation to Mi Via, including information about available services during the enrollment meeting. The In-Home Assessment (IHA), or client individual assessment, completed by the Third-Party Assessor(TPA) is used as a tool to complete the SSP. The SSP document itself contains a number of questions designed to prompt the participant through self-assessment as they develop their SSP.

New Allocations and Transfers:

During the enrollment meeting, the Consultant informs the participant of the services available in Mi Via as part of an orientation to the Mi Via Program and reviews the service definitions and the scope of services. The Consultant informs the participant that anyone in his or her circle of support may be invited to the SSP development meeting. The participant is also given additional program information literature, and/or where to locate resources online including: policies and procedures of the Consultant Agency, participant rights and responsibilities, incident reporting guidelines and training, Fair Hearing rights, the local resource manual, and other documents.

Current Participants:

The Consultant supports the participant with pre-planning activities for the next SSP development during the third quarter of the current plan. During the face-to-face monthly meeting, the Consultant re-informs the participant about the services available in Mi Via. During this visit the Consultant also informs the participant about any updated local resource manuals including where the manual may be located online. The Consultant informs the participant that anyone in his or her circle of support may be invited to the SSP development meeting.

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):

For development of the participant-centered service plan, the planning meetings are scheduled at times and locations convenient for the participant. The State obtains information about participant strengths, capacities, preferences, desired outcomes and any risk factors in the following ways: through the Level of Care (LOC) assessment and through the person-centered planning process that is undertaken between the consultant and participant to develop the participant's Service and Support Plan (SSP).

Assessments

Assessment activities that occur prior to the SSP meeting assist in the development of a person-centered plan that is accurate and functional for the participant. The functional assessments conducted during the LOC determination process address the following needs of a person: medical, adaptive behavior skills, nutritional, functional, community/social and employment. Assessments occur on an annual basis or during significant changes in circumstance. After the assessments are completed, the results are made available to the participant and his or her Consultant by the Third-Party Assessor (TPA) for use in planning. The participant and the consultant will ensure that the SSP addresses the information and/or concerns identified through the assessment process.

Pre-Planning

The Consultant contacts the participant upon his or her choosing Mi Via to provide information regarding Mi Via including: the range and scope of choices and options, rights, risks, and responsibilities associated with self-direction. The Consultant provides the participant with a copy of the Mi Via Service and Support Plan (SSP) template word version. The SSP includes sections on what kinds of services and supports the participant needs, how frequently and on what schedule, related goods necessary to support community living and other information that prepares the participant to develop their budget. The Consultant provides support during the annual redetermination process to assist with completing medical and financial eligibility in a timely manner.

Services and Support Plan Meeting

The participant receives a copy of the Mi Via SSP template form, LOC assessment and local resource manual prior to the SSP meeting. Prior to the SSP meeting, the participant may begin planning and drafting the SSP utilizing those tools alone or with their circle of support.

During the SSP meeting, the Consultant assists the participant in developing the SSP to address the participant's goals, health and, safety needs, and risks. The Consultant and the participant explore and document how concerns or needs will be addressed through natural or paid supports.

The Consultant ensures for each participant that:
- The planning process addresses the participants' needs and personal goals in at least the following areas: supports needed at home; community membership (including employment); health and wellness; and other supports. There are also sections for Environmental Modifications, Back-up Plan, Consultant Services and SSP Preparation Information.
- Services selected address the participant's needs as identified during the assessment process.
- The outcome of the assessment process for assuring health and safety are considered in the plan
- Services do not duplicate or replace those available to the participant through the Medicaid State Plan or other public programs;
- Services are not duplicated in more than one service code;
- The responsibilities are assigned for implementing the plan;
- The Back-up plans and acknowledgement form are complete and on file; and
- The SSP is submitted to the Third-Party Assessor (TPA) after the SSP meeting, in compliance with Mi Via Waiver Service Standards.

Consultants are required to have knowledge of state plan benefits and when the SSP/budget is developed, coordination with state plan benefits are addressed. During the SSP/budget review, the TPA is required to evaluate for coordination of benefits with state plan and/or Medicare covered benefits. During SSP development, the Consultant works with the participant to determine what other non-waiver services are being utilized or could be utilized to meet the participant's need. The SSP document prompts the consultant and participant to consider the amount of non-Mi Via and unpaid supports a participant utilizes or could utilize in addition to Mi Via supports. The participant, under

self-direction, has the responsibility to work with their non-waiver support entities to coordinate around their Mi Via services.

The SSP is updated if personal goals, needs and/or life circumstances change that may or may not result in a change of the LOC. Revisions may be requested by the participant. The Consultant may also confer with the participant to initiate revisions. The participant is contacted by the Consultant to schedule the SSP meeting in compliance with the Mi Via Waiver Service Standards. Consultants submit all SSPs.

Temporary, interim service plans are not utilized.

Monitoring

The Consultant is responsible for assisting the participant in directing the SSP pre-planning and development process. The quality measures developed by the participant, SSP support needs tables, and other details allows the Consultant and participant to monitor paid services in Mi Via with more ease. SSPs are monitored by the Consultant during monthly in person visits.

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.

The Mi Via philosophy of self-direction including responsibilities and plans for reducing identified risks through the use of specialized supports, natural supports, and other community resources and measures for reducing risks. However, the State must assure the participant's safety, and the consultant is required to work with the participant in developing a plan that addresses risks that may have been identified during the participant's LOC assessment and the SSP development process.

The LOC packet, which includes the Long-Term Care Assessment Abstract, History and Physical, and other assessment forms such as the Adaptive Behavior Skills Assessment to address the following needs of a person: medical, adaptive behavior skills, nutritional, functional, community/social, and employment.

A copy of the LOC determination is provided to the participant and Consultant by the Third-Party Assessor (TPA). LOC reviews occur on an annual basis, or more frequently if there is a significant change in life circumstances or the LOC.

Participants can mitigate risks by hiring trusted employees and vendors. They can proceed through interview processes with potential employees/vendors and have the opportunity to research those they may be interested in working with as part of mitigating risks. Participants address the hours per week of services they require and plan accordingly as part of mitigating risks. Participants also complete a Health and Wellness section of the SSP that can be utilized to mitigate risks.

Back-up plans are required for natural or paid supports that address critical areas of concern outlined in the LOC assessment/recommendation. An Emergency/Back Up Plan is also developed as part of the SSP which addresses paid services as well as outlines relatives, natural supports and consultant services that can be called upon to assist. It includes contacting 911 as well as listing who the participant will contact if scheduled employees/providers are unable to report to work and at least one alternative provider must be listed in this section. Consultants monitor the use and effectiveness of back-up plans during monthly contacts and/or visits to mitigate any future health and safety risks. Specifically, Consultants monitor following: employee training on individual specific needs, environmental modifications, equipment needs, relationships in the home and community, personal safety, and employer responsibilities. An emergency back-up plan must also be reviewed with the participant and signed off on which includes an attestation that the participant has been informed on the process to report suspected abuse, neglect, and exploitation (ANE).

An expedited SSP review process addresses risks identified in the assessment process. Consultants can request an expedited process to address concerns for new enrollees or emergent concerns for current participants. This process is in accordance with the Mi Via Waiver Service Standards.

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.

During the enrollment meeting, the participant is informed about every type of service offered in the Mi Via program. The participant has access to a list of State approved HCA consultant agency providers for Mi Via. Every Consultant Agency is required to maintain a resource listing either hard copy or online. Each Consultant Agency can obtain provider information from the FMA and incorporate new local providers into the agency provider listing ongoing. The philosophy of self-direction in Mi Via encourages participants to identify their own providers. A provider list can be shared with participants during initial SSP development, SSP revisions and at any other time as requested by the participant. The resource list is required to be updated on a periodic basis. Resource lists are reviewed as part of the Quality Assurance review of each Consultant Agency to ensure that information is current. As for other providers and vendors, the Consultant assists the participant, as requested, in identifying qualified providers and vendors, including making available a list of providers and vendors in his or her area that are enrolled with the HCA through the FMA, as well as information about other provider options.

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):

Consultants submit SSPs and budgets to the TPA Contractor for approval via an electronic system developed for Mi Via. (See Appendix H for oversight activities.)

On behalf of HCA, the TPA Contractor approves each participant's SSP annually or more often if there is a change in the participant's needs or circumstances. The TPA Contractor is required to monitor reviewers' approval accuracy and compliance with criteria during its monthly quality assurance activities and report findings to HCA quarterly. If HCA identifies any issues that are inconsistent with waiver requirements at any time, HCA ensures that the TPA Contractor corrects the problem. Corrective measures may begin with detailed letters of direction (LODs) and can escalate, if necessary, to corrective action plans and contract sanctions.

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:

Consultant Agency

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.

Implementation

The Consultant assists the participant with implementing their SSP and budget. Including assisting with developing a schedule, defining job descriptions for the participant's employees, providing information on how to obtain employee fingerprints for the background check, and monitoring delivery of services.

Monitoring
Mi Via Consultants support the participant in monitoring the services provided in accordance with their SSP. The SSP includes a quality assurance measure for each section that is developed by the participant to evaluate if services are addressing his or her needs and preferences.

The Consultant monitors the progress of the SSP to ensure that it is implemented as approved by the TPA Contractor.

The Consultant monitors the progress of the plan at least every month by contacting the participant. During the monthly contact, the Consultant:

- Reviews the participant's access to services and whether they were furnished, per the approved plan
- Reviews the participant's exercise of free choice of provider
- Reviews whether services received are meeting the participant's needs
- Reviews whether the participant is receiving access to non-waiver services identified in the approved plan
- Follows-up on complaints against service providers
- Documents any changes in status
- Monitors the use and effectiveness of the back-up plan
- Documents and follows-up (if needed) if challenging events occurred
- Assess the situation and the environment for suspected abuse, neglect or exploitation and report accordingly; if not reported, takes remedial action to ensure correct reporting
- Documents progress of time-sensitive activities outlined in the SSP including employee trainings and eligibility activities
- Determines if health and safety issues are addressed appropriately
- Discusses budget utilization concerns

During monthly face-to-face visits, the Consultant ensures purchased goods are present and operational. The Consultant also reviews the quality assurance sections of the SSP with the participant. The Consultant completes a quarterly review that addresses health and safety, employee issues, navigation of Mi Via services, eligibility process, complaints, and SSP implementation issues. As indicated, the Consultant takes prompt remedial action on all identified problems. Methods for remedial action range from working directly with the participant to resolve the problems that are identified, and, if indicated, reporting the problems to the Consultant Agency leadership, and the Operating State Agency for follow-up and remedial action. Monitoring results are documented in the participant's record and reported to the Operating State agency manager, as part of the Quality Improvement Strategy. Data collected from reports and on-site record reviews are aggregated and analyzed by the State, and remedial action is taken, as outlined in the Appendix D Quality Improvement: Service Plan.

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 SSP. 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 SSP. Denominator: Total number of new and annual service plans submitted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMA/FOCoS 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	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.	

Data 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: 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 service plans that were reviewed annually for participants with continuous enrollment of 12 months. Numerator: Number of service plans reviewed annually for participants with enrollment of 12 months. Denominator: Total number of service plans for participants with continuous enrollment of 12 months.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMA/FOCoS

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of service plans that were revised, as warranted by changes in participants' needs, for participants with continuous enrollment of 12 months. Numerator: Number of service plans revised for participants with enrollment of 12 months. Denominator: total number of service plans submitted for revision.

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: TPA	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.	

Data 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 waiver individuals who report receiving all services identified in the SSP including the specified type, scope, amount, duration, and frequency. Numerator: Number of individuals who receive all services identified in the SSP including the specified type, scope, amount, duration, and frequency. Denominator: Number of reviewed records.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Management Information System/Data Warehouse

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

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

Data Aggregation and Analysis:

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

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 MV waiver participants offered choice between/among waiver services and providers. Numerator: Number of new waiver participants who select a consultant agency on the Primary Freedom of Choice form. Denominator: Total number of new waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMA/FOCos 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	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.	

Data 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 DDSQI	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Additional data collection, analysis and aggregation will be done if necessary to address unusual issues that may arise.

Performance Measure:
Percentage of existing waiver participants who were offered choice among waiver services or institutional care. Numerator: Number of existing waiver participants with a completed on-line SSP acknowledgement. Denominator: Total number of existing waiver participants with an approved SSP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report from DDSD Intake and Eligibility and FMA/FOCoS.

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: DDSD/Pre-Service Intake Bureau	☑ **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 are identified by the State related to service plans, processes are in place to ensure that appropriate and timely action is taken. In addition, DDSQI 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: DDSQI	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual issues that may arise.

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Services and supports are based on assessed needs that are determined by an in-home assessment and based on needs identified in the SSP that the participant feels can be addressed by waiver services. Mi Via recognizes the essential direct role of participants in planning and purchasing of services and supports. To assume this leadership role and be successful in self-direction, the participant must have the requisite on-going education, training, information, tools, and support related to Mi Via, which includes but is not limited to information about: basic core values and philosophy of self-direction; Mi Via guiding principles and processes; rights, risks, and responsibilities; independent living; disability rights; range of services and supports; finding, training and managing providers; complaint process and incident reporting; individual budgeting and paying for services and supports; working with the consultant and financial management agent (FMA); and quality monitoring.

Mi Via affords opportunities to individuals to self-direct their services. The participant develops their individualized service and support plan (SSP), within the State-assigned budgetary allotment, and directs all services and supports identified in the participant's plan. These services and supports must address the participant's qualifying condition or disability and assist the individual to live at home, go to school, work, and integrate into the community as independently as possible. The services and supports should reflect all aspects of a participant's life, including but not limited to home, community, school, work, and productive activity. Using the person-centered approach, the SSP revolves around the individual participant and reflects the participants chosen lifestyle and culture. Planning should occur where, when and with whom the participant chooses. The participant directs development of the SSP, which serves as the foundation for participation in Mi Via.

The Consultant, Support Broker (voluntary or paid service), if applicable, and the FMA support the participant in self-direction. As is discussed in Appendix D, Consultants, who have strong interpersonal skills, know how to communicate with people who may have limited language skills and know how to generate trust, assist participants in understanding Mi Via and developing their SSP. The participant identifies the individuals they want to be involved in the development of their SSP, and the Consultant helps the participant explore options and make informed choices, based on the participants individual needs. The Consultant also helps the participant to negotiate services and supports with family members, providers, and others and build consensus.

The Consultant is trained in and must demonstrate understanding of all aspects of the Mi Via program, such as the guiding principles for self-direction, role of the participant in the person-centered planning process, available service and support options, locating and securing services and supports, and development and management of the individual budget. The Consultant must have knowledge about community resources and how to seek out resources. The consultant must provide the participant with a listing of community resources.

The FMA is independent of the entities/persons delivering services or supports to avoid conflicts of interest. The FMA is trained in and must demonstrate understanding of all aspects of Mi Via as it relates to the planning process and development and managing the individual budget. Based on the participant's individual SSP and budget, the FMA sets up an individual account, makes expenditures that follow the authorized budget, handles all payroll functions on behalf of the participant who hires service providers and other support personnel, provides the participant with a monthly report of expenditures and budget status, answers inquiries, solves related problems, and provides the State with quarterly documentation of expenditures.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ● **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***.

Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☑ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ● **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Prior to enrolling in Mi Via, the participant (or the participant's representative) must have ready access to on-going education, training, information, tools, and support related to key aspects of Mi Via so that the participant, or participant's representative, can make informed decisions regarding self-direction. A multifaceted approach is utilized to communicate Mi Via information, such as easy-to-understand written materials, website information, alternative formats, and community meetings for participants, families, providers, and other interested parties. Materials are developed in collaboration with and through contribution from participants, advocates, and families so that information is as clear as possible.

Participants, their representatives, and their Support Broker (voluntary or paid service), as applicable, enrolled in Mi Via complete trainings that are focused on what the participant needs to learn in order to be successful, such as what Mi Via is, e.g., its goals, basic core values, guiding principles, who is eligible to participate, what self-direction and self-determination mean, and what services, supports, and goods are covered; as well as planning and budgeting; service and support plan and budget implementation; health; safety; and quality assurance. The training includes multiple topics to support the learning objectives.

State staff as well as advocacy organizations and constituents in local communities conduct initial and on-going training as well as information-sharing programs. The State also uses State websites and existing information-sharing and training networks, as appropriate, to disseminate information.

Consultants are responsible for providing information regarding program rules including the Mi Via Standards. Consultants must provide participants with a hardcopy of the Mi Via Standards or information regarding how to access the Mi Via Standards electronically. These Standards outline participant rights, responsibilities and the philosophy of the Mi Via program highlighting choice, greater control and freedom regarding the services and supports they choose. These Standards also include information regarding the conditions for involuntary termination from the Mi Via program if there is a failure to comply with program rules under self-direction. During the enrollment meeting all Mi Via processes are reviewed with the participant to assure their understanding that failure to follow those processes could affect their Mi Via services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The state does not provide for the direction of waiver services by a representative.**
- ● **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
  Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Adult participants enrolled in waiver services may voluntarily designate a guardian, family member, or other natural support to serve as their Support Broker and assist them in directing their waiver services. The Support Broker role is intended to be a voluntary, unpaid position filled by an individual who knows the participant and is willing and able to provide support with self-direction.
For participants who do not have a guardian, family member, or other natural support available to serve in this voluntary role, Supports Broker Services are available to provide the assistance necessary for the participant to successfully self-direct and continue receiving Mi Via waiver services.

The following policies and safeguards are in place to ensure that all Support Brokers and Supports Broker service providers act in the best interests of the participant and support the participant's right to direct their own services.

1. Participant Choice and Authority:
The appointment of a non-legal representative is entirely voluntary and at the discretion of the adult participant. The participant retains full authority to change their Support Broker (voluntary or paid service) at any time.

2. Safeguards and Oversight:
- The Support Broker (voluntary or paid service) must complete mandatory training on Abuse, Neglect, and Exploitation (ANE) to ensure awareness and prevention of harm.
- Monthly consultant check-ins are conducted directly with the participant to monitor service quality and participant well-being. The non-legal representative does not attend these meetings to preserve participant autonomy and confidentiality; allowing the participant to work with their consultant to seek a new Support Broker (voluntary or paid service) as needed.
- The non-legal representative does not possess budgetary authority and may not make financial decisions on behalf of the participant.
- To prevent conflicts of interest, the Support Broker (voluntary or paid service) may not serve as a paid support provider under any circumstances.

3. Regulatory Framework:
These safeguards and procedures are governed by the New Mexico Administrative Code (NMAC) 8.314.6 and the Mi Via Service Standards, which outline the roles, responsibilities, and protections associated with participant-directed services.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Respite	☑	☑
Skilled Therapy for Adults	☑	☑
Personal Plan Facilitation	☑	☑
Transportation	☑	☑
In-Home Living Supports	☑	☑
Home Health Aide Services	☑	☑
Customized Community Group Supports	☑	☑
Environmental Modifications	☑	☑
Specialized Therapies	☑	☑

Waiver Service	Employer Authority	Budget Authority
Employment Supports	☑	☑
Community Direct Support	☑	☑
Nutritional Counseling	☑	☑
Individual Directed Goods and Services	☑	☑
Homemaker/Direct Support Services	☑	☑
Private Duty Nursing for Adults	☑	☑
Emergency Response Services	☑	☑
Behavior Support Consultation	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The FMA is procured according to New Mexico Procurement Code, a contract is signed, and individual participants are supported at the local level.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment will be negotiated during the contracting process. The FMA Contractor will be compensated by monthly fee per participant, as negotiated with the FMA Contractor.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☑ **Assist participant in verifying support worker citizenship status**
- ☑ **Collect and process timesheets of support workers**
- ☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☐ **Other**

  Specify:

Supports furnished when the participant exercises budget authority:

- ☑ **Maintain a separate account for each participant's participant-directed budget**
- ☑ **Track and report participant funds, disbursements and the balance of participant funds**
- ☑ **Process and pay invoices for goods and services approved in the service plan**
- ☑ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

  Specify:

Additional functions/activities:

- ☑ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☑ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☑ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

  Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

HCA contracts with the FMA and monitors reports submitted by the FMA to ensure contract compliance. Monthly reports are monitored to ensure all services paid on behalf of the participant are included in the participant's approved SSP and budget; all services paid on behalf of the participant are accurately processed by the FMA; and all claims are submitted to the MMIS appropriately. The State implements corrective actions with the FMA as necessary.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☑ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	☐
Support Broker Services	☑
Skilled Therapy for Adults	☐
Personal Plan Facilitation	☐
Transportation	☐
In-Home Living Supports	☐
Home Health Aide Services	☐
Customized Community Group Supports	☐
Environmental Modifications	☐
Specialized Therapies	☐
Employment Supports	☐
Community Direct Support	☐
Nutritional Counseling	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Individual Directed Goods and Services	☐
Homemaker/Dir ect Support Services	☐
Private Duty Nursing for Adults	☐
Emergency Response Services	☐
Consultant Services	☑
Behavior Support Consultation	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

While under appeal, participant's services will continue when the option to request Continuation of Benefits is Selected. With a "continuation of benefits", the participant's current budget and SSP may not be revised until the conclusion of the administrative hearing process. The option to request a Continuation of Benefits is provided through a denial letter from the TPA.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

When participants are allocated to waiver services, they are allocated to one waiver slot. They have the choice of the Mi Via Waiver or the Developmental Disabilities (DD) Waiver. They are allocated for services to the waiver they choose.

If a Mi Via waiver participant chooses to move to DD waiver, their Mi Via waiver "slot" goes with them to the DD waiver and vice versa. If Mi Via participant, who transitions from the DD or MF Waiver, decides to discontinue self-directing, may transition back to the DD or MF Waivers. The participant is assisted with the transition process and accessing services by the Mi Via Consultant and the DD Waiver Case Manager, both of whom coordinate Mi Via and traditional waiver services, plans and budgets to ensure that there is timely revision of the SSP, that there is no duplication of services and that there is no break in delivery of services needed.

A new Mi Via participant, who decides to discontinue self-directing their services, may transfer to the DD waiver. An individual that desires to transition out of Mi Via and into another waiver program will continue to receive the services and supports from the Mi Via Waiver until the day before the new waiver services start. This will ensure that no break in service occurs. The Mi Via Consultant and the DD Waiver Case Manager will work closely with the participant, and each other, to ensure that the participant's health and safety is maintained. The HCA Mi Via staff will also monitor the transition process as necessary.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Criteria for Involuntary Termination from Self-Direction Waiver Services (Mi Via)

Individual preferences and dignity are taken into consideration but the state also has an obligation to maintain health and safety in the circumstances of imminent risk of death or risk of irreversible or serious bodily injury or putting others in imminent danger despite focused technical assistance. In the event of involuntary termination from self-direction, individual preferences and dignity will be taken into consideration during any focused technical assistance attempts to identify alternatives for support. The state will maintain the obligation to involuntarily terminate those who are at immediate health and safety risk associated with self-direction (e.g. imminent risk of death or risk of irreversible or serious bodily injury or putting others in imminent danger) despite focused technical assistance.

A participant may be terminated involuntarily by HCA and offered services through the traditional waiver or through the Medicaid State Plan under the following circumstances:

1. The participant refuses to follow Mi Via program rules and regulations after repeated and focused technical assistance and support from the program staff, consultant, and/or FMA.
2. The participant is at immediate health and safety risk associated with self-direction, e.g., imminent risk of death or risk of irreversible or serious bodily injury related to participation in the waiver. Examples include but are not limited to:
   - The participant refuses to include and maintain services on their Service and Support Plan (SSP) and budget that would address health and safety challenges identified in his/her Level of Care assessment and the In-Home Assessment after repeated and focused technical assistance and support from the program staff, Consultant, and/or FMA.
   - The participant is experiencing significant health or safety needs, and, after having been referred to the State-Mi Via Unit for level of risk determination and assistance, refuses to incorporate the Team's recommendations, including resources referred to, into their SSP and budget (as applicable).
   - The participant puts themselves and/or others in danger.
3. The participant misuses Mi Via funds following repeated and focused technical assistance and support from HCA and the Consultant Agency and/or FMA.
4. The participant commits Medicaid fraud.
5. When HCA is notified the participant continues to utilize employees/vendors who have consistently been substantiated against for abuse, neglect, exploitation while providing Mi Via services after notification of this on multiple occasions by HCA.

An individual that is involuntarily terminated from the Mi Via Waiver program will be offered a non-self-directed waiver alternative. The participant will continue to receive the services and supports from the Mi Via Waiver until the day before the new waiver services starts. This will ensure that no break in service occurs. The Mi Via Consultant and the Traditional Waiver Case Manager in the new waiver will work closely with the participant and each other to ensure that the participant's health and safety is maintained. The HCA Mi Via staff will also monitor the transition process.

The client Fair Hearings processes will apply, as described in Appendix F.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		4155
Year 2		4570
Year 3		5027
Year 4		5530

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 5		6083

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☑ **Select staff from worker registry**

☑ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The state's method to conduct background checks, does not vary from, and is outlined in Appendix C-2-a.

☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☑ **Determine staff wages and benefits subject to state limits**

☑ **Schedule staff**

☑ **Orient and instruct staff in duties**

☑ **Supervise staff**

☑ **Evaluate staff performance**

☑ **Verify time worked by staff and approve time sheets**

☑ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☑ **Reallocate funds among services included in the budget**

☑ **Determine the amount paid for services within the state's established limits**

☑ **Substitute service providers**

☑ **Schedule the provision of services**

☑ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☑ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☑ **Identify service providers and refer for provider enrollment**

☑ **Authorize payment for waiver goods and services**

☑ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Participants in Mi Via have authority to expend waiver funds for services through an approved annual budgetary amount that is to be expended on a monthly basis. Each participant's annual individual budget is based on the 2007 Developmental Disabilities Waiver (DDW) Annual Resource Allotments (ARA) method. The ARAs allow the individual to utilize a flexible combination of services that are identified in the traditional DDW Individual Service Plan (ISP) up to the maximum available amount. Quarterly and annual review of Mi Via participant expenditures shows that average participant budget expenditure falls below the established IBA. The 2007 DDW ARA budget method is applicable using today's costs.

Adult Budget Methodology

The adult (21 and over) Mi Via budgetary Allocation are developed using the ARAs for residential services, deducting the cost for case management services and the State applied a 10 percent (10%) discount to the net remaining amount. The ten percent (10%) discount, which reflects administrative/overhead agency costs that are not provided by and included in the reimbursement to self-directed providers, is used to fund the fiscal management role under the self-directed waiver. The State performed this calculation for the remaining adult level of care ARAs. The State then calculated a weighted budget using the new amounts multiplied by the number of participants at the time of calculation in each corresponding level of care category to get a total cost divided by the total number of participants. The weighted residential ARA developed is added to the annual cost of the most flexible and community-oriented Community Living Service in the traditional DDW, Family Living, to derive the Adult Budgetary allotment for Mi Via.

Children's (0 - 20 years) Budget Methodology

The same methodology utilizing the DDW ARAs for children was applied. Generally, in New Mexico, children under 18 have residential options available through the Children, Youth and Families Department rather than through Waiver services. However, under the DDW, young adults ages 18-20 are eligible for Community Living Services. Should a young adult require residential or similar supports, a budgetary amount equal to Intensive Independent Living (IIL) under the DDW would be made available. The Intensive Independent Living rate was chosen as it provides assistance to an individual living at home or in their own home for 100 to 300 hours per month. This is equivalent to 8-10 hours per day and should provide sufficient support as these individuals are still receiving school services during the day.

The assigned budgets change as the person ages, at the time of the change or at recertification.

Medically Fragile

The State applies the same methodology to persons on the Medically Fragile Waiver (MFW) that transition to Mi Via, as they also would benefit from services available to other persons with developmental disabilities. The annual Mi Via budget for medically fragile children is calculated by removing case management and the ten percent (10%) discount (as with other Mi Via budget methodologies). The resulting budget, when included in the weighted calculations, is consistent with the weighted average of budgets for other children with developmental disabilities. For medically fragile individuals 21 years and over, the rates developed for Adults with Developmental Disabilities will apply including the opportunity to access community living services or enhanced supports.

Availability to the Public

The budget methodology for Mi Via is made available to the public. The waiver is posted to the HCA websites. The budget methodology is listed in the application.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant's Consultant has information regarding the budget and informs the participant of their individual annual budgetary allotment as the budget is being developed. The participant is also made aware of the total proposed SSP and budget amount once the budget development process is complete. The amount of the annual budget cannot exceed the participant's individual annual budgetary allotment. The rare exception would be a participant whose assessed or documented needs, based on their qualifying condition, cannot be met within the annual budgetary allotment, in which case the participant would initiate a request for an adjustment through their consultant. The participant and Support Broker (voluntary or paid service), if applicable, tracks budget usage over the course of the year through the monthly spending reports provided by the FMA.

The participant's budget is sent by the Consultant to the Third-Party Assessor (TPA) for review. The TPA will either approve, partially approve, or deny the budget. The budget is then sent to the participant with a letter of approval, partial approval, or denial of services. If any action is taken resulting in a reduction, termination, modification, suspension or denial of services, the Participant is notified in writing by the TPA of that action and his/her right to request a reconsideration and/or a fair hearing with the State Medicaid agency.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (•) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMA and Consultant work with the participant and Support Broker (voluntary or paid service), if applicable, to ensure that the budget is utilized according to the SSP. The State and the FMA have established two safeguards for the timely prevention of premature depletion or underutilization of the participant-directed budget:

1. The FMA sets up an individual account, based on the participant's approved individual SSP and budget. Expenditures are made against the account that follows the participant's SSP and authorized budget. The FMA generates a monthly report that is provided to the participant. The reports are a means for timely prevention of the premature depletion of the participant-directed budget. The reports include each service category, total approved dollars in the budget, total spent to date, and unused dollars.

2. The monthly report is provided to the participant to allow them to review for accuracy of expenditures, identify any inaccuracies, and for monitoring of budget balance. When problems are identified, the Consultant, FMA, and participant work together to find solutions and make changes as indicated. The reports can also be used to track budget underutilization. Real time reports are available at any time to the participant, consultants and state Mi Via staff through the online portal.

3. In addition to real-time and monthly reporting, the participant, Consultant, and Support Broker (voluntary or paid service), if applicable, and the State have online access to the participants budgetary and service plans via the FMA's online portal. Participants and Support Brokers receive training on the access and use of online portal, prior to receiving services. At any time, the approved budget, per service, charges and expenditures, timesheets, payments, balances can be viewed. When problems are identified, the Consultant, FMA and participant, and Support Broker (voluntary or paid service), if applicable, will work together to make changes as indicated.

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.

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

1. The participant is given information by the Consultant Agency (CA) during the initial training on Mi Via about his or her right and how to request a Fair Hearing, as set forth in the New Mexico Administrative Code (NMAC) 8.352.2 Recipient Hearing Policies. When services, the budget, LOC, and other waiver decisions result in a reduction, termination, modification, suspension, or denial of services, the participant is notified in writing about the right to a Fair Hearing. Consultants are trained in this process and available to assist participants in understanding how to request a Fair Hearing.

2. Various agencies are responsible for notifying the waiver participant of their right to a Fair Hearing as defined by 8.352.2 NMAC. A participant may request a Fair Hearing when they believe that the Health Care Authority (HCA) has taken an action erroneously. The participant is informed by the TPA, or the HCA, in writing, of the opportunity to request a Fair Hearing when Medicaid services are terminated, modified, reduced, suspended or denied, also called an adverse action. The adverse action letter explains the participant's right to continue to receive services during the Hearing process and the time frame to request continued services. The agencies responsible for notification of Fair Hearings are responsible for maintaining documentation of the notification.

a. The TPA Contractor provides notice to the HCA and the individual when an individual does not meet level of care criteria.
b. The TPA Contractor provides notice when services are denied, reduced, terminated, modified, or suspended.
c. The HCA/Developmental Disabilities Supports Division (DDSD) provides notice when HCA determines that an individual does not meet the definition of developmental disabilities.
d. The HCA/Income Support Division (ISD) office provides notice when an individual does not meet financial and/or medical eligibility criteria.
e. The HCA provides notice when an individual is involuntarily terminated from the Mi Via program.

3. Website postings https://www.hca.nm.gov/office-of-fair-hearings-faq/

4. Hard copy informational documents distributed by HCA and Office of Constituent Affairs at regular stakeholder meetings and public forums;

5. Written notice of rights accompanies the waiver application provided to the applicant, guardian and authorized representative at the start of the application process; and

6. Verbal explanation provided by HCA regional Offices as requested

AGENCY CONFERENCE

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.

CONTINUATION OF BENEFITS

The participant is informed of how to request a continuation of benefits during the period while the participant's appeal is under consideration through their Consultant as well as through information provided on the TPA's notice of denial of service. The TPA notice is sent to the participant and includes information on how to request a continuation of benefits and fair hearings rights.

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.

HCA operates the additional dispute resolutions process known as an Agency Review Conference (ARC).

The written notice provided by the TPA Contractor when a service is denied, reduced, terminated, modified, or suspended also includes information on how to request a reconsideration if the individual is dissatisfied with the LOC or service/budget decision as set forth in the New Mexico Administrative Code (NMAC) 8.350.2 Reconsideration of Utilization Review Decisions. The notice includes information on reconsiderations and fair hearing rights. Within the notice, the participant and/or guardian is informed that the dispute resolution mechanism is not a pre-requisite or substitute for a Fair Hearing.

A reconsideration request must be received by the TPA Contractor within 30 calendar days of the decision notice. The TPA Contractor furnishes the reconsideration decision within 10 business days of receipt of the reconsideration request. If the reconsideration decision is adverse to the individual, the TPA Contractor issues a notice that includes a statement advising the individual that he or she can request a fair hearing.

Eligible recipients are also offered the opportunity to participate in an Agency Review Conference (ARC) to allow the eligible recipient to meet and discuss the fair hearing issues to attempt clarification and possible resolution before the Fair Hearing.

The right to a Fair Hearing is preserved in 8.314.6 NMAC Mi Via Home and Community-Based Services Waiver, 8.352.2 NMAC Claimant Hearings, and 8.350.2 NMAC Reconsideration of Utilization Review.

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:

HCA is responsible for the operation of the grievance/complaint system.

• **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).

Participants may register a complaint or grievance about any issue they are dissatisfied with as it relates to the Mi Via Waiver. Participants may register complaints with HCA via email, mail, or by phone. The participant is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing.

When a complaint is received regarding a Consultant Agency, the participant will be encouraged to follow the Consultant Agency grievance/complaint procedures they are required to have per the Mi Via Standards (NMAC 7.26.4 Client Complaint Procedures). If the complaint is not resolved after the utilization of the Consultant Agency procedures, the Participant may file a complaint/grievance in writing or orally with the HCA Mi Via Unit staff who will adhere to the NMAC Regulation 7.26.4 regarding Client Complaint Procedures. If received in writing, the complaint/grievance will be acknowledged when received by the Mi Via Unit staff with the Participant. Upon receipt, the complaint/grievance will be tracked by the HCA.

The NMAC Regulation 7.26.4 requires the review of the complaint and notification to the Consultant Agency within 5 days of receipt of the complaint to obtain their response to the complaint if it has already been registered with them. HCA will determine if a full investigation is required to address the complaint and if so, will initiate an investigation into the complaint and will complete a report within 45 days of receipt of the complaint. If the HCA determines a full investigation is not necessary, the HCA will issue a report within 15 days of the receipt of the complaint. The Division Director will review the report and issue a written decision within 10 days of the receipt of the written report unless further investigation is warranted and at that time which should be completed in 14 days unless extension is granted by the Division Director. An Administrative Appeal can be initiated by the Participant if the complaint/grievance is not addressed satisfactorily at that time. Corrective action plans, sanctions or other relief or a complaint may occur as a result of this process.

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

The FMA tracks complaints and applies an internal standard for complaint resolution: urgent inquiries are reported to HCA within four (4) hours of reporting and must be resolved by close of business; resolution for high, medium, and low priority inquiries are completed in twenty-four (24), forty-eight (48) and seventy-two (72) business hours respectively.

Oral or written complaints and grievances from a participant to the TPA are resolved within thirty (30) calendar days of the date of the event causing dissatisfaction. Within five (5) business days of receipt of a complaint, the TPA provides a written acknowledgement that the complaint has been received and the expected resolution date. The TPA has thirty (30) calendar days of the date of the receipt of the complaint to investigate and render a final resolution. Informal grievances are documented and reported to the TPA Quality Improvement (QI) Department.

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

HCA REPORTING PROTOCOLS:

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

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

Training and information on reporting critical incidents is provided several ways: training and information, including incident reporting forms and phone numbers, is provided to participants and/or family members or legal representatives at the initial enrollment meetings and during the annual plan renewal meetings. As noted in Appendix E-1e., the basic Mi Via training includes a section on self-protection, how to recognize abuse, neglect and exploitation, and where to go for help.

Prior to working with the participant, Consultants must take the initial face-to-face training from HCA on incident reporting, abuse, neglect and exploitation. The online refresher training is required annually after the initial face to face training for all Consultants. Each Consultant Agency is required to have someone from that agency be trained as a trainer.

Consultants are required to train the participant and have the availability to offer face to face trainings, if requested. Consultants are resources to provide direction to participants, staff and circles of support. Consultants will work with participants to assure staff are trained on incident reporting, abuse, neglect and exploitation annually. Consultants are also responsible for providing Mi Via participants the HCA Reporting Suspected Abuse, Neglect and Exploitation Flyer at least annually. Online training is required for all participant employees and Support Brokers.

Information regarding abuse, neglect and/or exploitation as well as state reporting requirements for this will be distributed through employee and vendor packets.

This information is reinforced by the Consultants, who work with participants during the planning and monitoring process. HCA presents an abuse, neglect and exploitation training to identify the indications of abuse, neglect and exploitation as well as identify risk factors and risk reduction. HCA/DHI is also responsible in disseminating information about training and education to participants, families, and/or legal representatives.

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 HCA receives reports and investigates incidents of abuse, neglect, exploitation and death. The entire intake process must be completed within three (3) days following the date of receipt. The IMB does have an extended intake process that can be requested by the intake specialist in order to receive appropriate documentation.
Upon receipt of the Incident Report, HCA intake staff:
I. Search and print a history from the database of prior reported incidents (past 12 months) on the individual consumer
II. Verify or attain 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.
III. Triage/Intake Investigation is the decision process utilized by Intake staff to determine priority, severity and assignment of the case. Intake staff will triage the case within one working day of receipt; the IMB does have an extended intake process that can be requested by the intake specialist to receive appropriate documentation.

A. Reportable Incidents
A decision is made regarding whether the reported incident meets the definition of at least one of the seven categories of reportable incidents listed below. Categories include: Abuse; Neglect; Exploitation; Death; Environmental hazard; Suspicious Injury, and Financial abuse.

If the incident meets the definition of reportable, the following steps are taken:
1. Review Consumer History
Identify possible trends

2. Determine Severity and Priority
Medical Triggers that receive priority: Aspiration, fractures, dehydration, and a history of multiple emergency room (ER) visits (in a short period of time).
Priority is described as:
Emergency Case: Harm or potential for harm that is life threatening or could result in long term disability, or an unexpected death.
Allegations that the consumer is in a state of serious harm or potential for harm that is life threatening or could result in long term disability or unexpected death.
Due to the severity of the case the investigator will respond within three (3) hours.
Emergency Allegations include but are not limited to:
- Serious injuries - fractures, head injuries, lacerations requiring sutures, serious burns, internal injuries
- Lack of life sustaining medications
- Sexual abuse where there is danger of repeated abuse
- Severe lack of basic physical necessities that could result in dehydration or starvation
- Need for immediate medical attention to treat conditions that could result in irreversible physical harm - severe respiratory distress, unconsciousness, gangrene, advanced bedsores
- No caregiver is available, and the consumer is unable to perform critical personal care activities

Investigation Emergency Factor: serious risk that delay will impede collection of evidence.
Priority One: Harm or potential for harm that is moderate to serious but not life threatening; allegations that the consumer is abused, neglected, financially exploited and as a result is at risk of moderate to serious harm. The investigator will respond within twenty-four (24) hours, but does not require more immediate action.
Priority 1 allegations include but are not limited to:
- Falling or being pushed, hit or scratched which is alleged to have resulted in bruises or other injuries or severe mental anguish
- Critical need for medical or mental health treatment - disease or illness that is acute but not life threatening, small bedsores or pressure spots, insufficient food or medicine but not life-threatening
- Sexual abuse of consumer but clearly no danger of repeated abuse
- Threats of physical violence or harm to the consumer
- Improper use of the consumer's income or resources such that they are unable to meet basic needs or is threatened with substantial loss of income or resources.

Priority Two: Low or minimal potential for harm; all other allegations that the victim is in a state of abuse or neglect. The investigation will be initiated within five (5) calendar days.
Priority 2 allegations include but are not limited to:
- Verbal abuse - harassment, cursing, degrading remarks, intimidation
- Being pushed or scratched when there are no bruises, other injuries or severe mental anguish
- Marginal care
- Need for medical or mental health treatment that is not urgent - poor nutrition that is not acute

- Improper use of resources or income but the consumers' needs are being met

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

4. Determine Children Youth and Families Status: Reconciling Cases Children, Youth and Families Department (CYFD) Child Protective Services (CPS)
If CYFD (CPS) has accepted the case for investigation, and HCA has jurisdiction then the case will be assigned a HCA/DHI investigator and will be a collaborative investigation process.
If the HCA does not have jurisdiction, and the case involves an allegation of abuse, neglect, or exploitation, it will be referred to CPS after the Triage process.

5. The intake staff will then document the Triage decisions

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

7. After Data entry, the IR and attachments are given to the support staff for faxing to the assigned investigator and notifications to the appropriate entities within the required timeline dependent on priority.

8. Once all faxing has been completed, IMB intake will file the entire packet in the appropriate file and make a file folder for cases closed during the Intake process. Closure notifications will be sent at this time for each case completed during Intake to Consultants, guardians and the provider.

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

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

2. As appropriate Notifications should be made to the following entities:
Office of the General Counsel (OGC), HCA, ALTSD (APS),ALTSD (EDSD),CYFD (CPS),HCA/DHI and DDSD Director's Office, Law Enforcement, HCA/MAD, Medicaid Fraud Control Unit, NM Attorney General's Office, OIA, HCA
When an individual is at imminent risk for continued harm the immediate steps required to protect the safety of the individual is to contact law enforcement for intervention. The appropriate state agencies will follow up as applicable.
Reports and Trends
Numerous reports are generated and trends are addressed, including:
A. Multiple allegations for participants in one quarter are discussed by the HCA/DHI and appropriate interventions are taken as needed.
B. Multiple incidents for a participant are discussed by the HCA/DHI and appropriate interventions are taken as needed.
C. HCA/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 Mi Via 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 to HCA/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 and is staffed with a Supervisor who has the discretion of lowering or raising the status on any report. The report is generated electronically and submitted to the Supervisor for review to insure all the information is correct and the allegations match the narrative. The Supervisor then processes and assigns the report to the county where the family resides. The report is called out telephonically and an electronic report is created in the FACTS system, accessible by the particular county.

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

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

• Screen-Out which requires no investigation - These reports are faxed to law enforcement and the New Mexico Regulation & Licensing Department (as needed). Hard copies are kept at SCI for 18 months and then archived.
All reports generated at SCI whether investigated by CYFD or not are cross reported to local law enforcement agency. CYFD's Investigations Unit in each County then takes over the case.
Notification to the Participant:
In each situation that critical incident investigations are completed by APS, CYFD/CPS, or HCA/DHI, the Mi Via 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 Department of Health, Division of Health Improvement (HCA/DHI) has forty-five (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 seven (7) days to review and approve the closure of the investigation. If there is no further action needed at that time, a letter of findings is sent to the Consultant, Participant/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.

HCA is responsible for trending, remediation and oversight of critical incidents and management. As with all components of the Quality Improvement Strategy, HCA analyzes aggregated data and identify trends. Quality assurance and quality improvement action plans can be developed as needed, based on identified trends and other identified issues in order to prevent re-occurrence. The aggregated data and identified trends are then reported to the (DDSQI) for review. Trending and analysis of the data are used to prioritize improvements of the quality management system.

The operating agency, HCA, reviews incidents monthly through the "Regional Quality Management Meetings" that HCA and DHI attend to identify/review trends and any areas of necessary remediation. The Mortality Review Committee also meets monthly. Issues/concerns are followed up with the Mi Via Unit who then follows up with the Consultant Agency and informs HCA.

To meet CMS Assurances G (Health and Welfare) and H (Administrative Authority), the State of New Mexico uses critical incident data-including reports of Abuse, Neglect, and Exploitation (ANE)-to identify risks, respond quickly, and prevent future occurrences through the following processes:

- Data Review and Analysis: The state reviews incident data regularly to identify trends and inform necessary changes by provider, region, individual, and systemic level. In addition, the Division of Health Improvement reports systemic issues to the Developmental Disabilities System Quality Improvement Committee (DDSQI) to review the system as a whole and make recommendations for system improvements and participant protections.
- Targeted Action: Based on data findings, the state may require corrective action plans (CAP), provide technical assistance, contract management activities or adjust provider oversight. The Health Care Authority can refer providers with higher incident rates to the Internal Review Committee to identify further sanctions to include but not limited to closer monitoring and support, civil monetary penalties or termination of provider agreements,

This data-driven approach helps the state protect participants, improve provider performance, and uphold CMS requirements for health, safety, and effective oversight.

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 Consultant. Issues brought to the Mi Via Unit staff or Regional Offices by concerned Consultants will be addressed in terms of options or resources for the participant to pursue in mitigating their risks. HCA/DDSD 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 Mi Via waiver participants. HCA investigates and follows up regarding providers and critical incidents.

Appendix G: Participant Safeguards

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

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

- (●) **The state does not permit or prohibits the use of restraints**

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

HCA monitors safeguards against the use of restraints/restrictive interventions/seclusion through the Monthly Contact Form that is completed during the face-to face consultant-participant meetings.

The Monthly Contact Form is used in capturing information concerning the prohibited use of restraints/or restrictive interventions/seclusions. The Mi Via participant is directly asked if while utilizing Mi Via services if they have been restricted, retrained, or secluded in any way. Is so the Consultant will begin addressing any issues or concerns related to the use of these types of interventions. The state can be of assistance to Consultants determining any issues related to the use these types of interventions. Additionally, Consultants are trained to report, abuse, neglect, exploitation to the Department of Helth, Division of Health Improvement should they suspect this occurring as part of their monthly reviews. Participants are also trained by their Consultants on reporting requirements. The monthly reviews are also designed to assess participant satisfaction or concerns with service delivery.

○ **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 Consultant Monthly Site Visit Tool that is completed during the face-to-face consultant-participant meetings.

The Consultant Monthly Site Visit Tool is used in capturing information concerning the prohibited use of restraints/restrictive interventions/seclusion. The Mi Via participant is directly asked if while utilizing Mi Via services they have been restrained, restricted or secluded in any way. If the consultant will begin addressing any issues or concerns related to the use of these types of interventions. The state can be of assistance to consultants determining any issues related to these types of interventions. Additionally, consultants are trained to report abuse, neglect, exploitation to the HCA Division of Health Improvement (DHI) should they suspect this is occurring as part of their monthly reviews. Participants are also trained by their consultants on reporting requirements. The quarterly reviews are also designed to assess participant satisfaction or concerns with service.

○ **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 Consultant Monthly Site Visit Tool that is completed during the consultant/participant meetings.

- ( ) **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:
Number and percent of substantiated abuse, neglect and exploitation (ANE) and unexplained death investigations resulting in a corrective action plan (CAP) initiated by the HCA. Numerator: Number of substantiated ANE incidents and unexplained deaths involving participants that resulted in a CAP. Denominator: Number of substantiated ANE incidents and unexplained deaths involving participants

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

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

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

Data Aggregation and Analysis:

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

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:
Number and percent of Mi Via participants' critical incidents that were reported,

initiated, reviewed and resolved within required time frames as specified in the approved waiver. Numerator: Number of accepted participant critical incidents that were resolved within required time frames. Denominator: Number of accepted and reported participant incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHI tracking reports

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver providers trained on how to identify, address and seek to prevent abuse neglect, exploitation and unexplained deaths. Numerator: Number of waiver providers trained on how to identify, address and seek to prevent abuse, neglect, exploitation and unexplained death. Denominator: Total number of waiver 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: DHI	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-

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

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

Performance Measure:
Number and percent of Mi Via waiver participants without confirmed reports of restrictive interventions (including restraints and seclusion). Numerator: Number of Mi Via waiver participants without confirmed reports or restrictive interventions. Denominator: Total number of Mi Via participants.

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

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

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:
Number and percent of waiver participants who received physical exams in accordance with state waiver policies. Numerator: Number of waiver participants with a completed history and physical. Denominator: Total number of waiver participants.

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

LOC assessment documentation; HCA/MAD audits of TPA contractor.

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

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 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 are identified by the State related to health and welfare, processes are in place to ensure that appropriate and timely action is taken. In addition, DDSQI routinely collets, 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 HCA identifies at any time any issues that are inconsistent with Medicaid requirements related to health and welfare, 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	☑ **Annually**

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

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 primary goals for Mi Via's Quality Improvement Strategy (QIS) are to administer and evaluate a quality improvement system that:

- Supports participants in exercising greater choice and control over the types of services and supports that are purchased within a State assigned budgetary amount;
- Serves the most people possible within available resources;
- Identifies opportunities for improvement and ensures action, when indicated; and
- Ensures that the State meets each of its statutorily required assurances to CMS.

The Developmental Disabilities Services Quality Improvement (DDSQI) Executive Committee (comprised of HCA and DHI) utilizes the following measures and processes to ensure that the Mi Via Waiver program is meeting its QIS goals:

- Performance Measures: Performance measures are specific to each of the Waiver assurances and are described in Appendices A, B, C, D, G, and I. The Waiver assurance workgroups report to the DDSQI Steering Committee where data 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.
- Processes: The role of the DDSQI Committee is to ensure continuous quality improvement. The DDSQI Steering Committee is responsible for making systemic improvements to the Mi Via Waiver based on compliance monitoring. This committee has regularly scheduled meetings and an annual schedule by which it reviews data collected from various waiver programs. Workgroups, each of which are composed of at least one State agency representative, develop and implement quality improvement strategies which are reported back to the DDSQI Committee.

Performance data is reviewed through the Developmental Disabilities Services Quality Improvement work groups and Executive Committee.

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

The system design changes are communicated by the DDSQI to DDSD senior management, as well as the Mi Via Program staff and Contract Managers, who, in turn, inform the Contractors through letters of direction, as indicated, and other identified stakeholders of any changes that are directed or implied with the new system design. This information is shared at the time the decision is made and again when the change is implemented.

The format for the information is determined by the change and its perceived impact on participants and stakeholders. Information-sharing formats may include letters, announcements at scheduled meetings, website updates and state-wide meetings to share the information. If the Mi Via Service Standards or State regulation changes are needed, the State will follow applicable State rules.

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

The Advisory Council on Quality (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 Mi Via Waiver Stakeholders, which can include individual participants and their families. Findings are typically communicated to the Advisory Council on Quality and the Mi Via Advisory Committee (MVAC) during regularly scheduled meetings. These two committees include membership of Mi Via participants and, families, and consultants. The Mi Via monthly

newsletter serves as an avenue to present findings as does the Mi Via website in terms of getting information to families and participants. The ACQ participants give feedback and recommendations to HCA.

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: HCA/DDSQI FMA, Consultant Agencies, and the TPA Contractors. CA	☑ **Other** Specify: Additional monitoring/analysis will be done, as necessary, to address unusual/urgent issues.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The DDSQI Committee and its assurance workgroups monitor and analyze the effectiveness of system design changes by utilizing the ongoing process described in H.1.a.i. The workgroups utilize the data collection and strategies; the DDSQI Committee utilizes the review and analysis processes and reports that are sent by the workgroups. As part of its ongoing review of data collected, the DDSQI Committee considers the findings related to system design changes and incorporates them into the HCA program planning process.

The DDSQI has regularly scheduled meetings to review the performance data collected. The workgroups of the DDSQI meet to develop and implement quality improvement strategies related to the performance data collected. The DDSQI is also utilized for the 1915 (c) Developmental Disabilities and Medically Fragile home and community-based waivers.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

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

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

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

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

The Health Care Authority (HCA) contracts with the FMA, which is responsible for determining that providers of services and goods meet required qualifications. HCA has oversight responsibility of the FMA. The FMA reviews claims submitted for payment by the participant's provider and/or vendor to determine if the claims are consistent with the participant's approved Service and Support Plan and participant's budget. Based on this review, the FMA pays, suspends or denies payment. The FMA, in turn, bills HCA for claims paid retrospectively; HCA pays the FMA if claims are coded correctly and in accordance with the participant's authorized individualized annual budget. The FMA is required to conduct a 100 percent review of all paid claims to ensure all claims are correctly coded and paid in accordance with specific waiver requirements. The FMA submits a report titled, "Claims Paid-Detail" monthly to HCA which details the number of paid claims per each participant. HCA conduct an annual audit of the FMA to determine compliance with the contract, including oversight of provider qualifications and claims payment. An annual post-payment audit is conducted via a systematic random sample of the FMA records for monitoring purposes.

The annual post payment audit process for the FMA providers is comprised of a desk audit conducted by state staff of a representative sample of Mi Via post payment timesheets and vendor claims. Post payment timesheets and vendor claims are compared to participant budget plans and reviewed for frequency, type, and scope of service. To verify service delivery, the FMA sends out an Explanation of Medical Benefits (EOMB) to a random selection of waiver participants requesting them to verify date and service delivery.

The State does not require an independent audit of provider agencies.

In accordance with the Single Audit Act, the State Auditor of New Mexico contracts with an independent auditor to conduct an annual audit of the Health Care Authority (HCA) Medicaid program. This audit includes both a financial audit and a compliance audit focused on the program's allowable costs, ensuring accountability for federal funds and adherence to applicable regulations.

Electronic Visit Verification (EVV): Electronic visit verification (EVV): A telephone and computer-based system that electronically verifies the occurrence of selected services, as required by the 21st Century CURES Act. The EVV system verifies the occurrence of authorized service visits electronically by documenting the precise time and location where service delivery visit begins and ends. EVV is implemented according to federal requirements and timelines. The 21st Century CURES Act requires EVV for personal care services (PCS), defined as services that help with activities of daily living (ADLs) or instrumental activities for daily living (IADLs) effective January 1, 2020, and for home health services effective January 1, 2023. For Home Health services effective January 1, 2023. For Mi Via there are two services that MUST use EVV to clock in and out. The services are Homemaker and Respite Standard."

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:
Number and percent of Mi Via timesheets coded correctly in accordance with waiver coding requirements. Numerator: The number of timesheets coded correctly in accordance with waiver coding requirements. Denominator: Total number of timesheets submitted.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Fiscal Management Agent (FMA) audit 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 Contractor*	☑ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☑ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☑ ***Other*** *Specify:* *Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise.*	

Data Source *(Select one):*

Other
If 'Other' is selected, specify:
Fiscal Management Agent (FMA) audit 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*	☐ ***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 Contractor	
	☐ ***Continuously and Ongoing***
	☑ ***Other*** *Specify:* *Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise.*

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

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

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

	Ongoing	*Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of Mi Via claims paid in accordance with waiver claims payment requirements. Numerator: The number of claims paid in accordance with waiver claims payment requirements. Denominator: Total number of claims paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Fiscal Management Agent (FMA) web-based reviews; MMIS exception analysis reports. FMA report, "Claims Paid-Detail" submitted monthly to HCA, detailing the number of paid claims per each participant.

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 Contractor*	☑ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☑ ***Other*** *Specify:* *Additional data collection, analysis, and aggregation will be done, as necessary, to address unusual or urgent issues that may arise.*	

Data Aggregation and Analysis:

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

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

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:
Mi Via Rate Schedule

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction 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 are in place to ensure that appropriate and timely action is taken. In addition, the DDSQI routinely collects, aggregates, analyzes, and trends financial data, as described in Appendix H. Irregularities and/or areas of concern are discussed and remediation strategies are developed.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for*

public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Mi Via participants have their individual budgetary allotments and a range of rates for services, based on Medicaid waiver rates, to utilize in developing their Service and Support Plans and budgets, determining payment rates and negotiating with providers. Participants are informed of the waiver payment range of rates, which are based on what Medicaid currently pays for traditional waiver services, during the Service and Support Planning process. Payment rates for participant-delegated community membership supports, living supports, health and wellness supports, and other supports available through Mi Via will be negotiated by participants in the same way any individual in the community would in making a similar purchase. In the self-directed model, participants are given some flexibility in deciding how much to pay for services and goods; however, both the Service and Support Plan and budget, including payment rates, are authorized by the State, as discussed in Appendix E. The State establishes set rates for the traditional waiver services, such as therapies; however, for Mi Via, the State utilizes a rate range wherein each participant can establish their own rate with a particular provider of the service. This rate range is within the parameters the State uses for the traditional waiver service. For Individual Directed Goods and Services rates are "as approved by the TPA" and must be reasonable. The state determines reasonableness of the cost of Individual Directed Goods and Services based on a cycling review of utilization for the prior to year period. As costs for goods may change over time, the cycling utilization review process will allow the State to revise what may be considered reasonable for a specific item and keep current with the cost of goods in the marketplace. The method of rate determination is consistent across self-directed and provider managed services.

Payment, along with other key components of Mi Via, is discussed with participants and stakeholders during the many Mi Via workgroups and task forces. HCA works collaboratively to determine rates and obtain stakeholder input.

The Developmental Disabilities and Supports Division (DDSD) of the HCA is the state agency that performs the rate determination function and the oversight process that is employed to assure the integrity of the rate setting activity and consistency of rates with approved rate methodologies. In 2024, state law required rate reviews through biennial rate studies, along with the subsequent implementation of rate recommendations derived from these studies, effective July 1 of the year following their completion; therefore, the HCA can increase rates based on Legislative appropriation which includes cost-of-living adjustments. Most waiver services are reimbursed on a prospective, fee-for-service basis, with the exceptions noted below for items that are reimbursed based on cost. Services reimbursed at cost include: Environmental Modifications and Individual Directed Goods and Services. HCA will conduct rate studies with a frequency of every 2 years. The method of aligning rate increases is consistent across self-directed and provider managed services.

When changes to rates are necessary, providers and other stakeholders are notified via mail and the HCA website and are given the opportunity to provide input. All Mi Via Waiver rates are available on the HCA websites. Information about payment rates is made available to waiver participants by the consultant, through the HCA website, and/or upon request by the participant to the State. Once CMS approval is obtained for rates, Fee Schedules are posted on the HCA website.

In 2019 the State conducted a comprehensive rate study for all of its 1915(c) HCBS waivers including the Traditional Developmental Disabilities Waiver (DDW), Medically Fragile Waiver (MFW) and two services in the Mi Via Waiver (MVW). These two services were Consultant Services and In-Home Living Supports (IHLS). Factors that were reviewed during the rate study will included: effect of recent FLSA changes; the CMS Final Rule: HCBS Settings Requirements; EVV; current wages; productivity assumptions; benefits factors; administrative overhead; program support costs; paid time off and training time; and staffing ratios. The rate study assures that rates continually afford participants' access to services and are consistent with efficiency, economy, and quality of care.

The Mi Via Fee Schedule/Range of Rates can be found:
https://api.realfile.rtsclients.com/PublicFiles/6c91aefc960e463485b3474662fd7fd2/b8c2c9ab-e751-4199-b858-6123d303a936/Mi%20Via%20Waiver%20Fee%20Schedule%20

In 2023, the State conducted a comprehensive rate study for all of its 1915(c) HCBS waivers. The following services received rate increases through amendment NM.0448.R03.06, effective date 10/01/2024: Behavioral Support Consultation; Behavior Support Consultation Incentive; Community Direct Support; Customized Community Group Supports; Consultant Services; In-Home Living Supports; Private Duty Nursing Adults RN; Respite Standard; Physical Therapy; Physical Therapy; Occupational Therapy; Occupational Therapy; Speech Language Pathology; Speech Language Pathology; Transportation Mile; and Environmental Modifications. The State of New Mexico is currently conducting a comprehensive rate study of all services in 2025 for the Mi Via waiver program. Findings from the study will inform future rate adjustments.

In accordance with federal requirements, the New Mexico Medicaid agency actively solicits public input on rate determination methods. The agency provides opportunities for stakeholders, including tribes, providers, participants, advocates, and the general public, to review and comment on proposed rate methodologies and rate changes. Prior to submission of proposed rates to CMS via the amendment process, rate methodology is reviewed by a rate study committee. The rate study committee is comprised of providers from across all services and waivers; their work culminates in a set of preliminary recommendations that will be used to inform future rate setting. Final recommendations will be shared publicly through a waiver amendment. Public input is solicited through tribal notifications, public notices and hearings. For details on current public comment activities, please refer to Main Section 6-I, Public Input.

AMENDMENT NM.0448.R04.01 (NM.015.04.01)
Supports Broker Services were added as a new waiver service. The reimbursement rate for this service is based on the recommendations from the 2023 Public Consulting Group (PCG) rate study.

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:*

HCA budgets an annual amount for each individual participant. The Mi Via participant uses the annual amount in developing their Service and Support Plan and individual budget. The FMA pays the participant's providers of services and goods, based on the authorized Plan and budget, and, retrospectively, bills the State for those claims that are paid.

HCA may provide Mi Via Participants the opportunity to purchase approved goods using an electronic purchasing system through the FMA or a debit card. The Participant first obtains a price quote of an approved good and submits to the FMA for review. Once approved, the FMA will electronical purchase the good or load the approved amount onto the Participant's debit card and the participant makes the purchase as authorized.

Provider billings are routed through the FMA for payment. The provider or vendor delivers the service or goods and bills the FMA. The FMA, under its provider agreement with HCA, bills the HCA/MAD Medicaid Management Information System (MMIS) for the services or goods and pays the participant's service provider or vendor based on the authorized SSP and budget.

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 FMA verifies the participant's eligibility, the providers' and vendors' qualifications, and compares all claims submitted against the authorized Service and Support Plan (SSP) and individual budget. The services and goods must be identified in the Service and Support Plan, and the participant or his/her representative is responsible for verifying that services have been rendered by completing, signing and submitting documentation, including the timesheet, as applicable, to the FMA.

The HCA/MMIS pays the FMA after validating that the participant has waiver eligibility on the date of service and that the amount is within the participant's authorized SSP and budget.

Post-payment audits are conducted by the HCA to determine whether the services, supports and goods for paid claims were included in the SSP and budget and were rendered in accordance with Medicaid and the FMA contract requirements. Any paid claims that cannot be validated through the post-payment audit, are recouped and removed from the claim for FFP.

Electronic Visit Verification (EVV): Electronic visit verification (EVV): A telephone and computer-based system that electronically verifies the occurrence of selected services, as required by the 21st Century CURES Act. The EVV system verifies the occurrence of authorized service visits electronically by documenting the precise time and location where service delivery visit begins and ends. EVV is implemented according to federal requirements and timelines. The 21st Century CURES Act requires EVV for personal care services (PCS), defined as services that help with activities of daily living (ADLs) or instrumental activities for daily living (IADLs) effective January 1, 2020, and for home health services effective January 1, 2023. For Home Health services effective January 1, 2023. For Mi Via there are two services that MUST use EVV to clock in and out. For Mi Via there are two services that must use EVV to clock in and out. The services are Homemaker and Respite Standard.

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 HCA pays providers of some or all waiver services through the use of a limited fiscal agent.

The FMA is independent of the entities/persons delivering services or goods to avoid conflicts of interest. Based on the participant's authorized individual Service and Support Plan and budget, the FMA sets up an individual account, makes expenditures that follow the authorized budget, handles all payroll functions on behalf of the participant who hires service providers, other support personnel, and vendors, provides the participant with a monthly report of expenditures and budget status, answers inquiries, solves related problems, and provides the State with a quarterly documentation of expenditures.

All providers bill through the FMA. Vendor and employee packets, provided by the FMA, include instructions and directions on how to bill.

The FMA submits paid claims to HSD for retrospective payment. HSD monitors those claims and the expenditures against the participant's authorized individualized budget. HCA conducts annual audits of the FMA to determine compliance with all provisions of the contract and adherence to Mi Via policies and procedures and to ensure financial integrity and accountability. Where deficiencies are identified, corrective action will be required, according to the terms of the contract.

In addition, post-payment audits are conducted by HCA to determine if the services for paid claims were included in the SSP and budget and were rendered as specified.

☐ ***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:

Los Lunas Community Programs, operated by HCA, may be selected by a participant to provide services as a vendor. The Los Lunas Community Program could provide any Mi Via service if they meet the credentialing requirements, as outlined in the waiver, for that service. This would be determined through Financial Management Agency (FMA) review of the Vendor Agreement. If the program/agency did not meet the credentialing requirements for a particular service, they would not be able to provide that service. The amount of payment to public providers does not differ from the amount paid to private providers of the same services in that private providers and Los Lunas Community Programs may both negotiate their payment rate with the Mi Via participant. The TPA Contractor approves the budget including the payment amount for both the private provider and the Los Lunas Community Programs in the same way. In Mi Via, all payment rates are negotiable within established parameters. However, the aggregate amount of payment to Los Lunas Community Programs for Mi Via services does not exceed the cost of providing those services.

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:

- ***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	71347.25	11718.78	83066.03	152062.59	2304.64	154367.23	71301.20
2	71354.01	12070.34	83424.35	156624.47	2373.77	158998.24	75573.89
3	71365.98	12432.45	83798.43	161323.20	2444.99	163768.19	79969.76
4	71355.93	12805.43	84161.36	166162.89	2518.34	168681.23	84519.87
5	71350.98	13189.59	84540.57	171147.78	2593.89	173741.67	89201.10

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	4155	4155
Year 2	4570	4570
Year 3	5027	5027
Year 4	5530	5530
Year 5	6083	6083

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 335 days, the level reported on the federal fiscal year (FFY) 2024 CMS 372. Since this is a mature waiver, it is assumed that the yearly turnover and length of waiver stay will be fairly stable.

We acknowledge that the reported average length of stay (ALOS) values for waiver years 2021-2023, 295, 267, and 288 days respectively, reflect fluctuations during that period; however, these figures are not representative of long-term trends and were influenced by several temporary and external factors:

Post-COVID Recovery: The waiver experienced significant disruption during and immediately following the COVID-19 public health emergency. Service utilization patterns shifted, and many participants experienced interruptions in care or delayed enrollment, which impacted overall length of stay metrics.

Super Allocation Effects: In response to the availability of American Recovery Plan Act funding, New Mexico implemented the Super allocation, offering waiver slots to all Waitlist members. This led to a rapid influx of new participants, many of whom had shorter initial stays as they transitioned into services. This surge temporarily skewed the ALOS downward.

Given that these factors were atypical, we believe it is reasonable to project a return to pre-pandemic stability in waiver operations. The ALOS of 335 days reflects actual expenditure data for FFY 2024 and historical norms prior to these disruptions and aligns with expectations for a mature waiver with stable enrollment and service patterns. New Mexico will continue to monitor ALOS trends and adjust projections as needed in future submissions.

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 estimated number of users per service was calculated by applying the percentage of users associated with each service, as derived from actual utilization data collected during Federal Fiscal Year (FFY) 2024. For subsequent waiver years, the same percentage of users per service will be applied to the projected Unduplicated Recipient (UDR) count for each year

The average units per user were derived from actual expenditure data from FFY 2024.

Mi Via rates for services are a range of rates. The top dollar amount in the range of rates was used as the average cost per unit. The range of rates does not change from waiver year to waiver year.

AMENDMENT NM.0448.R04.01 (NM.015.04.01)
Support Broker Service was added as a new service. Utilization was estimated to be 25% of the unduplicated recipient counts as 75% of participants are reasonably expected to continue serving as their own Support Broker or utilize an available guardian/family member/natural support to assist with self-direction.

Utilization is estimated to be 30 units per month per participant and trended forward for WY1-WY5 based upon the URD for this waiver. Utilization will be reevaluated after WY2 to determine if any updates are necessary for remaining waiver years.

Rate per unit for Support Broker Services is based on the recommendations from the 2023 Public Consulting Group (PCG) rate study and held constant from WY1-5.

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 utilization data from FFY 2024.

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 reported in actual utilization data from FFY 2024, trended forward at the FFY 2025, Quarter 4, Medicare PPS Market Basket Index of 3.0%.

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' reported in actual utilization data from FFY2024, trended forward at the FFY 2025, Quarter 4, Medicare PPS Market Basket Index of 3.0%.

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	
Consultant Services	
Customized Community Group Supports	
Employment Supports	
Home Health Aide Services	
Homemaker/Direct Support Services	
Respite	
Skilled Therapy for Adults	
Personal Plan Facilitation	
Support Broker Services	
Behavior Support Consultation	
Community Direct Support	
Emergency Response Services	
Environmental Modifications	
In-Home Living Supports	
Individual Directed Goods and Services	
Nutritional Counseling	
Private Duty Nursing for Adults	
Specialized Therapies	
Transportation	

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
Consultant Services Total:						**16881286.80**
Consultant Services	Month	4151	10.00	406.68	**16881286.80**	
Customized Community Group Supports Total:						**2302368.57**
Customized Community Group Supports	15 Minutes	201	1233.00	9.29	**2302368.57**	
Employment Supports Total:						**459994.90**
Employment Supports	15 Minutes	61	1033.00	7.30	**459994.90**	
Home Health Aide Services Total:						**37422.63**
Home Health Aide Services	Hour	1	2177.00	17.19	**37422.63**	
Homemaker/Direct Support Services Total:						**18682239.80**
Homemaker/Direct Support Services	Hour	469	2590.00	15.38	**18682239.80**	
Respite Total:						**11.48**
Respite	15 Minutes	1	1.00	11.48	**11.48**	
Skilled Therapy for Adults Total:						**1342980.00**
Skilled Therapy for Adults	15 Minutes	360	75.00	49.74	**1342980.00**	
Personal Plan Facilitation Total:						**650.00**
Personal Plan Facilitation	Completed Service Plan	1	1.00	650.00	**650.00**	
Support Broker Services Total:						**7723926.00**
Support Broker Services	Hour	1039	360.00	20.65	**7723926.00**	
Behavior Support Consultation Total:						**187159.80**
Behavior Support Consultation	15 Minutes	59	102.00	31.10	**187159.80**	
Community Direct						**85690338.80**

GRAND TOTAL: **296447805.59**

Total Estimated Unduplicated Participants: **4155**

Factor D (Divide total by number of participants): **71347.25**

Average Length of Stay on the Waiver: 335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Total:						
Community Direct Support	15 minutes	3586	1466.00	16.30	**85690338.80**	
Emergency Response Services Total:						**1631.61**
Start-Up/Initiation	Each	1	1.00	0.01	**0.01**	
Monthly Monitoring	Month	4	10.00	40.79	**1631.60**	
Environmental Modifications Total:						**390000.00**
Environmental Modifications	Each	78	1.00	5000.00	**390000.00**	
In-Home Living Supports Total:						**160480153.92**
In-Home Living Supports	Day	2972	282.00	191.48	**160480153.92**	
Individual Directed Goods and Services Total:						**873709.76**
Individual Directed Goods and Services	Item	826	1.00	1057.76	**873709.76**	
Nutritional Counseling Total:						**225.55**
Nutritional Counseling	Hour	5	1.00	45.11	**225.55**	
Private Duty Nursing for Adults Total:						**458882.55**
Private Duty Nursing for Adults	15 Minutes	9	1715.00	29.73	**458882.55**	
Specialized Therapies Total:						**343448.52**
Play therapy	15 Minutes	1	1.00	26.33	**26.33**	
Massage therapy	15 Minutes	89	126.00	26.33	**295264.62**	
Naprapathy	Visit	1	1.00	105.32	**105.32**	
Hippotherapy	Visit	1	6.00	105.32	**631.92**	
Chiropractic	Visit	8	12.00	105.32	**10110.72**	
Acupuncture	15 Minutes	6	160.00	26.33	**25276.80**	
Biofeedback	Visit	1	31.00	105.32	**3264.92**	
Cognitive rehabilitation					**8767.89**	

GRAND TOTAL: 296447805.59

Total Estimated Unduplicated Participants: 4155

Factor D (Divide total by number of participants): 71347.25

Average Length of Stay on the Waiver: 335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
therapy	15 Minutes	1	333.00	26.33		
Transportation Total:						**591374.90**
Miles	Mile	198	4514.00	0.66	**589889.52**	
Trip	Hour	1	1.00	15.38	**15.38**	
Commercial Carrier	Each	6	1.00	245.00	**1470.00**	

GRAND TOTAL: 296447805.59
Total Estimated Unduplicated Participants: 4155
Factor D (Divide total by number of participants): 71347.25
Average Length of Stay on the Waiver: 335

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
Consultant Services Total:						**18569008.80**
Consultant Services	Month	4566	10.00	406.68	**18569008.80**	
Customized Community Group Supports Total:						**2531459.97**
Customized Community Group Supports	15 Minutes	221	1233.00	9.29	**2531459.97**	
Employment Supports Total:						**505240.30**
Employment Supports	15 Minutes	67	1033.00	7.30	**505240.30**	
Home Health Aide Services Total:						**37422.63**
Home Health Aide Services	Hour	1	2177.00	17.19	**37422.63**	
Homemaker/Direct Support Services Total:						**20554447.20**

GRAND TOTAL: 326087844.11
Total Estimated Unduplicated Participants: 4570
Factor D (Divide total by number of participants): 71354.01
Average Length of Stay on the Waiver: 335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker/Direct Support Services	Hour	516	2590.00	15.38	20554447.20	
Respite Total:						11.48
Respite	15 Minutes	1	1.00	11.48	11.48	
Skilled Therapy for Adults Total:						1477278.00
Skilled Therapy for Adults	15 Minutes	396	75.00	49.74	1477278.00	
Personal Plan Facilitation Total:						650.00
Personal Plan Facilitation	Completed Service Plan	1	1.00	650.00	650.00	
Support Broker Services Total:						8497062.00
Support Broker Services	Hour	1143	360.00	20.65	8497062.00	
Behavior Support Consultation Total:						203020.80
Behavior Support Consultation	15 minutes	64	102.00	31.10	203020.80	
Community Direct Support Total:						94268931.00
Community Direct Support	15 minutes	3945	1466.00	16.30	94268931.00	
Emergency Response Services Total:						1631.61
Start-Up/Initiation	Each	1	1.00	0.01	0.01	
Monthly Monitoring	Month	4	10.00	40.79	1631.60	
Environmental Modifications Total:						425000.00
Environmental Modifications	Each	85	1.00	5000.00	425000.00	
In-Home Living Supports Total:						176517369.84
In-Home Living Supports	Day	3269	282.00	191.48	176517369.84	
Individual Directed Goods and Services Total:						960446.08
Individual Directed Goods and Services	Item	908	1.00	1057.76	960446.08	
Nutritional Counseling Total:						270.66
Nutritional Counseling	Hour	6	1.00	45.11	270.66	

GRAND TOTAL: 326087844.11

Total Estimated Unduplicated Participants: 4570

Factor D (Divide total by number of participants): 71354.01

Average Length of Stay on the Waiver: 335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Private Duty Nursing for Adults Total:						**509869.50**
Private Duty Nursing for Adults	15 minutes	10	1715.00	29.73	**509869.50**	
Specialized Therapies Total:						**377519.54**
Play therapy	15 Minutes	1	1.00	26.33	**26.33**	
Massage therapy	15 minutes	98	126.00	26.33	**325122.84**	
Naprapathy	Visit	1	1.00	105.32	**105.32**	
Hippotherapy	Visit	1	6.00	105.32	**631.92**	
Chiropractic	Visit	8	12.00	105.32	**10110.72**	
Acupuncture	15 minutes	7	160.00	26.33	**29489.60**	
Biofeedback	Visit	1	31.00	105.32	**3264.92**	
Cognitive rehabilitation therapy	15 Minutes	1	333.00	26.33	**8767.89**	
Transportation Total:						**651204.70**
Miles	Mile	218	4514.00	0.66	**649474.32**	
Trip	Hour	1	1.00	15.38	**15.38**	
Commercial Carrier	Each	7	1.00	245.00	**1715.00**	

GRAND TOTAL: 326087844.11

Total Estimated Unduplicated Participants: 4570

Factor D (Divide total by number of participants): 71354.01

Average Length of Stay on the Waiver: 335

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
Consultant Services Total:						**20423469.60**
Consultant Services	Month	5022	10.00	406.68	**20423469.60**	
Customized Community Group Supports Total:						**2783460.51**
Customized Community Group Supports	15 Minutes	243	1233.00	9.29	**2783460.51**	
Employment Supports Total:						**558026.60**
Employment Supports	15 Minutes	74	1033.00	7.30	**558026.60**	
Home Health Aide Services Total:						**74845.26**
Home Health Aide Services	Hour	2	2177.00	17.19	**74845.26**	
Homemaker/Direct Support Services Total:						**22625825.60**
Homemaker/Direct Support Services	Hour	568	2590.00	15.38	**22625825.60**	
Respite Total:						**22.96**
Respite	15 Minutes	2	1.00	11.48	**22.96**	
Skilled Therapy for Adults Total:						**1626498.00**
Skilled Therapy for Adults	15 Minutes	436	75.00	49.74	**1626498.00**	
Personal Plan Facilitation Total:						**650.00**
Personal Plan Facilitation	Completed Service Plan	1	1.00	650.00	**650.00**	
Support Broker Services Total:						**9344538.00**
Support Broker Services	Hour	1257	360.00	20.65	**9344538.00**	
Behavior Support Consultation Total:						**225226.20**
Behavior Support Consultation	15 Minutes	71	102.00	31.10	**225226.20**	
Community Direct Support Total:						**103683876.20**
Community Direct Support	15 Minutes	4339	1466.00	16.30	**103683876.20**	
Emergency Response Services Total:						**2039.52**
Start-Up/Initiation	Each	2	1.00	0.01	**0.02**	

GRAND TOTAL: 358756791.08

Total Estimated Unduplicated Participants: 5027

Factor D (Divide total by number of participants): 71365.98

Average Length of Stay on the Waiver: 335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Monthly Monitoring	Month	5	10.00	40.79	2039.50	
Environmental Modifications Total:						470000.00
Environmental Modifications	Each	94	1.00	5000.00	470000.00	
In-Home Living Supports Total:						194174506.56
In-Home Living Supports	Day	3596	282.00	191.48	194174506.56	
Individual Directed Goods and Services Total:						1056702.24
Individual Directed Goods and Services	Item	999	1.00	1057.76	1056702.24	
Nutritional Counseling Total:						270.66
Nutritional Counseling	Hour	6	1.00	45.11	270.66	
Private Duty Nursing for Adults Total:						560856.45
Private Duty Nursing for Adults	15 Minutes	11	1715.00	29.73	560856.45	
Specialized Therapies Total:						428968.36
Play therapy	15 Minutes	2	1.00	26.33	52.66	
Massage therapy	15 Minutes	108	126.00	26.33	358298.64	
Naprapathy	Visit	2	1.00	105.32	210.64	
Hippotherapy	Visit	2	6.00	105.32	1263.84	
Chiropractic	Visit	9	12.00	105.32	11374.56	
Acupuncture	15 Minutes	8	160.00	26.33	33702.40	
Biofeedback	Visit	2	31.00	105.32	6529.84	
Cognitive rehabilitation therapy	15 Minutes	2	333.00	26.33	17535.78	
Transportation Total:						717008.36
Miles	Mile	240	4514.00	0.66	715017.60	
Trip	Hour	2	1.00	15.38	30.76	

GRAND TOTAL: 358756791.08

Total Estimated Unduplicated Participants: 5027

Factor D (Divide total by number of participants): 71365.98

Average Length of Stay on the Waiver: 335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Commercial Carrier	Each	8	1.00	245.00	1960.00	

GRAND TOTAL: 358756791.08
Total Estimated Unduplicated Participants: 5027
Factor D (Divide total by number of participants): 71365.98
Average Length of Stay on the Waiver: 335

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultant Services Total:						22469070.00
Consultant Services	Month	5525	10.00	406.68	22469070.00	
Customized Community Group Supports Total:						3069824.76
Customized Community Group Supports	15 Minutes	268	1233.00	9.29	3069824.76	
Employment Supports Total:						610812.90
Employment Supports	15 Minutes	81	1033.00	7.30	610812.90	
Home Health Aide Services Total:						74845.26
Home Health Aide Services	Hour	2	2177.00	17.19	74845.26	
Homemaker/Direct Support Services Total:						24896375.00
Homemaker/Direct Support Services	Hour	625	2590.00	15.38	24896375.00	
Respite Total:						22.96
Respite	15 Minutes	2	1.00	11.48	22.96	
Skilled Therapy for Adults Total:						1786909.50

GRAND TOTAL: 394598288.81
Total Estimated Unduplicated Participants: 5530
Factor D (Divide total by number of participants): 71355.93
Average Length of Stay on the Waiver: 335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Therapy for Adults	15 Minutes	479	75.00	49.74	1786909.50	
Personal Plan Facilitation Total:						650.00
Personal Plan Facilitation	Completed Service Plan	1	1.00	650.00	650.00	
Support Broker Services Total:						10281222.00
Support Broker Services	Hour	1383	360.00	20.65	10281222.00	
Behavior Support Consultation Total:						247431.60
Behavior Support Consultation	15 Minutes	78	102.00	31.10	247431.60	
Community Direct Support Total:						114054653.40
Community Direct Support	15 Minutes	4773	1466.00	16.30	114054653.40	
Emergency Response Services Total:						2039.52
Start-Up/Initiation	Each	2	1.00	0.01	0.02	
Monthly Monitoring	Month	5	10.00	40.79	2039.50	
Environmental Modifications Total:						515000.00
Environmental Modifications	Each	103	1.00	5000.00	515000.00	
In-Home Living Supports Total:						213559558.80
In-Home Living Supports	Day	3955	282.00	191.48	213559558.80	
Individual Directed Goods and Services Total:						1162478.24
Individual Directed Goods and Services	Item	1099	1.00	1057.76	1162478.24	
Nutritional Counseling Total:						315.77
Nutritional Counseling	Hour	7	1.00	45.11	315.77	
Private Duty Nursing for Adults Total:						611843.40
Private Duty Nursing for Adults	15 Minutes	12	1715.00	29.73	611843.40	
Specialized Therapies Total:						466725.58
Play therapy	15 Minutes	2	1.00	26.33	52.66	

GRAND TOTAL: 394598288.81

Total Estimated Unduplicated Participants: 5530

Factor D (Divide total by number of participants): 71355.93

Average Length of Stay on the Waiver: 335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Massage therapy	15 Minutes	119	126.00	26.33	394792.02	
Naprapathy	Visit	2	1.00	105.32	210.64	
Hippotherapy	Visit	2	6.00	105.32	1263.84	
Chiropractic	Visit	10	12.00	105.32	12638.40	
Acupuncture	15 Minutes	8	160.00	26.33	33702.40	
Biofeedback	Visit	2	31.00	105.32	6529.84	
Cognitive rehabilitation therapy	15 Minutes	2	333.00	26.33	17535.78	
Transportation Total:						788510.12
Miles	Mile	264	4514.00	0.66	786519.36	
Trip	Hour	2	1.00	15.38	30.76	
Commercial Carrier	Each	8	1.00	245.00	1960.00	

GRAND TOTAL: 394598288.81
Total Estimated Unduplicated Participants: 5530
Factor D (Divide total by number of participants): 71355.93
Average Length of Stay on the Waiver: 335

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
Consultant Services Total:						24713943.60
Consultant Services	Month	6077	10.00	406.68	24713943.60	
Customized Community Group						3367643.58

GRAND TOTAL: 434028016.54
Total Estimated Unduplicated Participants: 6083
Factor D (Divide total by number of participants): 71350.98
Average Length of Stay on the Waiver: 335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports Total:						
Customized Community Group Supports	15 Minutes	294	1233.00	9.29	**3367643.58**	
Employment Supports Total:						**671140.10**
Employment Supports	15 Minutes	89	1033.00	7.30	**671140.10**	
Home Health Aide Services Total:						**74845.26**
Home Health Aide Services	Hour	2	2177.00	17.19	**74845.26**	
Homemaker/Direct Support Services Total:						**27366095.40**
Homemaker/Direct Support Services	Hour	687	2590.00	15.38	**27366095.40**	
Respite Total:						**22.96**
Respite	15 Minutes	2	1.00	11.48	**22.96**	
Skilled Therapy for Adults Total:						**1965973.50**
Skilled Therapy for Adults	15 Minutes	527	75.00	49.74	**1965973.50**	
Personal Plan Facilitation Total:						**650.00**
Personal Plan Facilitation	Completed Service Plan	1	1.00	650.00	**650.00**	
Support Broker Services Total:						**11307114.00**
Support Broker Services	Hour	1521	360.00	20.65	**11307114.00**	
Behavior Support Consultation Total:						**272809.20**
Behavior Support Consultation	15 Minutes	86	102.00	31.10	**272809.20**	
Community Direct Support Total:						**125452950.00**
Community Direct Support	15 Minutes	5250	1466.00	16.30	**125452950.00**	
Emergency Response Services Total:						**2447.42**
Start-Up/Initiation	Each	2	1.00	0.01	**0.02**	
Monthly Monitoring	Month	6	10.00	40.79	**2447.40**	
Environmental Modifications Total:						**570000.00**
Environmental					**570000.00**	

GRAND TOTAL: 434028016.54

Total Estimated Unduplicated Participants: 6083

Factor D (Divide total by number of participants): 71350.98

Average Length of Stay on the Waiver: 335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modifications	Each	114	1.00	5000.00		
In-Home Living Supports Total:						**234942513.36**
In-Home Living Supports	Day	4351	282.00	191.48	**234942513.36**	
Individual Directed Goods and Services Total:						**1278831.84**
Individual Directed Goods and Services	Item	1209	1.00	1057.76	**1278831.84**	
Nutritional Counseling Total:						**315.77**
Nutritional Counseling	Hour	7	1.00	45.11	**315.77**	
Private Duty Nursing for Adults Total:						**662830.35**
Private Duty Nursing for Adults	15 Minutes	13	1715.00	29.73	**662830.35**	
Specialized Therapies Total:						**508695.60**
Play therapy	15 Minutes	2	1.00	26.33	**52.66**	
Massage therapy	15 Minutes	130	126.00	26.33	**431285.40**	
Naprapathy	Visit	2	1.00	105.32	**210.64**	
Hippotherapy	Visit	2	6.00	105.32	**1263.84**	
Chiropractic	Visit	11	12.00	105.32	**13902.24**	
Acupuncture	15 Minutes	9	160.00	26.33	**37915.20**	
Biofeedback	Visit	2	31.00	105.32	**6529.84**	
Cognitive rehabilitation therapy	15 Minutes	2	333.00	26.33	**17535.78**	
Transportation Total:						**869194.60**
Miles	Mile	291	4514.00	0.66	**866958.84**	
Trip	Hour	2	1.00	15.38	**30.76**	
Commercial Carrier	Each	9	1.00	245.00	**2205.00**	

GRAND TOTAL: ***434028016.54***

Total Estimated Unduplicated Participants: ***6083***

Factor D (Divide total by number of participants): ***71350.98***

Average Length of Stay on the Waiver: 335