New Mexico Legislative Finance Committee
Progress Report

Developmental Disabilities and Mi Via Waivers

November 18, 2024

Legislative Finance Committee

Senator George K. Muñoz, Chair
Representative Nathan P. Small, Vice-Chair
Representative Gail Armstrong
Representative Brian G. Baca
Senator Pete Campos
Representative Jack Chatfield
Representative Meredith Dixon
Representative Harry Garcia
Senator Roberto "Bobby" J. Gonzales
Senator Siah Correa Hemphill
Representative Derrick J. Lente
Senator Steven P. Neville
Senator Nancy Rodriguez
Senator William E. Sharer
Representative Debra M. Sariñana
Senator Pat Woods

Director

Charles Sallee

Deputy Director for Program Evaluation

Micaela Fischer, CFE

Program Evaluation Team

Josh Chaffin, MAIA
Sarah M. Dinces, Ph.D.
Lizza Dodson, MA
Matt Goodlaw, MS
Stephanie Joyce
Margaret Klug
Sam Lesemann, MPP
Clayton Lobaugh, MPA
Sarah Rovang, Ph.D.
Ryan Tolman, Ph.D.
John Valdez, Ph.D.
Drew Weaver, MA

Contents

Summary **1**

Background **3**

The DD, Mi Via, and Supports Waivers served 7,849 New Mexicans at a cost of almost $800 million in FY24. 3

Waiver costs continue to increase, with New Mexico continuing to have some of the highest client costs in the nation. 5

A small subset of services makes up the majority of DD expenditures. 6

The state uses a multistep process for enrollment in traditional DD or Mi Via waiver services. 8

Despite some progress, key findings of the 2018 evaluation are still unresolved, including rising costs and a need for improved oversight. 8

New Mexico has Limited Provider Capacity for High Demand Services **10**

For most services, provider availability for new clients decreased between 2018 and 2024 by up to 30 percentage points across counties. 10

DDSD is working to address provider capacity but could also proactively implement future federal policies and best practices. 12

HCA is Addressing Some Safety Concerns but Others Regarding Client Monitoring and Requests for Assistance Remain **16**

Recent findings of abuse, neglect, and exploitation led to HCA implementing new procedures to improve participant safety. 17

Roughly 1-in-4 four case management agencies and over 80 percent of Mi Via consultants are not adequately monitoring DD clients. 18

DDSD and DHI need to improve processes and timeliness regarding determinations of ANE and responses to requests for assistance. 19

DDSD and DHI monitor compliance but have not traditionally assessed participant quality of life or other participant outcomes. 20

DDSD Has Limited Oversight of Participant Budget and Service Delivery **26**

Actual waiver costs have exceeded LFC and Medicaid Assistance Division projections. 26

Participants are using higher-level and more services. 26

The lack of a two-step review and a validated assessment decreases oversight and may increase the risk of misallocation. 28

Many DD and Mi Via participants are significantly over budget allotments or caps. 30

Appendix A. Progress on Past Recommendations **33**

Appendix B. DD, Mi Via and Supports Waiver Demographics **37**

Appendix C. Number of Providers Accepting New Participants by Service and County, 2024 ..... **38**

Appendix D. Accenture Findings and Recommendations **39**

Appendix E. Regional Office Requests for Assistance by Provider **42**

Appendix F. Excerpts from the Waldrop Settlement **43**

Appendix G. Responsibilities of Employers of Record **60**

Appendix H. Supported Living Cost Explanation **61**

Summary

The developmental disabilities (DD) and Mi Via waiver programs, administered by the Developmental Disabilities Supports Division (DDSD) of the Health Care Authority, serve approximately 7,900 New Mexicans with intellectual and developmental disabilities. The waiver programs use federal and state Medicaid dollars to contract with providers to deliver living supports, community services, therapy, employment, and other services to allow participants to live in their homes and communities rather than in an institutional setting.

Since the LFC 2018 program evaluation, DDSD fully resolved the *Jackson* lawsuit concerning mistreatment in state institutions and used approximately $211.4 million in federal America Rescue Plan Act dollars to mostly eliminate a 13-year waiting list for DD waiver services. However, the consequences of adding this many new people to the waivers resulted in issues with provider capacity, and persistent quality-monitoring and cost-containment issues remain. Compared to FY17, the state is serving 69 percent more DD clients, which has placed a strain on providers, and, as of FY24, at least half of providers are not accepting new clients. The state is working to increase provider capacity by increasing reimbursement rates, establishing telehealth frameworks, and collaborating with the Workforce Solutions Department. Yet providers report limited ability to serve this larger clientele, largely due to staffing shortages.

DDSD also improved its processes to identify and respond to abuse and neglect, including clarifying roles and orienting staff to points of risk. However, DDSD and the Division of Health Improvement, also in HCA, have not yet fully assessed the internal capacity of case managers and consultants to monitor participants, the result of which has been uncertainty regarding visit quality. Further, DDSD lacks outcome-based performance tracking. The division does not monitor the percentage of participants living as independently as possible nor does it measure the percentage of individual goals met. Rating providers on client quality of life, a federal practice with other Medicaid programs, could also be helpful.

Waiver costs continue to increase, limiting the number of new individuals the state can provide services to. The 2018 evaluation found a cost-per-client increase of 17 percent between FY14 and FY17, from $67 thousand to $78 thousand across the DD and Mi Via waiver programs. By FY24, that cost-per-client had grown another 26 percent to $98 thousand for a total 46 percent increase over a ten-year period, about 13 percent above inflation. The difference is largely due to higher levels of care and rate increases.

To improve access and service quality, DDSD should require providers to pass on 80 percent of their reimbursement revenue to direct support staff, change provider survey tools to include quality of life measures, use a

The Evaluation:

The 2018 program evaluation *Developmental Disabilities and Mi Via Waivers* evaluated the cost-effectiveness of DD waiver services, examined participant outcomes and quality measures, and reviewed the costs and impact of the *Jackson* and *Waldrop* litigations on the delivery of DD waiver services. The evaluation highlighted specific steps the Developmental Disabilities Supports Division (DDSD) and other key stakeholders could take to improve the waiting list and control costs.

Of the 14 recommendations from the previous report, DDSD completed four and is progressing or has not acted on the other 10.

While enrollment in the DD and Mi Via waivers increased 69 percent from FY17 to FY24, total DD and Mi Via waiver costs increased approximately 118 percent from $355 million in FY17 to $773.4 million in FY24.

validated assessment tool to guide the client planning and budget development process, and develop and adhere to service caps.

Key Recommendations

The Legislature should consider:

- Enacting legislation to require providers to, starting in FY27, pass 80 percent of Medicaid reimbursement rate revenues to the salaries of direct support professionals per the federal Centers for Medicare and Medicaid Services' final rule. This legislation should also require the Developmental Disabilities Supports Division to publish a compliance monitoring plan by September 1, 2025; and
- Funding provider expansion and start-up costs to increase the number of providers able to serve new clients.

The Developmental Disabilities Supports Division of the Health Care Authority should:

- Encourage the train-the-trainer model for therapists and direct support providers by January 2026;
- Work with the Legislative Finance Committee and Department of Finance and Administration to create FY27 Accountability in Government Act performance measures for client outcomes, quality of life, and provider quality;
- Ensure case manager and consultant ability to meet current standards, and increase training and oversight of the case management and consultant process if they cannot;
- Participate in the National Core Indicator survey to understand the waiver's strengths and challenges from a participant perspective;
- Follow through on plans to require the Vineland Adaptive Behavior Scale-3 and require the results of the scale be used to develop individualized service plans within the traditional Developmental Disabilities waiver;
- For the traditional developmental disabilities waiver, develop appropriate budgetary caps for services for new enrollees, and for the Mi Via waiver adhere to the individual budgetary allotment unless there are justifiable extenuating circumstances. Developmental Disabilities Supports Division should report to the Legislature annually on average budget, service utilization, expenditures per participant, and information about individuals exceeding expected budgetary allotments and service caps.

The Division of Health Improvement and the Developmental Disabilities Supports Division of the Health Care Authority should:

- Work to change the current Division of Health Improvement Quality Management Bureau survey tool to add measures of quality of life, including assessing percent of goals met and if clients are living as independently as possible, by January 2026.

Background

The Health Care Authority (HCA) oversees four home and community-based programs for individuals with intellectual and developmental disabilities. The programs are referred to as waivers because they require a waiver of standard Medicaid rules. These waivers allow the state to use Medicaid dollars, with a state match, to support individuals with diverse needs. The waivers provide a large array of supports to allow for community participation based on waiver participant's needs and preferences. Since LFC's last program evaluation on the waivers in 2018, the state has seen notable progress, officially exiting the *Jackson* lawsuit in 2022 and eliminating a 13-year waiver waiting list. However, costs continue to increase while program quality, participant satisfaction, and outcomes are uncertain.

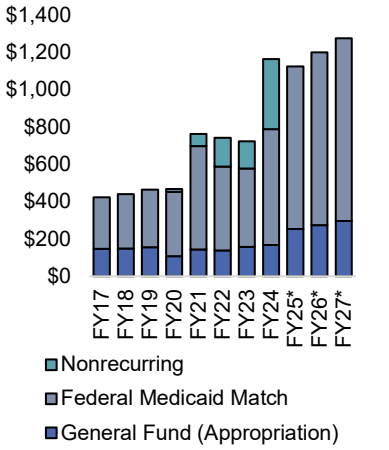
The DD, Mi Via, and Supports Waivers served 7,849 New Mexicans at a cost of almost $800 million in FY24.

The state funds home and community-based services waivers through federal and state Medicaid dollars. Total appropriations to the Developmental Disabilities Supports Division (DDSD), the division overseeing these waivers, reached $1.2 billion in FY24. The DD and Mi Via waivers make up the largest portion of the DDSD budget. This budget increase is largely due to provider rate increases and increased enrollment, with a $211.4 million nonrecurring American Rescue Plan Act appropriation to mostly eliminate the waiting list for the DD and Mi Via waivers in FY22 through FY24.

The developmental disabilities waiver program offers home and community-based services to individuals with intellectual and developmental disabilities so they can live and participate in their communities. The division's mission is to "serve those with intellectual and developmental disabilities by providing a comprehensive system of person-centered community supports so that individuals live the lives they prefer, where they are respected, empowered, and free from abuse, neglect, and exploitation." Importantly, the developmental disabilities waiver is not a federal entitlement, so states can have waiting lists for these services when adequate funding is not available. New Mexico, which had a waiting list for many years, effectively cleared its waiver waiting list in FY23, though over 2,000 potential participants have declined to participate in the program at this time.

DDSD operates four waivers, including a medically fragile waiver, under Section 1915(c) of the Social Security Act. DDSD was recently housed at the Department of Health under a joint powers agreement between the Human Services Department, which oversaw funding and waiver administration, and the Department of Health, which oversaw operations.

Chart 1. DDSD Budget, FY17-FY27
(in millions)



Note: Nonrecurring funding from HCBS ARPA.
*FY25-FY27 are projections.
Source: LFC files

Table 1. Types of Developmental Disabilities Waivers Available in New Mexico

Waiver	Description
DD Waiver	Provides services for eligible individuals with intellectual or developmental disabilities with services coordinated by a case manager.
Mi Via Self-Directed Waiver	Permits participants to choose and manage their services using a set budget allocation. Same eligibility as the traditional DD waiver.
Supports Waiver	Provides $10 thousand for individuals on the waiver waiting list or who have been allocated services. Supports Waiver services are intended to complement unpaid supports provided to individuals by family and others.

Source: HCA

Beginning in FY25, DDSD moved entirely under the new Health Care Authority, including all staff and funding for the division.

The traditional DD waiver, which serves the most participants (4,598 or 59 percent), offers community-based services coordinated by a case manager at an average cost in FY24 of approximately $116 thousand per client. The Mi Via waiver provides greater self-direction by offering participants more flexibility in their program oversight and monitoring, with the aid of a designated employer of record (the individual responsible for directing the work of employees and providers for Mi Via participants), if needed. The Mi Via Waiver had an average cost of $74 thousand per client in FY24. Lastly, the Supports Waiver provides up to $10 thousand for those on the waiting list to secure agency-based or participant-directed services to help complement the other Medicaid services they may receive while awaiting an allocation to the more comprehensive waivers.

Table 2. FY24 Waiver Costs and Enrollment

	Enrollment	Total Cost	Average
Traditional DD	4,598	$532,596,629	$115,832
Mi Via	3,248	$240,835,271	$74,148
Supports	3	$2,548	$849

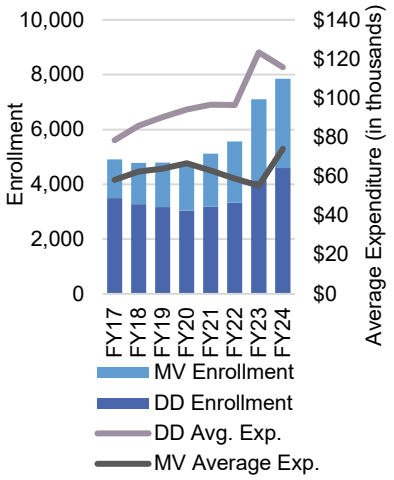
Note: Costs are projected based upon 88 percent of expenditures reported when LFC received data in August 2024. Supports waiver enrollment and total costs were significantly higher in FY22 and FY23, likely due to a larger waitlist meaning that FY24 could be an outlier or could be predictive of future utilization if HCA maintains a minimal waitlist.

Source: LFC analysis of DDSD data

Since FY22, DDSD has offered waiver services to approximately 5,700 participants. In the first half of FY22, the waiting list for waiver services reached over 4,100, with people waiting upwards of 13 years to be offered services. From November 2021 through FY23, DDSD removed hundreds of people per quarter, with several particularly large allocations, such as in the third quarter of FY22, when 1,453 individuals were allocated—this effectively eliminated the waiver services waiting list.

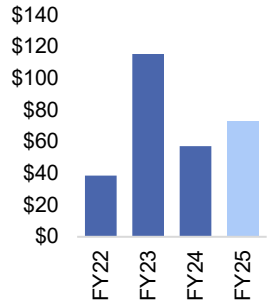
Ending the waiting list was a legislative and executive priority. The state used $211.4 million of federal America Rescue Plan Act (ARPA) funding to allocate these individuals. However, with the end of ARPA funding, the state will need to use general fund and Medicaid dollars to continue to support these and any additional newly enrolled individuals. DDSD expects to continue to allocate waiver services annually to those on the waiting list as long as funding is available. Therefore, the waiting list may increase throughout the year between annual allocation events. Because DDSD plans to continue to request additional allocations, the overall budget for DDSD will likely increase proportionately. For FY25, HCA projects it will need between $73 million and $89 million in both general and federal funds to move individuals off the waiting list.

Chart 2. DD and Mi Via Enrollment and Average Expenditures



Source: HCA

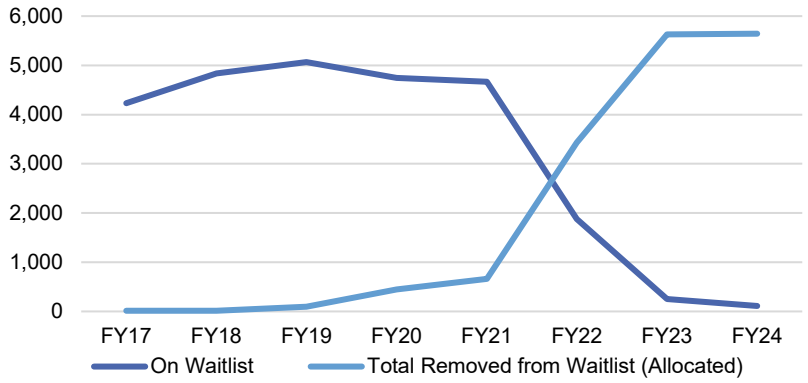
Chart 3. Appropriations for Waiting List Elimination, FY22-FY25
(in millions)



Note: FY25 is a projection from HCA's July Medicaid Projection meeting and includes adjustments for rate-increases, the November projection did not include details regarding expected costs for waiting list elimination. Prior to FY22 the state was not appropriating large amounts for waiting list elimination.

Source: LFC Post-Session and HCA

Chart 4. Total Number of People Offered Services and On Waiting List, FY17-FY24



Note: Waiting list point-in-time based on Q4 numbers. While DDSD provided allocations to approximately 5,700 individuals, only roughly 3,300 have started going through the service allocation process.

Source: DDSD

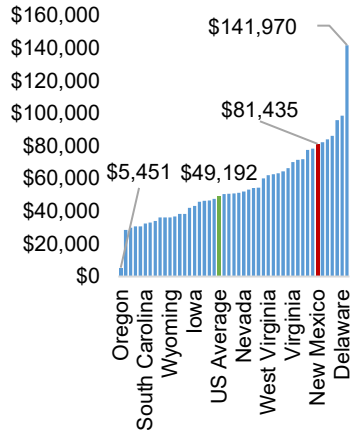
While minimizing the waiting list has positive impacts such as providing services to individuals as soon as possible, the increase in enrollment also has some unintended consequences. One, this growth is testing provider capacity. Two, as waiver enrollment increased sharply from FY22 through FY23, the performance of two DDSD performance metrics declined. The percentage of adults receiving employment support dropped from 18.4 percent in FY21 to 9.5 percent in FY23 (at least partially due to pandemic-related effects) and the percentage of waiver program applicants with a service plan and budget in place within 90 days of their clinical eligibility determination fell to 87 percent, down from 96 percent from FY22 to FY23.

Waiver costs continue to increase, with New Mexico continuing to have some of the highest client costs in the nation.

New Mexico's per-participant traditional DD waiver costs grew the seventh most and were some of the nation's highest between federal fiscal year 2014 (FFY14) and FFY19. Additionally, HCA estimates waiver costs will increase 27 percent from FY24 to FY25. The increases in both actual and projected costs are largely due to enrollment growth, higher provider reimbursement rates, and the increase in New Mexico's share of Medicaid costs. Medical inflation, which has hovered around 3 percent the last few years, is another important factor.

New Mexico's traditional DD waiver spending per participant was the seventh highest and grew the seventh most in the nation between FFY14 and FFY19. The most recent state-by-state comparison data available from the federal Centers for Medicare and Medicaid Services (CMS) show that New Mexico has the seventh highest per-participant cost for Intellectual and Developmental Disabilities (I/DD) waivers at $81

Chart 5. Developmental Disability Waiver Spending Per Participant by State, FFY19



Note: Cost per participant shown here are from FFY19 which is the most recent available data nationwide. Earlier cost per participant numbers in text for New Mexico are from FY24.

Source: CMS 372

thousand per patient in FFY19. This high cost may be partially attributable to the large number of participants using a high number of services. For example, New Mexico has higher caps for therapies than in other states and no caps for employment, community, and similar supports, likely leading to high utilization. In New Mexico, cost per participant grew by 32 percent from FFY14 to FFY19, significantly outpacing the national average of 5 percent. Among the states and the District of Columbia, which had higher cost growth than New Mexico, only D.C. had a higher per-participant cost at $141 thousand. Importantly, different states also have different services offered on their developmental disability waivers. New Mexico has one of the most comprehensive and wide-reaching service arrays to support waiver participants, which may also impact costs.

The Medicaid Assistance Division (MAD) projects a 14 percent increase in DD costs between FY24 and FY25. MAD projects DDSD waiver expenditures to increase from $794 million to $907 million in one year due to increasing enrollment, provider rate increases, and a drop in the state's Federal Medicaid Assistance Percentage (Medicaid matching rate). The division projected the most significant cost jumps to be due to increased enrollment and rate increases, but MAD did not specify amounts attributable to these components in the November projection. Importantly MAD projections are not actual expenditures and may not reflect actual expenditures.

From FY18 to FY25, DD reimbursement rates increased between 16 percent and 64 percent. Most rates kept pace with or surpassed the 24 percent inflation rate during this time. Increases vary across service categories, ranging from 64 percent for skilled therapies (occupational therapy, physical therapy, and speech-language pathology) to 16 percent for supported living for lowest acuity individuals. In FY24, provider rate increases added $48 million in expenditures. In the 2024 legislative session, the Legislature appropriated $20.5 million from the general fund. This appropriation can be matched with Medicaid dollars for a total of approximately $91 million to fully fund rate increases for FY25. LFC staff analysis projects DDSD will need an additional $75 million, or approximately $16 million in general fund, in both FY26 and FY27 to continue funding rate increases.

Table 3. Provider Rate Increases in Key DD Waiver Service Categories Since FY18

	FY25 Rate	% Change
Case Management (Month)	$331	32%
Behavioral Support Consultation (15 min.)	$26	42%
Family Living (Day)	$161	37%
Supported Living (Day)	$222-$459	16-24%
Customized In-Home Supports (15 min)	$8	25%
Community Support, Individual (15 min.)	$9	33%
Occupational Therapy, Physical Therapy, & Speech Language Pathology (15 min)	$37	64%

Note: Per BLS CPI, inflation was 25 percent between July 2018 and July 2024. Rates rounded to the nearest dollar.

Source: LFC analysis of DDSD data

A small subset of services makes up the majority of DD expenditures.

New Mexico's home and community-based waivers offer an array of residential, community-based, and professional services to foster independence, well-being, and safety. All waivers, including the traditional DD and Mi Via waivers, offer individually tailored case managers or consultants to coordinate services to foster independence and the participant's desired life outcomes. These services include living supports provided in the home, either in a personal home or a supported-living group home, assistance with daily living activities, and other in-home supports,

including home modifications. Annual per-client reimbursement rates for supported living in FY24 ranged from $79 thousand for participants in low acuity care to $164 thousand for participants in high acuity care. Services also include community-based support and inclusion, which enable participants to connect with their community and participate in functions of community life. Skilled therapy and nursing services are also available and include behavioral support consultancy, occupational and physical therapy, speech-language pathology, and adult nursing.

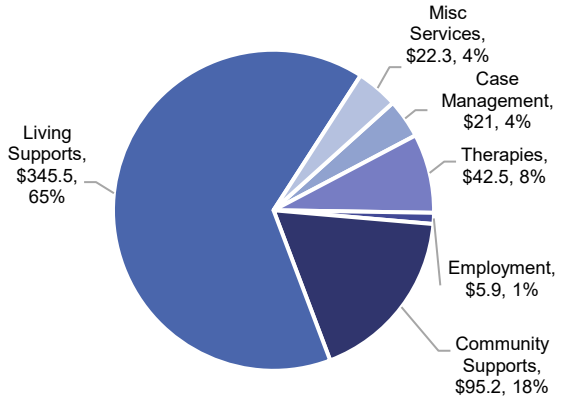
Table 4. DD and Mi Via Key Service Definitions and Costs

DD Waiver		Cost (in millions)	People Served
Living Supports	Residential support for individuals within a supported living home in the community, a family home, or an independent living situation, family living is 33 percent of living support costs.	$345	3,316
Community Support	Skills training, including educational supports, communication & social skills, community integration and relationship building.	$95	2,917
Case Management	Assists recipients in accessing services & service delivery & provides advocacy/support.	$21	4,550
Employment	Supports individuals pursuing jobs to increase independence and social connections.	$6	460
Mi Via Waiver			
In-Home Living	Provide individually designed services related to the participants qualifying condition, enabling them to live in their residence, or family home in the community of their choice, frequently provided by family members.	$135	2,288
Community Support	Assist the participant in community connections across social, educational, and recreational activities within the larger community.	$68	2,875
Consultant	Intended to provide information, support, guidance, and assistance both during the pre-eligibility/enrollment phase and for ongoing consultant services.	$15	3,243
Common to DD & Mi Via			
Skilled Therapy	Occupational, physical, & speech-language pathology services	$42 & 1.2	2,635 & 235
Nursing	Provided by a nurse and includes assessment, consultation, and ongoing services.	$3.2 & $0.84	2,061 & 15
Behavioral Support Consultation	Includes assessment of the person, identifies barriers to independent functioning, and tests of strategies to improve independence.	$11 & 0.17	2,255

Note: Numbers prorated using 88 percent of FY24 DDSD cost data.

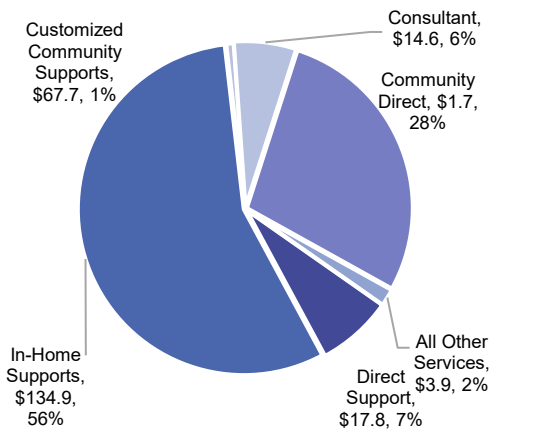
Source: HCA

Chart 6. DD Expenditures by Major Cost Category FY24
Total: $532.6
(in millions)



Source: DDSD

Chart 7. Mi Via Expenditures by Major Cost Category FY24
Total: $240.8
(in millions)



Source: DDSD

The state uses a multistep process for enrollment in traditional DD or Mi Via waiver services.

Once an individual with a qualifying condition identifies a need for waiver services, they can apply to the DDSD central registry. When the central registry receives an application, the intake bureau determines initial eligibility based on existing medical documentation. If they meet the developmental disabilities definition, they are placed on the waiting list and offered the Supports Waiver. When funds become available, a candidate must choose between an intermediate care facility or the two comprehensive waiver options: traditional DD waiver, or the more self-directed Mi Via waiver.

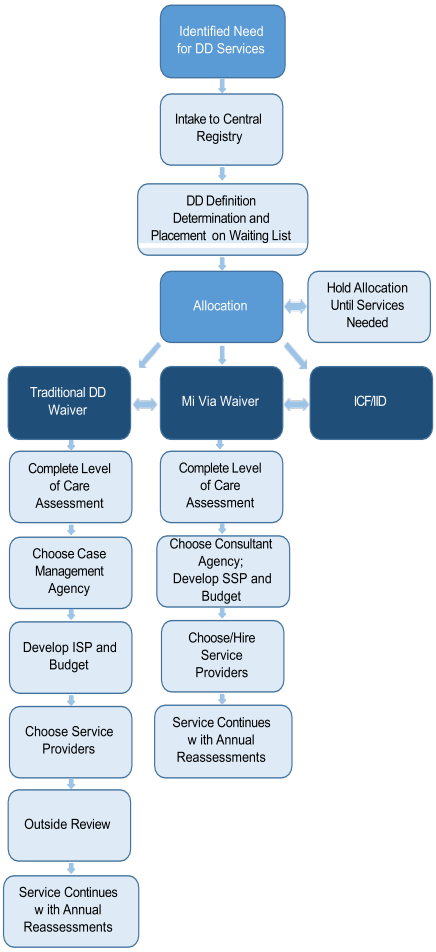
Once a candidate selects either comprehensive (DD or Mi Via) waiver option, they then select a case manager (traditional DD) or a consultant (Mi Via) to build and implement their individualized service plan. These case managers or consultants also draft a budget and an individual service plan for traditional DD waiver clients or a service and support plan for Mi Via clients.

Despite some progress, key findings of the 2018 evaluation are still unresolved, including rising costs and a need for improved oversight.

DDSD has made significant progress since the release of the 2018 evaluation, drastically reducing the state's waiting list, ending the over 35-year *Jackson* lawsuit, and improving its timeliness of abuse and neglect investigations. The waiting list is significantly smaller than it has been, with only approximately 200 individuals waiting to be allocated, down from around 4,100 in FY22; DDSD plans to offer services to individuals on the waiting list at least annually if funds are available. However, other challenges, such as limited DDSD oversight of service delivery, which can weaken program integrity, remain. The significant increase in waiver recipients results in the need for DDSD to be able to analyze and report on waiver cost drivers, focus on outcomes in performance metrics, and audit the individuals responsible for employees and training for Mi Via participants.

.

Figure 1. DD and MI Via Service Enrollment Process



Source: LFC files

Table 5. 2018 Program Evaluation:
Developmental Disabilities and Mi Via Waivers
Key Finding Status

2018 Key Finding	Status
DOH was beginning to reduce the waiting list, but New Mexico was still the only state with a higher rate of waiting list participants to those receiving services	Resolved
The Jackson lawsuit remains a major cost driver for the DD system	Resolved
Other states delivered IDD services in a more cost-effective manner; two potential reasons/mechanisms were that they offered fewer or more limited services, and that they took advantage of the Affordable Care Act Community First Choice levers that would have increased the federal matching percent by 6%	Partially Resolved
Improved oversight is necessary to mitigate risk to waiver participants, through Department of Health Improvement's timely processing of case investigations, and to mitigate the risk to public funds, through stricter rules for Mi Via employers of record.	Partially Resolved
DD Waiver cost per client rose 17 percent between FY14 and FY17, even though total enrollment declined 13 percent	Unresolved
Mi Via, through its rate range model and lack of effective oversight for employers of record, was driving cost increases for the state's developmental disability programs	Unresolved
DOH's assessment and budget allocation tool lacks standardization and is a cost driver, particularly since the standards-based SIS was dropped as a screening tool in response to the settlement of the Waldrop due process lawsuit, in favor of the more individualized and expensive Outside Review	Unresolved
Data collection offers DOH an opportunity to improve performance management and client outcomes, particularly by including DD-specific measures into DOH strategic priorities and goals.	Unresolved

Source: LFC files

New Mexico has Limited Provider Capacity for High Demand Services

Like many other states nationwide, New Mexico struggles with healthcare provider capacity due to having too few workers for direct support (direct support professionals or DSPs) and too few therapists. From FY17 to FY24, the state increased the number of participants served by home and community based waivers by 69 percent to a total comprehensive waiver enrollment of 7,849. However, after this large enrollment increase, fewer providers are accepting new clients, potentially impacting participant access and provider choice and cost. Although DDSD has more total provider agencies than one year ago, the need for more provider agencies and greater participant choice remains, specifically in the areas of clinical services: nursing, physical, occupation, and speech therapies.

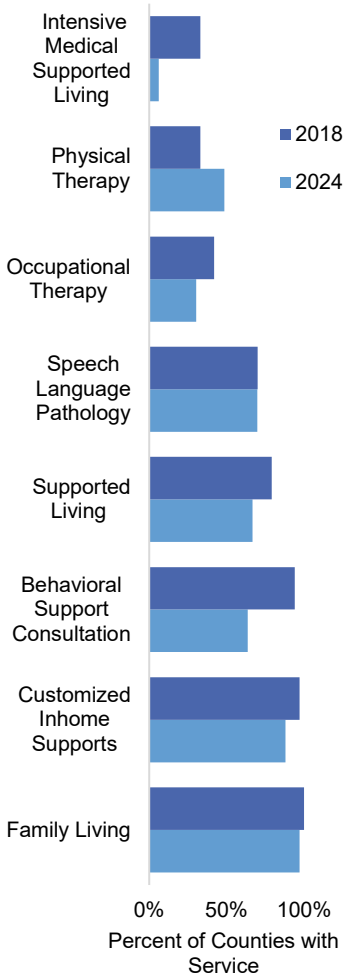
In 2023, a state-funded provider capacity study conducted by the Public Consultant Group (PCG) included recommendations to increase provider capacity, most of which DDSD is pursuing. This report found that most waiver participants had challenges receiving at least one service. Even as DDSD pursues most of these recommendations, other activities could ease provider burden, such as implementing wage pass-throughs to direct support professionals, increasing uptake of telehealth, and working with therapists and direct support professionals to free up provider time.

For most services, provider availability for new clients decreased between 2018 and 2024 by up to 30 percentage points across counties.

While the state has over 200 providers supporting participants on the traditional DD and Mi Via waivers across all service areas, the rate of counties with providers accepting new clients has decreased since 2018 (based on point-in-time comparisons, which may change). Capacity constraints are particularly noticeable for high-cost and high-demand services, with 83 percent of traditional DD waiver participants using at least one of the top eight services, according to the Public Consulting Group. As more individuals come onto the waivers, ensuring there are available providers is essential for participants to receive needed services.

Among the eight most expensive services, only physical therapists are accepting new clients in more counties in 2024 than in 2018—all others have dropped in availability. Similar to 2018, intensive medical living support has the fewest counties with providers accepting new clients. Importantly, no providers in the most populous counties—Bernalillo, Dona Ana, or Sandoval counties were accepting new clients for Intensive Medical supported living (see Appendix C. for a breakout of service availability by

Chart 8. Percent of Counties with Providers Accepting New Clients, 2018 versus 2024



Note: Data from 2024 was pulled from July 15-17, 2024. 2018 data was pulled in spring 2018.
Source: Secondary Freedom of Choice Website

county). If the most populous counties do not have access for new waiver participants, then the largest proportion of individuals may not be able to access the services they need. The state could help increase the number of providers through allocating funding for startup costs.

In July 2024, more than half of waiver providers were not accepting new clients. Of those not accepting new clients, the vast majority were on a self-imposed moratorium, meaning the provider told the state they could not take on new clients, generally due to staffing shortages. Providers can move on and off a moratorium at their discretion, such that the number of providers accepting new clients may be different from day to day. However, in the sample of monthly provider reports provided to LFC staff, at least 150 providers were on moratorium each month, meaning, on average, at least half of potential providers are not accepting new clients.

Table 6. Number of Total Providers and those on Moratorium for Select Months

	September 2023	May 2024	July 2024	August 2024
# on Moratorium	157	162	152	159
# Total providers	282	258	260	282
% on Moratorium	**56%**	**63%**	**58%**	**56%**

Note: These numbers are across all waivers, including DD, Mi Via, and Medically Fragile as some of these providers serve multiple waivers, this number may contain duplicates and is therefore an underestimate of the % of providers on moratorium.

Source: DDSD

Most provider capacity shortages are for highly utilized services, especially within the traditional DD waiver. The Public Consulting Group (PCG) disability services provider capacity report in 2023 identified roughly eight service types with limited capacity (listed in Table 7.) In FY24, 83 percent of DD waiver participants engaged in at least one of these limited-access services. Together these services accounted for 66 percent of total DD waiver expenditures. In Mi Via, where support is more self-directed, these services were less utilized except for community supports, which 89 percent of participants used, constituting 29 percent of all Mi Via expenditures.

Table 7. Percent of Waiver Participants Utilizing Limited Access Services in FY24

Service	DD Waiver	Mi Via Waiver
Customized Community Supports	63%	89%
Behavioral Support Consultation	49%	2%
Speech Therapy	45%	4%
Occupational Therapy	34%	3%
Physical Therapy	34%	2%
Supported Living	31%	N/A
Respite	7%	N/A
Private Duty Nursing	N/A	1%

Source: DDSD

PCG's provider capacity report found DD and Mi Via participants were generally satisfied, but at least 46 percent could not access all authorized services. Specifically, at least two-thirds of participants agreed they had services that met their needs, were culturally appropriate, respected their dignity and privacy, and were delivered in an individualized way. Yet roughly half of traditional DD (46 percent) and Mi Via waiver (53 percent) participants indicated they could not always access *all* the services in their service plan. Case managers and consultants also responded that access to services was a concern, with 86 percent of case managers indicating participants cannot access one or more needed services within their plan, while 60 percent of Mi Via consultants stated participants could not access some of the needed services in their plan. These services include the most expensive services identified above as well as respite and private duty nursing. Through surveys of participants, PCG noted the most

While 2 out of 3 participants agreed they had services that met their needs, roughly one in two traditional DD and Mi Via waiver participants indicated they could not always access *all* the services included in their individual service plan.

common barriers to service availability included providers not accepting new clients, no providers in the area, or providers unable to staff service due to the complexity of participant needs.

DDSD is working to address provider capacity but could also proactively implement future federal policies and best practices.

The PCG study of New Mexico's DD and Mi Via waivers provider capacity included recommendations to improve the provider workforce. National research shows that to recruit and retain low-income workers, employers may need financial work incentives to support advancement. So far, DDSD has taken steps to implement most of the PCG recommendations, but more could be done, especially with the fast-tracking adoption of federal policy, due to be implemented by 2030 and adoption of some best practices done in other states.

PCG made 12 recommendations to DDSD to improve provider capacity, of which DDSD is currently pursuing nine. These recommendations centered on provider recruitment and retention, rates and wages, telehealth strategies, conducting additional research into specific access areas, examining Mi Via participant engagement, and ensuring use of requests for assistance.

Table 8. PCG Recommendations and DDSD Action

Recommendation	Is DDSD Pursuing this Recommendation?
Providers Enhance Recruitment and Retention Efforts	Yes- posting positions but could use incentive payments &/or career ladder
Support Recruitment and Retention by Leveraging the Advisory Council on Quality Supports for People with Developmental Disabilities and Their Families	Yes
Collaborate with Department of Workforce Solutions	Yes- starting grant
Implement Wage Pass Throughs	No, waiting for federal rule
Implement Rate Modifiers to Target Wage Pass Throughs	No, waiting for federal rule
Establish Telehealth Oversight Framework	Yes – but could better utilize services
Develop a Telehealth Quality Assurance and Monitoring Process	Yes
Additional Study of Service Availability	Yes
Explore Cause and Impact of Providers' Inability to Staff Services for Participants with Complex Needs	Yes, but long term
Additional Survey or Targeted Focus Group of Mi Via Waiver Participants	No
Implement a Participant Data Management System to Enhance Participant Communication and Engagement	Partially – waiting for MMISR
Outreach to Encourage the Use of and Feedback on the Regional Office Request for Assistance (RORA) Process	Yes- but need to also understand if RORA resolved challenge

Note: green = the recommendation is implemented or started, orange = the recommendation is started but with risks and/or not following best practices and red = the recommendation is not started

Source: PCG Report

Federal rule will require DD waiver providers to pass through 80 percent of the service rate revenue to direct support professionals by 2030, but New Mexico could require this sooner to improve retention of individuals providing direct care. According to the PCG rate study, a separate study focused on determining appropriate reimbursement rates for DD services, only 69 percent of New Mexico's DD service rates are passed through to support the salaries of direct support professionals (DSPs), who provide the actual care to participants on the waiver. This information was self-reported by providers, which, according to DDSD, are already requesting exemptions from the future CMS required pass-through requirement.

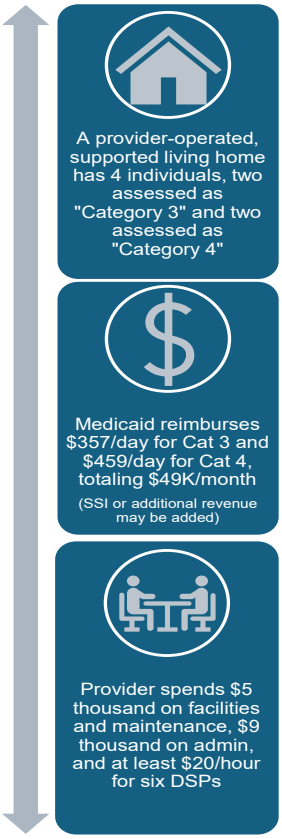
These jobs have historically been low-paid and often do not require experience or a degree. In September 2024, DDSD reported the 2023 salary ranges for DSPs were largely between $12 and $17 per hour, with 2 percent of DSP salaries reported at the state minimum wage. Additionally, DDSD reported that in 2023 agencies hired 4,939 DSPs, but another 3,419 (or roughly 32 percent of all DSPs) left their agency.

LFC staff analysis of one large supported-living provider indicates the impending federal wage pass-through could be feasible to implement now. The examined provider ran several supported living homes with a mixture of levels of care (acuity). LFC staff found this sample of homes received an average of approximately $40 thousand in monthly Medicaid reimbursements. If administrative costs were capped at 20 percent and operating expenses deducted, the provider still would have sufficient funding to pay up to $30 per hour for the provider's supportive living DSP staff.

The federal government has yet to publish guidance regarding how the 2030 requirements should be implemented. However, North Carolina preemptively included pass-through recommendations in its 2023 budget bill, encouraging 80 percent of rates to go directly to DSPs. To get ahead of the federal rule, the New Mexico Legislature could follow North Carolina and enact legislation to require 80 percent pass-throughs sooner, mirroring the federal definitions. DDSD would need to develop a plan for monitoring providers if the 80 percent pass-through requirement was established and may need to adjust course if its implementation conflicts with any eventual federal guidance on the pass-throughs.

Another strategy to improve recruitment and retention could be DSP incentive payments. Incentive payments are a common strategy for recruiting and retaining staff. Oklahoma, Ohio, and other states use incentives to improve provider capacity by decreasing DSP staff vacancies. Ohio pays qualified providers 6.5 percent of total claims for eligible services paid in a quarter as retention payments for staff. Oklahoma started incentive payments this year that provide a $1,000 recruitment incentive for new DSPs, a $1,000 retention incentive for existing workers, and a $1,000 retention incentive every six months through January 31, 2025.

Figure 2. Example of Supported Living Reimbursement Process



Note: This is an illustrative example. Category 3 is the second highest level of supported living and Category 4 is the highest level of support.
Source: LFC analysis of provider data

The state rents 22 homes for the Los Lunas Community Program (LLCP), spending more on some homes than they are worth especially for long-term rentals. LLCP spent almost half a million at two properties and will have paid more in rent than the homes' current value in the next 24 months. Additionally, the state spent $1.8 million for its ICF/IDD at LLCP, almost three times the estimated value. To get the best value, reduce monthly overhead costs, and reduce modification costs, the state should buy its homes, a practice done by many supported living providers.

Source: LLCP

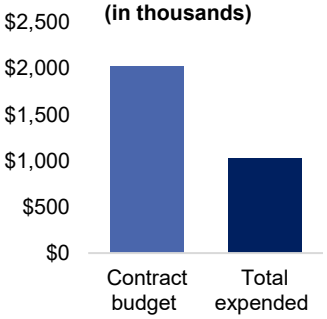
New Mexico could pilot an incentive program for DSPs using Government Results and Opportunity funding. Creating a pilot program with funding for approximately 1,000 DSPs to receive either $500 or $1,000 every six months for one year would cost approximately $1.8 million.

As of July 1, 2024, federal rule increased the salary cap for overtime requirements to $44 thousand, likely increasing DSP pay but potentially minimizing profit for provider agencies. The cap will increase again in January to $59 thousand, meaning employers will need to pay overtime to employees making less than the cap. In New Mexico, the average salary for healthcare support jobs is $28 thousand, with 25 percent of those in field making between $36 thousand and $44 thousand a year meaning up to 13.5 thousand health care support workers could potentially qualify for overtime.

The recently settled Golden vs. Quality Life Services lawsuit, in which plaintiffs alleged the direct service agency they worked for was in violation of overtime rules, showed these federal changes could affect the DD waiver provider network and force providers to reclassify employees, potentially raising wages and minimizing provider profits.

Leadership changes and contract amendments delayed use of a 24/7 telehealth service, leading to the division spending 51 percent of its $2 million contract. The 2023 PCG report highlighted the need for providers to expand their use of telehealth to better serve each DD waiver participant. Telehealth can provide immediate access to care, ease some provider capacity challenges, and improve participant and provider experiences. DDSD contracted with StationMD in FY23 and FY24 for just over $2 million to provide telemedicine services as an emergency room diversion strategy. However, the division only spent $1.03 million, and, as of September 2024, only an estimated two out of every three supported-living providers used the platform. However, use of StationMD is optional for providers. The division reported not fully expending the contract due to leadership changes within the agency and contract amendments. Yet turnover should not stop providers from using a needed service, nor should it stop assistance to providers to increase use of StationMD. This tool could likely alleviate the need for more on-call nurses and DSPs, improving capacity. For FY25, DDSD expanded StationMD to Mi Via and Medically Fragile providers, likely increasing uptake.

Chart 9. DDSD Expended Only 51 Percent of a Telehealth Contract in FY23 and FY24
(in thousands)



Source: SHARE

New Mexico's waiver application anticipates more therapy usage per participant than nearly any other state, potentially exacerbating provider shortages¡ LFC analyzed I/DD waiver applications for states with similar waivers and found New Mexico's traditional DD Waiver allowed and anticipated more therapy units (or 15 minutes of therapy) per participant than any other state. This high usage and demand could worsen the state's limited provider capacity; according to PCG, occupational therapy, physical therapy, and speech-language pathology are three of the four services most frequently identified as having limited access for participants.

The need for therapists to train DSPs on participant service plans potentially exacerbates this problem and takes up more time, especially given the high turnover for the DSP profession. Current waiver standards allow for the designation of supported living provider staff as DSP trainers. Therapists can train these supported-living provider staff who will then train their own

DSPs, allowing therapists to provide services to more participants. Fidelity to this "train-the-trainer" model could provide greater flexibility in how services are delivered and free up therapists' time to see more patients. For example, if New Mexico had units-per-participants at the level of West Virginia, the most comparable of the peer states listed below, it could free up 60 percent more therapist time.

Table 9. Anticipated Therapy Use Per State 1915(c) Application

	New Mexico	Alabama	D.C.	Maine	West Virginia
OT Units Per Participant	92-108	49	23	40	89
PT Units Per Participant	108-125	55	32	127	108
SLP Units Per Participant	148-160	29	37	127	24

Note: Data taken from Year 1 Projections from most recent applications for NM019, AL001, WV007, ME006 and DC0037 waivers; waivers selected are comparable, predominately non-institution states and include the two waivers above and below New Mexico in CMS average cost (excluding states that do not provide therapy). Actual median usage for OT, PT, and SLP in New Mexico exceed unit ranges stipulated above

Source: State waiver plans

Recommendations

The Legislature should consider:

- Enacting legislation to require providers pass through 80 percent of Medicaid reimbursement revenues to direct support professionals per the Centers for Medicare and Medicaid Services final rule starting in FY27. This legislation should require Developmental Disabilities Supports Division to come up with a monitoring and support plan by September 1, 2025, that would allow the state to ensure providers successfully pass through at least 80 percent of Medicaid reimbursement rates;
- Funding provider expansion and startup costs to increase the number of providers able to serve new clients; and
- Funding with the government results and opportunity fund a pilot to randomly test the effect of different levels of incentive payments to help recruit and retain direct support professionals at an estimated cost of $1.8 million annually.

The Developmental Disabilities Supports Division of the Health Care Authority should:

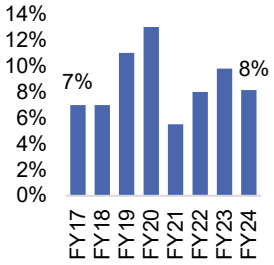
- Present to the Legislature by September 1, 2025, a plan that will consider how Developmental Disabilities Supports Division's monitoring and technical assistance practices will change when providers are required to pass through at least 80 percent of rates to those directly providing services as will be required by federal Centers for Medicare and Medicaid Services;
- Continue to utilize StationMD, tracking spending and provider uptake of the service, and provide technical assistance to increase provider use of the platform; and
- Continue to implement a train-the-trainer model, through encouragement for therapists and direct support providers by January 2026.

HCA is Addressing Some Safety Concerns but Others Regarding Client Monitoring and Requests for Assistance Remain

In 2023, a waiver participant died due to abuse. This case led DDSD to perform routine health and wellness checks on all the waiver participants and evaluate its current processes to ensure the safety of all people on DD waivers. While few cases of abuse, neglect, or exploitation (ANE) were found in these first wellness checks, the state's overall rate of ANE has remained practically unchanged since FY17.

Since the state served 69 percent more waiver participants in FY24 than in FY17, the effectively flat rate between these two years means almost 400 more waiver participants were subject to ANE in FY24 than in FY17. Considering this increase, the state should continue to monitor the rate of ANE.

Chart 10. ANE rate for DD and Mi Via Waiver Participants



Source: Report cards and DHI

Table 10. Total Cases of Abuse, Neglect and Exploitation, FY22-FY24

	Total Cases	Victims with Substantiated Cases	% Cases Substantiated	Substantiated Abuse Cases
FY24	2,409	645	27%	69
FY23	2,256	547	20%	22
FY22	1,701	341	23%	19

Source: DHI

In 2023, DDSD contracted with Accenture to evaluate the state's processes to ensure the safety of those on the waivers. This evaluation led to several immediate and longer-term recommendations. DDSD is currently working to address most of the immediate recommendations, and the Health Care Authority's Division of Health Improvement (DHI) —the division responsible for investigating ANE involving waiver participants —is working to ensure it has enough workforce to investigate cases per the state's timelines. The report included 16 findings and 29 recommendations, with seven recommendations the report suggested DDSD enact immediately (see Appendix D. for a full list of recommendations).

Beyond ANE, the agency should also monitor participant outcome metrics, including measures of quality of life at the provider level. For other Medicaid and Medicare services, the federal government includes these in provider ratings, and elsewhere states may play a larger role in ensuring providers measure quality of life or assess it themselves.

Recent findings of abuse, neglect, and exploitation led to HCA implementing new procedures to improve participant safety.

In the aftermath of a participant dying due to abuse in 2023, DDSD, with help from DHI, began monitoring participant safety through twice-yearly wellness checks. The state is responsible for monitoring and investigating critical incidents and monitoring whether a provider has repeated incidents of ANE. The Accenture report highlighted there is no clear accountable or responsible party for addressing ANE incidents. However, DDSD and DHI have taken steps to address this and other safety issues.

In spring 2023, DDSD began wellness checks for all waiver participants but did not have final procedures for these checks until summer 2024. In April 2023, DOH announced its plan to visit all 6,800 people receiving DDSD services within 30 days. According to DDSD Advisory Council on Quality meeting minutes, members expressed inconsistent experiences with the visits. Some people reported that the visits went very well, while others expressed concern over the visits' intrusive nature and lack of staff training. However, a finalized checklist was not in place until August 2024.

To conduct these visits, staff are supposed to schedule the visit beforehand. While severe abuse or neglect will likely still be caught in an announced visit, announcing visits may pose a risk due to providers potentially being able to hide lower levels of neglect or exploitation. While DDSD initially had unannounced visits, these were a major concern and an issue for individuals in service, families, and guardians. DDSD now visits every person receiving DDSD services twice a year, meaning they will conduct an estimated 18 thousand wellness visits annually.

The 2023 Accenture report found DDSD failed to provide adequate crisis management services and was unable to evaluate consumer risk, likely increasing the risk for abuse, neglect, and exploitation. Accenture's recommendations include ensuring case managers engage with participants meaningfully and adequately, have clearly communicated processes, leverage best practice risk assessment tools to determine individual consumer risk, and develop technology solutions that allow DDSD to easily access key consumer information.

DDSD worked or is working to address six of the seven recommendations that needed immediate attention. Additionally, while staff members do not yet have access to ASPEN (the state's Medicaid information system), DDSD is working to ensure access to select staff members, especially after joining HCA.

Table 11. Immediate Remediations Suggested for the Waiver System

Key Recommendation	DDSD Action
Articulate key concepts and principles for self-directed programs	DDSD clarified and rewrote its mission and guiding principles and identified ways to adopt the mission and principles into daily practice
Create holistic process visuals to orient people to the overall process activities, handoffs, and points of risk	DDSD created processes to highlight practices as of 2023 and were focusing on additional mapping for further clarity around risk for ANE.
Clarify roles and responsibilities across waiver program processes to: • identify the accountabilities for risk and safety activities, assess resource capacity, • update job descriptions with enhanced role details and responsibilities, • develop and deliver communications, change management, and training outlining key accountabilities and owners per program	DDSD has a planned reorganization of its bureaus including adding a safety bureau, stood up in April 2024. This reorganization will include some shifting of bureau responsibilities and staff. The reorganization will be ongoing with a plan to be done by January 2026.
Develop & operationalize additional risk-oriented tools and processes that support decision capacity for self-direction and individual consumer risk assessment	On-going, a bureau dedicated to this was stood up April 2024.
Assess current case management/consultant/service coordinator capacity in context of resource realignment	No progress at this time
Grant ASPEN access to an expanded list of appropriate DOH staff	Working on since shift to HCA
Build on the recently validated data from the home visitation effort to create a tracking database	Created a template to support DDSD in conducting visits with more standardization and efficiency and using Therap to track visits

Note: green = the recommendation is complete, orange = the recommendation is started but not complete and red = the recommendation is not started. ASPEN is the state's Medicaid information system.

Source: Accenture

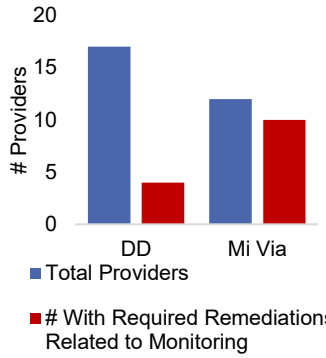
Roughly 1-in-4 four case management agencies and over 80 percent of Mi Via consultants are not adequately monitoring DD clients.

According to the most recent case management and consultant audits (surveys) posted to the DHI's Quality Management Bureau's website, 23 percent of case management providers and 83 percent of consultant providers were cited for not having evidence of visiting participants, having monthly contact, or recording this information in Therap, the participant tracking system used by providers.

Case managers and consultants can be participants' first line of defense to ensure quality service provision. Participant safety can be at risk if case managers or consultants are absent or provide low-quality visits. Evidence within the Accenture report showed case managers sometimes performed only a perfunctory role instead of fully engaging with the participant and quality management bureau data found no evidence of client visits for roughly 25 percent of case management and over three-quarters of consultant agencies.

According to Accenture, ensuring DDSD staff know how to best engage with people on the waivers is essential as DDSD and DHI staff visit thousands of people each year when conducting wellness checks. DDSD needs to immediately assess its case manager, consultant, and service coordinator capacity to ensure those on the waivers have someone looking to help with their needs and life choices rather than, in Accenture's words, a "check the box" interaction.

Chart 11. Case Management and Consultant Providers with Deficiencies Regarding Monitoring or Contacting Participants



Note: severity of noncompliance varied Some providers had only 1 instance of monitoring issues while others had around 50% of sample with issues.

Source: DHI

The University of New Mexico (UNM) currently administers a training hub for DD waiver providers and hosts DDSD online training for providers and other stakeholders in the DD waiver community. In 2021, the Human Services Department's American Rescue Plan Act (ARPA) Spending Plan for Home and Community Based Services stated they planned to work with UNM to offer additional training for applied behavior analysis, nursing, and direct care workers. However, the state did not report ARPA spending on these activities.

DDSD and DHI need to improve processes and timeliness regarding determinations of ANE and responses to requests for assistance.

Currently both DDSD and DHI can improve processes regarding client risk. For both DDSD and DHI the Accenture report found the process to report or respond to ANE was unclear. Both divisions worked together and will need to continue to work together to address this risk. For DHI, while the division improved staffing, in FY24 staffing levels impeded timely case closure—a problem highlighted in the 2018 evaluation. These risks require HCA to conduct system monitoring to ensure client safety and quality service provision. For both divisions, ensuring the public and providers know how to report concerns is also essential. For DDSD this risk is partially related to regional requests for assistance. When requests are not resolved timely, clients can be put at risk. Furthermore, according to a PCG report, requests do not resolve client issues for 40 percent of clients.

Accenture found a lack of clarity regarding roles and responsibility, including when dealing with ANE, and the department is implementing some of the recommended solutions. The report found "When individuals were unsure of the responsibility to report or act, they would hand-off to other departments or team members to act, resulting in delay of care, reporting and resolution." Recommendations included identifying who is accountable and the criteria for risk and safety behaviors across the various DDSD and DHI processes, updating job descriptions with enhanced role details to specify responsibilities, and enhancing communication across agencies including who is responsible for responses. DDSD began implementing these recommendations and developed processes outlining responsibilities, along with a new bureau dedicated to risk management and ANE response processes within DDSD. Progress on these and other recommendations is not reported, though Accenture also did not require such reporting.

Accenture Recommendations Regarding Improving Process ANE Clarity

- Identify the accountabilities and criteria for key risk and safety behaviors across processes that support the waiver programs
- Assess resource capacity to support assignment of actions to specific roles
- Update job descriptions with enhanced role details and clear responsibilities and actions
- Develop communication, change management, and training across agencies outlining key accountabilities and owners per program

Source: Accenture

While the percentage of abuse and neglect cases completed on time has improved since the 2018 evaluation, for FY24, inadequate staffing led to only 80 percent being closed on time, the lowest in five years. In the first two quarters of FY24, DHI's Incidence Management Bureau did not close around 20 percent of cases on time. Bureau staff stated this failure was largely due to a lack of staffing. The division recently hired four new staff and has increased its rate of timely closures to 98 percent as of the first

quarter of FY25. HCA highlighted staffing as a key priority for DHI in its FY26 budget request. As reports of abuse and neglect continue to increase, potentially due to increases in the number of participants on the waiver, the division will need to continue to prioritize timely investigations and adequate staffing levels.

Regional office requests for assistance took an average of two months to resolve in FY24, significantly longer than the 45-day guideline but an improvement since FY23. DDSD has regional offices to assist and oversee providers, assist participants, and help potential participants apply for the waivers. Regional office requests for assistance (RORAs) can be filed by providers or participants when these people need assistance in getting services or ensuring other providers implement services timely and correctly. Typically, case managers or providers will submit a RORA to the state's regional office, which will then determine the priority level for the case and assign it to various bureaus depending on the reason for the request. For example, if a participant struggles to find a therapist, the RORA will go to the Clinical Services Bureau. When RORA cases take too long to close, individuals can be at risk.

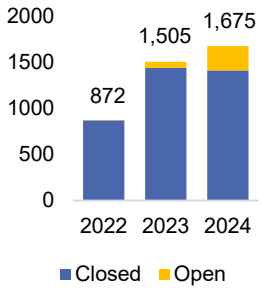
Table 12. Case Assignment Timeframes for Regional Office Request of Assistance

	FY22	FY23	FY24
Days to Assignment	3	8.8	9.2
Days from Assignment to Closure	68.9	93.8	58.3

Source: DDSD

DDSD is also taking longer than expected to assign these RORA cases. Cases should be assigned within five days and closed within 45 days, although this timeline was not enforced by DDSD supervisors until 2023. Since enforcement, average days to closure have improved, but days to assignment have increased since FY22. DDSD data show that when a case takes longer to be assigned, it is more likely to remain open. Open cases took an average of 46 days to assign, while closed cases took an average of only four days to assign. According to DDSD, open cases are generally related to provider service unavailability. While 92 percent of cases are closed, roughly 8 percent, or 333, of all cases between FY22 and FY24 are still open. Furthermore, the 2023 PCG report found 40 percent of participants' problems were not resolved by DDSD through the RORA process. Therefore, DDSD should continue to monitor and enforce timelines for a RORA and determine if client needs were met to ensure participants and providers receive the assistance they need.

Chart 12. Open Cases by Fiscal Year



Source: DDSD

Beyond the RORAs, providers and the public may reach out to DDSD, DHI, or Adult Protective Services in the Aging and Long-Term Services Department if there is a concern with client safety. However, Accenture highlighted the lack of clarity regarding who to reach out to and how.

DDSD and DHI monitor compliance but have not traditionally assessed participant quality of life or other participant outcomes.

Both DDSD and DHI monitor provider compliance with standards in numerous ways. The Quality Management Bureau (QMB) at DHI focuses on meeting with providers at least once every three years to assess whether the provider is compliant with set standards regarding health and safety and

whether they are implementing a participant's individual service plan. While ensuring compliance with standards is essential, understanding more about how providers contribute to participant quality of life could be important when determining if providers are helping participants meet their goals. In other fields, such as nursing facilities, the federal Centers for Medicare and Medicaid Services (CMS) includes measures of quality of life when rating providers. Furthermore, the state could do a better job of measuring whether DDSD is meeting expected participant outcomes and the stated goals of the program, as is done elsewhere.

Current QMB surveys focus predominantly on compliance rather than quality of life. The QMB survey tools contain questions related to whether a participant has an individual service plan and behavior plan or other plans, and if there is documentation of specific training needed to support the participant. However, the tools do not focus on participant satisfaction or outcomes of these plans. If a provider is rated by whether a home is safe and meeting standards, the provider may not focus as much on ensuring a participant is also meeting their goals and increasing their independence. Therefore, measuring the percentage of goals met and other quality of life metrics within the QMB survey could help providers focus on these important metrics.

DDSD and DHI could model provider surveys after CMS annual ratings of nursing homes that are determined by a health inspection, staffing levels and turnover, and quality measures. Each year CMS rates all nursing homes that participate in Medicare or Medicaid. This 5-star system rating provides families an easy way to determine nursing home quality and looks at metrics beyond the health and safety of participants.

Table 13. Components of CMS' Five Star Rating System

Health Inspections- measures based on outcomes from state health inspections
Staffing- measures based on staffing levels and staff turnover
Quality Measures- measures based on claims-based quality measures (e.g. ED visits, bed sores, mental health, and successful return home)

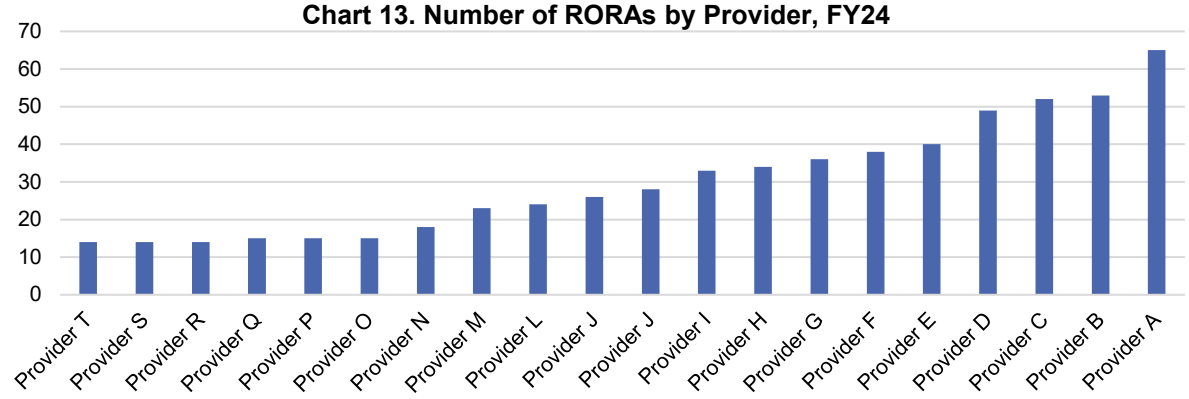
Source: CMS

Adding staffing and quality of life components to the state's current survey instrument could provide insight into provider quality. Furthermore, publicly posting these ratings, as CMS does for nursing homes, could provide more transparency for families, participants, and case managers when determining appropriate living arrangements and service provision.

Washington and California either have providers monitor quality of life performance with tools provided from the agency or monitor state outcomes regarding participant quality of life. In California, the state gives providers a tool kit to help assess participant's quality of life, including metrics of independence and participant satisfaction. In Washington, the state has an annual report highlighting the outcomes of its DD program, including the percentage of participants making progress toward a goal. Washington also participates in the National Core Indicators Survey to get participants' perspectives on services. In New Mexico, while the state requires agencies have a quality assurance team that meets at least quarterly, the state does not provide a quality-of-life assessment framework like California, nor does the state participate in the National Core Indicators Survey, a practice that could illuminate challenges and strengths of waiver service provision.

The number of regional office requests for assistance (RORAs) involving providers varies significantly by provider, indicating RORAs could be useful when determining provider quality. Of the 1,675 unduplicated RORAs in FY24, 1,050, or 63 percent, focused on specific providers, with the number of RORAs filed against a provider ranging from one to 65. This large variability in RORAs could indicate some providers are delivering higher quality services than others. Therefore, the state may want to consider information about RORAs when conducting provider surveys.

Chart 13. Number of RORAs by Provider, FY24



Note: This is the total number of RORA requests and is not adjusted by provider size. Provider names are masked.

Source: DDSD

Beyond provider monitoring, DDSD could better align its performance metrics with outcomes focused on the division's stated goals. The 2018 LFC evaluation highlighted the need for DDSD to collect performance metrics more directly tied to program and participant goals. The division's mission statement highlights the desire to provide a comprehensive system of support centered on the person, allowing participants to live the lives they want where they are respected, empowered, and free from ANE. However, DDSD and DHI's current performance metrics still do not track many outcomes related to this mission.

Table 14. Current Performance Measures for DDSD or DHI related to DD waivers

	Measure	FY22 Actual	FY23 Actual	FY24 Target	FY24 Actual
DDSD Performance Measures	Percent of adults between ages twenty-two and sixty-two served on a developmental disabilities waiver (traditional DD or Mi Via) who receive employment supports	9.8 %	9.5%	27%	9%
	Percent of general event reports in compliance with general events timely reporting requirements (two-day rule)	85%	90%	86%	92%
	Percent of developmental disabilities waiver applicants who have a services plan and budget in place within ninety days of income and clinical eligibility determination	96%	87%	95%	76%
	Number of home visits	New	New	New	New
	Percent of home visits that result in an abuse, neglect, or exploitation report	New	New	New	New
	Number of individuals on the home and community based waiver waiting list	2,610	250	N/A	111
	Number of individuals receiving home and community based waiver services	5,416	8,285	N/A	7,522
	Percent of people receiving waiver services that have received their annual level of care assessment	100%	100%	98%	100%
DHI Performance Measures	Percent of abuse, neglect, and exploitation investigations completed according to established timelines	95%	95%	95%	80%
	Abuse rate for developmental disability waiver and mi via waiver clients	7.9%	9.8%	Not reported	Not reported
	Re-abuse rate for developmental disabilities waiver and Mi Via waiver clients	6%	0%	Not reported	Not reported
	Percent of incident management bureau-assigned abuse, neglect, and exploitation investigations initiated within required timelines	New	New	New	New
	Percent of quality management bureau 1915c home and community based services waivers report of findings distributed within 21 working days from end of survey	New	New	New	New
	Percent of home visits that result in an abuse, neglect, or exploitation	New	New	New	New
	Percent of developmental disabilities support division clients receiving wellness checks per year as part of the audit conducted by the quality management bureau	New	New	New	New

Source: LFC report cards, Vol III, and DDSD

The division's performance measures should reflect important service quality standards, such as whether people are living in the least restrictive environment for their needs, participant health and safety, and community inclusion. By collecting and reporting on performance metrics tied to outcomes, DDSD will be able to track improvement on any potential areas of concern currently not seen due to a lack of collecting outcome data.

Table 15. Potential Performance Measures Focused on Outcomes Related to DDSD's Mission

Desired Outcome	Potential Performance Measure
Strong community inclusion	Average length of time in job development before employment
	Percent of individuals employed who included employment as an individual service plan goal
	Percent of customized community supports conducted in the community
Individuals on the waivers are safe and healthy	Rate of abuse, neglect, and exploitation*
	Percent of abuse, neglect and exploitation investigations completed on time*
	Rate of general event reporting
	Rate of hospitalizations
	Percent individuals on the waivers who experience improved health outcomes in the areas of diabetes, substance abuse, and obesity
Individuals reside in the least restrictive environment for their needs	Percent of individuals living at home with customized in home supports
Individuals receive needed services	Percent of individuals on waiting list receiving Medicaid or State General Fund
	Average days from allocation to receipt of services
Individuals progress towards personalized goals	Percent of individual service plan goals met

Note: * indicates current performance measure

Source: LFC files

Recommendations

The Developmental Disabilities Support Division of the Health Care Authority should:

- Ensure wellness checks are conducted based on the established checklist and guidelines published;
- Ensure case manager and consultant ability to meet current standards, including workload monitoring, and increase training and oversight of the case management and consultant process if they cannot;
- Report to the Legislature bi-annually on progress to implement all the recommendations in the Accenture report.
- Improve the regional office request for assistance (RORA) process by ensuring both timely assignment and closure as well as by monitoring participant and provider experiences using the system;
- Work with the Legislative Finance Committee and Department of Finance and Administration to create performance measures on the percent of RORAs assigned and closed within guidelines, as well as metrics related to participant quality of life and outcomes such as those outlined in Table 15.;
- Participate in the National Core Indicator survey to understand the strengths and challenges of the waiver from a participant perspective; and

The Developmental Disabilities Support Division and the Division of Health Improvement of the Health Care Authority should:

- Change the current quality management bureau survey tool to add measures of quality of life and consider regional office requests for assistance when determining provider compliance.

The Division of Health Improvement of the Health Care Authority should:

- Monitor staffing to ensure timely response by investigators to reports of abuse, neglect, and exploitation.

DDSD Has Limited Oversight of Participant Budget and Service Delivery

Both the traditional DD and Mi Via waivers have limited oversight of budget development, allocation of services, and service utilization for participants. When assigning services and developing budgets, standardized tools could help determine the level of support needed, allowing the participant and family members who determine service provision with the help of a team of professionals, to allocate services more appropriately. Once services are determined, DDSD could further monitor both DD and Mi Via participants approaching or over service caps or budgetary allotments.

Actual waiver costs have exceeded LFC and Medicaid Assistance Division projections.

The Medicaid Assistance Division (MAD) and LFC staff each project expected costs of waiver services. When removing individuals from the waiting list, the state used projections to determine the cost of enrolling new participants. However, especially in FY24, costs exceeded these projections. While the difference between expected cost per client and actual cost per client was relatively small for the Mi Via waiver, it was relatively large for the traditional waiver, with costs per client up to 39 percent higher than expected. Furthermore, total waiver costs exceeded MAD projections in FY24, with actuals at $773 million while MAD projected costs of $733 million. This high cost per client and high total costs are due to a variety of factors, including more clients using high-level services, not enough outside oversight, and participants spending more than budget allotments and service caps.

Furthermore, in FY24, traditional DD waiver participants were expending $80 thousand in their first full fiscal year, which is $4,000 above current projections for all traditional DD participants. A similar trend was found for Mi Via. LFC's 2018 program evaluation found that new waiver recipient expenditures grew up to 78 percent between the first and second years of service and up to 23 percent between the second and third years of service. Budget projections may be underestimating growth caused by this trend, an important factor given the recent super allocation.

Table 16. Per Client Actual versus Projected Costs

Traditional DD Waiver			
	FY22	FY23	FY24
Actual	$96,562	$123,407	$115,832
Projection	$72,500	$74,675	$76,915
Difference	25%	39%	34%
Mi Via Waiver			
	FY22	FY23	FY24
Actuals	$58,941	$55,319	$74,149
Projection	$60,000	$61,800	$63,654
Difference	-2%	-12%	14%

Source: LFC analysis of DDSD and LFC data

Participants are using higher-level and more services.

The state's provider-driven method for recommending services and frequency of services may lead to overallocation. Individual service plans for the traditional DD waiver rely on the waiver participant choice and their

Table 17. Annual Supported Living Rates FY24-FY25

Cat.	FY24	FY25
1	$79,091	$75,324
2	$97,264	$92,633
3	$127,497	$121,424
4	$163,860	$156,060

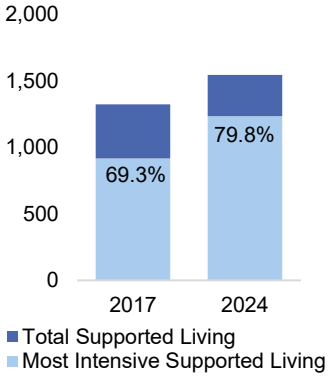
Note: Assuming 340 service days. FY24 rates were 5 percent higher due to ARPA funding.
Source: HCA

service provider team's recommendations, which is made up of family members and the providers who will be contracted for services.

Over half of the traditional DD waiver participants in supported living are categorized as having the highest acuity and, therefore, the highest cost. Supported living, delivered through provider-owned and operated community homes, accounts for 39 percent of total DD waiver costs. Individuals receive supported living through four acuity designations, ranging from category one (basic support) to category four (extraordinary medical/behavioral support.) In FY25, provider reimbursement rates vary with these levels from $222 to $459 per day, for up to 340 days per year.

Currently, about 80 percent of individuals in supported living are registered in the highest acuity levels (including category three, category four, and intensive medical), a 10 percent increase since the last program evaluation. Over half of supported-living participants are in the very highest acuity level, category four, and; this ratio has slightly increased since the effective elimination of the waiting list two years ago, even as the waiver population has become younger and more likely to need lower acuity care.

Chart 14. Number and Percent of Supported Living Participants in Highest Acuity Levels



Note: Most intensive supported living includes category 3, category 4, and intensive medical

Source: HCA

Table 18. Yearly Supported Living and Intensive Medical Living Enrollment by Category

	Category 1 Basic	Category 2 Moderate	Category 3 Extensive	Category 4 Extraordinary Medical/Behavioral Support	Intensive Medical Living	Percent of SL under Category 4
FY22	37	229	373	639	32	50.0%
FY23	44	249	441	741	44	50.4%
FY24	62	252	437	768	32	50.6%
Growth	25	33	64	129	0	

Note: Data for all DD waiver participants using supported living (SL). Data may include duplication for participants who switched their SL category.

Source: HCA

LFC staff analyzed data from one large supported-living provider and found a relationship between average acuity level in four-person homes and agency profit. The three homes with at least three category four individuals made an average of $11.8 thousand over a three-month period, while the six homes with two or more individuals at category two or below lost an average of $14 thousand over a three-month period. Given the lack of a validated assessment tool to determine patient needs when making service determinations, this trend toward higher support designations will likely continue.

DDSD is not following the best practices of using fade-out plans for therapy services. When participants meet their goals through therapy, they are expected to "fade out" of using that service. For example, if a participant has a goal to tie their shoes, once this goal is reached, the client either gets a new goal and maintains therapy or stops using it. Planning for the end of therapy services is a best practice, with the American Journal of Occupational Therapy stating in service standards that occupational therapy should "prepare and implement a safe and effective transition or discontinuation plan based on the outcomes of the intervention and the client's needs, goals, performance, and appropriate follow-up resources."

Table 19. Anticipated Percent of Waiver Recipients Using Therapy Services

State	Percent
Occupational Therapy	
NM	38%
AL	2%
D.C.	17%
ME	2%
WV	6%
Physical Therapy	
NM	37%
AL	2%
D.C.	35%
ME	1%
WV	8%
Speech Language Pathology	
NM	54%
AL	1%
D.C.	49%
ME	1%
WV	5%

Source: State Waiver Applications

Furthermore, DDSD includes fade-out plans as part of the state's DD waiver standards.

However, in the last three fiscal years, the state did not receive any therapy fadeout plans, meaning participants are either not ending therapy or the therapists are not submitting fadeout plans. If participants are not ending therapy usage after years of enrollment, understanding why and how to help those participants is necessary to make sure the participants get what they need. Because New Mexico has the highest enrollment rates in therapies among similar states, participants are likely staying in these services longer. On the other hand, if participants are ending therapy, but the therapist is not completing a fade-out plan, it is unknown if the participants received what they needed as they transitioned away from that therapy. Therefore, the state should oversee what participants are experiencing and if the quality and service duration of therapies received is appropriate. DDSD and DHI do not conduct compliance or quality reviews of therapy services. Understanding if participants receive appropriate and high-quality services is necessary to ensure they can transition from therapies to meet their full potential. Therefore, DHI and DDSD should work together to determine how to best audit therapy services.

Thirty-four percent of physical therapy, 22 percent of occupational therapy, and 16 percent of speech language pathology participants exceeded the 280-unit (15 minutes) limit, for an additional $2.5 million.

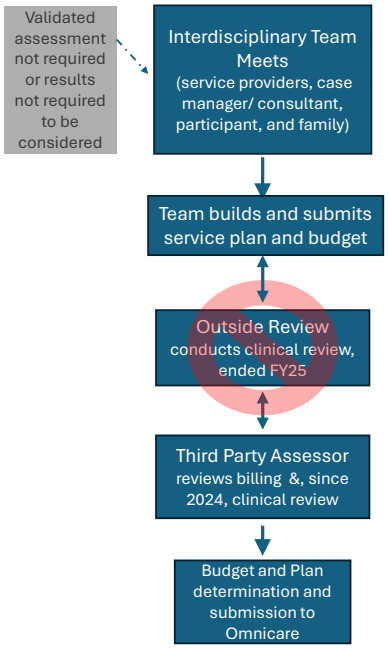
The lack of a two-step review and a validated assessment decreases oversight and may increase the risk of misallocation.

Recent DDSD changes, including eliminating a two-step system to ensure clinical justification and appropriate billing, have likely diminished oversight. Furthermore, while DDSD uses a validated assessment tool in its in-home assessment of those on the Mi Via waiver, the state does not require the assessment results to be part of the service allocation process.

DDSD uses a validated assessment tool for the Mi Via waiver but not as a required part of its individualized service plan development. Validated assessment tools help determine participant needs by looking at individual strengths and challenges using previous data to ensure consistency across users. Assessing needs can help ensure appropriate service provision, but only if the results are included in budget development and service planning. The third-party assessor currently uses a validated assessment tool, the Vineland Adaptive Behavior Scale-3 (a tool used by 12 other states), as part of the in-home assessment for Mi Via, but DDSD does not require the team working with the participant to use the assessment when determining individualized services.

New Mexico's service allocation process relies on recommendations from teams made up of the participant, family members, and providers serving the participant. These providers may benefit financially from delivering more or a higher level of service to participants. This structure makes it more important for the team to consider results from a validated assessment during the planning and budget development process. In 2018, the LFC

Figure 3. Service Plan and Budget Development Approval Process



Note: Starting in FY24, the Third-Party Assessor conducts a clinical justification review similar to the OR which is removed from the process.

Source: LFC files

evaluation recommended DDSD use a validated assessment tool to help assess participant needs. DDSD has not yet acted on this recommendation. However, beginning in 2026, DDSD will require Vineland to be used for traditional DD participants in the individualized planning process, but the department has not specified how or by whom.

Resolved lawsuits have long lasting impacts on the waiver process in New Mexico including on budget creation and oversight. Disability Rights New Mexico and others filed the *Jackson* lawsuit in 1987 due to conditions in state-run institutions for DD participants. The court dismissed the lawsuit in 2022, with DDSD continuing to operate under revised procedures to ensure participant service needs were met.

In addition to *Jackson*, the *Waldrop* lawsuit filed in 2014 by Disability Rights New Mexico and others focused on the due process rights of those whose services were reduced based on a new validated assessment tool. The *Waldrop* lawsuit was settled in 2015. This lawsuit led to DDSD discontinuing the validated assessment tool and adopting the outside review process to determine service allocation. The settlement did not require the state stop the use of an assessment tool to help with service allocation. The settlement outlined how the assessment process would occur and required DDSD to strengthen its due process system (see Appendix F). Both *Jackson* and *Waldrop* settlements focus on continued high-level service provision for participants.

Beyond these lawsuits, a 2022 lawsuit regarding the right for medically fragile children to receive nursing care is still in court. This lawsuit states Medicaid managed care organizations cannot limit nursing care based on supply and are required to provide care solely based on the child's needs. Depending on the case outcome, this suit could impact how the state designates services for waiver recipients generally rather than just for the Medically Fragile waiver.

DDSD may have increased the risk of budget delay and misallocation as it shifted away from a two-party review system beginning in FY25. Throughout FY24, DDSD began to phase out the outside review, citing cost and timing efficiencies. However, removing a level of review can increase risk to program integrity because there is less oversight, even though the TPA is required to assess for clinical justification as specified by current DDSD standards.

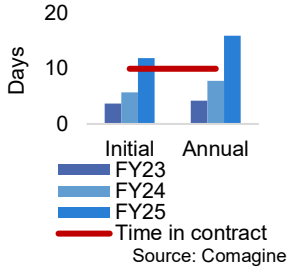
New Mexico's outside review process required all services be clinically justified. The outside reviewers determined if the service provided met that standard.

HCA contracts with Comagine to act as the TPA for multiple Medicaid-related services, including the DD and Mi Via waivers. The current contract between HCA and Comagine is for $17.2 million, with Comagine receiving $712 per initial and annual assessment and $101 per prior authorization review of those on the DD or Mi Via waivers. The contract also specifies budget and prior authorization reviews should be turned around within 10 business days. It is essential prior authorizations are turned around quickly because participants cannot receive services until the authorization is signed and services must be reauthorized annually. Adding additional responsibilities for the TPA in FY25 may have increased delays; with many requests taking 20 percent to 50 percent longer than the stipulated time to review in the contract.

The third-party assessor is the contractor that performs utilization review and assessment functions for Medicaid services, including the DD waivers.

Due to the complexity and limited oversight provided to employers of record, the 2018 evaluation recommended auditing employers of record, but the Division of Health Improvement has yet to implement this practice. For the Mi Via waivers, people regulate their own services with limited oversight from HCA. The standards specify participants may have an employer of record (EOR), a voluntary position which the vast majority of Mi Via participants use to help with many aspects of service allocation including hiring and paying service providers. While participants also have a consultant who assists the participant and EOR in their

Chart 15. Average Decision TIme by Third-Party Assessor Increased Upon Removal of Second Reviewer



Source: Comagine

responsibilities, the consultants do not regulate service providers, which is the responsibility of the EOR, and no one oversees the EOR.

As was found in the 2018 report, New Mexico refers participants and EORs to consultants for technical assistance; however, the state does not monitor EORs to ensure the EOR or participant completes these responsibilities (see Appendix G. for responsibilities of the EOR). New Mexico's Attorney General's Office also flagged issues with EORs living outside the state. A regular audit of a sample of EORs, similar to DHI's surveys of traditional DD Waiver providers, case managers, and consultants, may help determine compliance with service standards and ensure the Mi Via waiver and EORs meet participant service needs and division standards.

New Mexico's Attorney General's Office also flagged issues with employers of record (EORs) including living outside the state.

An audit of EORs, like the surveys of other providers, may help determine compliance with standards and ensure EORs meet participant needs.

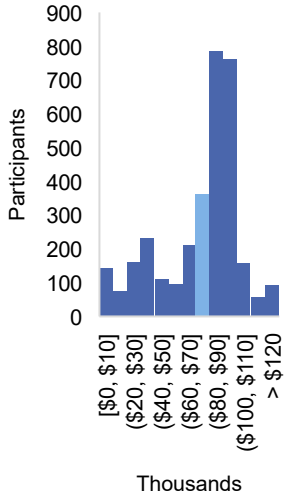
Many DD and Mi Via participants are significantly over budget allotments or caps.

While both waivers have service standards specifying service limits and caps, to what extent DDSD enforces these standards is unclear. DDSD sets a total budgetary allotment for Mi Via, but approximately two-thirds of waiver participants surpassed this expenditure amount in FY24. For the DD waiver, DDSD sets some caps regarding units of service for individual services, but these caps are frequently exceeded, with 88 percent of supported-living individuals expending more than published rates and caps by a combined $25.6 million. For services such as community-based supports and other forms of employment services, implementing caps common to other states could save an additional $20 million. DDSD could further monitor overutilization of services that are not clinically justified and enforce existing caps.

Average Mi Via waiver participant costs increased to $74 thousand for FY24, higher than the annual individual budgetary allotment of $72.7 thousand, leading to an additional $42 million in spending. Self-directed participation in Mi Via is subject to an individual budgetary allotment (IBA), or a maximum amount of funding for each participant. For adults over 21, the IBA was $72,710 in FY24, and individuals were required to justify additional expenditures through behavioral or medical conditions. Two-thirds of Mi Via waiver participants, or over 2,100 individuals, surpassed this cap. While DDSD has since increased the IBA to $85 thousand for FY25, half of all enrollees would have surpassed this amount the previous year.

By setting a maximum allotment, the state may have incentivized providers and participants to elevate budgetary levels to this limit, as was discussed in the previous LFC evaluation. LFC analysis of sample service and support plans (SSPs) showed original budgets for over half of these plans fell within $200 of the $72,710 mark, and one-third fell within $10. This proximity to the budget limit allowed for it to be easily surpassed with simple revisions.

Chart 16. Number Mi Via Participants by Expenditure Amount, FY24



Note: Individual Budgetary Allotment for FY24 was $72,710 (the IBA falls within the sky blue bar)
Source: LFC analysis of DDSD data

For example, when DDSD provided rate range increases in FY23, it allowed participants to update their living support budgets and exceed their IBA's, even though it is not a typical exception allowed for within NMAC 8.314.6.17 B(3)(a). Over half (19 out of 30) of participants in a sample of SSPs LFC staff analyzed utilized this exception, moving their in-home living supports rate to the new max, surpassing the IBA by approximately 10 percent. However, these exceptions fail to account for most high-cost participants, such as the two hundred individuals exceeding $100 thousand. Within the same SSPs, over 10 percent of individuals (four out of 30) also utilized a cost-of-living adjustment to increase community direct rates to triple their original amount. Increasing budgetary oversight and adherence to the Mi Via cap, except for justifiable circumstances, could help the division better plan for participant expenditures and allow DDSD to allocate services to more individuals. For instance, if all participants who went over their budget instead spent the $72,710 theoretical maximum in FY24, the state would have saved $42 million, or enough to fund another 575 estimated participants at the IBA.

If all Mi Via participants who went over budget instead spent the theoretical maximum in FY24, the state would have saved $42 million or enough to fund another 575 estimated participants at the IBA

In FY24, 88 percent of supported-living participants exceeded the yearly maximum reimbursement for the service at an estimated cost of $25.6 million. Supported-living services are capped at 340 days of service per year, with providers reimbursed daily depending on the level of participant acuity. In FY24, rates ranged between $232 and $482 (temporarily elevated from Table 17 due to federal American Rescue Plan Act and cost of living adjustment funding), meaning the maximum provider reimbursement for a participant annually was between $79 thousand and $164 thousand. However, over 1,000 individuals exceeded DDSD's published expenditure rate in FY24. For individuals in category four living, 547 participants exceeded the $164 thousand limit, and 185 exceeded $200 thousand. Billing schedules could account for some discrepancies because participant budget years do not align with fiscal years. Between the four categories, over $25.6 million more expenditures were recorded than would have been anticipated given published daily rates. Exceeding reimbursement rates negatively affects projections and cost containment.

In New Mexico, services like community-based supports and employment services do not have caps, a common practice in most states. In the states and districts identified as having similar waivers—Alabama, D.C., Maine, and West Virginia— all have caps for services like community integration, group support, day programs, and employment. For example, D.C. allows up to 40 hours per week for day programs and employment. Maine sets a monetary cap of $40 thousand for the same services, allowing participants to determine how to allocate these funds. DDSD could develop appropriate caps for services to ensure participants' needs are met responsibly. If New Mexico followed D.C.'s waiver provisions, which allocate more significant resources than other peer states, participants would have spent an estimated $17 million less on community-based services in FY24, freeing up additional funding for other waiver needs.

If New Mexico followed D.C.'s waiver provisions, which allocate more significant resources than other peer states, participants would have spent an estimated $17 million less on community-based services in FY24, freeing up funding for other waiver needs

Recommendations

The Developmental Disabilities Supports Division of the Health Care Authority should:

- Follow through on plans to require the Vineland Adaptive Behavior Scale-3 and require the results of the scale be used to develop individualized service plans within the traditional Developmental Disabilities waiver;
- Monitor the impact of eliminating the outside review and moving to using the third-party review as the sole budget review and report to the legislature by December 31, 2024, on the number of reviews conducted, the percentage and number needing requests for information, and the percentage conducted meeting contract timelines;
- For the traditional developmental disabilities waiver, develop appropriate budgetary caps for services for new enrollees, and for the Mi Via waiver adhere to the individual budgetary allotment unless there are justifiable extenuating circumstances;
- Report to the Legislature annually on average budget, average expenditures, and how many individuals exceeded their expected allotment; and
- Work with the Legislative Finance Committee and the Department of Finance and Administration to create performance measures focused on status of current expenditures, including average expenditures, how many individuals exceeded their expected allotment and the percent exceeding budgetary caps.

The Division of Health Improvement of the Health Care Authority should:

- Have the Quality Management Bureau in collaboration with the Developmental Disabilities Supports Division perform audits of therapy services; and
- Perform audits of employers of record for the Mi Via Waiver through the Quality Management Bureau;

The Medical Assistance Division, Developmental Disabilities Supports Division, and the Legislative Finance Committee should:

- Work together to monitor cost per client trends based upon client age and length of time on the waiver and use this information to inform projections.

Appendix A. Progress on Past Recommendations

Finding

The Traditional DD Waiver is Costing More Per Client, Even as Enrollment Declines.

Recommendation	Status	Comments
Analyze and report annually to the Legislature on clients with highest costs on the DD Waiver, looking at how their service needs and costs change over time.	Progressing	DDSD has not reported data on highest cost clients, but has created a report that pulls highest cost client data across services. However it is unclear how the agency uses this report to make decisions.
Examine cost drivers within the DD Waiver and Mi Via waivers, identify patterns leading to these cost increases and address issues programmatically, more specifically looking at: • Physical, occupational, and speech language therapy utilization and • Changes in intensity level and associated costs for living supports.	No Action	DDSD has not addressed these issues, nor has it published any reports highlighting these data.

Finding

Mi Via, the Self-Directed Waiver, is Driving Cost Increases of the State's Developmental Disability Programs.

Recommendation	Status	Comments
Analyze and report to the Legislature on Mi Via clients with highest costs, looking at how their service needs and costs change over time.	Progressing	DDSD has not reported data on highest cost clients, but has created a report that pulls highest cost client data across services. However it is unclear how the agency uses this report to make decisions.
Examine cost drivers within Mi Via, identify patterns leading to these cost increases and address issues programmatically, more specifically looking at: • Living supports such as direct care services; Community-based supports such as community direct support and customized community supports; and • Changes in utilization for these services	No Action	DDSD has not addressed these issues, not has it published any reports highlighting these data.

Finding

Other States Deliver More Cost Effective Services for Individuals with Developmental Disabilities.

Recommendation	Status	Comments
Model other state cost containment practices specifically around living and community-based supports.	Progressing	DDSD has researched other states' cost containment strategies over the years. DDSD implemented a number strategies between 2018-current, however these have not been successful in keeping costs from increasing faster than in other states.
Analyze the feasibility of instituting the Community First Choice option under the ACA to leverage an additional 6 percent federal match for home- and community-based attendant and support services.	Complete	DDSD explored the community first choice option, but did not implement this strategy.

Finding

DOH Has Improved Management of the DD Waiver Waiting List, but Needs to Do More to Predict Future Needs and Service Capacity.

Recommendation	Status	Comments
Create a five-year plan to reduce the waiting list by 25 percent to 50 percent. Funding the plan would require the Legislature to commit a total of approximately $4 million to $8 million general fund for the first year of waiver services over the five-year period and approximately $33 million to $65 million on a recurring basis thereafter. This plan should then be submitted to the Legislature with annual DOH budget submissions, detailing progress toward the stated goal, and any changes in funding requirements year-to-year to support these new clients. Should DOH demonstrate cost containment in the DD and Mi Via waivers, the Legislature should consider reappropriating these savings to increase the rate the waiting list will be reduced in the five-year plan.	Complete	DDSD effectively eliminated the waiting list with the super-allocation plan that began in November 2021. However, the number of individuals on the waiting list are a point-in-time data point, as people apply every day. As of 7/19/24 there are 129 people on the waiting list. DDSD plans an annual allocation process for these individuals , based upon funding availability.
Track and include utilization of state general fund and non-waiver Medicaid services by individuals on the waiting list as part of the annual DDSD Central Registry Report.	Progressing	DDSD tracks state general funds utilization of people on the waiting list. The non-waiver Medicaid services data is tracked by the Medical Assistance Division, HCA.

Finding

DOH's Current Assessment and Budget Allocation Process Lacks Standardization and Contributes To Rising Annual Client Budgets.

Recommendation	Status	Comments
Implement a standardized, validated, and evidence-based assessment and allocation tool to drive and inform its person-centered review and allocation process, while incorporating appropriate safeguards to protect client rights.	Progressing	DDSD's currently utilizes the Vineland Adaptive Behavior Scales assessment tool for its Mi Via Waiver. This tool will be implemented for the DD Waiver at the next waiver renewal in 2026 however these tools are not required to be considered as part of the budget allocation process.

Finding

Improved Oversight is Necessary to Mitigate Risk to Waiver Participants and Public Funds.

Recommendation	Status	Comments
Establish more efficient and effective protocols as well as ensuring staffing is adequate across the state for DHI IMB to complete and close abuse, neglect, and exploitation cases on time.	Progressing	Weekly investigator one-on-one meetings with their supervisor was implemented to ensure adequate support and direction is provided to staff with every case. Face-to-face interview and remote/phone interview protocols were established to promote efficiency and effective utilization of resources. While IMB has currently improved staffing, HCA should continue to monitor to make sure staffing continues to be adequate and cases are closed timely.
Audit a sample of employers of record annually to ensure client needs are met.	No Action	This is not a practice of IMB. This oversight could possibly be handled through the oversight (survey) practices of QMB. However, employers of record (EOR) are not required to respond to such requests. These are voluntary positions through the Mi-Via program.

Finding

Data Collection Offers DOH an Opportunity to Improve Performance Management and Client Outcomes.

Recommendation	Status	Comments
Use the key performance indicator framework to examine more client-centered outcome information.	Progressing	DDSD got rid of their key performance indicator framework and instead relies on CMS performance measures and HCA performance measures; some, although not many include outcome metrics..
Work with LFC and DFA to create performance measures focused on client outcomes and provider quality such as: percent of individuals seeking employment services who gain employment, percent of abuse neglect or exploitation investigations completed on time, and the percent of individuals living at home with customized in home supports.	No Action	While DDSD stated they can work with LFC and DFA to adjust performance measures this has not happened to date. Currently, HCA Performance Measures track the number of people receiving waiver services, the number of people who have received their annual level of care assessment, people who receive employment supports, people who have service plan and budgets in place within 90 days of eligibility determination and reporting timeliness compliance

Finding

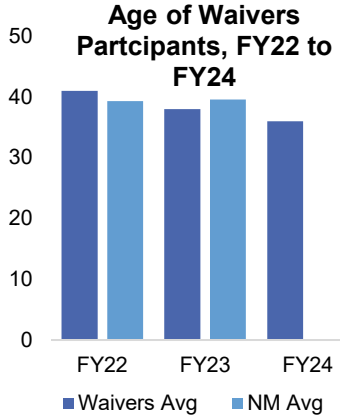
New Mexico Has Made Progress on Resolving the Jackson Lawsuit, but It Remains a Significant Cost Driver For The Entire DD System.

Recommendation	Status	Comments
Provide triannual reports to the Legislature on the status of disengagement from outstanding obligations of the Jackson case.	Complete	The Jackson lawsuit ended May 2022.

Appendix B. DD, Mi Via and Supports Waiver Demographics

In FY24, over 50 percent of those on a waiver lived in the metro region and were between 20 and 40 years old. In FY24 there were 7,849 people on the DD, Mi Via, or Supports waivers. Of these individuals, the majority live in the metro area, followed by the southwest and southeast regions (see Appendix B). These numbers roughly match the state demographics; however, slightly more participants live in the metro, likely due to the increased availability of services. From FY22 through FY24, most individuals on the DD and Mi Via waivers were between the ages of 20 and 40, and the average age on the waiver decreased from 41 to 36. The decreasing age of waiver participants is likely due to DDSD's allocation of younger individuals from the waiting list in FY22 and FY23.

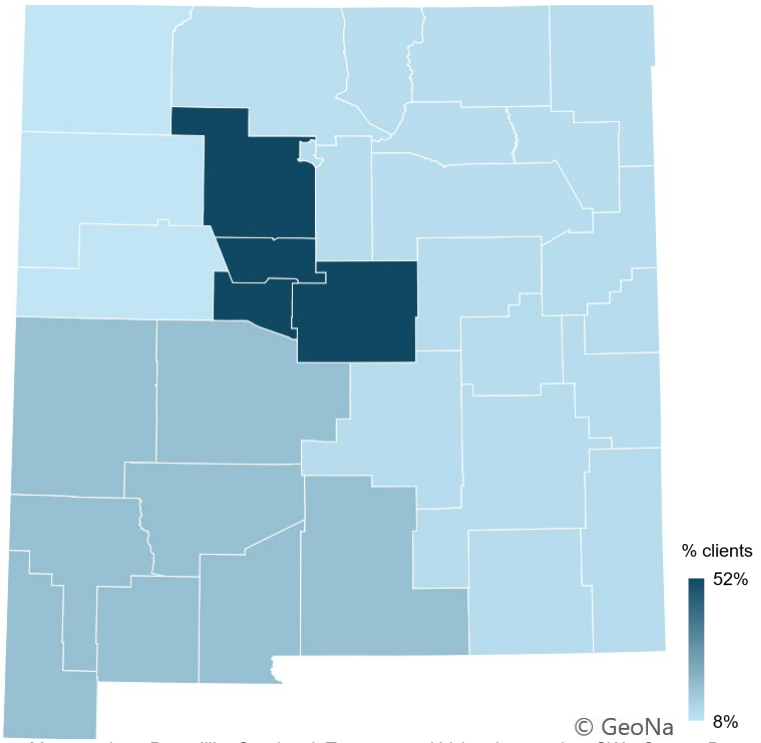
Chart 3. Average Age of Waivers Partcipants, FY22 to FY24



Note: The average age in NM has yet to be reported for FY24

Source: LFC files

Map of Waivers Participants by Region



Note: Metro region= Bernalillo, Sandoval, Torrance and Valencia counties. SW= Catron, Dona Ana, Grant, Hidalgo, Luna, Otero, Sierra, and Socorro counties. SE= Chaves, Curry, De Baca, Eddy, Guadalupe, Lea, Lincoln, Quay, and Roosevelt counties. NE= Colfax, Harding, Los Alamos, Mora, Rio Arriba, San Miguel, Santa Fe, Taos, and Union counties. NW= Cibola, Mickinley, and San Juan counties.

Source: DDSD

Table 2. Waivers Participants by Geographic Region

	# Participants	% Participants
Metro	3999	52%
SW	1427	19%
SE	819	11%
NE	801	10%
NW	636	8%

Source: DDSD data

Appendix C. Number of Providers Accepting New Participants by Service and County, 2024

Number of Providers for High Cost Services by County, 2024

County	Customized In-home Supports	Family Living	Intensive Medical	Supported Living	Behavior Support Consultation	OT	PT	Speech Therapy	Total Providers	Change from 2018
Bernalillo	9	13	0	3	2	2	2	3	34	-107
Catron	2	3	0	0	0	0	0	0	5	-1
Chaves	3	4	2	2	1	2	2	3	19	-3
Cibola	4	6	0	0	2	0	0	0	12	-8
Colfax	1	1	0	1	1	0	1	1	6	-2
Curry	4	5	0	0	0	0	1	3	13	-5
De Baca	1	3	0	0	0	0	0	1	5	1
Dona Ana	9	8	0	6	1	0	0	2	26	-14
Eddy	1	4	0	1	0	0	0	2	8	-4
Grant	4	7	NA	2	1	1	0	1	16	-2
Guadalupe	0	2	0	0	1	0	0	1	4	-4
Harding	0	0	0	0	0	0	0	1	1	-2
Hidalgo	2	2	NA	0	1	0	0	0	5	-1
Lea	4	4	NA	1	0	0	1	2	12	0
Lincoln	3	5	NA	1	0	0	0	1	10	-1
Los Alamos	3	5	0	1	3	1	1	2	16	-4
Luna	4	6	NA	2	1	0	0	0	13	-3
McKinley	2	6	NA	3	1	0	0	0	12	-7
Mora	4	4	0	1	3	0	1	2	15	-9
Otero	3	6	NA	2	1	0	1	0	13	-9
Quay	2	4	NA	1	0	0	0	1	8	4
Rio Arriba	5	5	NA	1	0	1	2	2	16	-10
Roosevelt	3	5	0	0	0	0	1	3	12	0
San Juan	0	5	0	1	0	1	2	0	9	-9
San Miguel	0	5	0	1	5	0	2	2	15	-13
Sandoval	7	13	0	3	3	1	2	3	32	-48
Santa Fe	8	8	1	1	6	1	1	1	27	-16
Sierra	3	5	NA	0	1	0	0	0	9	-8
Socorro	4	7	0	0	1	0	0	1	13	-7
Taos	4	5	NA	0	1	2	2	1	15	-5
Torrance	4	11	0	2	2	1	0	0	20	-22
Union	1	1	0	1	0	0	0	1	4	-1
Valencia	6	13	0	2	2	0	1	0	24	-55
Average	3	5	0	1	1	0	1	1	14	-12
Percent Counties w/o services	**12%**	**3%**	**94%**	**33%**	**36%**	**70%**	**52%**	**30%**		
Change since 2018	**9%**	**3%**	**27%**	**12%**	**30%**	**22%**	**-25%**	**0**		

Note: Data was collected from the secondary freedom of choice website from July 16-19, 2024. The secondary freedom of choice website is a point in time measure with information changing at least weekly if not daily. OT= occupational therapy, PT=physical therapy

Source: Secondary Freedom of Choice Website

Appendix D. Accenture Findings and Recommendations

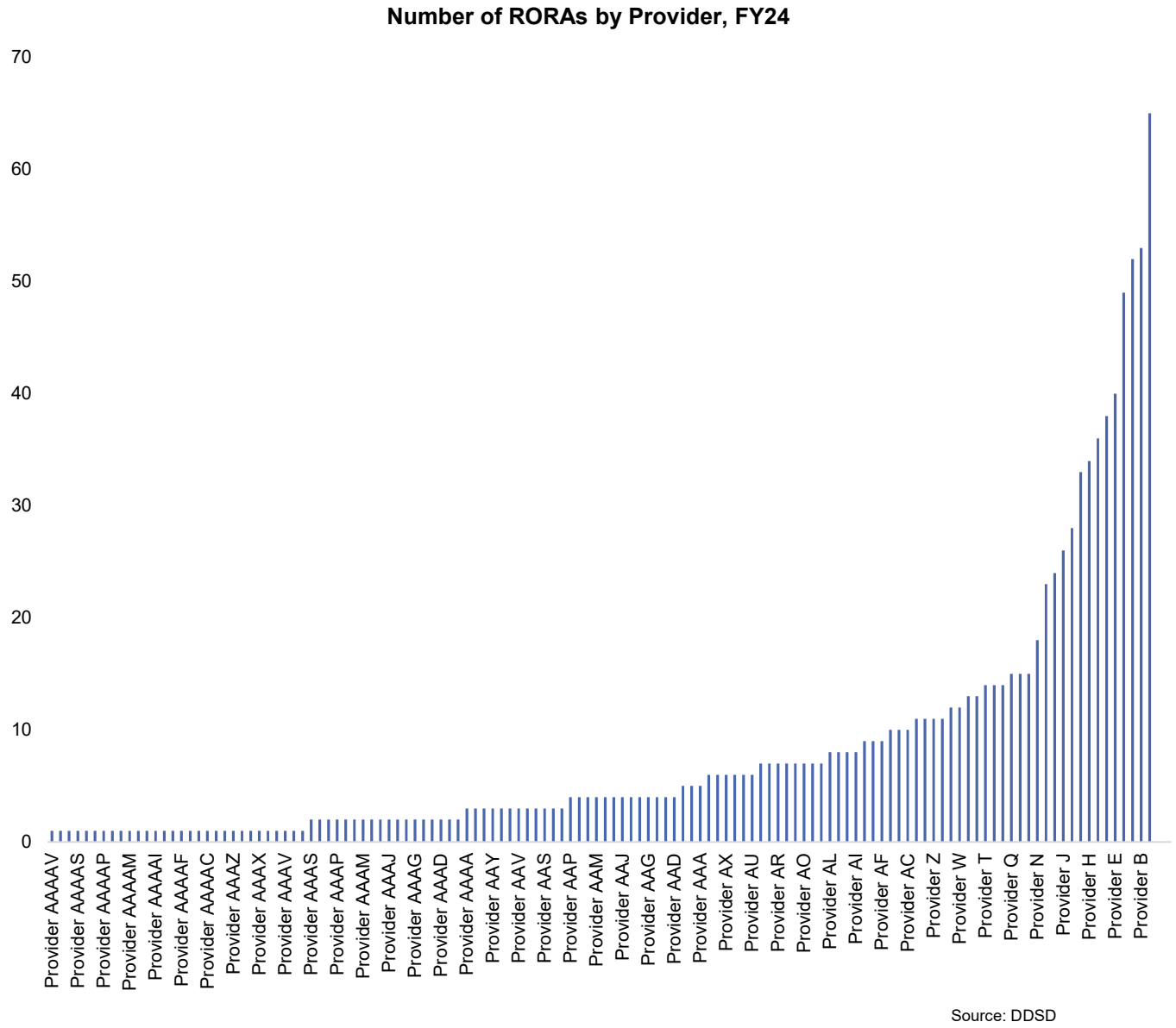
	Finding	Recommendation
People Themes	Interviews with consumers are "check the box" rather than a meaningful interaction with the consumer	Consider expanding the current case management model to include a broader social aspect to complement the current medical model, responding holistically to client, and embracing the neurodiversity model of care Expand the initial and monthly assessment content to include more holistic items and narrative, introduce prompts with measurable responses, and include integrated ANE checklist to also show trends, trigger action
	Case management tools are not person centric but focused on compliance requirements	
	Definitions of the key program concepts are individually interpreted, leading to behaviors that are variable and can be inconsistent with consumer safety and program goals	Create a unified DOH vision for operational guidance and to help drive culture change and alignment
		The following concepts need program level definitions that define expected behaviors. Definitions must include enough detail to determine that the consumer or representative can demonstrate informed decision making: 1. Dignity of Risk 2. Duty of Care, 3. Freedom of Choice
		In conjunction with more detailed definitions of these concepts, we recommend that there also be a process to assure that the consumer's wishes are respected and implemented through supported decision-making versus substituted decision making.
		Design the strategy for provider monitoring so it is built on shared understanding of program concepts and that targets behaviors in conflict with these key tenets. o Consider performance incentives for accurate performance or penalties for failure to comply with well-defined program processes o Consider creating a case management entity within DOH versus current agency structure.
	In DDSD there is potential tension between technical assistance and vendor oversight within the Social and Community Service Coordinator Role.	Consider creation of new DDSD roles to separate the technical assistance support tole from the provider oversight role
	Current DDSD workforce was heavily weighted to Jackson population management Now DD waiver and Mi Via staff report increasing workloads and not enough staff to complete the work timely and effectively.	Evaluate the process for selection and volume of needed monthly home visits. While there was evidence of minimal selection criteria, further investigation into the home visit data would be required to confirm that the criteria are being applied and that the criteria are applied and that the criteria accurately IDs consumers most at risk.
		There is a need for headcount rebalancing and upskilling and cross training across DOH and prover program staff.
	External stakeholder engagement is often done late in the process of designing and launching program changes, generally when the program is ready to launch vs earlier during program design (e.g. SIS tool situation)	Include stakeholders in initial stages of development. Engage early with providers, consumers, and family members and internal stakeholders to capture and include their needs and input during program design
Process and Program	Current program does not use an assessment of consumer risk to ID those most at risk for harm or delayed care and adjust the intensity and frequency of intervention with high risk consumers.	Consider leveraging current tools developed by UMASS to optimize training and additional tools and processes that support decision capacity, individual consumer risk assessment, and processes and policies that trigger a re-assessment when significant changes occur in a consumers circumstances that increase risk for safety.

Risk is not continually assessed in subsequent visits which would enable the organization to shift resources in response to a consumer's change in condition or circumstance.	
No clear accountable or responsible party for addressing ANE incident findings nor for ensuring conclusive actions are taken.	ID the accountabilities and criteria for key risk and safety behaviors across processes that support the waiver programs
	Assess resource capacity to support assignment of actions to specific roles
	Update job descriptions with enhanced role details and clear responsibilities and actions
	Develop communication, change management and training across agencies outlining key accountabilities and owners per program
Waiver standard documents do not have sufficient process detail necessary to help waiver staff achieve efficient and timely intervention and remediation. Departments vary in the level and extent of process documentation. Process activities are also not optimized between department from "end to end or tracked over time to validate whether all activities deliver value.	Create holistic process visuals and orient people to the overall process handoffs and key points of risk
	Define program level metrics that measure the performance of the entire process, agnostic of department boundaries
	ID and confirm a central repository for process documentation
	Communicate changes in decision making behavior and reinforcement tactics
	Include updated process training in core training and onboarding for new hires.
Provider monitoring is mostly manual process with outputs documented in a variety of digital formats as well as paper forms that do not work well to provide insights or help surface trends overtime.	Design and document a provider monitoring process that IDs variations in process and noncompliance with program standards.
	Transfer all current data to appropriately vetted digital business systems
	Ensure data is available to DOH, DHI and DDSD staff that require this information
	Incentivize desired provider behaviors and outcomes based on reporting elements that can be tracked over time. Example: decreased transitions, increased consumer satisfaction
DHI investigation and survey cycles in conjunction with DDSD RORAs can be repetitive and lengthy with time to action delayed potentially putting consumers at risk before interventions occur	Comprehensive provider monitoring requires the collection of key performance indicator data that can be used to determine next best actions for provider management
	Develop additional program KPIs targeted toward provider incident reporting
Differing interpretations of standards during program operations result in misinformation given to providers related to addressing deficiencies	Develop and expand training related to incident management, quality management, standards and policy guidance, and reporting
	Using refreshed process documentation, develop or expand training related to: o Incident Management o Quality Management o Standards and policy guidance o Reporting – using data and insights to determine Next Best Actions o Develop post-session knowledge checks to assess understanding and include in performance metrics

	Strategic planning has not been occurring annually delaying needed program updates including for modernization to meet the needs of a growing younger consumer population and the influx of new waiver participants since the waiting list has been cleared.	Develop a forward looking framework for the DD waiver and Mi Via programs that IDs needed improvements focused on 4 key goals: expanding access to services, ensuring equitable distribution of resources, improving quality and enhancing the use of data and evidence to improve program outcomes. Consider past strategic planning model as well as industry best practices to design and execute refreshed Strategic Planning process. Within Strategic Planning process, consider the priority and urgency of waiver program model optimiza7 Consider past strategic planning model as well as industry best prac7ces to design and execute refreshed Strategic Planning process. o Within Strategic Planning process, consider the priority and urgency of waiver program model optimization
Technology	DOH does not have a unified business system for waiver programs and oversight leading to the lack of knowledge of current consumer addresses.	DOH should own a single platform that houses or connects waiver related data sources to ensure all data is digitized where key consumer information can be captured in a single record for providers and consumers even if it is managed or updated in a separate case management system. Constitute a cross-functional design team and RFP to support identifying program technology needs and begin to develop requirements for a platform
	The Therap system used by DD waiver teams is not sufficient for best practice case management practices and reporting due to the lack of integrated data platforms	The department must move to a technology platform that can address key gaps
		Solution development should be prioritized by capability that best provides safety and care to consumers. This can build on the recently validated data from the home visitation effort to create a tracking database. Implement care management platform across the programs to capture longitudinal experience and progress toward life goals that can be shared across all departments. Automate reporting starting with key performance indicators and regulatory reporting.

Source: Accenture

Appendix E. Regional Office Requests for Assistance by Provider



Source: DDSD

Appendix F. Excerpts from the Waldrop Settlement

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF NEW MEXICO

John and Karin Waldrop as parents and legal guardians of B.W., The Arc of New Mexico as legal guardians and next friends of S.K. and L.D., Lynda and Joseph Petros as grandparents and legal guardians of A.J., Daniel and Blanca Sarabia as parents and legal guardians of D.S., Lynette Jaramillo as parent and legal guardian of A.C., Doris Johnson as parent and legal Guardian of C.J., Sharranna and Richard Friedman as parents and legal guardians of S.F., Disability Rights New Mexico and the Arc of New Mexico,

Plaintiffs,

v. CIV No. 14-047 JCH/KBM

NEW MEXICO HUMAN SERVICES DEPARTMENT; NEW MEXICO DEPARTMENT OF HEALTH; SIDONIE SQUIER, Secretary, New Mexico Human Services Department, in her official capacity; RETTA WARD, Secretary, New Mexico Department of Health, in her official capacity; CATHY STEVENSON, Director, Developmental Disabilities Supports Division of the New Mexico Department of Health, in her official capacity;

Defendants.

SETTLEMENT AGREEMENT AND RELEASE

Plaintiffs John and Karin Waldrop, as Parents and Legal Guardians of B.W., The ARC of New Mexico, as Legal Guardians and Next Friends of S.K. and L.D., Lynda and Joseph Petros as Grandparents and Legal Guardians of A.J., Daniel and Blanca Sarabia, as Parents and Legal Guardians of D.S., Lynette Jaramillo, as Parent and Legal Guardian of A.C., Doris Johnson, as Parent and Legal Guardian of C.J., Sharranna and Richard Friedman, as Parents and Legal Guardians of S.F., Disability Rights of New Mexico and The ARC of New Mexico, and Defendants New Mexico Human Services Department; New Mexico Department of Health; Sidonie Squier, Secretary, New Mexico Human Services Department, in Her Official Capacity; Retta

1

Supported Living Services. The parties agree that no notice of right to appeal needs to be included with this letter.

D. Letter to all DDW Participants except (a) newly allocated DDW Participants after November 1, 2012, and (b) Jackson class members.

By July 1, 2015, the Defendants will send via first class United States mail a letter requesting notification of any perceived lost services. *See* "catch-all" letter yet to be drafted and approved.

E. Instructions to Case Managers (yet to be drafted and approved) regarding individuals whose ISP and budget expired prior to October 31, 2015.

For individuals with an ISP and Budget that expires prior to October 31, 2015, the ISP and Budgets will be renewed and revised, if needed, according to current procedures (including access to therapies allowed under the Director's Release). These individuals may apply under the DOH "Group H" policy and procedure for Family Living, Supported Living, or additional "day" services if the IDT can justify the clinical need for these services, regardless of the individuals' DDW Group assignment.

II. Performance of SIS Assessment

Each DDW Participant will receive a periodic SIS assessment at an interval of approximately three years. Prior to each SIS assessment, DDW Participants—and guardians (if applicable) —will receive a Pre-SIS Letter. *See* Attachment 6.

Until a DDW Participant receives a new SIS assessment through the regular cycle, his or her IDT will use the existing SIS assessment and other information for planning purposes.

SIS assessments will be conducted in the same manner as previously performed, utilizing AAIDD-certified SIS assessors employed by Defendants' outside contractor or contractors. DDW Participants may, if desired, have counsel present to observe the performance of the SIS assessment. However, counsel will not participate in or interrupt the performance of the SIS assessment. Additionally, the SIS assessors will be available to participate in Fair Hearings if the Outside Reviewer relied on the SIS assessment in the denial of any service at issue in the case.

III. Verification

The verification process will operate as currently conducted until the Outside Review process is fully operational and will not result in lower benefits than would have been assigned through the SIS assessment process. Once the Outside Review process is in place, the Outside Review contractor will perform the functions currently performed in the verification process.

IV. Requests for Reassessment

Defendants shall use the present criteria for SIS reassessment – change in circumstances and problems with protocol – and the Pre-SIS letter will address how to make protocol concerns heard during the assessment. Any request for reassessment must be postmarked within 30 days of the date of the DDW Planning Packet cover letter (Attachment 7).

V. DDW Planning Process

A. DDW Planning Packet

Each DDW Participant, case manager, and guardian (as applicable), will receive a DD Waiver Planning Packet containing the following:

- Informational Instructions Cover Letter *(Attachment 7)*
- Notice that the DD Participant's existing services and benefits will continue in effect until the resolution of the procedures described below.
- A report called *My Supports Profile* created by AAIDD for that DDW Participant.
- Notice of the DDW Group assignment and associated service package.
- Notice of the proposed annual budget for that DDW Participant.
- A copy of the DDW Group Assignment Decision Rules.

B. Roles and Responsibilities of the IDT

- The IDT should consider the DDW Group's suggested service packages and proposed budget with the understanding that the focus must always be on the individual's DD Waiver support needs that can be clinically justified.
- The ISP must include specific clinical justification of the services and supports requested, and the IDT must compile and attach any documents necessary to justify the requested services and supports.
- Once the IDT prepares the ISP setting forth specific clinical justifications for requested services, the Case Manager shall develop a requested budget for submission to the Outside Reviewer.

VI. Outside Review

Defendants will contract with an independent third party (the "Outside Reviewer") to provide clinical review of the requested services. The DDW Participant, case manager, and/or guardian may submit to the Outside Reviewer additional information relating to support needs.

The Outside Reviewer will make a written clinical determination on whether the requested supports are needed, and will recommend whether the requested annual budget should be approved. The DDW Participant, case manager, and guardian (if applicable) will be provided with this written determination and notice of an opportunity to request a fair hearing.

Plaintiffs may provide input in developing the scope of work, clinical criteria, and qualifications for the Outside Reviewer with Defendants having the final decision-making for all three areas. Plaintiffs will respond within seven (7) calendar days of Defendants providing drafts of each.

Overview of Outside Review Process:

1. The IDT is responsible for compiling information to identify the needs and to justify the requested services and budget.

2. The Case Manager submits proposed ISP and budget to the Outside Reviewer approximately sixty (60) days prior to the expiration of the ISP with all necessary justification.

3. The Outside Reviewer will review every proposed DDW ISP and budget within ten (10) business days of receipt.

4. The Outside Review Program Coordinator confirms that the packet is technically complete and assigns it to an Outside Review team for review or returns it to the case manager for additional justification. If clinical justification is absent for a specific requested service, the Outside Review Team will send a request for additional information for justification to the Case Manager with a copy to the DDW Participant and guardian, if applicable (RFI).

5. If the Outside Review Program Coordinator sends an RFI to the Case Manager, the Case Manager must provide additional justification within ten (10) business days of transmission. If justification is received within ten (10) business days of transmission, the packet is forwarded for clinical review. If justification is not received by the eleventh day, the services for which there is insufficient justification will be technically denied.

6. The Outside Review Team Lead reviews the packet and convenes the appropriate Outside Review Team.

7. The Outside Review Team completes a review of the Outside Review packet (i.e. proposed ISP, requested budget, and supporting materials) and renders its decision (i.e. approval, denial, or partial denial) within ten (10) business days from the date of receipt of the packet from the Program Coordinator.

8. If the Outside Review Team approves in whole or part the requested ISP and budget, it must send the approved portion of the budget to the State's Third Party

Assessor, and the Third Party Assessor must enter the budget into the Medicaid Management Information System and issue a prior authorization to the Case Manager within ten (10) business days. The Outside Reviewer will send an approval letter to the Case Manager.

9. If there is a denial in part or whole, the Outside Review Team's decision must be in writing, identify the materials reviewed, and state the reasons for any denial of requested services. The DDW Participant, case manager, and guardian (if applicable) will be provided with this written determination and notice of an opportunity to request a fair hearing. More specifically, the decision will include:

    a. A list of all documents and input considered by the Outside Review Team during their review;

    b. Specific and comprehensive justification for the denial of any requested DDW service, including the clinical, factual basis for the decision.

    c. A notice of the opportunity to request a fair hearing contesting the Outside Review Team's decision as well as an Agency Review Conference ("AC"). *See* Part VII.

10. The decision of the Outside Review Team is binding on the State. However, the State may agree to overturn a decision to deny services at a requested AC.

11. Anticipated Timeline for implementation of the Outside Review Process shall be as follows:

May	Create SOW for UNM to consider
June 1	Meet w/ UNM or other contractor
July	Create SOPs for DDW Outside Reviewer
June-Oct	Train DDSD & MAD staff, train Case Manager's, Providers, and Clients on clinical justification, train Outside Reviewer Staff/Qualis
Nov 1	Outside Reviewer begins reviewing ISPs & Budgets based on expiration of ISP (Dec. ISPs)

VII. Agency Review Conference

An agency review conference (AC) means an optional conference offered by the DOH to provide an opportunity to informally resolve a dispute over the denial, suspension, reduction, termination or modification of DDW benefits or services. An AC will be attended by the DDW Participant and/or the authorized representative and by a representative of the DOH. The DDW Participant may also bring whomever they wish to assist them during the AC. The AC is optional and shall in no way delay or replace the fair hearing process or affect the deadline for a fair hearing request.

An authorized representative means any individual designated by the DDW Participant or his or her guardian, if applicable, to represent and act on behalf of the DDW Participant. The authorized representative must provide formal documentation authorizing him or her to access the identified case information for this specific purpose. An authorized representative may be, but need not be, a guardian or an attorney representing the DDW Participant.

If a resolution is reached through the AC, DOH will issue written notification within seven (7) business days of the AC to the DDW Participant, the guardian (if applicable), and the case manager. Unless the fair hearing request is withdrawn by the DDW Participant or guardian, any requested fair hearing will proceed. The case manager will then prepare a budget for submission to the Third Party Assessor based on that resolution.

VIII. Fair Hearing

DDW Participants will be given a Notice of a Right to Appeal when the Outside Reviewer issues its decision, and DDW Participants may request a fair hearing consistent with the timelines and procedures in the New Mexico Administrative Code.

DDW Participants will be scheduled for a fair hearing before an ALJ with the Fair Hearings Bureau of HSD. At the fair hearing, DDW Participants will not be limited in the information and issues that they may choose to present or raise. DOH and/or HSD will assure the presence of all necessary witnesses, including, when relevant to a denial of services or when requested by the DDW Participant, the SIS assessor, a representative(s) of the Outside Reviewer who has knowledge of the reasons for the denial in whole or part of any requested services, and necessary witnesses within DOH's control. No ex parte communications with an ALJ are permitted by any DDW Participant or counsel regarding any pending case. The MAD Director shall not have ex parte communications regarding any pending case with any DDW Participant or counsel involved in that case. The MAD Director's decision shall be limited to an on the record review.

Once any fair hearing has concluded, the IDT will develop an ISP and budget for submission to the third party assessor based on the outcome of the fair hearing.

IX. Appeals from Third Party Assessor decisions related to budget submissions

Until the Outside Review process is fully implemented, a DDW Participant will have the right to appeal any decisions under the current process made by the existing Third Party Assessor (Qualis letters subject to approval).

X. Miscellaneous

Training:

By May 28, 2015, Plaintiffs will provide to Defendants a list of suggested topics for training.

Rules and Regulations:

DOH and HSD shall amend the relevant rules under the NMAC to implement the provisions set forth above. To the extent that existing rules may conflict with the terms of this Agreement, this Agreement shall control. Plaintiffs will provide within seven (7) calendar days written comments to draft regulations provided to them by Defendants prior to formal public notice.

"H" Process:

Defendants agree that access to residential services will be available through "Group H" policy and procedure if clinical criteria are met. Defendants will review their current "Group H" policy and, if necessary, modify that policy to allow access to residential services regardless of an individual's Group Assignment based upon clinical demonstration of need. DDW Participants, guardians, if applicable, and case managers will be informed of any changes to the policy. The parties recognize that once the Outside Review process has been implemented, there may be a reduction of requests for additional services through "Group H." Defendants will instruct Case Managers that a "Group H" application must be initiated if the guardian or DDW Participant requests it.

XI. Court Approval and Dismissal of Lawsuit/Appeal

Court Approval:

This executed Agreement shall be submitted to the Court for its consideration. If the Agreement is approved, the Court shall enter an Order Approving the Settlement Agreement, and the Order shall include a finding that the terms of the Agreement constitute compliance with the Order of Preliminary Injunction and satisfy Constitutional Due Process requirements. The Order entered by the Court will specifically provide that the Court will retain jurisdiction to enforce the terms of this Agreement based upon the time limitations contained in the following paragraph.

Period of Enforcement:

If this Agreement is approved by the Court, all parties shall be bound by the terms of the Agreement for a period of only two years from the date that the Outside Reviewer receives the first Outside Review packet. During this time, all terms of this Agreement shall remain in effect. If there are changed circumstances that require a

Dear DD Waiver Participants and Guardian, if applicable:

The purpose of this letter is to inform you of changes to the DDW as a result of a court-approved settlement agreement in the *Waldrop* lawsuit against the State brought by Disability Rights New Mexico and the ARC of New Mexico.

The State will continue to use the Supports Intensity Scale (SIS) for person centered planning and to establish group assignments with suggested service packages and a proposed budget. The IDT should consider the DDW Group's services and budget along with additional documentation when developing the ISP and identifying services. Your IDT will get a DDW Planning Packet that includes your My Supports Profile Report, and you will also receive information on the DDW Group assignments and suggested service packages. If the IDT determines you need services not included in your suggested service package, you may request those services with appropriate clinical justification.

The New Mexico Department of Health (DOH) and the Human Services Department (HSD) will implement a **new** process for the review of all DDW participants' ISPs, budgets and required documentation to determine whether **all** requested services are clinically justified based on established criteria.

The DOH will contract with an independent third party (the "Outside Reviewer") to conduct a clinical review of all requested services. The Outside Reviewer will make a written clinical determination on whether the requested supports are needed and will recommend whether the requested ISP and budget should be approved. If the Outside Reviewer denies any part of your budget, you will have an opportunity to request a fair hearing.

These changes will require system-wide training for DDW participants, families, guardians, case managers, providers and DDSD staff. The DOH and HSD will be sending out additional communication regarding the new Outside Review process and training timelines.

The Outside Review process will begin in Fall 2015 and will be based on annual ISP expiration dates. Once all parties have been trained, your case manager will be your primary point of contact.

For individuals with an ISP and Budget that expire prior to October 31, 2015, the ISP and Budgets will be renewed and revised, if needed, according to current procedures, including access to up to three therapy disciplines. These individuals may apply under the DOH "Group H" policy and procedure for Family Living, Supported Living or additional "day" services if the IDT can justify the clinical need for these services, regardless of the individuals' DDW Group assignment.

If you are a Mi Via Waiver participant, you have the right to exercise your freedom of choice to return to the Traditional DDW.

Thank you for your patience as we implement these changes. If you have any questions, please contact your local DDSD Regional Office.

ATTACHMENT 1

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD)

DIRECTOR'S RELEASE (DR) **EFFECTIVE DATE:** ~~May 2015~~ June 1, 2015

Signature Date:	May 2015
FROM:	**Signature on File** **Cathy Stevenson, DDSD Director**
TO:	All DD Waiver providers, DDSD staff and DHI surveyors
SUBJECT:	Allowance of three therapy disciplines

I. SUMMARY:

The purpose of this Director's Release is to remove restrictions in the current DD Waiver which limit the amount of therapy a DD Waiver recipient receives and to allow every DD Waiver recipient to receive services from up to three (3) therapy disciplines (Physical Therapy, Occupational Therapy and Speech and Language Pathology,) through the Developmental Disabilities Home and Community Base Waiver (Developmental Disabilities Waiver or DD Waiver) if clinical criteria are met.

II. REQUIREMENT AMENDMENTS OR CLARIFICATIONS:

A. All three therapy disciplines: Physical Therapy (PT,) Occupational Therapy (OT,) and Speech and Language Pathology (SLP) will be available to all DD Waiver recipients if they and their Interdisciplinary Team (IDT) determine the therapy disciplines are necessary.
B. PT, OT, and SLP, with the exception of the initial therapy assessment and evaluation, must have prior authorization using the Therapy Services Prior Authorization Request (TSPAR-attached.) No changes have been made to the TSPAR process.
C. The case manager is responsible for submitting the revised budget worksheet and the TSPAR to the Medicaid Third Party Assessor.

III. DEFINITIONS:

CASE MANAGER: The individual responsible for service coordination for individuals with intellectual and/or developmental disabilities (I/DD) on the Medicaid Developmental Disabilities Waiver (DDW). The Case Manager is external to and independent from all other direct services provided to the individual.

INTERDISCIPLINARY TEAM (IDT) MEMBERS: The interdisciplinary team (IDT) is responsible for the development of the individual service plan (ISP) and for identifying the agencies and individuals responsible for providing the services and supports identified in the ISP. The IDT shall consist of the following core members: individual, case manager, guardian, helper,

ATTACHMENT 3

key community service provider staff, direct service staff, service coordinator, ancillary service providers, designated healthcare coordinator, and others.

NEW MEXICO MEDICAID THIRD PARTY ASSESSOR (TPA): The contractor that determines and re-determines Level of Care (LOC) and medical eligibility as well as review and approval of Individual Service Plans and prior authorization and utilization management activities for the Developmental Disabilities (DD) Waiver Program.

PRIOR AUTHORIZATION: The process for submitting a request for approval of services for budgeting and billing purposes.

PHYSICAL THERAPY: Physical therapy is a skilled licensed therapy service involving the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. PT addresses the restoration, maintenance and promotion of optimal physical function, wellness and quality of life related to movement and health.

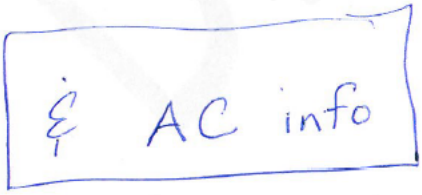
OCCUPATIONAL THERAPY: Occupational therapy is a skilled licensed therapy service involving the use of everyday life activities (occupations) for the purpose of evaluation, treatment and management of functional limitations. OT addresses physical, cognitive, psychosocial, sensory and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being and quality of life.

SPEECH AND ~~LANGAUGE~~ LANGUAGE PATHOLOGY: Speech and language services is a skilled therapy service provided by a SLP that involves the non-medical application of principles, methods and procedures for the diagnosis, counseling and instructions related to the development of and disorders of communication including speech, fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction and sensorimotor competencies.

THERAPY SERVICE PRIOR AUTHORIZATION REQUEST (TSPAR): DDSD form to request prior authorization for on-going therapy services.

IV. REFERENCES

None



Options Letter to 200+
Date

Dear DD Waiver Participant/Guardian:

According to our records, you were an adult 18 years or older enrolled in the DD Waiver Program as of November 1, 2012, and you were receiving Family Living or Supported Living services under an approved ARA budget at that time. You later received a needs assessment utilizing the Supports Intensity Scale® (SIS®) and were assigned to a DD Waiver Group A, B, C, D, E, F or G. As a result of that transition, you are no longer receiving Family Living or Supported Living services, and you may also have seen a reduction in Day Services.

The New Mexico Department of Health/Developmental Disabilities Supports Division (DOH/DDSD) and the Human Services Department (HSD) will restore your Family Living or Supported Living services to you but **only** if you choose to have those Family Living or Supported Living services returned to you. DOH/DDSD and HSD need to hear from you about your preference.

No matter which option you and your guardian select in terms of your living situation at this time, at your next ISP, your IDT must consider both your most recent SIS assessment and additional information in planning for your service needs. This planning may or may not result in the continuation of Family Living and Supported Living Services in the future. You will also be required to undergo a needs assessment utilizing the Support Intensity Scale® (SIS®) following the regular three-year cycle.

ATTACHMENT 4

In regards to your Day Services, you and your guardian need to decide if you want to return to your level of service from your last ISP prior to November 1, 2012 (under your old ARA budget) or stay at the level authorized in your current ISP and budget. Please talk to your case manager if you have questions about any of these decisions.

You and your guardian (if applicable) are required to meet with your case manager and your IDT to review this letter and the enclosed Decision Form for Family Living, Supported Living, and Day Services.

With regard to your living situation, you and your guardian (if applicable) must choose between:

1) returning to Family Living or Supported Living, or,
2) remaining in your current living care arrangement under the current services and budget.

With regard to your Day Services, you and your guardian (if applicable) must choose between:

1) returning to the level of your previous Day Services, or
2) remaining in your current level of Day Services under the current services and budget.

In the future, your Interdisciplinary Team (IDT) will need to develop a person-centered Individual Service Plan (ISP) with a focus on your DD Waiver support needs that can be clinically justified. The ISP must include specific clinical justification for the services and supports requested, and the IDT must attach any documents appropriate to justify the recommended services and supports. The ISP and the requested budget prepared by the IDT will be subject to a new outside clinical review process. **It is possible that the IDT planning process or the outside clinical review process could potentially result in a reduction or loss of some of your benefits or services.**

However, no matter which options you select in terms of your living situation or day services, **those services that you choose will remain in effect until (a) your next ISP and budget have received final approval or (b) the final resolution of any fair hearing or appeal.**

Once you and your guardian (if applicable) meet with your case manager and IDT and review the options regarding your living situation and day services, please complete, sign and date the attached Decision Form. Your case manager will submit the signed and completed Decision Form, but please make sure that you and your guardian receive a copy of the completed, signed and dated Decision Form with the case manager's attestation.

HSD and DOH appreciate your immediate attention to this matter and would like to thank you in advance for your timely cooperation. **If we do not receive your completed Decision Form by July 31, 2015, you will continue your currently authorized services until your next ISP.** If you have any questions or concerns about this letter, please contact your case manager.

Sincerely,

Cathy Stevenson, Director
Developmental Disabilities Support Division

JDH:CS:bad
Enclosures: Decision Form for Family Living or Supported Living Services
cc: Case Management Agency

\\Abq-tamarack\ProData\006352-047090\Client Documents\2725310.docx

SUSANA MARTINEZ, GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

RETTA WARD, CABINET SECRETARY

[Letter date]

5/5/15

5/5/15

[Individual/Guardian Name]
[Address]

Subject line (DDW 001): Notice of New Mexico Department of Health/Developmental Disabilities Supports Division (DOH/DDSD) use of the Supports Intensity Scale®(SIS), NM DDW Group Assignments, DDW Service Packages, and individual right to appeal

Dear [Individual/Guardian],

The University of New Mexico, Center for Development and Disability ("CDD") is scheduling a support needs assessment called the Supports Intensity Scale® (SIS) for you. You will be receiving a phone call soon to schedule your SIS assessment. The SIS measures the pattern and intensity of support needs an individual with Intellectual or Developmental Disability (I/DD) has to live life in the community. The SIS is required for adults receiving DD Waiver services. Your SIS results are used in two ways:

1. Your SIS results are used by your Interdisciplinary Team (IDT) to help plan for the use of natural and community supports.

2. DOH/DDSD uses the SIS as a tool along with other information to place you in a NM DDW Group. Your SIS results will be reported in standard scores and percentiles which describe your support needs compared to a representative sample of individuals with I/DD. Knowing how your needs compare to others helps DOH/DDSD share resources in a fair way with many people in need in New Mexico.

Each NM DDW group describes individuals with a similar pattern of support needs. Each NM DDW group also has an array of service options available that generally meet the needs of the majority of individuals in that group.

The New Mexico Department of Health and the New Mexico Human Services Department use both the SIS and an outside clinical review process when developing annual service plans and budgets for each DD Waiver participant. **Please be aware that this process may result in a reduction or increase in services and benefits previously utilized by you. However, your existing services and benefits will remain in effect until (a) your annual Individual Service Plan and budget have received final approval or (b) the final resolution of any fair hearing decision or appeal.**

Prior to attending the SIS assessment, you may wish to educate yourself concerning how the SIS assessment is conducted. After your SIS assessment has been scheduled by CDD, CDD will mail

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
810 San Mateo, Suite 204 • P.O. Box 26110 • Santa Fe, New Mexico • 87502-6110

ATTACHMENT 6

you a packet of information regarding the SIS assessment. Here are additional resources for more information about the SIS:

Access Community Together (ACT) New Mexico: http://actnewmexico.org

CDD website regarding SIS: http://www.cdd.unm.edu/sis/index.html

AAIDD website regarding SIS: http://aaidd.org/sis

DDSD Regional Offices (contact information at http://actnewmexico.org/contacts.html)

It is in everyone's best interest that your SIS assessment be successful. During the SIS assessment, the SIS assessor is available to answer any questions that you may have. If you do not understand the meaning of any question or score, or if you have any other questions for the SIS assessor, you should immediately ask the SIS assessor for clarification during the SIS assessment. At the end of the SIS assessment, you will be asked to complete the SIS assessment checklist regarding how the SIS assessment was conducted. This SIS assessment checklist will also provide you with an opportunity to note any additional questions or areas of disagreement.

Following your SIS assessment, and prior to developing your ISP, you will receive a DD Waiver Planning Packet that contains materials including your SIS results; information on how to request a SIS reassessment under certain circumstances; information on how to develop and submit your Individual Service Plan for outside clinical review; and notice of your fair hearing rights.

Sincerely,

Christina Hill
SIS Program Manager

Cc w/encls: [case manager]

Enclosure:

Notice of Right to Appeal

DDW 00001
Page **2** of **2**

5/9/13 4:45pm

Draft of DD Waiver Planning Packet cover letter

Date:

[DDW Participant name, address]

[Legal Guardian name and address]

Dear DD Waiver Participant [and Legal Guardian (if applicable)]:

The New Mexico Department of Health and the New Mexico Human Services Department use both the Supports Intensity Scale ("SIS") and an outside clinical review process when developing annual service plans and budgets for each DD Waiver participant. The Interdisciplinary Team ("IDT") will have information from the SIS available to consider when developing a person-centered Individual Service Plan ("ISP"). The ISP and requested budget prepared by the IDT are then subject to the outside clinical review process.

Enclosed is your New Mexico DD Waiver Planning Packet. This packet includes information and resources to assist you in developing your annual ISP and submitting your ISP and requested budget to the outside reviewer. **Your existing services and benefits will remain in effect until (a) your annual Individual Service Plan and budget have received final approval or (b) the final resolution of any fair hearing decision or appeal.**

New Mexico uses a standard system to group individuals with similar supports needs together based on their SIS assessments. The services and supports provided in your DDW Group are generally appropriate for individuals with service and support needs similar to yours.

The IDT should consider the DDW Group's suggested service packages and proposed budget with the understanding that the focus must always be on the individual's DD Waiver support needs that can be clinically justified. The ISP must include specific clinical justification for the services and supports requested and the IDT must attach any documents appropriate to justify the recommended services and supports.

This New Mexico DD Waiver Planning Packet contains the following:

ATTACHMENT 7

1. *My Supports Profile* report—This report summarizes your current SIS assessment and profile results. This report also includes responses to Supplemental Questions and information about how your SIS results can be used in planning.

2. NM SIS Assessment Checklist. This is a quality assurance mechanism which is completed by respondents during your SIS assessment. It is used to help verify that key elements of the NM Scheduling and Interview Guidelines were followed.

3. NM DD Waiver Group Assignment Decision Rules.

4. Notice of your NM DDW Group assignment, associated service package, and proposed annual budget amount.

5. Instructions for submission of proposed Individual Service Plan and requested budget for outside clinical review.

6. Information on how to request a SIS reassessment.

7. Notice of Right to Appeal.

For more information on this and related topics, please refer to the ACT New Mexico website at http://actnewmexico.org/index.html. If you have questions, or if you want paper copies of instructions or information, please contact your Case Manager or your DDSD Regional Office.

Sincerely,

Roberta Duran

Bureau Manager

Cc: [_____], Case Manager

Appendix G. Responsibilities of Employers of Record

Responsibilities of the Mi Via Participant or Employer of Record

In General:
Comply with the program rules and regulations
Maintain an open relationship with the consultant to determine support needs, develop an appropriate service and support plan, receive necessary assistance with carrying out the plan and with documenting service delivery
Designate an employer of record (if using non vendor services)
Communicate with consultant at least once a month, including reporting any concerns with Mi Via to consultant
Use program funds appropriately by only requesting services covered by Mi Via and only purchasing after the request is approved by the third party assessor
Comply with the approved plan and not spend more than the authorized budget
Work with the third party assessor to schedule meetings and in home assessments and to provide documentation as
Respond to requests for additional documentation within the required deadlines
Report to the income support division with 10 days of any change in circumstance
Report to the third party assessor and consultant if hospitalized more than 3 nights
Communicate with Mi Via service providers, contractors, and state personnel
Responsibilities Related to being an Employer of Record:
Submit all required documents to the fiscal management agency by the timelines established
Report any incidents of abuse, neglect, or exploitation by any employer or service provider to the state
Arrange for delivery of services, goods and supports
Hire, train, schedule, supervise and dismiss service providers
Maintain employee service records and documentation
Manage the program budget
Request assistance from consultants if necessary

Source: Mi Via Service Standards

Appendix H. Supported Living Cost Explanation

LFC analyzed participant expenditures made for supported living costs in FY24. In order to calculate actual expenditures compared to anticipated expenditures based upon published DDSD rates, LFC utilized published DDSD rates, which in FY24 rose as high as $481.94 for category 4 participants, with the addition of both a cost of living adjustment and ARP funding. Based upon 340 allowable, billable days, expenditures are not expected to exceed $163,859.60. For those exceeding this amount (with individuals expending as much as $233 thousand), the difference between actual expenditures and the expected rate was found, with these differences added for all individuals who exceeded published rates. This was repeated for categories 1-3, totaling $26 million over expected amounts. While fiscal years do not align directly with budget years, and therefore billing in one fiscal year may exceed these rates based upon timing, three year rolling averages were also calculated, with individuals averaging as high as $200 thousand per year over a three-year time frame.

Supported Living Expected Annual Rates (EAR) vs. Actual Expenditures

	Category 1	Category 2	Category 3	Category 4	Total
FY24 Daily Rate	$232.62	$286.07	$374.99	$481.94	
Expected Annual Rate (340 Days)	$79,090.80	$97,263.80	$127,496.60	$163,859.60	
# Exceeding EAR	28	159	295	547	**1,029**
Upper Range	$99,954.66	$128,229.30	$170,977.90	$233,261.46	
Cost for those exceeding EAR	$2,571,565	$18,189,899.60	$44,445,852.10	$105,324,347.10	
Expected Cost (# times EAR)	$2,214,542	$15,464,944.20	$37,611,497	$89,631,201.20	
Difference	$357,022.6	$2,724,955.41	$6,834,355.07	$15,693,145.92	**$25,610,479**

Note: Expenditures based upon 88 percent of the year reporting

Source: DDSD