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

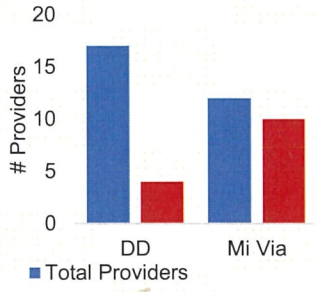
Roughly 1-in-4 four case management agencies and over 80 percent of Mi Via consultants are not adequately monitoring DD clients.

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.

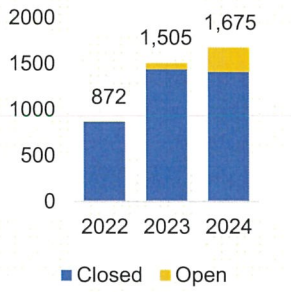
Table 12. Case Assignment Timeframes for Regional Office Request of Assistance

	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)

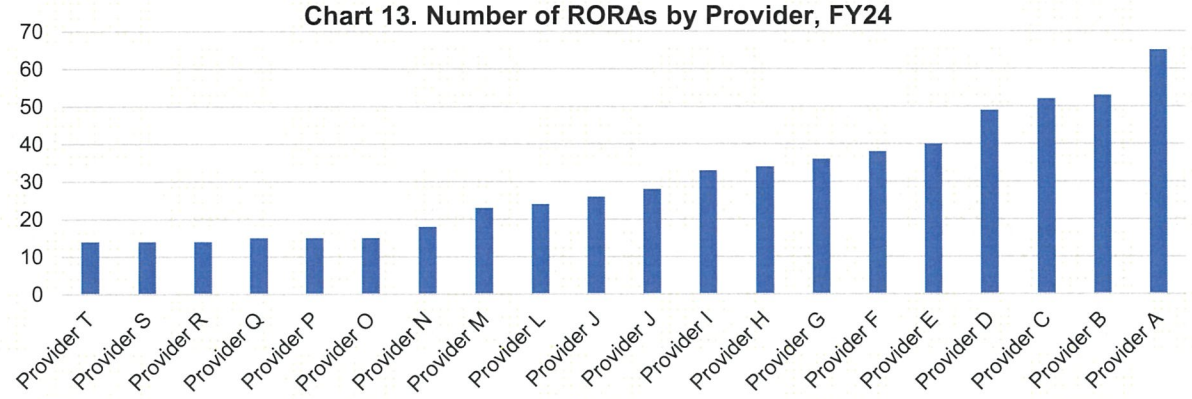
Source: CMS

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

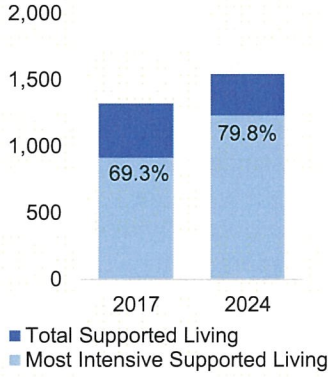
Note: Assuming 340 service days. FY24 rates were 5 percent higher due to ARPA funding.
Source: HCA

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.

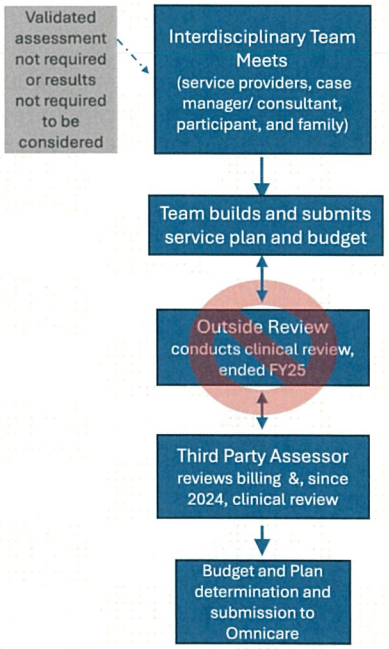
The lack of a two-step review and a validated assessment decreases oversight and may increase the risk of misallocation.

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.

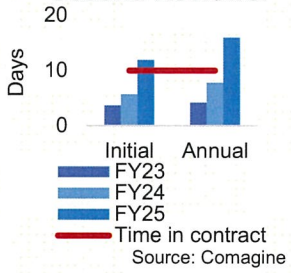
DDSD may have increased the risk of budget delay and misallocation as it shifted away from a two-party review system beginning in FY25. Throughout FY24, DDSD began to phase out the outside review, citing cost and timing efficiencies. However, removing a level of review can increase risk to program integrity 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.

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



Source: Comagine

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

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.

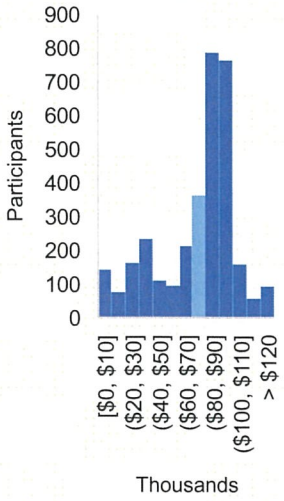
Many DD and Mi Via participants are significantly over budget allotments or caps.

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.

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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

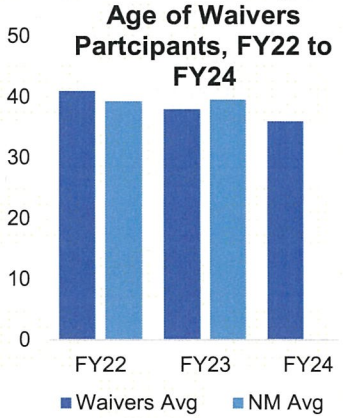
New Mexico Has Made Progress on Resolving the Jackson Lawsuit, but It Remains a Significant Cost Driver For The Entire DD System.

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.

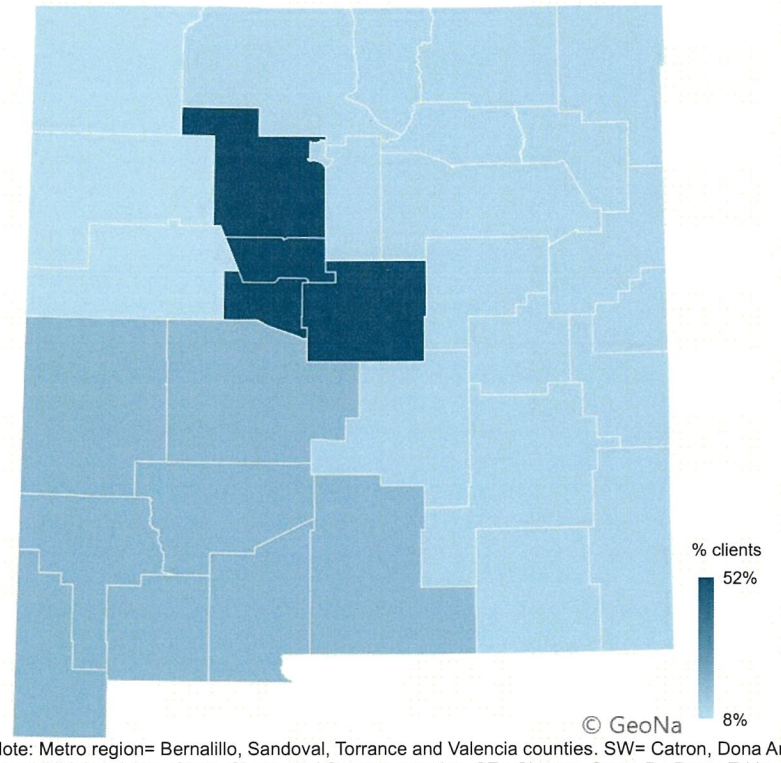
Chart 3. Average Age of Waivers Partcipants, FY22 to FY24



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