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Program
Evaluation
Unit

Developmental Disabilities and Mi Via
Waivers

July 20, 2018

Report #18-06

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July 20, 2018

Ms. Lynn Gallagher, Cabinet Secretary
Department of Health
Harold Runnels Building
1190 St. Francis Dr.
Santa Fe, New Mexico 87505

Dear Secretary Gallagher:

On behalf of the Legislative Finance Committee, I am pleased to transmit the evaluation report, *Developmental Disabilities and Mi Via Waivers*. This review examined the costs and performance of New Mexico's Medicaid waiver programs for individuals with developmental disabilities.

This report will be presented to the Legislative Finance Committee on July 20, 2018. An exit conference to discuss the contents of the report was conducted with the Department of Health on July 10, 2018. The Committee would like a plan to address the recommendations within this report within 30 days from the date of the hearing.

I believe this report addresses issues the Committee asked us to review and hope New Mexico's Developmental Disabilities Waiver programs will benefit from our efforts. We very much appreciate the cooperation and assistance we received from your staff.

Sincerely,

A handwritten signature in cursive script that reads "David Abbey".

David Abbey, Director

Cc: **Representative Patricia Lundstrom, Chairwoman, Legislative Finance Committee**
Senator John Arthur Smith, Vice-Chairman, Legislative Finance Committee
Ms. Duffy Rodriguez, Cabinet Secretary, Department of Finance and Administration
Mr. Brent Earnest, Cabinet Secretary, Human Services Department
Mr. Keith Gardner, Chief of Staff, Office of the Governor
Mr. Wayne Johnson, State Auditor

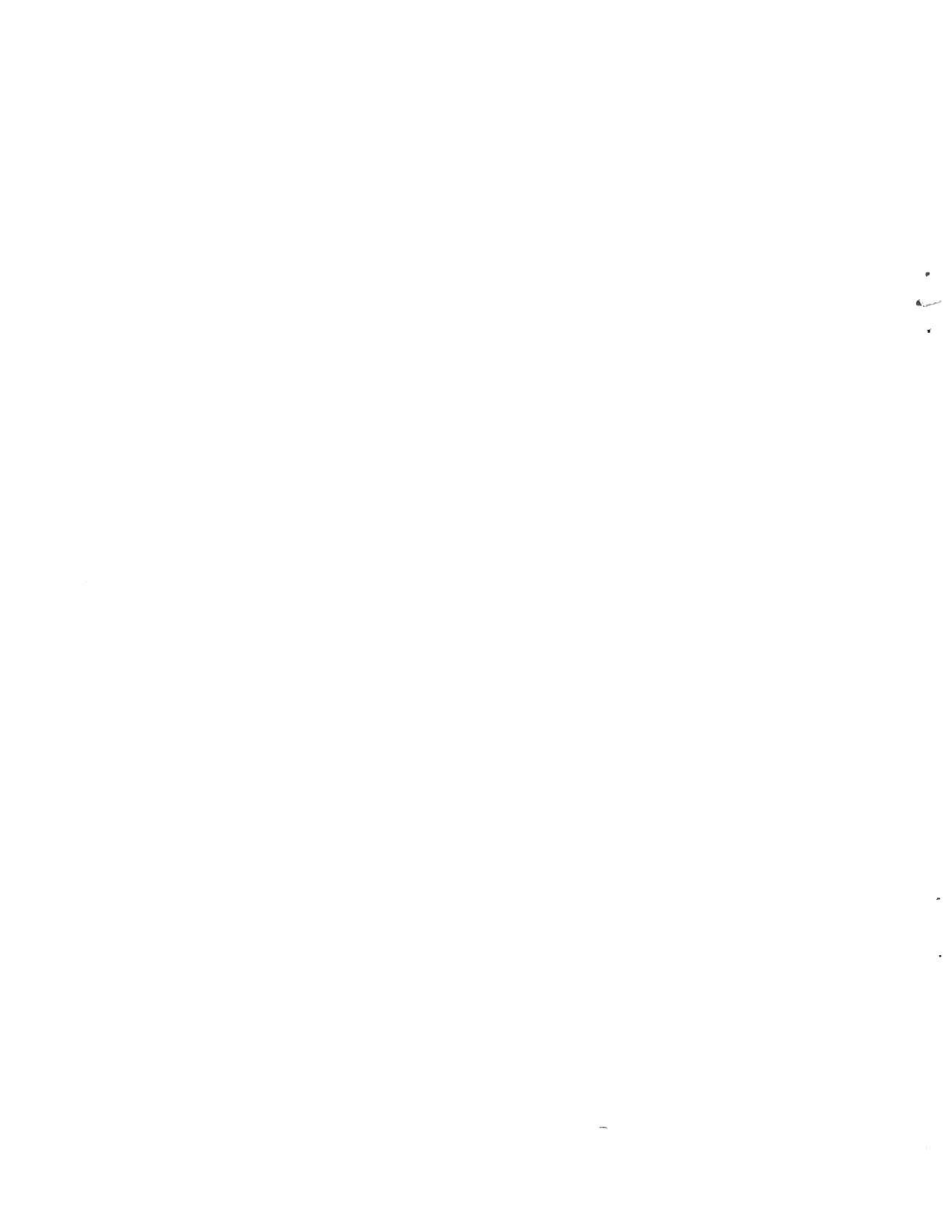


Table of Contents



Executive Summary	1
Key Findings and Recommendations.....	2
Background	6
Findings and Recommendations	11
The Traditional DD Waiver is Costing More Per Client, Even as Enrollment Declines ..	11
Mi Via, the Self-Directed Waiver, is Driving Cost Increases of the State's Developmental Disability Programs	18
Other States Deliver More Cost Effective Services for Individuals with Developmental Disabilities	23
DOH Has Improved Management of the DD Waiver Waiting List, but Needs to Do More to Predict Future Needs and Service Capacity.....	27
DOH's Current Assessment and Budget Allocation Process Lacks Standardization and Contributes to Rising Annual Client Budgets.....	35
Improved Oversight is Necessary to Mitigate Risk to Waiver Participants and Public Funds	40
Data Collection Offers DOH an Opportunity to Improve Performance Management and Client Outcomes.....	44
New Mexico Has Made Progress on Resolving the Jackson Lawsuit, but It Remains a Significant Cost Driver for the Entire DD System	50
Agency Response	55
Appendices	62
Appendix A: Evaluation Objectives, Scope, and Methodology.....	62
Appendix B: Mi Via Service Cost per Client and Utilization Rate Changes Between FY12 and FY17	63
Appendix C: Waiver Services Offered in States Without Institutions.....	64
Appendix D: Fiscal Integrity Measures Used in Vermont	65
Appendix E: Providers of High Cost Services by County, FY18.....	67
Appendix F: Counties Receiving Incentive Rates	68
Appendix G: Mi Via Scorecard	69
Appendix H: Minnesota Self Directed Waiver Assessment.....	70
Appendix I: Eastern New Mexico University Roswell Special Services Program Outcomes Data, 2013-2015	74
Appendix J: Jackson Remedial Plan (Revised Table IV) as of January 2018	75
Appendix K: DD and Mi Via Waiver Key Service Definitions.....	95



New Mexico's Developmental Disabilities Waivers Continue to Face Cost Control and Oversight Challenges

New Mexico's traditional developmental disabilities (DD) Medicaid waiver and the self-directed Mi Via waiver are among the state's largest health and human services programs, serving nearly five thousand New Mexicans with intellectual or developmental disabilities in FY17. The Department of Health (DOH) administers services to this population through a joint powers agreement with the Human Services Department (HSD). Waiver participants receive living supports, day habilitation, therapy, employment, and other services in their homes and communities rather than institutional settings.

As one of 14 states without institutions for individuals with intellectual or developmental disabilities, New Mexico has developed a statewide system of home- and community-based services that promote participant independence. However, rising per-client costs and waits of over 10 years point to issues with predicting and meeting demand for services, and oversight of the system is complex, dependent on multiple agencies and compliance with court orders.

Increased service utilization, client movement from the traditional DD Waiver to Mi Via, and changes to how client service plans and budgets are developed have contributed to rising per-client costs in both waivers. Meanwhile, growth in the number of people waiting for waiver services continues to outpace the state's ability to fund them. To contain costs while serving more people, DOH needs to monitor cost drivers, examine the cost-effectiveness of services, and reassess provider rate structures while the Legislature sets aside more resources to reduce and manage the roughly four-thousand-person waiting list.

Strengthening oversight of program quality, including incident investigations and Mi Via providers, can serve to promote positive client outcomes and mitigate risk to both clients and state funds. Improved strategic planning, data collection and analysis, and outcome-based performance reporting can help DOH understand issues and drive system improvements. These types of actions could also contribute to the state's disengagement from the three-decade-old Jackson lawsuit by addressing court-mandated obligations. The lawsuit has resulted in over \$40 million in costs since FY13, and remains active in federal court.

To improve these waivers, DOH should more thoroughly analyze and report on patterns and trends in DD waiver cost drivers, institute more intensive reviews of high-cost services and clients, and incorporate a standardized and validated assessment tool into the process for developing client service plans and budgets. Along with the Legislature, DOH should also create a five-year plan with committed funding to reduce the waiting list by 25 percent to 50 percent. Finally, DOH should strengthen oversight of program performance by leveraging data collection to analyze and report on outcome-based performance measures.

In FY17, about 3,500 people received services through the traditional DD Waiver and 1,400 received services through Mi Via, with a waiting list of roughly 3,900.

Combined state and federal funding for the DD and Mi Via waivers totaled \$360 million in FY17, including \$111 million in state general fund appropriations.

The Jackson lawsuit resulted in over 300 obligations with which the state must demonstrate compliance.

KEY FINDINGS AND RECOMMENDATIONS

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

DD Waiver enrollment has been on a steady decline of 13 percent between FY14 and FY17, however cost per client over that same time period increased 17 percent. Using the most recent annual growth rate of 7 percent for the DD Waiver, the DD Waiver could fail the cost neutrality test as soon as FY27.

DDSD and HSD have not been successful in predicting the cost of the DD Waiver, requiring the Legislature to provide additional funding six of the last eleven years. The Legislature had to provide additional funding to the DD Waiver to cover costs totaling \$15 million between FY08 and FY18.

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

The Mi Via Waiver grew significantly in its first ten years, with 1,434 enrolled and \$86 million in expenditures in FFY17. Annual costs for Mi Via clients new to the waiver in FY17 will reach the budget cap by FY19. If third year costs for the FY17 clients grew at the same 20 percent rate as FY16 clients, these third year costs would be greater than the annual cap of \$72,710. While capping budgets provides a safeguard against rising costs, there is a mechanism for Mi Via clients to request budget increases, which could be an upside cost risk.

The rate range model offers the client greater flexibility to obtain desired services under Mi Via, but creates a risk that costs may be higher for these services. Economic theory states when an artificial maximum price is set, as is the case with Mi Via, all prices will eventually settle at the maximum as there is limited incentive for providers to accept a lower rate.

Other States are More Cost Effective in Delivering Services for Individuals with Developmental Disabilities

States with lower waiver costs appear to offer fewer or more limited services than New Mexico. While DDSD performs some oversight functions including an annual needs review for waiver clients, and delivers technical assistance for providers of waiver services, the division could do more to identify cost drivers and financial risks to the DD and Mi Via Waivers.

The Affordable Care Act offers the Community First Choice (CFC) that has increased federal funding of home and community-based services like those offered under the DD and Mi Via Waivers. CFC allows states to provide home- and community-based attendant services and supports to eligible Medicaid enrollees under their state Medicaid plan. States participating in CFC receive an additional 6 percent in federal matching dollars for eligible services. For New Mexico, this would mean a composite FMAP of 77.85 percent for CFC-designated services offered to DD clients.

DOH is Improving Its Management of the DD Waiver Waiting List, but Needs to Do More to Predict Future Needs and Service Capacity

As of the end of FY17, there were approximately 6,600 total individuals on the Central Registry including about 3,900 individuals with completed registrations awaiting allocation. While the number of individuals on the Central Registry has grown by 11 percent since FY12, the number awaiting allocation is 5 percent lower than in that year, although it has grown by roughly 5 percent in each of the past two fiscal years.

DDSD does not track the number of individuals on the waiting list enrolled in Medicaid except through a survey included as part of its annual Central Registry report. According to data from HSD, approximately 65 percent of

clients on the Central Registry were enrolled in Centennial Care at the end of FY17. Out of all states without DD institutions, New Mexico is the only state where the rate of individuals waiting for DD waiver services exceeds the rate of those receiving services.

Removing people from the waiting list for DD Waiver services requires better planning of required resources. The Legislature designated \$2 million in the 2018 General Appropriation Act to reduce the total number of individuals awaiting DD Waiver services. DDS/D plans to use these funds to reduce the waitlist by 80 people, including approximately 24 new clients by August 2018. Holding back any unused funds could make them available to cover previous year shortfalls and other costs, contrary to legislative intent.

Over the last 10 years, DDS/D has had three different assessment and budget allocation tools for people on the DD waiver. DOH's current review of client need and budget allocation, the Outside Review (OR), focuses on client individual service plans (ISPs) and uses interdisciplinary team meetings to justify services. Consequently, the clinical justification varies from person to person. The lack of a standardized tool in this process can lead to each client's review being different as each client's ISP and person-centered assessment may be different. If clients do not have similar justification criteria, people with similar needs may receive different levels of services.

Ending the use of the Supports Intensity Scale (SIS), an evidence-based tool, may have contributed to increasing costs. In FY14, the first full fiscal year in which DDS/D used the SIS to determine DD waiver client support needs, average annual cost per client was around \$67 thousand. Approximately one year after the revocation of the SIS assessment, average annual cost per client went up by approximately \$5 thousand to \$79 thousand, growth of 7 percent

There is negligible oversight from DOH of Mi Via providers, with designated employers of record responsible for monitoring client services. People on Mi Via, unlike those on the traditional DD Waiver, regulate their own services, with little oversight mentioned in the current standards. While clients also have a consultant who assist the client and employer of record in their responsibilities, the consultants do not regulate client service providers, which is the responsibility of the employer of record, and no one oversees the employer of record. In New Mexico, out of the approximately 1,400 current Mi Via clients, only 42 are their own employer of record.

In a survey of providers, the Division of Health Improvement (DHI) did not complete investigations on 81 percent of reported cases within the 45-day deadline. Incident Management Bureau (IMB) data shows in FY17 it took an average of 87 days from when the case was received to case closure, an improvement of 33 days from FY16, however still 40 percent beyond the 62-day deadline

DDS/D should address gaps in oversight of Mi Via self-directed services to mitigate certain areas of risk. National best practice for self-directed waivers states these waivers should include clear assessments of client need, available training, person-centered planning, and measurement of support quality. New Mexico currently meets at least 10 of the 19 best practices.

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

Improved Oversight Is Necessary to Mitigate Risk to Waiver Participants and Public Funds

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

When combined with federal funds, the DD and Mi Via Waivers are the largest DOH program with a budget of roughly \$400 million, and when looking only at state general fund spending, DDS is the second largest DOH program with a budget of \$103.4 million in FY18. However, DOH's FY17-FY19 strategic plan contains no priorities or goals specific to this program, nor any performance indicators to track and measure progress.

DOH needs expanded outcome and quality measures tied to key system goals to aid Legislative oversight of the DD Waiver program. DOH should work with stakeholders, the Legislature, and DFA to increase reporting of outcome-based measures to improve oversight of the waiver system. Measuring client outcomes can help all stakeholders understand the effectiveness of specific services and the effects of successful ISP and service implementation.

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

Recent developments have led to the state pursuing two separate courses of action with respect to the Jackson case. First, the state is preparing new legal arguments to resolve the lawsuit following a ruling by the U.S. Court of Appeals for the Tenth Circuit in January 2018. Second, New Mexico must continue to abide by the existing system of court oversight and compliance until the district court reaches a decision under the Tenth Circuit's framework.

New Mexico has spent over \$40 million on Jackson lawsuit-related costs since FY13, and the state could serve approximately 140 additional clients for the same amount it spent in Jackson-related compliance costs in FY17. LFC staff conservatively estimate approximate savings of \$3.2 million in general fund spending if the state were no longer subject to costs most directly attributable to Jackson compliance.

Key Recommendations

The Department of Health, in consultation with the Legislative Finance Committee and Legislative Health and Human Services Committee, should:

- 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 waitlist will be reduced in the five-year plan.

The Department of Health, with data provided by the Human Services Department, should:

- Analyze and report annually to the Legislature on clients with highest costs on the DD and Mi Via Waivers, looking at how their service needs and costs change over time;

-
- Examine cost drivers within the DD and Mi Via Waivers, identify patterns leading to these cost increases and address issues programmatically

The Department of Health should:

- Model other state cost containment practices specifically around living and community-based supports;
- 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;
- Track and include utilization of state general fund and non-waiver Medicaid services by individuals on the waiting list as part of the annual DDS Central Registry Report;
- 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
- 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;
- Audit a sample of employers of record annually to ensure client needs are met;
- Use the key performance indicator framework to examine more client-centered outcome information;
- 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; and
- Provide triannual reports to the Legislature on the status of disengagement from outstanding obligations of the Jackson case

Total Developmental Disability Program Costs Grew 28 Percent from FY09 to FY17

Prevalence of Intellectual and Developmental Disabilities

In the United States, roughly 4.8 million to 8.1 million people, or 1.5 percent to 2.5 percent, are estimated to have an intellectual or developmental disability. Using this same estimate there are between 30 thousand to 50 thousand New Mexicans with an intellectual or developmental disability. A subset of this population are high acuity and need intensive services, which are provided through federal Medicaid waivers for those with an intellectual or developmental disability. To qualify for one of the waivers related to developmental disabilities in New Mexico, an individual needs to have an intellectual disability or one of the following specific conditions: cerebral palsy, seizure disorder, autistic disorder, or certain chromosomal disorders, syndrome disorders, inborn errors of metabolism or development disorders of brain formation as defined in New Mexico Administrative Code 8.290.400.10.

Many conditions meeting the state's definition of developmental disability have increased in prevalence.

Many conditions for which individuals may qualify for the DD waivers have increased in prevalence in the United States over the last several years. Autism spectrum disorder is one of the more common disorders with a prevalence rate of 1 in 59 individuals in 2014; a significant increase from 2000, when only 1 in 150 individuals were diagnosed with autism spectrum disorder. Down syndrome has also increased in incidence, increasing by 30 percent from the 1970s to 2003 and epilepsy has increased from 2.3 million Americans in 2010 to 3 million in 2015. The increase in individuals diagnosed with a developmental delay will likely lead to an increased need for waiver services.

Overview of the Developmental Disabilities and Mi Via Waivers

The federal Centers for Medicare and Medicaid Services (CMS) authorizes states to apply for waivers under section 1915 of the Social Security Act that allow for certain populations to receive home and community-based services (HCBS) rather than institutional services under the regular Medicaid state plan. New Mexico's traditional Developmental Disabilities Waiver (DD Waiver) and self-directed Mi Via Waiver provide this option for most of the state's population of individuals with intellectual or developmental disabilities. To be eligible for DD Waiver services, state regulations require an individual to have been diagnosed with a developmental or intellectual disability, a specified related condition and to require a level of care suitable for an intermediate care facility for individuals with intellectual disabilities (ICF/IID). A third waiver, the Medically Fragile Waiver, authorizes services for a smaller group of New Mexicans who have been diagnosed with a medically-fragile condition before age 22 or who are at risk for a developmental delay.

Under the traditional DD Waiver, eligible participants may receive services including, but not limited to, residential care in an agency supported living home or their own home, integrated community-based day habilitation,

behavioral supports, physical, occupational, and speech and language therapy, and assistive technology and environmental modifications to facilitate the ability to live independently. Participants work with case managers and an interdisciplinary team (IDT) to develop an individual service plan (ISP) and choose service providers within a budget determined in part by the level of care needed.

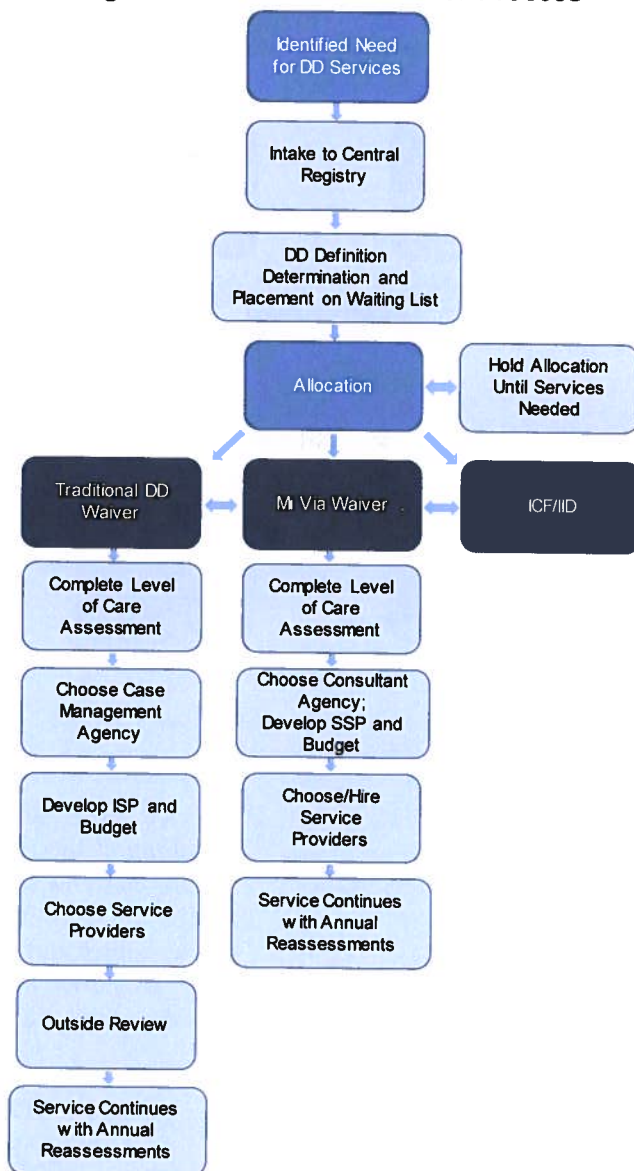
The Mi Via (“My Way”) Waiver offers many of the same services, excluding residential services, and allows participants a much greater degree of freedom in choosing services and those who deliver them. However, as a self-directed model, Mi Via requires clients to procure services directly. This requires the client, or oftentimes a legal guardian, to serve as the Employer of Record (EOR) for the purposes of hiring providers and paying for waiver services.

New Mexico’s HCBS waivers for individuals with intellectual or developmental disabilities are jointly overseen by the Human Services Department (HSD) and the Department of Health (DOH). HSD, as the official state Medicaid agency, is responsible for administering the waiver itself as it relates to the overall Medicaid system, while delegating most day-to-day functions of programs and services to DOH through a joint powers agreement. DOH, through the Developmental Disabilities Supports Division (DDSD), provides oversight of participant enrollment and the waiting list, manages agreements and relationships with service providers, and monitors the day-to-day operations of waiver programs through a network of regional offices. State general fund appropriations for waiver services are appropriated to DOH, while the federal Medicaid match is budgeted to HSD.

As shown in Figure 1, once an individual with a qualifying condition identifies a need for DD services, he or she may apply to be placed on the DDSD Central Registry. After an initial intake and screening to determine whether the person meets the definition for having an intellectual or developmental disability, the individual is placed on the waiting list for waiver services. When the person reaches the top of the waiting list, he or she receives notification of allocation to an available funded slot, and goes through the process of determining Medicaid medical and financial eligibility.

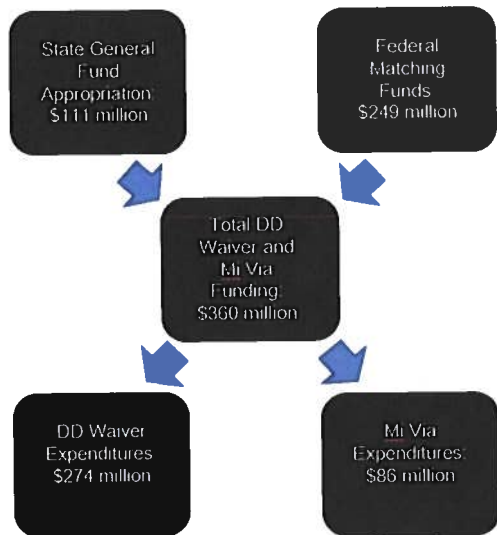
When this is complete, the person may choose to receive services under the traditional DD waiver, the Mi Via self-directed waiver, or in an ICF/IID. Depending on the option chosen, the client then goes through a case management (traditional DD waiver) or consultant agency (Mi Via waiver) to develop a service plan and budget. Case managers work with participants and the client’s IDT to handle most aspects of service coordination and monitoring under the traditional DD waiver, whereas Mi Via clients have the authority to choose the amount and type of services they need, with consultants serving in more of an advisory capacity.

Figure 1. DD and Mi Via Waiver Process



Source: LFC analysis

Figure 2. FY17 Funding for the DD and Mi Via Waivers



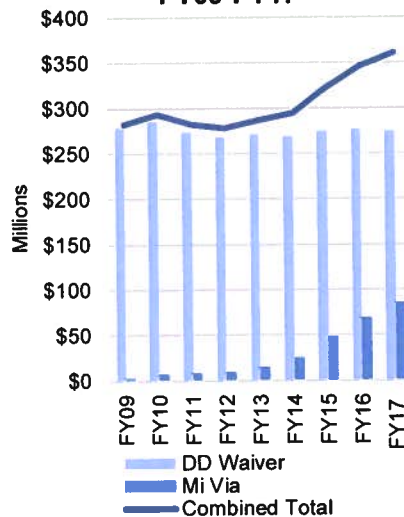
Source: 2016 GAA, HSD April 2018 Medicaid Projection, and HSD data for 2017 CMS-372 Report

Waiver Funding

The DD and Mi Via Waivers are financed through a combination of general fund and federal funds matched at New Mexico’s Federal Medical Assistance Percentage (FMAP) rate, which as of FY17 was a blended rate of 71 percent for the DD and Mi Via Waivers. DDSD transfers general fund dollars appropriated by the Legislature to the Human Services Department (HSD), which draws down the federal match dollars and pays claims for DD and Mi Via Waiver services. HSD manages all financial data for the waivers through the Medicaid Management Information System (MMIS). HSD contracts with a third party assessor, Qualis Health, responsible for reviewing client service plans for both waivers and inputting the information into MMIS. HSD also contracts with Conduent, formerly Xerox, for processing of invoices and payment for Mi Via services. HSD also models expected revenues and expenditures for the waivers as part of its quarterly Medicaid projection process. Figure 2 shows revenues and expenditures for both the DD and Mi Via Waivers for FY17.

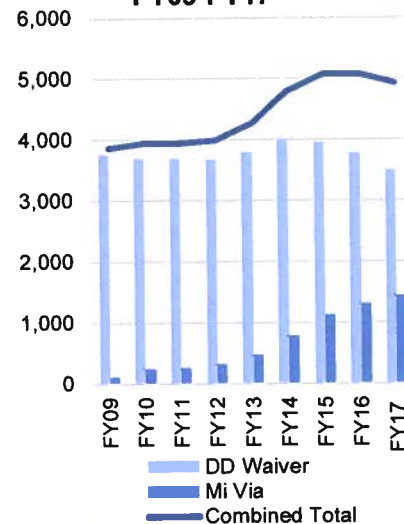
A 2010 LFC evaluation found New Mexico DD Waiver services were amongst the ten most expensive programs in the country. Looking at the most recent nine-year period of FY09-FY17, costs from the traditional DD waiver declined almost 2 percent from \$279 million to \$274 million. For Mi Via, New Mexico’s self-directed waiver option, expenditures grew significantly from \$3 million to \$86 million since it was implemented in 2007 as shown in Chart 1 and Chart 2. Mi Via enrollment continues to grow rapidly, while traditional DD waiver enrollment is declining.

Chart 1. DD Waiver and Mi Via Expenditures FY09-FY17



Note: FY09 Mi Via total includes FY07-FY09

Chart 2. DD Waiver and Mi Via Enrollment FY09-FY17



Note: FY09 Mi Via total includes FY07-FY09

Comparison to Other States

New Mexico's cost per client for the DD and Mi Via Waivers had improved when compared to other states, but reversal of cost containment measures may have caused costs to surge most recently. For 2010, New Mexico's average cost per client was \$74 thousand, and the national average was \$45 thousand. In 2010, New Mexico had the seventh highest cost per client for the DD and Mi Via Waivers combined when compared to other states' waivers for the same population, as shown in Chart 3.

In 2014, the most recent year all state data is available, New Mexico reduced its average cost by almost 18 percent to \$61 thousand per waiver participant. The U.S. average that same year showed a cost growth rate of 5.5 percent, with New Mexico being one of 19 states with lower costs between 2010 and 2014. New Mexico's lower average costs in 2014 made it the 13th most costly state for developmentally disabled waiver services, as shown in Chart 4.

These cost savings could partially be attributed to the implementation of the Supports Intensity Scale (SIS) assessment tool, which aimed to allow DD Waiver participants to be assessed

for service need using a nationally validated tool. In 2015, following the settlement of the Waldrop lawsuit, DOH discontinued use of the SIS and now exclusively uses a more individualized evaluation methodology to determine service needs. In 2016, average cost per client increased to \$73 thousand and to \$79 thousand in 2017, a one-year increase of 7 percent.

The Jackson Lawsuit

New Mexico's current system of services for individuals with developmental disabilities has been highly impacted by litigation, most notably the Jackson class-action lawsuit. In 1987, a group of residents of New Mexico's state-operated facilities for individuals with developmental disabilities sued the state over violations of federal law connected to conditions in those facilities and the rights of individuals living there. While New Mexico closed its residential

Chart 3. Average DD Waiver Cost per Client by State 2010

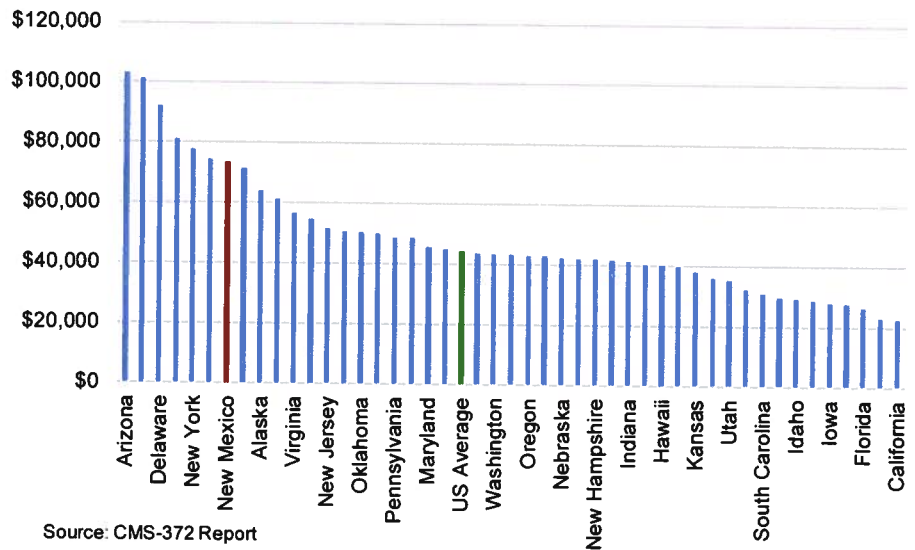
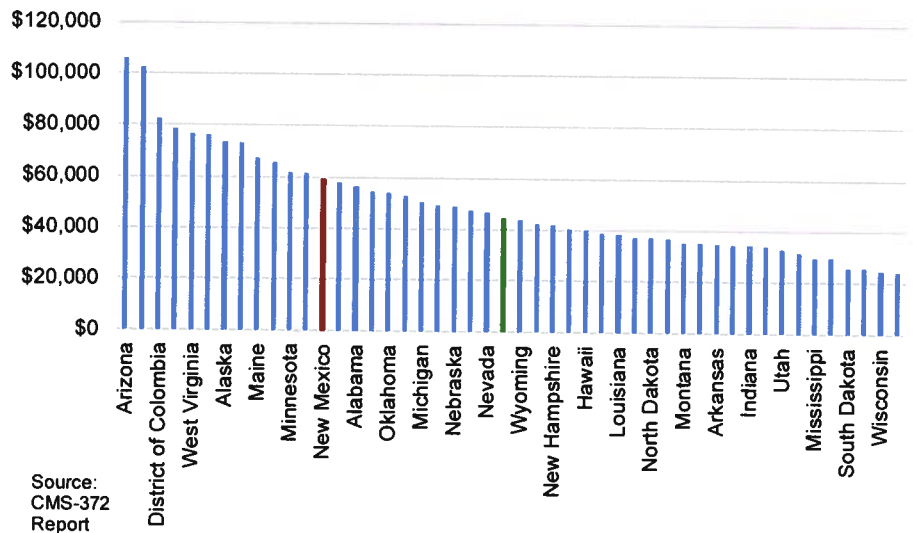


Chart 4. Average DD Waiver Cost per Client by State 2014



facilities for this population in the 1990s, the case remains active in federal court. Under a series of court orders dating to 1997, the state is required to demonstrate compliance with hundreds of obligations as determined by court-appointed monitors before it can disengage from the lawsuit completely. These ongoing obligations and the attendant administrative complexities that have arisen as a result have led to over \$40 million in state spending since FY13. The state appealed to the Tenth Circuit Court of Appeals in 2016, arguing the original violations of law that resulted in the lawsuit had been corrected, and in January 2018, the appeals court remanded the case to the lower court for further review to determine if there are ongoing violations of federal law and whether the state has a durable remedy in place to adequately serve the interests of class members.

Previous LFC Evaluation

Due to the Legislature’s commitment to operate an effective DD waiver system, the program has been evaluated periodically by the LFC. A 2010 program evaluation found waiver costs were increasing, clients were not adequately assessed to determine need, more individuals were put on the waitlist than were allocated services and improved cost management strategies were needed. A 2013 progress report highlighted some changes occurring between 2010 and 2013 such as the implementation of a new assessment and a rate study, which indicated the current rates matched those nationally. However, when examining the key findings of the 2010 evaluation, numerous findings continue to be relevant (Table 1).

Table 1. Status of Key Findings from the 2010 LFC DD waiver evaluation

2010 Evaluation Finding	Status
Spending levels for the existing DD waiver program enrollment are becoming unsustainable.	Remains a Concern
DD waiver program lacks a needs-based assessment tool and utilization review process to ensure participants receive the right care at the right time.	Remains a Concern-although using a different tool than in 2010
The number of individuals being placed on the waiting list considerably outpace allocations to the DD waiver causing individuals with unknown needs to wait seven to eight years for waiver services.	Remains a Concern
Increased program oversight, improved cost management, and benefit redesign will be necessary to maintain or expand the DD waiver program.	Remains a Concern
Enhanced performance reporting to the Legislature and public could help build on positive benefits initially provided through the DD waiver program and federal consent decrees.	Remains a Concern

Source: LFC Files

FINDINGS AND RECOMMENDATIONS



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

The DD Waiver has been in place since 1984 as a community-based service alternative to facilities for those with developmental or intellectual disabilities in New Mexico. Waiver services include living supports, employment supports, therapies (physical, occupational, and speech/language), and supports while in the community. The waiver is financed through a combination of general fund and federal funds matched at New Mexico’s Medicaid federal medical assistance percentage (FMAP) rate. A 2010 LFC evaluation found New Mexico DD Waiver services were amongst the ten most expensive programs in the country. Looking at the most recent nine-year period of FY09-FY17, costs from the DD Waiver declined almost 2 percent from \$279 million to \$274 million (Chart 5).

Average traditional DD Waiver costs are increasing in a time when total program enrollment is dropping.

While it appears to be positive news that DD Waiver costs stabilized around \$270 million from FY11 to FY17, this pattern needs to be further examined in the context of enrollment and cost per client.

As shown in Charts 7 and 8, DD Waiver enrollment has been on a steady decline of 13 percent between FY14 and FY17, however cost per client over that same time period increased 17 percent. It is worth noting here only three components impact cost per client: total cost, total enrollment, and service utilization.

Chart 5. DD Waiver Total Expenditures FY01-FY17

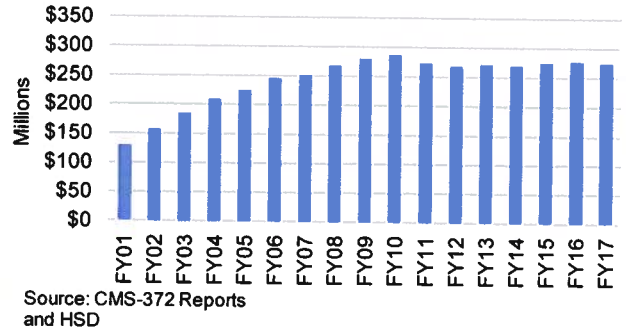


Chart 6. DDW Expenditures by Major Cost Category FY17

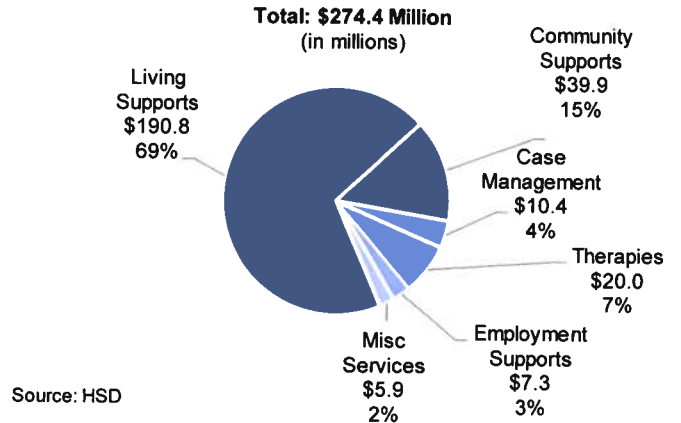
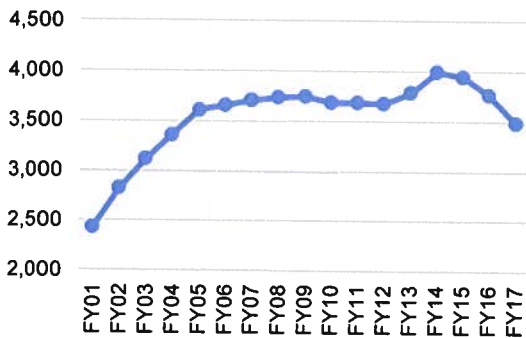
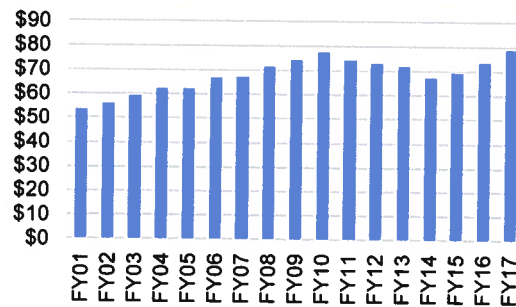


Chart 7. DD Waiver Enrollment FY01-FY17



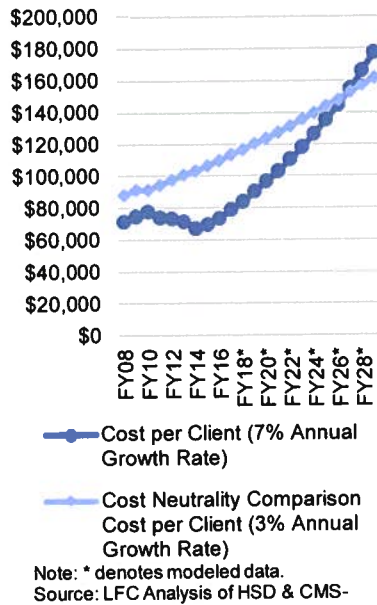
Source: CMS-372 Reports and HSD

Chart 8. Average Cost per Client FY01-FY17 (in thousands)



Source: LFC Analysis of CMS-372 Reports and HSD Data

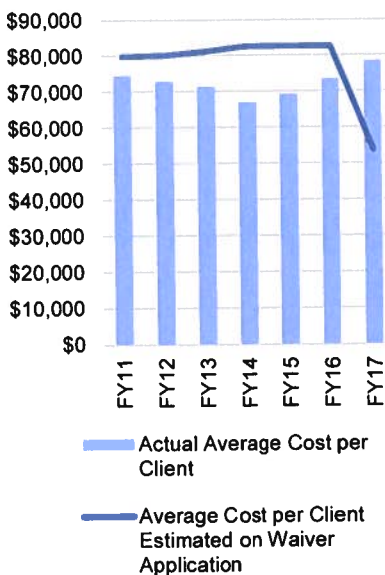
Chart 9. DD Waiver Cost per Client, FY08-FY29 Modeled



In this case of declining enrollment, and knowing provider rates were mostly static between FY14 and FY17 (with the exception of select living and community-based supports, which received rate increases in FY15 and FY16), the primary driver for this cost growth is increased service utilization. These increases can come in the form of higher assessed need overall, or higher need for specific services. With no service caps built into the DD Waiver, not fully understanding the causes of service utilization increases pose a prominent risk to the finances of this program.

DD Waiver cost per client could fail the federally-required cost neutrality test within the next ten years if current spending growth continues. CMS requires waiver programs such as the DD Waiver be cost neutral when compared to the institutional equivalent for the clients being served through the waiver, in this case, Intermediate Care Facility (ICF) care. As part of its annual reporting to CMS, the state includes what total annual expected ICF costs per client would be and compares this total to annual average cost per waiver client. While ICF services are still available in New Mexico, instead of using the actual costs of this service for the cost neutrality test of the DD and Mi Via Waivers, HSD economists calculated expected ICF and other Medicaid costs for clients if they did not use waiver services for the initial five-year waiver period, trending this data forward over subsequent waiver renewals using CMS' Market Basket Index as a proxy for cost growth. For the DD Waiver, this results in an annual ICF cost growth rate of 3 percent. However, as shown in Chart 9, using the most recent annual growth rate of 7 percent for the DD Waiver, and assuming cost growth has somewhat stabilized after more than ten years since Mi Via's implementation, average annual costs for the DD Waiver could fail the cost neutrality test as soon as FY27.

Chart 10. DDW Average Annual Cost per Client CMS-Approved Estimate vs. Actual Costs FY11-FY17



While CMS has approved this methodology for testing the costs of the DD Waiver compared to institutional care, this cost neutrality test is based completely on a set of assumptions and does not reflect the actual costs of a client in an ICF today. While the methodology does not reflect the actual costs of a client in an ICF facility today, a projection is used as current day ICF costs do not accurately reflect the average length of stay and care level needed to support individuals who are on the DD Waiver instead of residing in an ICF.

In order to remain cost neutral, DDSD will need to take action to curb spending growth, or find a viable alternative benchmark for cost neutrality that CMS will approve. Based on other analyses in this evaluation, DDSD has various opportunities to scrutinize service utilization growth in the DD Waiver and right-size service allotments more appropriately, which could stave off failure of the cost neutrality test for federal waiver approval.

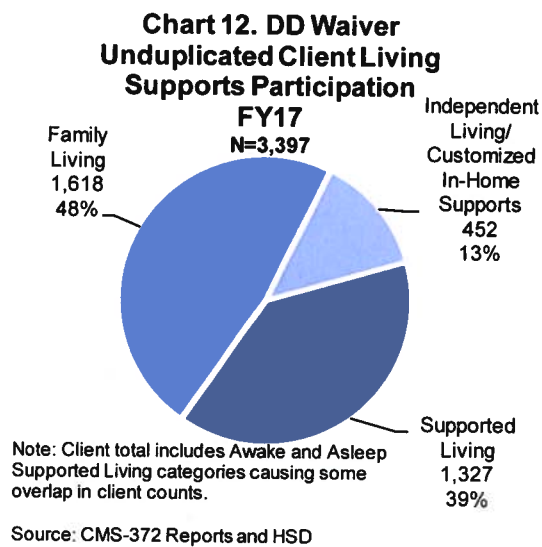
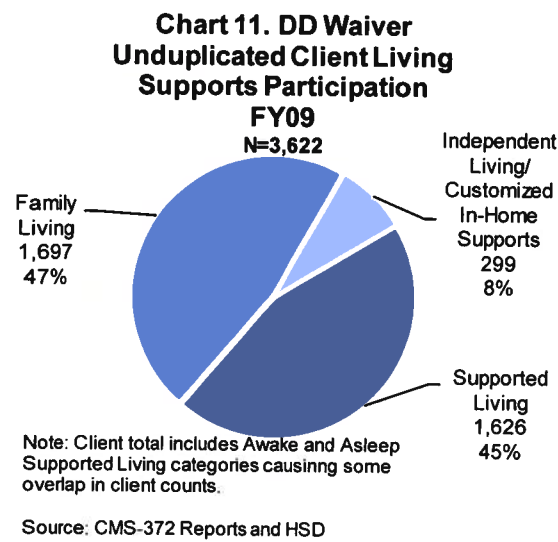
DD Waiver costs significantly exceed the expected costs approved by CMS in the waiver application for the first time in the past seven years. For FY17, the first year of the most recent five-year waiver period, average cost per client is 46 percent higher than what the state estimated on the waiver application approved by CMS. For FY11 through FY16, the actual average cost per client was below the estimated cost submitted to CMS by an average of 13 percent, as shown in Chart 10. At the time HSD submitted the waiver application covering FY17, the most recent available claims data for waiver clients was for FY14. HSD then used this data to estimate the number of clients on the waiver for the next five-year period. However, the rate at which clients were allocated onto the DD Waiver in FY17 has not reached the estimate in the waiver application, resulting in a higher cost per client than expected.

Source: NM Applications for 1915(c) HCBS Waiver

Additionally, the waiver application incorporated lower client expenditures anticipated as a result of improved client assessment and resource allocation potentially due to use of the SIS tool (as discussed in the assessment chapter beginning on page 35). However, DOH ended use of the SIS in 2015. HSD is addressing this cost disparity with an amendment to the DD Waiver application for the five-year period FY17 through FY21.

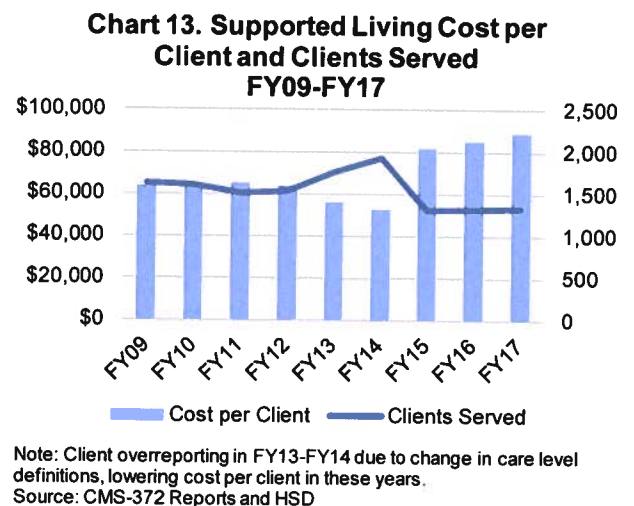
Increased therapy service utilization and clients requiring more intensive supported living is driving DD Waiver cost growth.

Living supports under the DD Waiver fall under three categories: supported living, family living, and customized in-home supports for those living independently. In FY17, these three service categories accounted for 68 percent (\$185 million) of a total \$274 million spent for DD Waiver services. Between FY09 and FY17, the total number of clients receiving some form of living supports dropped by 6 percent, as shown in Charts 11 and 12.

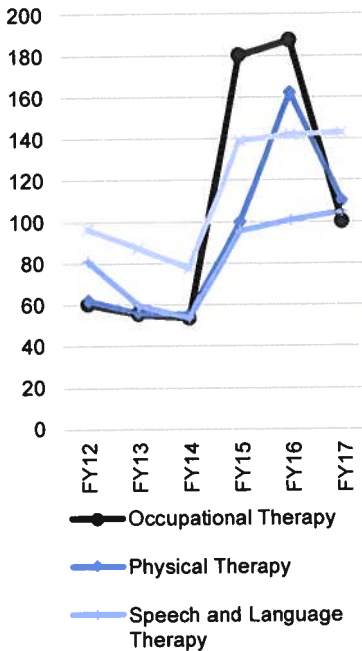


Waiver participants increasingly use more intensive and costly living supports despite lower enrollment in this service. Also, a greater proportion of clients are receiving services to live independently in FY17 versus FY09. However, while the average overall waiver cost per client increased 6 percent over this same time period, the average cost for supported living grew 40 percent.

In FY09, the number of clients in the least intensive form of supported living during wake hours totaled 11, whereas in FY17 this total was zero. In the case of the most intensive level of supported living, there were 855 clients in FY09 and 918 in FY17. In FY09, the most intensive supported living per diem rate was slightly more than two times the rate for the least intensive level of supported living. In FY17, the most intensive rate was 1.5 times greater than the least intensive, however, if the client required intensive medical or behavioral supports, the rate was almost 2.25 times higher. Additionally, DDSD and HSD increased per diem service rates for the two highest supported living categories twice since 2012, resulting in a rate increase of 2 percent for each of these categories.



**Chart 14. DDW
Therapy Utilization
FY12-FY17**



Source: LFC Analysis of HSD Data

DDSD does not currently look at how spending for supported living changes over time. As the largest cost category, service utilization and changes in the intensity of care clients require play a major role in predicting future costs. DDSD and HSD need to expand the analysis of client behavior beyond average cost per client and look at individual services such as supported living.

Therapy utilization increased, with physical therapy alone growing 77 percent between FY12 and FY17. Therapies are the third largest cost center for the DD Waiver after supported living and day habilitation. LFC staff analyzed how utilization changed over the last six years to see if clients on average are using more services. As shown in Chart 14, utilization for the four types of therapeutic services saw a significant increase starting in FY14.

Before a dramatic drop in utilization in FY17, occupational therapy experienced the largest utilization increase between FY12 and FY16. Physical therapy use also spiked, but did not decline to the same degree for a growth rate of 77 percent between FY12 and FY17. Behavioral support consultations and speech and language therapy also showed increases of 48 percent and 30 percent respectively during this time period. While overall costs for these services dropped 14 percent during this time when overall DD Waiver enrollment also dropped, increased therapy utilization could pose a risk for increased costs if enrollment stabilizes and these utilization rates hold steady.

DDSD and HSD have not been successful in predicting the cost of the DD Waiver, requiring the Legislature to provide additional funding six of the last eleven years.

The Legislature had to provide additional funding to the DD Waiver to cover costs totaling \$15 million between FY08 and FY18, largely consisting of costs associated with the Jackson lawsuit. It is important to note DDSD received \$3.1 million in FY11, even though this was a year of significant fiscal challenges for the state. Despite this, DOH reverted \$32.3 million between FY08 and FY14. Since non-reverting language was added to the General Appropriation Act for FY15, DOH has carried over an additional \$3.8 million between FY16 and FY18, although in decreasing amounts each year (Table 2). According to DOH, these amounts carried forward were used to fund additional clients, expedited allocations, and overall cost increases of the traditional DD and Mi Via waivers.

HSD tracks expected revenues and expenditures for the DD Waiver as part of the Medicaid projection process. At any given time, three fiscal years are being tracked as a part of this process. As of April 2018, this meant HSD provided data on FY17, FY18, and FY19 as part of the projection. However, this small window does not allow for adequate long-term financial planning for the DD Waiver. For example, when DOH submitted its budget request for FY19, HSD had not released FY19 Medicaid projections. While this data was available in time for the legislative session, it does not allow for more robust planning for DD Waiver financing beyond the next fiscal year. Any long-term planning for the waiver would require more years of financial analysis and forecasting looking at factors such as client service utilization, availability of services, transfers to and from the Mi Via Waiver, client demographics, and acuity, as well as expected ongoing costs of litigation.

Table 2. DDSD Funding for DD and Mi Via Waivers FY08-FY19

(in millions)

Fiscal Year	General Fund Appropriation to DDSD	Included Funds to Reduce Waitlist	Special, Supplemental, and Deficiency Appropriations (GF only)	Unexpended Balance	Status of Unexpended Balance
FY08	\$78.0	\$5.0	\$0.0	\$0.0	Reverted
FY09	\$85.0	\$4.0	\$2.5	\$11.6	Reverted
FY10	\$66.7	\$5.4	\$0.0	\$2.1	Reverted
FY11	\$60.6	\$2.3	\$3.1	\$2.4	Reverted
FY12	\$90.5	\$1.0	\$0.0	\$3.3	Reverted
FY13	\$94.4	\$2.8	\$2.3	\$7.4	Reverted
FY14	\$99.0	\$4.6	\$0.0	\$5.5	Reverted
FY15	\$102.8	\$3.3	\$0.0	\$2.5	Non-reverting; fund balance carried over to FY16
FY16	\$103.3	\$0.5	\$4.0	\$0.9	Non-reverting; fund balance carried over to FY17
FY17	\$105.1	\$0.8	\$1.0	\$0.4	Non-reverting; fund balance carried over to FY18
FY18 (Operating Budget)	\$103.4	N/A	\$2.3	N/A	Non-reverting
FY19 (Appropriated)	\$110.5	\$2.0	\$0.0	N/A	

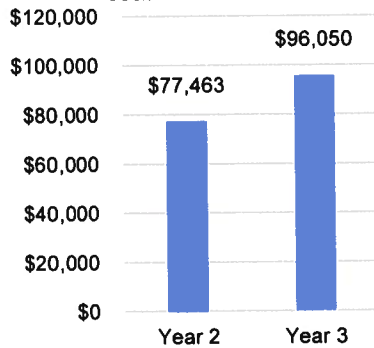
Notes:

- (1) The 2009 GAA included a \$4 million supplemental appropriation to DOH for DD waiver and facilities management costs, but capped the amount to be used by facilities management at \$1.5 million.
- (2) The 2013 GAA includes a supplemental for Jackson disengagement of \$2.25 million GF and \$374.7 thousand ISF/IAT for FY13 and FY14.
- (3) The 2016 GAA includes a supplemental for Jackson disengagement and Waldrop compliance of \$4 million GF and \$2.84 million ISF/IAT for FY16 and FY17.
- (4) The 2017 GAA includes a supplemental for Jackson disengagement and Waldrop compliance includes \$1 million GF and \$230 thousand ISF/IAT for FY17 and FY18.
- (5) The 2018 GAA includes a \$269.3 thousand supplemental in FY18 for DHI to bring Jackson IQR in-house and \$2 million for a DD waiver shortfall.

Source: General Appropriation Acts, DOH

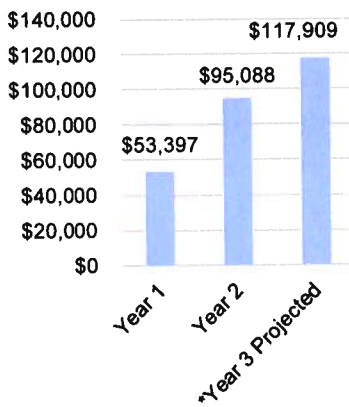
DD Waiver clients experience significant cost increases in the second and third years of waiver services. HSD tracks expenditure activity for DD Waiver participants in the first three years of receiving services, as part of the Medicaid projection process. While it is reasonable to assume costs will increase from the first to second year of waiver services, as it can take as long as nine months to get services in the first year of allocation, it is less expected to see another jump in costs from the second to third year of services. Below is a snapshot of a group of new clients who started DD Waiver services in FY16 and another group who started services in FY17. The common trend across these two groups is costs increase over the first years of service. However, the size of those cost increases greatly differ between the two groups of clients as shown in Charts 15 and 16.

Chart 15. New FY16 DD Waiver Average Client Budgets for Second and Third Waiver Years



Source: HSD

Chart 16. New FY17 DD Waiver Average Client Budgets for First and Second Waiver Years



Note: Year 3 projection based on 24% growth rate in Year 3 for new DDW clients in FY16.
Source: LFC Analysis of HSD Data

While Year 1 data was no longer available for the FY16 clients, and HSD has yet to perform this analysis for Year 3 for the FY17 clients, the data still offers some insight. Of most concern is how much higher the average cost in the second year of services is for the FY17 clients than the FY16 clients. In a matter of one year, it costs 23 percent more to serve clients in their second year of waiver services. Also, if costs grow in the third service year for the FY17 clients as they did for the FY16 clients, we could expect average annual expenditures of \$118 thousand. HSD only tracks this cost behavior data for the first three years on the DD waiver, assuming costs do not change after the third year of waiver services. If HSD's assumption holds true, average annual costs for this group would remain over \$100 thousand for the foreseeable future, much higher than the average cost for all DD Waiver clients of \$79 thousand.

DDSD does not use cost data to analyze cost drivers and utilization behavior. The financial function of the DD Waiver is managed at HSD as part of the Medicaid program, as the DD Waiver is funded the same as Medicaid. Due to this role, HSD has access to a great deal of information through claims in the Medicaid Management Information System (MMIS). In addition to regular reports HSD provides to DDSD (quarterly Medicaid projections, a client report to track enrollment, and invoices for state matching funds appropriated to DOH requiring transfer to HSD), HSD also provides raw data from MMIS related to claims and prior authorizations for DD services. However, DDSD has not effectively leveraged this cost data to manage the waiver.

The costliest 10 percent of clients on the DD Waiver in FY12 accounted for 22 percent of total expenditures.

In FY12, 3,678 people received services through the DD Waiver. LFC staff analyzed the cost trends for the top 10 percent of this total, or 368 individuals. The average annual expenditure for a client falling into the top 10 percent was \$162 thousand, more than double the \$73 thousand average annual expense for the entire DD Waiver population. The most expensive and highly-utilized service was supported living, with an average cost of \$120 thousand in FY12, followed by habilitation services (day programming) at an average cost of \$23 thousand. As a significant cost driver for the DD Waiver, LFC staff analyzed the most expensive DD Waiver clients more closely to identify service patterns between FY12 and FY17.

Supported living and habilitation programs accounted for 88 percent of expenditures for the most costly DD Waiver clients. All 368 clients in the costliest 10 percent received habilitation or day services. However, only 81 clients, or 22 percent, participated in employment supports in FY12. Also, while there was high utilization of speech and occupational therapies, with 291 and 215 participants respectively, these services, along with behavioral supports crisis intervention, respite care, and other services accounted for only 9 percent of total FY12 expenditures.

When looking at this high-cost population's spending patterns in FY17, while overall expenditures decreased by 17 percent, not much changed in how spending was distributed between supported living, habilitation services, and employment supports. The one exception was three clients receiving services to live independently in FY17 who were not receiving these services in FY12. In the case of therapies and other services, there was a slight uptick in expenditures.

Lower expenditures in FY17 for the highest cost clients can be attributed to attrition from the DD Waiver. Thirty-nine of the 368 people originally in the top 10 percent of DD Waiver spending left the waiver. Thirty-five clients left DD services altogether. Four clients transferred to Mi Via, where their annual average expenditures were \$87 thousand in FY17, a reduction of almost half from the FY12 average. However, one of these four clients had \$188 thousand in annual costs in Mi Via in FY17, as opposed to \$143 thousand in FY12 in the DD Waiver. Not only was this a 31 percent increase in spending, but it was over two and a half times more than the annual spending cap of \$72,710 for Mi Via. Cost patterns amongst clients transferring from the DD Waiver to Mi Via will be further reviewed in the next chapter.

DDSD does not currently perform this level of analysis to better understand cost drivers within the DD Waiver. Looking at cost and utilization patterns for high-cost clients should be a priority in understanding how the waiver is performing, as these clients drive the costs of the waiver.

Recommendations

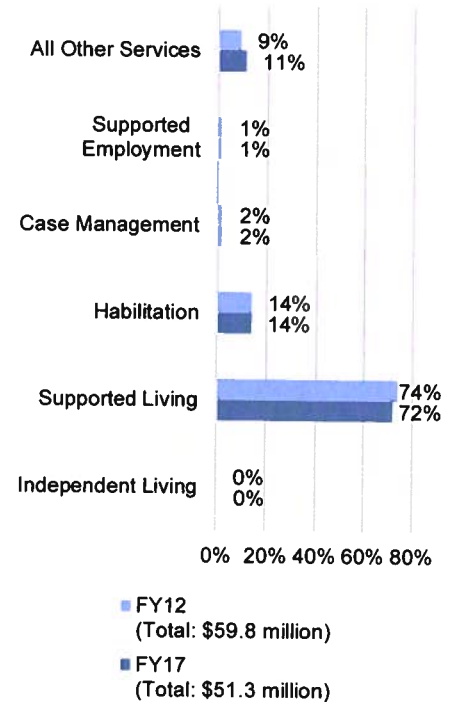
DOH, with data provided by HSD, should:

- 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;
- Examine cost drivers within the DD Waiver, 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.

Chart 17. DDW Top 10 Percent Costliest Clients: Percent of Spending by Category FY12 and FY17

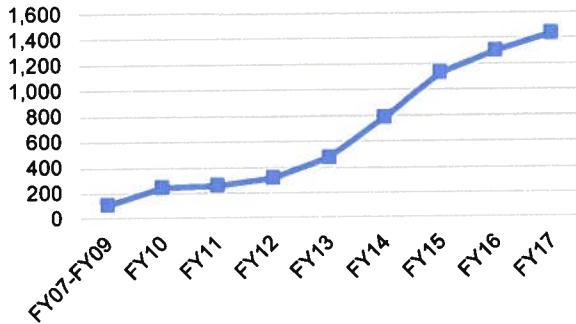


Note: Percentages reflect portion of spending for only the costliest 10 percent of traditional DD Waiver clients.
 Source: LFC Analysis of HSD Data

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

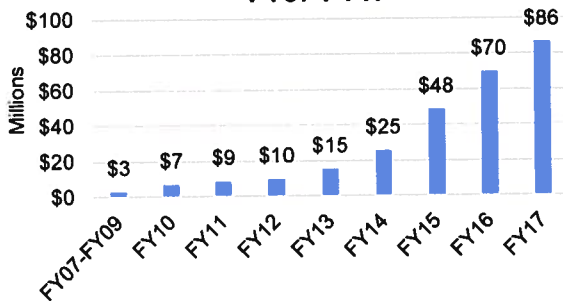
The Mi Via Waiver grew significantly in its first ten years, with 1,434 enrolled and \$86 million in expenditures in FFY17.

**Chart 18. Mi Via Enrollment
FY07-FY17**



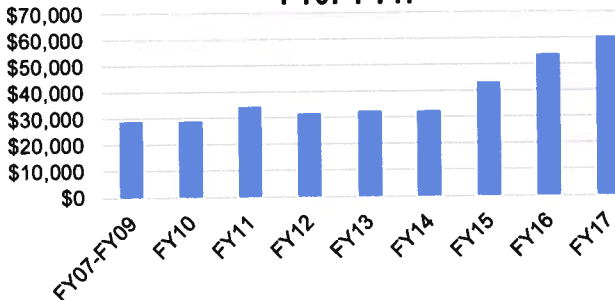
Source: CMS-372

**Chart 19. Mi Via Waiver Total Expenditures
FY07-FY17**



Source: CMS-372

**Chart 20. Mi Via Average Cost per Client
FY07-FY17**



Source: CMS-372

The Mi Via Waiver began in FFY07, allowing developmentally disabled clients to self-direct their support services. Eligible services under Mi Via include living supports, community-based supports, goods such as computers and fax machines in order to facilitate invoicing and service payments, therapies (physical, occupational, and speech/language), as well as services such as chiropractic care, massage, and acupuncture.

As opposed to the DD Waiver, which operates on a state fiscal year, Mi Via operates on a federal fiscal year. The program is funded the same as the DD Waiver, with a state match from the general fund and federal dollars generated using the state's Medicaid FMAP rate. Instead of functioning with a case manager and a treatment team fostering the client's service plan, Mi Via puts control of the service plan in the hands of the client with advice from service providers and a designated Mi Via consultant, which is then reviewed by the HSD's contracted third party assessor. The the employer of record is responsible for hiring service providers, negotiating payment rates based on a DDS-approved rate range, and submitting requests for payment to HSD's contracted payor. Differing from the DD Waiver, there are annual budget caps for Mi Via of \$72,710 for adults over 21 years of age, \$54,589 for ages 18-20, and \$23,443 for children under age 18.

While Mi Via has continued to grow in its first decade, FFY14 was a pivotal year for this program in both enrollment and cost growth. In FFY14, Mi Via enrollment and costs both grew by 67 percent. However, over the next three years, while enrollment grew 83 percent, costs grew 239 percent. Costs outpacing enrollment clearly appears in the average cost per client, which grew from \$32 thousand in FFY 14 to \$60 thousand in FFY 17, as shown in Chart 20.

While Mi Via's average cost per client is still below the adult annual budget cap of \$72,710, and is also less than the FY17 DD Waiver average cost per client of \$79 thousand, the exceptional cost growth is a concern for the long-term financial viability of this program.

**Table 3. Mi Via Costs by Major Cost Category
FY12, FY15, FY17**
(in millions)

	FY12	FY15	FY17
Living Supports	\$5.7	\$28.5	\$54.2
Community Supports	\$2.2	\$13.7	\$24.0
Therapies	\$0.2	\$0.7	\$0.5
Employment Supports	\$0.0	\$0.2	\$0.4
Consultant	\$0.7	\$2.4	\$3.6
Related Goods	\$0.5	\$1.1	\$1.0
Other Services	\$0.5	\$1.8	\$2.5
Total	\$9.8	\$48.5	\$86.1

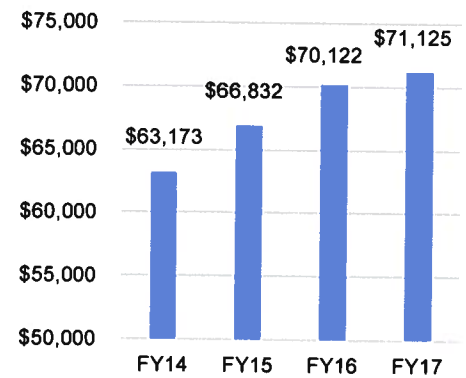
Source: CMS-372

In FFY14, the number of clients moving from the DD Waiver to Mi Via greatly increased, along with their expenditures in the first three years on Mi Via. In FFY14, these transitioning clients had an average cost of \$63 thousand. However, by FFY17, these same clients had an average cost of \$71 thousand, for a total cost growth of 13 percent between FFY14 and FFY17 as shown in Chart 21.

Additionally, these clients were approaching the maximum annual expenditure limit in Mi Via of \$72,710. While this spending cap ensures stability and predictability in future years, this analysis indicates DD Waiver clients moving to Mi Via are becoming more expensive to serve. This runs counter to the original concept of Mi Via as a less expensive waiver due to its self-directed framework, and with 63 percent of total FFY14 Mi Via enrollees coming from the DD Waiver, the increasing costs of these transitioning clients is a key factor in Mi Via's increasing costs.

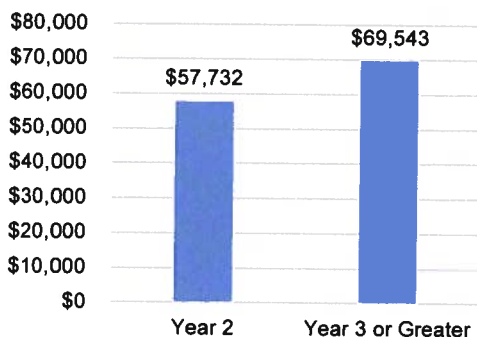
Annual costs for Mi Via clients new to the waiver in FY17 will reach the budget cap by FY19. HSD tracks budget data for the first three years a client is on the DD or Mi Via Waivers as part of the Medicaid budget projection process. When looking at clients who began services under Mi Via in FY16 and FY17, there is a significant jump in average annual costs in the second and third waiver years, as shown in Charts 22 and 23.

Chart 21. Average Cost per Client for Cohort of DD Waiver Clients Switching to Mi Via in FY14
Initial N=174



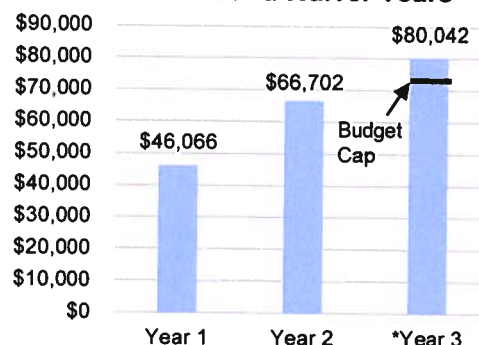
Note: Cohort size changed as follows: FY15=172, FY16=170, FY17=169. FY14 data reflects a combination of DD and Mi Via costs.
Source: HSD

Chart 22. New FY16 Mi Via Average Client Budgets for Second and Third Waiver Years



Source: HSD

Chart 23. New FY17 Mi Via Average Client Budgets for First and Second Waiver Years



Note: Year 3 projection based on 20% growth projected rate in Year 3 for new Mi Via clients in FY16.
Source: LFC Analysis of HSD Data

For clients who first received Mi Via waiver services in FY16, there was a 20 percent jump in costs between year two and year three of services. For clients who began services in FY17, second year costs were 16 percent higher than second year costs for clients starting services in FY16. Most importantly however, if third year costs for the FY17 clients grew at the same 20 percent rate as FY16 clients, these third year costs would be greater than the annual cap of \$72,710. While capping budgets provides a safeguard against rising costs, there is a mechanism for Mi Via clients to request budget increases, which could be an upside cost risk. Also, if DDS decided to increase the annual cap for all clients, overall costs could increase significantly.

The costliest 10 percent of clients on the Mi Via Waiver in FY12 accounted for 28 percent of total expenditures.

The 24 costliest clients for Mi Via had total expenditures in FY12 ranging from \$72 thousand to \$164 thousand, with an average cost of \$90 thousand. Seventy-nine percent of these clients received direct living support services, costing an average of \$67 thousand per client. Similar to the highest cost clients on the DD Waiver, living and community supports (homemaker services, customized in-home living supports, and community direct support) representing the largest portion of annual costs as shown in Chart 24. The next largest cost center was other services including skilled therapies (occupational, physical, and speech/language), costing an average \$13 thousand per client in FY12.

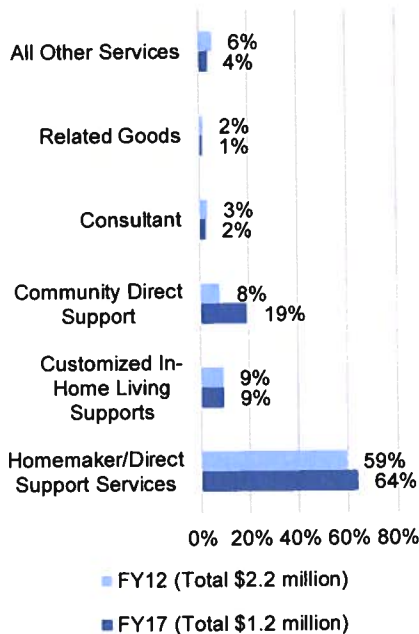
Twelve of the 24 clients were still on Mi Via in FY17. On average, client costs for these 12 clients increased 4 percent from FY12 and FY17. Important spending changes between FY12 and FY17 for this high cost population include a higher percentage of spending on living supports such as direct support services and community-based direct supports, while all other services, including therapies, dropped significantly for this group, differing from the most expensive DD Waiver clients over the same time period. Additionally, ten of these 12 clients spent more than the cap of \$72,710 in both FY12 and FY17. For these 10 clients, costs increased 6 percent from FY12 to FY17.

Of the 12 clients who did not appear in the FY17 data, one returned to the DD Waiver, with a budget increase of 38 percent in FY17 to \$103 thousand. The other 11 clients left the waiver altogether.

Increasing costs in areas such as living supports and community-based supports is driving Mi Via waiver cost growth.

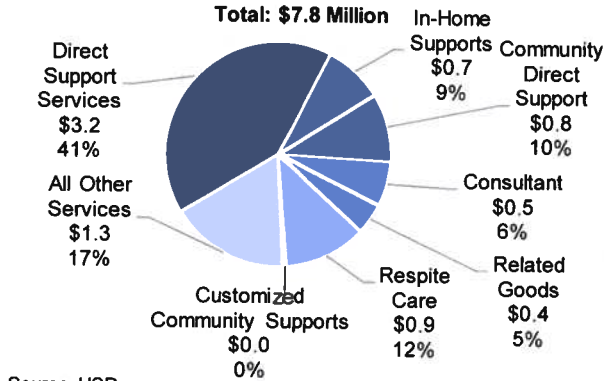
Mi Via enrollment and expenditures increased between FY12 and FY17, from almost \$8 million and 231 clients in FY12 to \$83 million and 1,416 clients in FY17.

Chart 24. Mi Via Top 10 Percent Costliest Clients: Percentage of Spending by Category FY12 and FY17



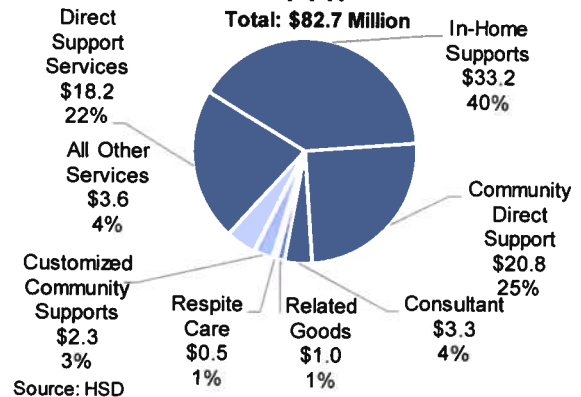
Note: Percentages reflect portion of spending only by the costliest 10 percent of Mi Via clients.
Source: LFC Analysis of HSD Data

Chart 25. Mi Via Costs by Major Service Category FY12



Source: HSD

Chart 26. Mi Via Costs by Major Service Category FY17



Source: HSD

Primary cost drivers in Mi Via include direct support services, in-home supports for independent living, community direct supports, and customized community supports. Similar to the case with the highest cost Mi Via clients, in FY12, other services, including physical, and occupational, and speech/language therapies, accounted for a larger portion of total cost in FY12 than in FY17. Conversely, support services, especially for independent living and in the community, increased dramatically in this period.

Additionally, these support services experienced a significant increase in cost per client between FY12 and FY17, meaning not only were more clients using these services, but clients were either using more services or paying more for these services, as shown in Appendix B.

Table 4 shows how average rates changed for the top four Mi Via services between FY12 and FY17. All average rates increased, but rates for community direct support and customized community supports more than doubled in this time period.

Table 4. Average Rate Changes for Top Mi Via Services FY12 and FY17

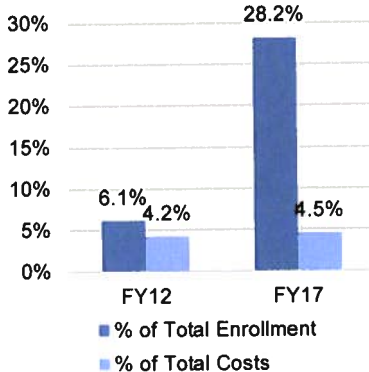
Service	Rate Range	FY12 Average Rate	FY17 Average Rate	Percent Change
Direct Support Services	\$7.50-\$14.60	\$11.91	\$12.79	7.4%
Customized In-Home Supports	\$25.00-\$131.50	\$96.17	\$118.96	23.7%
Community Direct Support	\$1.88-\$15.48	\$2.37	\$6.10	157.9%
Customized Community Supports	\$1.36-\$8.82	\$1.34	\$2.85	113.5%

Source: LFC Analysis of HSD Data

As shown in Table 4, there are wide rate ranges for these services. While the rate range model offers the client greater flexibility to obtain desired services under Mi Via, it also creates a risk that costs may be higher under for these services. Economic theory states the demand for a good or service in combination with the available supply will determine the appropriate price. However, when an artificial maximum price is set, as is the case with Mi Via, all prices will eventually settle at the maximum as there is limited incentive for providers to accept a lower rate. Considering Mi Via rate ranges are not adjusted based on the supply of available services in different areas of the state, it is reasonable to assume negotiated rates will continue to increase towards the maximum, creating further cost increases for the program.

Additionally, the number of units each client is using of the support services in Table 4 will contribute to increasing costs. Service units are not currently tracked between HSD and DDS on a regular basis, though the information could be extracted from the Medicaid Management Information System (MMIS). Between FFY12 and FFY17, utilization for community-based supports increased significantly: 116 percent for customized community support and 108 percent for community direct support (Appendix B). The combination of average rates and utilization both increasing over time explains the higher cost per client for community-based support services. It is important to know how participant-negotiated rates and utilization are changing over time, in order to ensure the program is adequately funded, rates foster system adequacy and accurately reflect service costs, and provides the appropriate amount of services.

Chart 27. Approved Budget Overages as Percent of Total Enrollment and Costs FY12 & FY17



Source: LFC Analysis of HSD Data

Budget increases over the designated cap greatly increased between FY12 and FY17. As mentioned earlier in this section, Mi Via client budgets are capped at \$72,710 for adults over age 21. In FY12, 19 clients (6 percent of total enrollment) received budget increases beyond the cap totaling \$410 thousand in additional approved expenditures, or 4 percent of total Mi Via costs for that year. In FY17, 404 clients (28 percent of total enrollment) received budget increases above the cap, resulting in almost \$4 million in additional approved expenditures, or 5 percent of total Mi Via costs, as shown in Chart 27.

Recommendations

DOH, with data provided by HSD, should regularly:

- Analyze and report to the Legislature on Mi Via clients with highest costs, looking at how their service needs and costs change over time;
- 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 and customized in-home living supports;
 - Community-based supports such as community direct support and customized community supports; and
 - Changes in utilization for these services; and
- Create an annual forecast for Mi Via costs for at least five future years to better inform the Legislature of long-term funding needs as part of the budget process including:

Tracking negotiated rates for services and use this data to inform the budget and planning process.

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

Various states have found ways to manage costs and address waiting lists in their waivers for people with developmental disabilities.

A 2010 LFC evaluation of the DD Waiver found other states implemented different system or benefit designs which allowed for fair and cost-effective allocation of resources. The evaluation spoke of states operating home- and community-based waivers similar to the DD Waiver and with few or no state-operated facilities. LFC staff surveyed these states and Alaska, Nebraska, Virginia, and Vermont provided responses. The evaluation summarized some of these states' practices, which included:

- A standard assessment tool used to determine need;
- Standards for case management requiring fewer visits; and
- Three of the four respondents not paying for family living services.

At the time of the 2010 evaluation, DDSD did not have a standard assessment tool, and after using a standard tool for a few years, the tool was replaced with a person-centered model for determining service need which remains in place to this day. This is further discussed in a subsequent chapter of this report. Also, different from the majority of responding states, the DD Waiver pays for family living services, costing an average of \$36 thousand per client in FY17 and serving 1,618 clients.

Additionally, in LFC's FY19 Appropriation Recommendations (Volume 2), staff encouraged DOH to leverage higher federal match for Native American clients referred through Indian Health Services, which does not currently occur. While there are administrative requirements to leverage this higher FMAP, it is something DOH and HSD should continue to pursue. In light of increasing costs for both the DD and Mi Via Waivers, it is worthwhile to look again at how other states are more effectively managing costs while serving the needs of the developmentally disabled population.

States with lower waiver costs appear to offer fewer or more limited services than New Mexico. Among the 12 states that do not have institutions for individuals with developmental disabilities and serve participants through home- and community-based services (HCBS) waivers, New Mexico ranked in the middle in cost per client at roughly \$61 thousand in 2014. This is the most recent year for which the Centers for Medicare and Medicaid Services (CMS) has public cost data for all states. The District of Columbia had the highest cost per client at over \$102 thousand, while Oregon had by far the lowest at just over \$6,500 due to moving many of its services onto its Medicaid state plan, as discussed later in this section. Appendix C compares these 2014 costs with the array of services offered under current waivers. Rhode Island and Vermont do not have institutions, but also do not have HCBS waivers, instead offering many services to participants with intellectual or developmental disabilities through universal Medicaid demonstration waivers (1115 waivers).

Person-Centered models are directed by the individual or family and are intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual.

Several states do not offer therapy services, including physical therapy, occupational therapy, and speech and language therapy, under their waivers, or do so under a significantly different structure. Alaska, Minnesota, Michigan, and Oregon offer therapy services through their state Medicaid plans, as does Hawaii, although Hawaii offers therapy consultation to waiver participant caregivers that can inform the actual therapy treatment the client receives through other funding means. Alaska, Michigan, and Oregon also omit behavioral supports from their waivers, while New Hampshire bundles these with other therapy services under the umbrella of “specialty services,” and Hawaii again offers behavioral consultation only for caregivers.

Four states offer participant-directed services alongside more managed services in their DD waivers, unlike New Mexico, where these are provided through the separate Mi Via Waiver. These states vary in the degree to which participant-directed services are available. For example, Minnesota’s DD Waiver allows participant direction for a wide range of services under the umbrella of “Consumer-Directed Community Supports,” but requires an annual assessment to both remain on the waiver and consumer-directed benefits. West Virginia requires the use of participant-directed goods and services to be based on a documented need and pre-approved by the state’s utilization management contractor. Any changes to waiver services would require CMS approval.

Unlike other states, DDS does not review cost effectiveness of services nor analyze service needs and utilization patterns of high-cost clients.

For its DD services, Vermont monitors various activities to ensure fiscal integrity including having a committee review process for new and additional services for clients, quality and cost effectiveness reviews for services and supports, and bi-annual reviews of high-cost budgets. A full list of Vermont’s fiscal integrity protocols is located in Appendix D. While DDS performs some similar oversight functions including an annual needs review for waiver clients, and delivers technical assistance for providers of waiver services, the division could do more to identify cost drivers and financial risks to the DD and Mi Via Waivers.

DDS could do more to identify cost drivers and financial risks to the DD and Mi Via Waivers

The Affordable Care Act offers options for increased federal funding of home and community-based services like those offered under the DD and Mi Via Waivers. Five states (California, Maryland, Montana, Oregon, and Texas) have leveraged an available option under the Affordable Care Act (ACA) known as Community First Choice (CFC). Under CFC, states can provide home- and community-based attendant services and supports to eligible Medicaid enrollees under their state Medicaid plan. States participating in CFC execute a state plan amendment requiring approval from CMS in order to receive an additional 6 percent in federal matching dollars for eligible services. For New Mexico, this would mean a composite FMAP of 77.85 percent, based on HSD’s FY18 Medicaid projection, for CFC-designated services offered to DD clients. To qualify for CFC services, a person must be eligible for an institutional level of care, similar to the ICF level of care for the DD Waivers, or meet general Medicaid and financial eligibility of no more than 150 percent of the Federal Poverty Level. States participating in the CFC option also require the client maintain eligibility and access one waiver service monthly under the state’s 1915(c) waiver for DD services.

The states use one or a combination of service delivery models including agency-based, self-directed, or a hybrid of agency and self-direction. All CFC states offer services as defined by the ACA to assist with activities of daily living (ADLs) such as dressing and toileting, instrumental activities of daily living (IADLs) such as cleaning, maintaining a home and managing money, and health-related tasks through hands-on assistance, supervision or cueing. The plans also include services related to acquiring and maintaining skills related to ADLs, IADLs, and health-related tasks, as well as personal emergency response systems, and access to support planning services. These services most closely relate to waiver services such as supported living, customized in-home supports, and case management under the DD Waiver and direct support services, in-home supports, and consultant services under Mi Via. As living supports, such as supported living and in-home supports, constitute the majority of total costs for the DD and Mi Via Waivers, the increased federal match available under CFC could be an option to defray costs and increase DDSD's ability to reduce the waiting list for waiver services. New Mexico previously expressed interest in CFC, but has not executed an application.

While many states assign a priority to individuals on their DD Waiver waiting list based on urgency of need, New Mexico does not, potentially leading to worse outcomes and increased costs.

The National Association of State Directors of Developmental Disabilities Services (NASDDDS) contacted for a survey of 21 states to examine DD and home and community based services (HCBS) waivers. All of the 21 states included in the survey determine eligibility for DD services before the person is placed on a waiting list. While New Mexico determines whether a person meets the definition of developmental disability prior to placement on the waitlist, it does not determine medical and financial eligibility for Medicaid waiver services until the person comes up for allocation. This may artificially inflate the waitlist, leading to inaccurate projections of how many people need services as well as the total cost of services for those in need.

Furthermore, 19 of the 21 states surveyed have an emergency prioritization for those enrolled in the waitlist. Emergency prioritization is generally defined as loss or incapacitation of a caregiver or when the individual is subject to abuse, neglect or exploitation or is homeless. Each of the 21 states also created priority categories for people on the waiting list so those who had the highest need for services received services first. Prioritization may be based on the acuity of a person's condition, the amount of time in which they expect to need services, or some combination of these. An individual's place on the waitlist is determined by both their priority category as well as time on the waitlist. Of those on the waiting lists, 88 percent were receiving other Medicaid services. By ensuring the majority of individuals on the waitlist were receiving services, it may decrease the likelihood a condition may worsen while on the waiting list.

Currently, New Mexico does not have prioritization categories for those on the waiting list apart from those requiring expedited allocation. Expedited allocations occur only at the discretion of DDSD based on criteria listed in Table 5. If individuals were prioritized based on the urgency of need for services, it is more likely those needing immediate services would receive care more quickly.

Table 5. DDSD Criteria for Expedited Allocation

- A person may qualify for consideration of expedited allocation if they are on the Central Registry, has been determined to have a developmental disability, and either:
- A) There is a substantiated allegation of abuse, neglect, or exploitation of the person;
 - B) The person's primary caregiver is no longer able to provide continued care and an alternate primary caregiver is unavailable; **or**
 - C) The person was most recently on a civil DD commitment and continues to need DD services to ensure health and safety.
- And:**
- D) Current available resources are inadequate to maintain and/or assure the health and safety of the individual.

Source: DDSD

Recommendations

The Department of Health should:

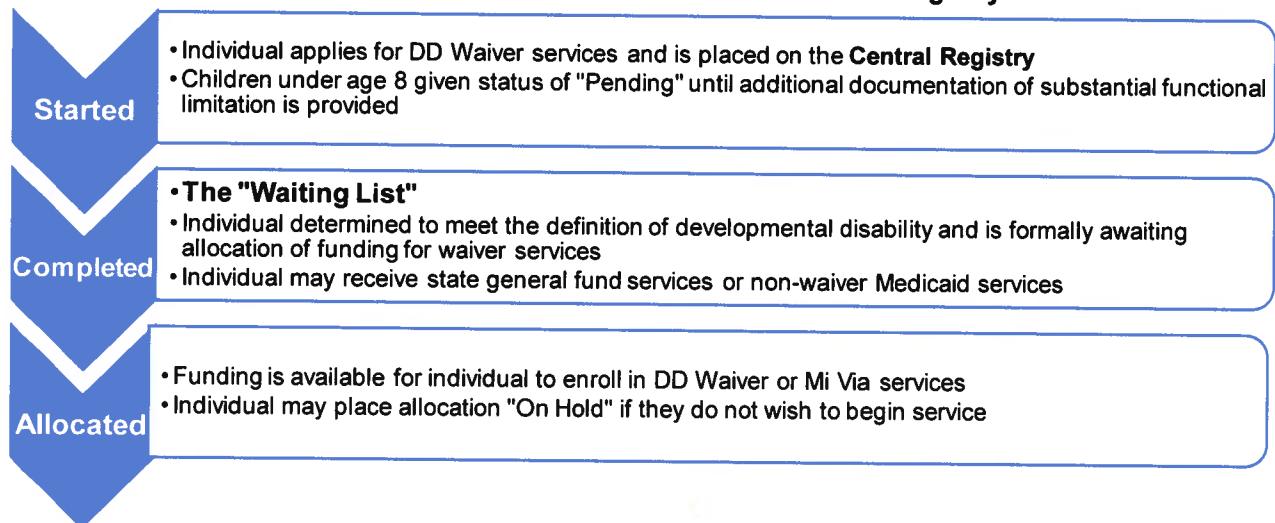
- Model other state cost containment practices specifically around living and community-based supports;
- Perform a more intensive in-home assessment annually for highest cost DD and Mi Via Waiver clients;
- Analyze the feasibility of instituting the Community First Choice option under the ACA to leverage an additional 6 percent federal match for home- and community-based attendant and support services; and
- Institute an assessment for those on the waiting list to prioritize funding based on urgency of need for DD and Mi Via Waiver applicants.

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

DDSD is taking steps to manage increases in the number of individuals waiting for DD waiver services, but its growth still outpaces enrollment.

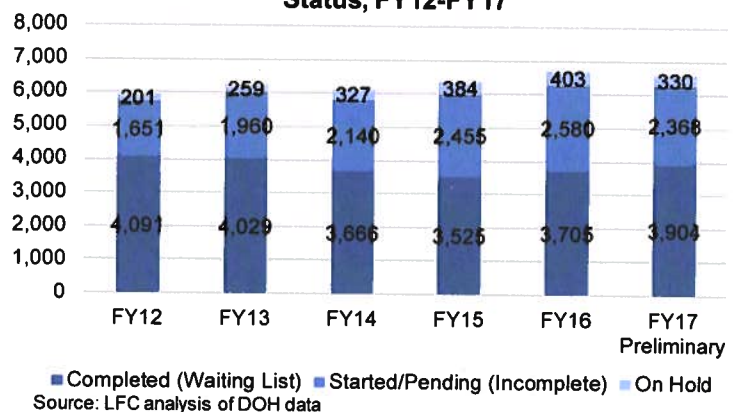
Individuals who apply for DD Waiver services are placed on the DDSD Central Registry, a compiled database of all applicants who have not yet been allocated funding for services. When a person is determined to meet the definition of developmental disability and has completed the registration process, the individual is considered to be awaiting allocation, or “on the waiting list” for services. The waiting list is a subset of the larger Central Registry of everyone who has applied for services. This process is illustrated in Figure 3.

Figure 3. Flow of Individuals on DDSD Central Registry



As of the end of FY17, there were approximately 6,600 total individuals on the Central Registry including about 3,900 individuals with completed registrations awaiting allocation. While the number of individuals on the Central Registry has grown by 11 percent since FY12, the number awaiting allocation is 5 percent lower than in that year, although it has grown by roughly 5 percent in each of the past two fiscal years (Chart 28). According to DOH, the average amount of time a person has been on the waiting list as of FY17 is 10.7 years.

Chart 28. Applicants for DD Waiver Services by Status, FY12-FY17



Individuals on the waiting list may receive certain services funded by state general fund revenues or Medicaid, but these are more limited than waiver-funded services. DDSD offers a range of state general fund (SGF) services to individuals who have completed a registration for waiver services and are awaiting allocation. For adults, these include day habilitation, residential services (including supported living and independent living), supported employment, and behavioral supports. Respite is available for both

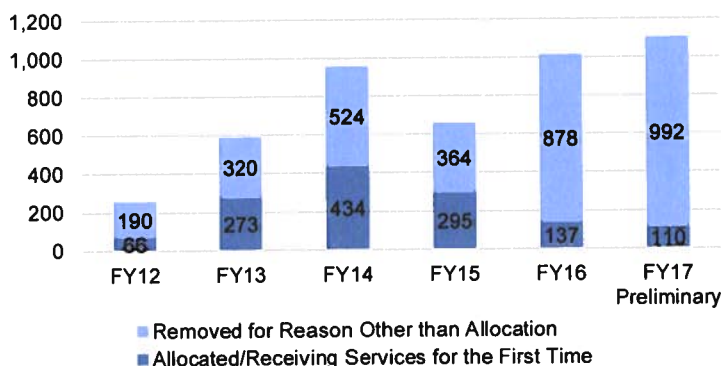
children and adults, but therapies and other waiver-funded services are not included under the SGF program. For certain services, such as day habilitation and supported employment, clients may access SGF services after they have exhausted alternative sources of funding, such as the Division of Vocational Rehabilitation. Since FY12, the amount DDS has spent on SGF services has decreased by 21 percent, from \$7.1 million to \$5.6 million. In FY17, approximately 350 individuals received non-respite SGF services for adults.

Individuals on the waiting list may also use traditional Medicaid for regular physical and behavioral health services or long-term care services. However, these services are not directly comparable to those available under the waiver, as federal regulations prohibit waiver services from duplicating services available under the Medicaid State Plan. For example, New Mexico’s State Plan limits physical and occupational therapy to acute and temporary conditions, whereas therapies provided under the waiver are geared toward long-term maintenance and community integration purposes. While HSD provides client-level data to DDS that includes the Centennial Care enrollment status of clients on the Central Registry, DDS does not track the number of individuals on the waiting list enrolled in Medicaid except through a survey included as part of its annual Central Registry report. According to data from HSD, approximately 65 percent of clients on the Central Registry were enrolled in Centennial Care at the end of FY17.

Reductions in the number of applicants on the Central Registry are mostly due to DDS reducing the backlog of ineligible and incomplete registrations. DDS periodically removes individuals from the Central Registry for a variety of reasons, including not meeting clinical criteria for DD

Waiver services, not completing a registration, or because the individual could not be contacted or requested their registration be closed. In FY16, in an effort to more accurately assess demand for services, DDS’s Intake and Eligibility Bureau began addressing a backlog of older applications and found many either did not meet the clinical definition of eligibility or had not completed the registration process. DDS removed 878 individuals from the Central Registry for these reasons in FY16 and 992 individuals in FY17. By comparison, 137 individuals in FY16 and 110 individuals in FY17 left the waiting list because they began receiving services (Chart 29).

Chart 29. Individuals Leaving the DDS Central Registry, FY12-FY17

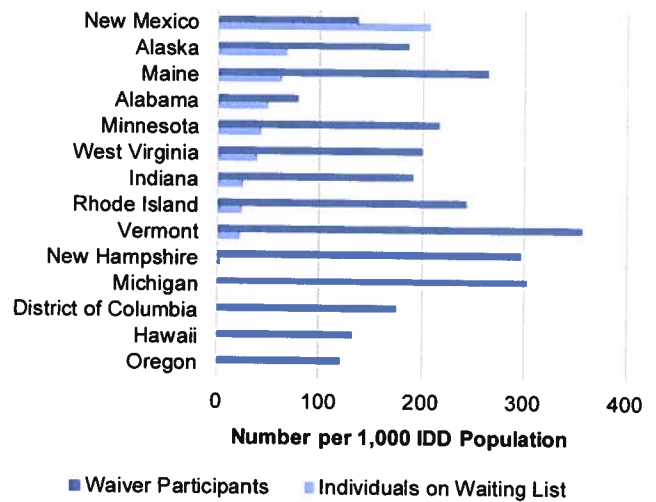


Source: DOH

Meanwhile, an average of 857 individuals started an application for DD Waiver services annually during the same period. In FY17, 933 new individuals started an application and were added to the Central Registry. While this is less than the number of individuals removed for reasons other than allocation, it remains to be seen how many of these new sign-ups do not ultimately complete their registrations, as DDS does not report on cohorts of individuals who sign up in a given year. Tracking applications and registrations in this manner would permit both DDS and stakeholders, including providers, case managers, HSD, and the Legislature to have a more accurate picture of demand for waiver services.

Out of all states without DD institutions, New Mexico is the only state where the rate of individuals waiting for DD waiver services exceeds the rate of those receiving services. In 2015, the most recent year for which data is available for all states, there were an estimated 30,687 New Mexicans with an intellectual or developmental disability, about 1.5 percent of the state’s total population. For every 1,000 individuals with an intellectual or developmental disability in New Mexico, roughly 138 were receiving Medicaid home- and community-based waiver services in 2015, while 207 were waiting for such services. In all of the other 13 states without institutions, the rate of the population receiving services was greater than those waiting. However, the other states offered fewer or more limited services (see Appendix C). Alaska had the next highest rate of individuals on its waiting list, at about 68 individuals per 1,000 with developmental disabilities. Vermont served the highest rate of individuals through its programs, at a rate of 357 individuals served per 1,000 with developmental disabilities (Chart 30).

Chart 30. Rate of Waiver Participants and Individuals on Waiting List in States Without Institutions, 2015



Note: Four states (DC, HI, MI, and OR) do not have a waiting list
 Source: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration; LFC analysis

Removing people from the waiting list for DD Waiver services requires better planning of required resources to avoid budget shortfalls.

DDSD planned to use 15 percent of a \$2 million appropriation the Legislature made in 2018 to reduce the waiting list, but now expects to be able use more of these funds in FY19. The Legislature designated \$2 million in the 2018 General Appropriation Act to reduce the total number of individuals awaiting DD Waiver services. While DDSD plans to use these funds to reduce the waitlist by 80 people, it was going to leave \$1.7 million unused in FY19, according to HSD Medicaid projections. DDSD now expects approximately 24 new clients to be receiving waiver services by August 2018, much sooner than the original estimated entry date. HSD plans to revise the Medicaid projection to reflect this faster uptake rate into the waivers. However, it is worth noting holding back unused funds for new allocations could still make them available to cover previous year shortfalls and other costs, which was not the legislative intent of these funds.

In its April 2018 Medicaid projections, HSD noted costs for the 80 new waiver clients, considering historical enrollment patterns and first year budget utilization rates, would total almost \$300 thousand with an average state share per client of \$3,750 the first year of allocation, based on a first year budget of \$12,500. Once clients receive services for a full year, usually by year two or year three of waiver enrollment, DDSD anticipates an average annual state share of approximately \$25 thousand for the 80 clients with an average client budget of \$83 thousand, which would then fully utilize the \$2 million appropriation. However, based on 2017 data on client budget distribution, DDSD may be underestimating the cost of these additional 80 waiver recipients by as much as \$600 thousand annually once clients are fully accessing services, assuming all clients remain on the DD Waiver.

Table 6. General Fund Cost Estimates for Reducing the DD Waiver Service Waitlist

(dollars in thousands)

Number of Clients Removed from Waitlist	Estimated First Waiver Year Costs	Second Waiver Year Costs
50	\$187.0	\$1,635.5
100	\$375.0	\$3,270.9
200	\$750.0	\$6,541.8
500	\$1,875.0	\$16,354.5
1000	\$3,750.0	\$32,709.0
4000	\$15,000.0	\$130,836.0

Note: First year cost estimates based on GF cost of \$3,750 per client used in April 2018 Medicaid Projections. Full service cost assessed using distribution of 2017 DD Waiver client budgets.

Source: LFC Analysis of HSD Data

Once a waiver client reaches the top of the waitlist and receives an allocation, there is a lengthy process for assessing need and obtaining services. In many cases, a client does not receive services until the final quarter of the fiscal year in which the person is allocated funding. That said, any plan for reducing the size of the waitlist would need to anticipate a sharp increase for the first two full years of waiver services before some budget stability could be attained, not accounting for changes in quantity of needed services in these years. If DDSD allocated the full \$2 million appropriated for new slots in FY19, approximately 533 people, or 14 percent of the 3,900 waitlisted as of the end of FY17, could start to receive waiver services. However, based on data HSD provided on how client budgets are distributed from less than \$25 thousand to greater than \$200 thousand, and conservatively assuming clients are using all allocated budget dollars, the state would need to provide \$17 million to fund these clients for the first full year of waiver services.

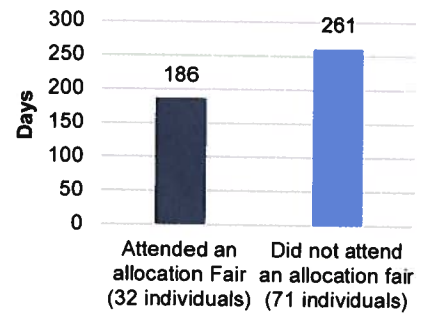
LFC staff analyzed additional scenarios of how to reduce the size of the waitlist while balancing additional funding requirements in subsequent years for newly allocated clients as shown in Table 6. With this data, it is clear DDSD needs to craft a plan for reducing the waitlist by larger amounts than it currently is annually. Additionally, commitment from the Legislature is needed to provide required funding to not only reduce the waitlist, but also continue to serve the new clients into the future. While general fund revenues can be volatile at times, careful long-term planning can help the state address the length waitlist for waiver services.

It is important to note reducing the waiting list would require increased general fund dollars for state matching funds for these additional clients beyond the first year of allocation. For example, if the Legislature wanted to reduce the waitlist by 100 people in FY20, it would require \$375 thousand for 100 first year allocations for FY20, and \$3.2 million to fund these 100 clients for FY21, and so forth for every year these clients were on the waiver.

Additionally, funding new allocations may still result in a net decrease in the number of individuals served if DDSD does not fill waiver slots vacated through attrition. During the period FY12 through FY17, roughly 1,300 individuals began receiving services, compared to total attrition of 537, for an overall net increase in individuals enrolled. This is largely due to a spike in allocations tied to an infusion of funds for this purpose in FY13 through FY15. In FY17, attrition from both the DD and Mi Via waivers totaled 101 individuals, more than the 80 new allocations planned for FY19. Therefore, DDSD should be able to allocate 181 slots in FY19. Any plan for reducing the waiting list must take into account availability of slots due to attrition, maintaining the funding for vacated slots, and funding for new slots.

Allocation fairs may be one way to shorten the time between allocation and start of services. According to DDS, it takes at least six months for individuals to enter into services, creating issues with efficiently spending funds for new allocations. In FY17, DDS piloted allocation fairs in each region of the state for individuals who would become eligible to begin services. Of the 103 individuals receiving a new allocation in FY17, about 30 percent (32 people) attended an allocation fair. During the fairs, DDS staff explained the allocation process, including what needs to be completed to determine eligibility before services can start under the waiver. Those who came to a fair took an average of 186 days from the time they received their letter of introduction to the completion of their individual service plan. This was 75 days, or about two and a half months, less than those who did not attend an allocation fair (Chart 29). Additional methods for helping families and individuals navigate the eligibility process should be examined, but the allocation fair should be continued as slots for the waiver become available.

Chart 29. Time from Allocation to Receipt of Waiver Services, FY17



Source: DOH

Infrastructure issues such as provider capacity and turnover must be examined to determine if the system can absorb additional participants.

Many counties in New Mexico have limited availability of DD Waiver services, potentially leading clients to switch to Mi Via. Currently in the state, three of the eight highest cost DD Waiver services are unavailable in more than 50 percent of the counties. These services include intensive medical living supports, occupational therapy and physical therapy. Additionally for these services, there is only an average of one provider serving each county, effectively removing choice for many individuals living outside of the Rio Grande corridor. Two of the three available therapies have few providers, and the third, speech therapy, has capacity issues with most counties only served by two speech therapists. Appendix E contains a table listing the number of providers of these services in each county.

In urban counties, there are providers for each service, although it is unclear if the number of providers is sufficient to serve the client population. Services are particularly sparse in rural counties such as Colfax, Quay and Union counties, with few therapists serving these counties, and still fewer providers for services such as intensive medical living supports. For example, there are 21 counties unserved by a provider of intensive medical living supports, and these counties are mostly outside the Rio Grande corridor. However, it should be noted this analysis focused only on provider availability and did not examine the number of clients in each county needing specific services. DDS and the New Mexico Healthcare Workforce Committee should work together to determine provider adequacy across the different services provided under the DD and Mi Via Waivers.

In places where there are few approved DD Waiver providers, it may lead clients to switch to Mi Via as Mi Via allows for the client to receive services from providers or individuals who have not formally signed a provider agreement with DOH. For example, this would allow a family member to provide needed living or community supports. This has implications for the quality of services due to the limited oversight of Mi Via providers, as well as the potential to further disincentivize providers from participating in the traditional DD Waiver where services may otherwise be unavailable. The state offers incentive rates for certain services in most rural counties in an effort to

attract and retain providers in these areas intended to defray certain costs incurred by providers that may not otherwise be compensated, such as transportation to client locations across long distances. However, as discussed below, how these rates are structured may impact the capacity of the system with respect to certain services in certain areas.

Disparities in rates for similar services in the DD Waiver and Mi Via could create system adequacy issues. While Mi Via fosters more independence through its self-directed model, it has many similar services to the DD Waiver. However, rates for these services can differ significantly as shown in Table 7. Most notable is how high the Mi Via rate ranges are for services such as in-home living supports, and customized community group supports. This would certainly induce providers to serve Mi Via clients.

Table 7. Service Rates for Similar Services in the DD Waiver and Mi Via

DD Waiver			Mi Via		
Service Name	Service Unit	Rate	MV Service Name	Service Unit	Rate Range
Case Management	Monthly	\$249.91	Consultant Services	Monthly	\$215.00
Customized In-Home Supports	Monthly	\$2,535.17	In-Home Living Supports	Day	\$25.00-\$131.50 (\$750-\$3,945 monthly based on 30-day month)
Customized Community Supports- Group	15 minutes	\$2.63 for lowest acuity	Customized Community Group Supports	15 minutes	\$1.36-\$8.82
Occupational Therapy- Incentive	15 minutes	\$28.63	Occupational Therapy	15 minutes	\$12.74-23.71
Physical Therapy- Incentive	15 minutes	\$28.63	Physical Therapy	15 minutes	\$13.51-\$24.22
Speech Therapy- Incentive	15 minutes	\$28.63	Speech/Language Pathology	15 minutes	\$16.06-\$24.22
Behavior Support Consultation- Incentive	15 minutes	\$23.20	Behavior Support Consultation	15 minutes	\$12.24-\$20.65

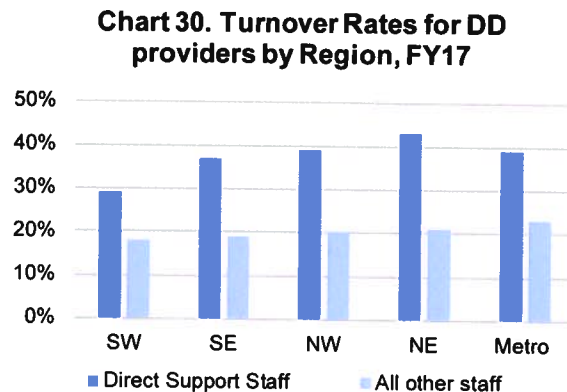
Source: LFC Analysis of DOH Data

On the other hand, therapy service rates are higher on the DD Waiver than Mi Via in some cases. There is a separate incentive rate paid for providers in certain hard-to-serve geographic areas in the DD Waiver (a full list of incentive counties is included in Appendix F). Mi Via does not offer this type of incentive, however rates ranges are universally applicable to all providers statewide, implying incentives for hard-to-serve regions are built into the range. Lower rates for therapies through Mi Via could be contributing to decreasing utilization that was discussed in a previous chapter.

A contracted rate study for the DD and Mi Via Waivers is currently underway with the final report expected in 2019. DDS D needs to consider long-term implications of how rate setting will impact client movement between waivers, the ability to obtain services, and the impact of rate changes on long-term financing requirements for both waivers.

DDS D could estimate provider staffing needs by leveraging the database it uses to track employee training. DOH currently pays \$111.6 thousand annually to the University of New Mexico Center on Development and Disability (UNM CDD) for a database to track provider staff through all required trainings. This database was developed as a result of training requirements implemented due to the Jackson lawsuit. Because the database has the ability to track trainings for all new and ongoing provider staff, it can also be used as a proxy tool to analyze staff turnover. This may allow DDS D to determine if an agency is facing higher than average turnover as well as to highlight providers with potential staffing issues.

LFC staff requested UNM CDD analyze this data to estimate direct service worker turnover by region. Based on this analysis, the turnover rate for direct service workers at DD Waiver providers statewide was 38 percent in FY17, 17 percentage points higher than the turnover rate for all waiver provider staff. These rates vary by region with average turnover rates ranging from 43 percent in the northeast to 29 percent in the southeast (Chart 30).



Source: UNM CDD

New Mexico’s turnover rate is lower than the national rate of approximately 45 percent per year for direct service providers, according to the 2016 National Core Indicators Staff Stability Report. Nationally, other home health aides have a turnover rate between 50 and 60 percent. Since turnover rates are high among other home health aides and among developmental disability direct care staff, it is essential to determine effective strategies in retaining staff in these positions. States with lower than average turnover rates tend to have higher average wages, are more likely to provide additional benefits and use retention strategies such as supporting staff to get credentialed or have a ladder to reward highly skilled workers. High staff turnover rates may impact providers as they need to train new staff, and national research highlights the negative impact on clients as clients need to create a new relationship with a new caregiver.

Recommendations

The Department of Health, in consultation with the Legislative Finance Committee and Legislative Health and Human Services Committee, should:

- 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 waitlist will be reduced in the five-year plan.

The Department of Health should also:

- 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;
- Review how rates for Mi Via and the DD Waiver impact utilization and adjust rates as appropriate to consider provider supply in hard-to-serve areas;

-
- Partner with the New Mexico Healthcare Workforce Committee to determine provider adequacy across the different services provided under the DD and Mi Via Waivers;
 - Analyze how Mi Via rates may be contributing to low therapy utilization, institute a separate incentive rate for therapists in medically underserved counties, and readjust rate ranges for therapy services to better align with DD Waiver therapy rates; and
 - Work with UNM CDD to leverage the provider staff training database to regularly analyze provider turnover and identify areas of greatest staffing needs.

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

Over the last 10 years, DDS has had three different assessment and budget allocation tools for people on the DD waiver.

The process used to determine client need and budget allocation is important, as it directly defines the services a client may receive and the amount of money a client will have for these services. Using reliable and valid assessment and allocation tools help to improve the confidence that individuals receive the services they need.

Prior to FY13, DDS used the Level of Care assessment as its primary assessment and budget allocation tool. The Level of Care tool separated individuals on the waiver into one of three categories with most individuals in the higher two levels of care. However, many other states were moving towards using more advanced assessment tools, such as the Supports Intensity Scale (SIS). The SIS is a nationally validated tool to determine client need based on a comprehensive array of support factors, but it is quite long and requires the involvement of individuals who are able to provide the client with natural supports.

DDS adopted the SIS tool in 2012 with the goal of improving client assessment and resource allocation. However, there were challenges with the state's implementation of the SIS, leading to reductions in services for some clients, without a clear path to appeal these reductions. This led to the filing of the Waldrop lawsuit in 2014, and its subsequent settlement in 2015. The litigation, brought by Disability Rights New Mexico (DRNM), the Arc of New Mexico, and a group of affected DD Waiver participants and their guardians, centered on the due process rights of participants whose services had been reduced due to the state's overreliance on SIS scores and categorizations to determine service levels and budget allocations.

In New Mexico, DOH used the SIS along with some supplemental questions as the main tool for determining allocation. The American Association on Intellectual and Developmental Disabilities (AAIDD), who developed the SIS, recommends using the SIS as part of the resource allocation process, but cautions against using only the SIS for resource allocation. The AAIDD specifically states there are various factors the SIS does not measure, which can have a significant impact on resource consumption.

Although the Waldrop settlement did not require the state to stop using the SIS, DDS chose to discontinue its use due to numerous concerns raised by stakeholders. In 2015, New Mexico's DD Waiver program implemented the Outside Review (OR) to review client needs and determine whether a client budget is appropriate to address those needs. UNM's Continuum of Care currently administers the OR under an annual contract with DDS for \$1.4 million, with a total cost of \$4.2 million for FY16-FY18.

The intent of the OR is to review client's individual service plans (ISPs) and budgets to determine if the services requested meet clinical criteria and are

justified based on the person’s need, demonstrated by the clinical justification of the team. To assist with the budget allocation process, the OR specifies different clinical acuity levels with corresponding suggested budget amounts and includes rates for each level of service (see Chapters on the costs of DD and Mi Via Waivers). However, the OR has no standardized set of criteria for assessment or budget allocation. Currently, the OR examines participants’ ISPs against a set of clinical criteria to develop individual budgets based on the frequency and intensity of needed services. Materials reviewed by the OR may contain a person-centered assessment as well as other clinical documentation, including the interdisciplinary team (IDT) meeting minutes.

DOH lacks a valid and reliable assessment and budget allocation tool and process to determine services for people on the DD waiver.

The OR focuses on client ISPs and uses IDT meetings to justify services: consequently, the clinical justification varies from person to person. The lack of a standardized tool in this process can lead to each client’s review being different as each client’s ISP and person-centered assessment may be different. If clients do not have similar justification criteria, people with similar needs may receive different levels of services.

DDSD and UNM Continuum of Care have not tested the OR to determine if it is a valid process. Therefore, it is unknown if individuals are receiving the appropriate level of services for their need.

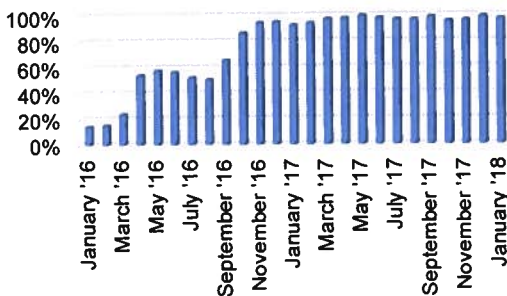
UNM Continuum of Care initially implemented the Outside Review poorly. Specifically, UNM Continuum of Care initially did not complete the majority of client budget reviews timely, in part due to incomplete or inadequate documentation. Additionally, the OR still has a high number of

requests for additional information, potentially delaying the budget approval process. The OR took almost one year to complete more than 80 percent of clinical assessments or budget determinations on time (Chart 31). DDSD and the OR are currently on their fourth version of clinical review and clinical service criteria over the last two years. The most recent service criteria change did not change clinical criteria but affected technical aspects of the process such as the timeframe for review and maximum units allowed for different services.

Frequent changes to service criteria may lead to confusion among providers as well as OR staff. Stakeholders interviewed by LFC staff suggested increased collaboration between OR staff, providers, and DDSD may lead to a more effective process in client clinical reviews. The most recent version of clinical review criteria became effective on March 1, 2018 and extends the length of time a clinical review is valid from 1 year to 3 years as long as there are no changes in client need. The new criteria also increases the number of services that do not require a review. While this change may lead to a more efficient process for stable clients by having fewer reviews and less paperwork, it may also increase the potential for unnecessary additional services and cost.

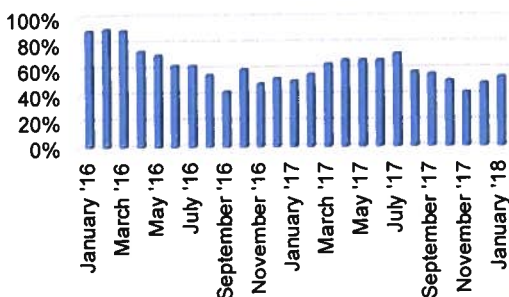
DDSD and OR staff are working together to determine how to reduce the number of requests for information during the review

Chart 31. Percent of Reviews Turned Around on Time



Source: UNM Continuum of Care

Chart 32. Percent of Reviews Resulting in Request for Information



Source: UNM Continuum of Care

process. While the number of requests for additional information decreased from 90 percent in the first few months of the OR to just above 50 percent in late 2017 and early 2018, the majority of reviews still need more information to be completed (Chart 32). Requests for information may slow down services for people on the DD waiver as the OR must approve services before clients can begin receiving these services unless the services are for crisis management.

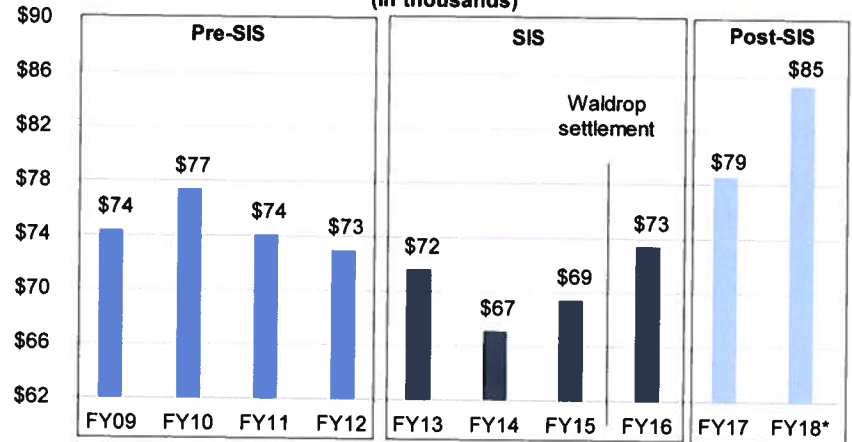
Lack of a strong assessment and budget allocation tool may contribute to higher than necessary costs.

Ending the use of an evidence-based tool may have contributed to increasing costs. DDS D began using the SIS in November 2012, partially as a mechanism to more consistently predict and control client service costs. That fiscal year, the average cost per client on the DD Waiver was roughly \$72 thousand. Client expenditure data was examined as budget allocation information was not provided from FY09-FY17, and when both budget and expenditure data was reviewed for a subset of years, clients spent 90 percent to 93 percent of their total budget allocation. In FY14, the first full fiscal year in which DDS D used the SIS to determine DD waiver client support needs, average annual cost per client was around \$67 thousand, \$4.5 thousand, or 7 percent, less than the average client budget in FY13. Costs per client grew at roughly 4 percent per year in FY15 and FY16, while the SIS was in effect, and then by 7 percent between FY16 and FY17. That year, approximately one year after the discontinuation of the SIS assessment, average annual cost per client went up by approximately \$5 thousand to \$79 thousand, growth of 7 percent (Chart 33).

From FY17 to FY18, costs are projected to continue to increase \$7 thousand, a growth of 9 percent. It should be noted the cost changes cannot be solely attributed to changes in assessments, as costs started decreasing in FY11, before introduction of the SIS when DDS D reduced all provider rates by 5 percent and the annual resource allotments by 8 percent. Other potential reasons for the cost decrease from FY10 through FY14 include provider capacity, client attrition and changes in client acuity. In examining the distribution of budgets before and after SIS implementation, they are fairly similar. However in FY12, the second most frequent budget range was from \$5 thousand to \$50 thousand, while in FY17 it was from \$100 thousand to \$150 thousand (see Charts 34 and 35). This change could be due to the assessment changes or the additional factors listed above.

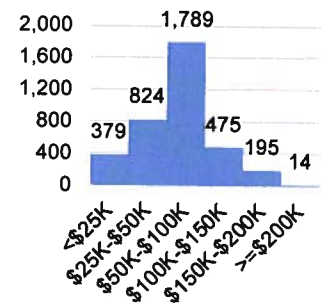
The implementation of the SIS resulted in DOH and HSD incurring costs to train staff and providers on the administration of the tool. The state contracted with AAIDD, which created the test, to conduct these trainings in New Mexico. The total SIS cost to New Mexico from FY11-FY16 was \$6.3 million, which included training and implementation costs.

Chart 33. Average Annual Cost DD Waiver Per Client (in thousands)



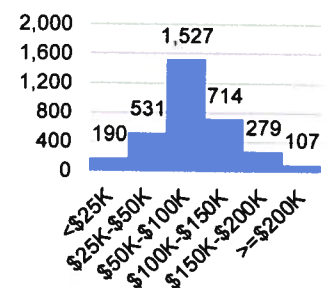
Source: DOH Files and CMS 372; Note: In FY13 and FY16 the SIS was used for part of the year. In FY16, DOH started to implement changes due to Waldrop; FY18 data based on HSD's April 2018 Medicaid projections.

Chart 34. DD Waiver Approved Client Budgets FY12 (N=3,676)



Source: HSD

Chart 35. DD Waiver Approved Client Budgets FY17 (N=3,348)



Source: HSD

The majority of non-institution states use an evidence based assessment to determine service need for people with intellectual and developmental disabilities.

Out of the 11 other states without institutions operating a 1915(c) waiver, seven use an evidence based assessment to determine need. Of the four that do not use an evidence based tool, two use a state created and validated tool, and two did not have an assessment with validation information available.

When examining all states nationally, similar trends are found. Some states such as Florida and North Carolina created their own tool and then published research on its validity, while others use tools, such as the SIS, which was validated independently. The SIS has the most research showing its reliability as both a tool for determining client need as well as budget allocation. Almost 20 states and Canadian provinces use the SIS to assess client need. This tool however may not be the best to use in New Mexico due to its previous implementation issues. If DOH decides to return to a standardized evidence based tool, they may need to use an assessment that does not have as much research as the SIS.

The Questionnaire for Situational Information (QSI) is an assessment developed and used in Florida to determine DD Waiver client need. Florida tested the tool for reliability and as of 2015 used the results of the assessment as part of an allocation algorithm to determine client budget amount.

North Carolina uses the North Carolina Support Needs Assessment Profile (NC-SNAP) for assessment of client need and resource allocation; however, North Carolina now uses both the SIS and the NC-SNAP on a county-by-county basis to assess client need. The NC-SNAP requires a certified examiner to administer the assessment. DOH should research other assessment tools if it determines to re-institute an evidence-based standardized assessment.

People on both the DD and Mi Via Waivers currently complete a Level of Care assessment annually to determine if they continue to meet medical eligibility for Waiver services. This level of care assessment is the only assessment used for for people on Mi Via. The Level of Care assessment, determines if a client is level 1, 2, 3 or not eligible for DD Waiver services and has two components, one completed by a nurse or doctor and one completed as an in-home assessment by the third party assessor, if on Mi Via, or the case manager or interdisaplinary team (IDT), if on the traditional DD Waiver. In interviews with LFC staff, providers, case managers, and consultants said the Level of Care might be a viable assessment to use to assist in determining client need. However, as this assessment has not been validated, it is unclear how accurately the assessment determines client need for services or if and how it may need to be adapted to become useful in this regard. Since this is the only assessment completed for Mi Via clients and is also used with DD Waiver clients, DOH should validate the assessment to ensure clients are assessed with a reliable and valid tool to help determine what services clients need.

Out of the 11 other states without institutions operating a 1915(c) waiver, 64 percent use an evidence based assessment to determine need

The Level of Care assessment, used to determine Medicaid medical eligibility, has also not been validated

Recommendations

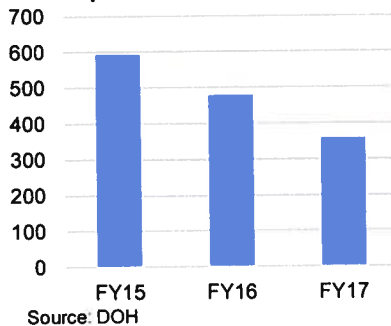
The Department of Health should:

- 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;
- Monitor budget allocation trends over time to ascertain need for increased oversight and validation of client budgets; and
- Validate the level of care assessment and edit the tool to be as clear as possible regarding the differences between each level of care.

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

Two DOH divisions play significant roles in waiver program oversight.

Chart 36. Number of Substantiated Cases of Abuse, Neglect, and Exploitation, FY15-F17

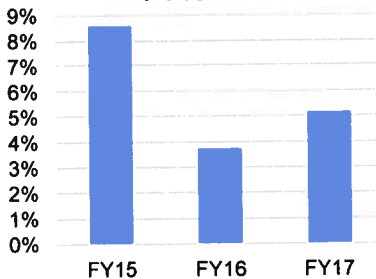


DOH's Division of Health Improvement (DHI) is responsible for assessing waiver provider compliance with state and federal regulations as well as investigating reported cases of abuse, neglect or exploitation for DD and Mi Via Waiver participants. DHI's Incident Management Bureau (IMB) conducts investigations of abuse, neglect, or exploitation of people on the DD or Mi Via waiver. DHI is required to respond to an investigation between 3 hours and 5 days, depending upon the priority level, to complete the investigation within 45 days, and close the case within 62 days. These investigations are similar to those investigations conducted by Adult Protective Services.

DDSD is responsible for promulgating policies and procedures to assist providers, case managers, and Mi Via consultants in implementing high quality services as well as training providers to ensure they have the necessary knowledge to provide these services. DDSD issues standards for both the traditional DD Waiver and Mi Via that include what each provider, client and case manager or consultant is required to do under each program. Generally, Mi Via has less oversight than the traditional DD Waiver.

Program oversight performance varies widely throughout DHI and DDSD.

Chart 37. Percent of Waiver Clients Who Were Victims of Abuse, Neglect, and Exploitation, FY15-F17



Note: Percent calculated by dividing number of consumers abused by number of people enrolled in DD or MV.
Source: DOH

The number of substantiated cases of abuse and neglect decreased from FY15 through FY17. From FY15-FY17, neglect was the most common substantiated type of abuse, neglect, or exploitation case. Of the 359 cases substantiated in FY17, 271 or 72 percent of the cases were substantiated for neglect. Out of the 1,272 cases investigated in FY17, 359 were substantiated, a rate of 28 percent, down substantially from 53 percent in FY16, and 41 percent in FY15. The total number of substantiated cases decreased from FY15 to FY17, from 592 to 359 (Chart 36). In total, 254 DD or Mi Via Waiver clients were victims of abuse, neglect or exploitation in FY17, or 5.15 percent, up from 3.74 percent in FY16 (Chart 37), but down from roughly 9 percent in FY15. The main causes for abuse, neglect and exploitation as identified by IMB were inadequate care plans and supervision or training.

People on Mi Via, unlike those on the traditional DD Waiver, regulate their own services, with little oversight from DOH. The standards specify clients may have an employer of record help them with hiring and paying service providers. While clients also have a consultant who assist the client and employer of record in their responsibilities, the consultants do not regulate client service providers, which is the responsibility of the employer of record, and no one oversees the employer of record. In New Mexico, out of the approximately 1,400 current Mi Via clients, only 42 are their own employer of record. Below is a table of client or employer of record responsibilities under Mi Via (Table 8).

Table 8. Responsibilities of the Mi Via Client 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 needed
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
Request assistance from consultants if necessary

Source: DOH Mi Via Service Standards

DHI and DDSD can improve oversight functions by adhering to best practices.

The Incident Management Bureau (IMB) is not closing cases timely, potentially putting clients and the state at risk. IMB does not complete the majority of abuse, neglect and exploitation investigations within the prescribed 45-day timeframe, potentially leading to loss of direct service staff and liability for the state. When IMB receives a notification of potential abuse, neglect, or exploitation, providers are required to create an immediate action and safety plan that often includes suspending staff until IMB investigates the incident and the case is closed. However, if IMB takes too long to complete and notify the agency of an investigation decision, staff may find a new job so they can continue to earn a living. Additionally, if the state does not close an investigation timely and further harm occurs to the client in question, the state may be liable.

In meetings with provider agencies statewide, almost all mentioned IMB does not close cases timely or adequately communicate the status of cases to providers. In a survey of providers, DHI did not complete investigations on 81 percent of reported cases within the 45-day deadline. This is corroborated by examining IMB data, which shows in FY17 it took an average of 87 days from when the case was received to case closure, an improvement of 33 days from FY16, however still 40 percent beyond the 62-day deadline (Table 9).

Table 9. Average Days from Assignment to Closure and Completion by Year, FY16 & FY17

	Investigations Completed	Cases Closed
FY16	63	120
FY17	54	87

Note: Cases should be completed in 45 and closed in 62 days.
Source: DOH

According to IMB, it increased efficiencies in the investigation process, leading to the improvement between FY16 and FY17, however more work needs to be done. Specifically investigations are completed an average of 9 days, or 20 percent, beyond the 45 day deadline, but cases are closed 25 days, or 40 percent, beyond the 62 day deadline, highlighting the need to reduce the amount of time between a completed investigation and case closure.

Current IMB vacancy rates are similar to the rest of DOH. The state personnel roster for April 2018 showed IMB had a vacancy rate of only 16 percent, lower than DOH or state government as a whole. As of April 2018, of the 37 total FTE for IMB, 31 positions were filled and six were vacant. Adult Protective Services, the division of the Aging and Long Term Services Department which investigates allegations of abuse, neglect, and exploitation for those not on the DD or Mi Via Waivers has 116 FTE, which is roughly three times that of IMB.

Table 10. Regional Differences of Average Caseload per Worker and Percentage of Cases Completed Timely, FY18

Region	Cases Assigned	Average Caseload	Percent Cases Completed On Time
Metro	541	16.5	82.5%
Northeast	41	9	77.3%
Northwest	72	6	83.9%
Southeast	121	13.5	78.6%
Southwest	189	14.3	49.1%

Source: DOH

Potential issues in closing cases may be investigator caseloads or specific regional practices for closing cases. Average caseloads vary by region from six in the Northwest to 16.5 in the Metro region. However, as the Metro and Northwest had the highest and lowest caseloads and both of these regions closed the highest percent of cases on time, it does not seem caseloads are the problem with cases being closed in an untimely manner. However, even with a lower caseload than the Metro region, the Southwest region performed poorest, completing less than half of its investigations within the required 45 days. (Table 10). Due to issues leaving cases open, DOH should determine how

to best allocate resources to IMB based upon which regional offices have the most issues in closing cases timely.

Best practices for self-directed waivers include:

- **Measurement of support quality;**
- **Public Transparency; and**
- **Support available in a crisis.**

DDSD should address gaps in oversight of Mi Via self-directed services to mitigate certain areas of risk. National best practice for self-directed waivers states these waivers should include clear assessments of client need, available training, person-centered planning, and measurement of support quality (Appendix G). New Mexico currently meets at least 10 of the 19 best practices mentioned by the Human Services Research Institute. DOH should consider how to meet additional best practice measures, especially those focused on determination of provider quality and service crisis availability as both of these measures may directly impact client outcomes.

Furthermore, to provide support to clients or employers of record, some states, such as New York, California, and Oregon, have support brokers that provide technical assistance to clients or employers of record regarding financial issues. While consultants can assist with some financial aspects, they frequently do not have a financial background and may not be able to assist with the financial components as easily as support brokers. As it may be difficult to navigate all responsibilities necessary to be an employer of record, the state needs to provide assistance and oversight as well as help clients determine if they may be a good fit for the Mi Via program.

Minnesota currently conducts an assessment to determine whether a client may be a good fit for self-directed services (Appendix H). This assessment does not

limit who can apply for such services, but helps inform potential clients and their teams of the different responsibilities and requirements, allowing them to make a more informed choice. Currently, New Mexico refers clients and employers of record to consultants for technical assistance, but the state does not provide oversight to ensure the employer of record or client completes these responsibilities. A regular audit of a sample of employers of record, similar in nature to DHI's audits of traditional DD Waiver providers and case managers, may help to determine compliance with service standards and ensure the Mi Via Waiver and employer of record are meeting client service needs.

Recommendations

The Department of Health should:

- 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;
- Consider helping potential Mi Via participants examine whether they are well-suited for self-directed services; and
- Audit a sample of employers of record annually to ensure client needs are met.

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

DDSD collects a significant amount of performance data on DD services to monitor the program.

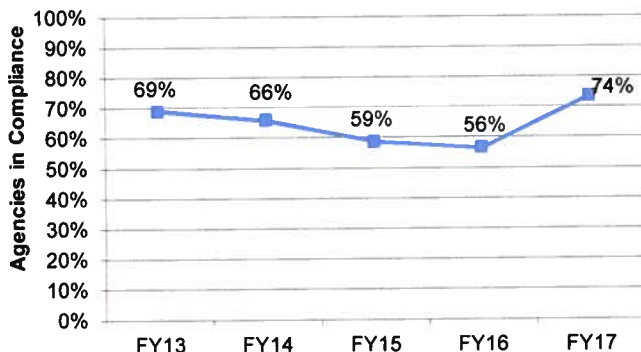
DDSD collects data from many different sources, including a number of DDSD divisions, providers, and DHI to look at various client measures. DDSD combines some of this information to create a composite of current measures called Key Performance Indicators (KPI). Determining outcome-specific information allows DDSD to have a more comprehensive view of how well the waiver serves clients. If clients have strong outcomes, then the state can be confident it provides effective services for the target population. DDSD's Bureau of Systems Improvement (BSI) collects KPI data from providers and examines whether providers meet the target for these performance measures quarterly. The specific measures include those related to training compliance, abuse, neglect, and exploitation (ANE), individual service plan (ISP) implementation, and general events reporting. As shown in Table 11, most of these measures currently reflect that in general provider agencies are meeting DDSD performance targets.

Table 11. Key Performance Indicator Data Collected by DDSD Prior to March 2018

Performance Indicator Measure	FY16	FY17	FY18	Target
Provider compliance rate with DDSD training requirements by service category (including one with nurses, behavioral support consultants, and therapists)	87%	87%	82%	All providers >85%
Abuse, neglect, and exploitation rate per person for people on the waivers	Not included in KPI	6%	5%	Stable within 1% for 3 quarters
Percent of cases investigated substantiated for abuse, neglect, or exploitation	Not included in KPI	42%	22%	N/A
Percent of agencies in compliance with Individual Service Plan implementation	65%	78%	72%	80% or greater
Percent of agencies in compliance with quality assurance or quality improvement plans	68%	81%	81%	80% or greater
Caregivers Criminal History Screening compliance	98%	99%	99%	Rolling average >97%
Employee Abuse Registry compliance	96%	96%	98%	Rolling average >97%
Percent of agencies reporting and analyzing general event reporting	95%	99%	96%	Rolling average >90%

Note: All data are Q1 data, the FY16 ANE rate and percent of cases substantiated was not included in the KPI report provided.
Source: DOH

Chart 38. ISP Implementation Compliance, FY13-FY17



Note: Data presented are the FY average across the 4 quarters.
Source: DOH

One measure that did not meet DDSD's target is compliance with ISP implementation (Chart 38). ISP implementation compliance declined from FY13 through FY16, but improved in FY17, indicating providers may have made needed changes from FY16-FY17. However, additional improvements should be made to ensure providers are delivering the necessary services and ISPs are updated to reflect the current array of services needed for clients.

Best practice for performance management requires aligning the strategic plan and robust performance metrics to monitor success. According to the Urban Institute, strategic planning defines what needs to be measured for an agency to determine if they meet their desired goals. Without

both a strong strategic plan and strong performance metrics, it is difficult to understand the current situation of an agency or division. Integrated strategic planning and performance measurement can set a baseline for results-based budgeting.

A number of national reports focused on the assessment of home and community based services highlight the relative lack of performance measurement regarding client and provider outcomes. These reports state that much of these data are not collected due to the complex nature of person-centered information and while some locations assess quality, many of these assessments happen in silos. Person centered data is difficult to collect as it may oftentimes need to be qualitative and outcomes may need to be individualized to each participant.

Without examination of client and provider outcomes for New Mexico as well as other states, it is difficult to determine if clients are receiving the best services to meet their needs. A report by the Center for Health Care Strategies highlights seven quality performance benchmarks from the Human Services Research Institute (Table 12). One component of these benchmarks is safe services in the least restrictive setting possible that highlights community inclusion.

Table 12. Quality Performance Benchmarks

Individuals have timely access to needed services
Services are provided in the least restrictive setting possible
Services and supports are person-centered and include opportunities for beneficiaries and families to self-manage services
Services support "valued outcomes" such as personal independence, employment and community integration
Sufficient infrastructure is in place to allow ready access to needed services
Services continuously meet essential quality standards
Systems promote economy and efficiency in the delivery of services

Source: Adapted from Enquist et al., 2012

The National Quality Forum 2016 report included recommendations to assist both the federal government as well as state stakeholders to better measure client outcomes. These recommendations for system accountability and oversight include improving current data collection systems to examine more client and provider related outcomes, standardizing measures and looking at data for an individual or provider in a comprehensive way by combining a number of measures to understand the overall effect. DDS, working with providers and other stakeholders should consider adopting some of these recommendations.

DOH’s strategic plan lacks a focus on DD services and agency Accountability in Government Act (AGA) measures.

The DD and Mi Via Waivers are among the largest programs under DOH authority, but the DOH strategic plan contains no priorities or goals exclusively for it. Specifically, when combined with federal funds, DD and Mi Via Waivers are the largest DOH program with a budget of roughly \$400 million, and when looking only at state general fund spending, DDS is the second largest DOH program with a budget of \$103.4 million in FY18. While the budget for the waiver programs is very high, it serves near 5 thousand New Mexicans with intellectual and developmental disabilities. However, DOH’s FY17-FY19 strategic plan contains no priorities or goals specific to this program, nor any performance indicators to track and measure progress. This absence of long-term planning with respect to the DD and Mi Via Waivers and lack of specific performance measures makes it more difficult for DDS to determine what data they should collect or how they should examine data they currently have.

The AGA requires a plan, created in consultation with the division, for monitoring and reviewing an agency's programs to ensure that performance data is maintained and supported by agency records and that performance measures are integrated into the planning and budgeting process and maintained on an ongoing basis. Currently, while DDS D has a strategic plan of its own and collects some performance measures, these measures focus on the number of people served and whether they are receiving services, but not the outcome of these services. Currently, only two measures are classified as an outcome measure (Table 13), and one measure was new for FY18.

Table 13. Current DDS D Performance Measures

Type of Measure	Measure	FY15 Actual	FY16 Actual	FY17 Actual
Efficiency	Percent of DD Waiver applicants with a service plan in place within 90 days of eligibility determination	91 %	53%	73.6%
Explanatory	Number of individuals receiving DD Waiver services	4,610	4,660	4,691
Explanatory	Number of individuals on DD Waiver waiting list (central registry)	6,365	6,526	6,529
Outcome	Abuse rate for DD and Mi Via Waiver clients	New	New	7.2%
Outcome	Percent of Individuals on DD Waiver who receive employment supports			New for FY18

Source: LFC Volume 2

DDS D improved performance management practices through systems quality improvement, but has limited internal performance tracking.

The Developmental Disabilities Systems Quality Improvement (DDS QI) Committee is an internal body organized to track the performance of the state's developmental disabilities system, consisting of the DDS D director and deputy directors, as well as key staff from BSI and Division of Health Improvement (DHI). DDS QI meets monthly to review general event reports and track key performance indicators across DDS D functions. Since 2015, DDS QI's membership was streamlined from 19 members to 11 and the number of meetings was increased from six to 12 annually. This has allowed the committee to work more efficiently and effectively, according to DDS D.

Many of the data issues and indicators DDS QI tracks focus on process and compliance, such as completion of individual service plan (ISPs). However, this information may still provide an indication of overall performance in some service domains for DDS D. For instance, some of this information may help to determine provider effectiveness or safety, such as abuse and neglect, and ISP implementation.

As of March 1, 2018, DDS D requires all providers to report to DDS D on the same three key indicators: percent of individuals whose ISPs are implemented as written, percent of appointments attended as recommended by medical professionals, and percent of people accessing Customized Community Supports in a non-disability specific setting. HSD collects additional measures as required by CMS assurances, but these measures are not reported by DDS D. By having all providers report information on the same three indicators, the state will be able to more comprehensively determine provider compliance with these measures, but will not have the same breadth of information. Once the state and providers determine how to consistently collect these three required KPIs, additional measures should be added to allow the state, providers, and other stakeholders, such as the Legislature, to examine more provider and client based information allowing for a more comprehensive picture of the system to be examined.

DDS D streamlined their quality improvement committee, but does not report all data collected

DOH needs expanded outcome and quality measures tied to key system goals to aid Legislative oversight of the DD Waiver program.

DOH should work with stakeholders, the Legislature, and DFA to increase reporting of outcome-based measures to improve oversight of the waiver system. Measuring client outcomes can help all stakeholders understand the effectiveness of specific services and the effects of successful ISP and service implementation. DDS, LFC and DFA staff should work together to create a list of performance measures which highlight client outcomes and service quality to supplement the current list of performance measures. These measures should reflect important service quality standards such as examination of whether people are in the least restrictive environment for their needs, the overall safety and health of those on the waivers, and community inclusion (Table 14). DDS should publicly report its performance data so providers, the Legislature, and other stakeholders are aware of the status of the waiver program. Additionally, legislative and stakeholder oversight groups should work with DDS to improve any potential areas of concern that currently may be unnoticed due to lack of collection of outcome data.

DOH agreed to 2 of the potential 11 new performance measures, neither of which are outcome measures

Table 14. Potential Performance Measures

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 ISP 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 SGF
	Average days from allocation to receipt of services
Individuals progress towards personalized goals	Percent of ISP goals met

*Current performance measure

While New Mexico has above average employment outcomes nationally, employment levels have declined recently.

New Mexico performs better than the national average for DD Waiver employment supports; although the number of individuals in integrated employment has decreased since 2008. Research indicates integrated employment for individuals with intellectual and developmental disabilities may contribute to greater self-satisfaction and higher earnings than those employed in a segregated setting. National employment data finds New Mexico places individuals with intellectual or developmental disabilities in employment in the community at higher rates than the national average. Thirty percent of New Mexicans with intellectual or developmental disabilities enrolled in employment and day services participated in integrated employment as opposed to employment in segregated settings, according to the annual 2016 National Report on Employment Services and Outcomes by

Table 15. Percent of Participants in Integrated Employment, FY15

State	Percentage
OK	60%
NM	30%
CO	28%
UT	23%
AZ	20%
TX	9%
US Average*	22%

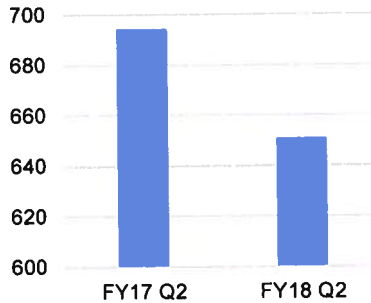
* Excludes six states for which data was not reported
 Source: Institute for Community Inclusion, University of Massachusetts Boston

the Institute for Community Inclusion at the University of Massachusetts Boston. This is higher than the nationwide average of 22 percent, and higher than all of New Mexico’s neighboring states except Oklahoma, as shown in Table 15.

The percentage of New Mexicans with intellectual or developmental disabilities in integrated employment decreased in recent years from 44 percent in 2008 to 30 percent in 2015. As of the second quarter of FY18, there were 651 people on the DD Waiver receiving employment services, down slightly from the second quarter of FY17 when 694 were receiving employment services (Chart 39). Additional New Mexico outcome data show of those receiving employment services, the average client worked almost 14 hours a week in the second quarter of FY18 and made \$7.19 an hour. While the average wage is higher than the average wage in FY17, which was \$6.18, clients are working about a third of an hour less than they were a year ago. However, information regarding the number of individuals who want to work and the number of hours clients can and want to work need to be examined to determine the effectiveness of the current program.

DOH should leverage existing employment programs to connect waiver participants with employment. New Mexico implements programs focused on employment for individuals with intellectual and developmental disabilities including Partners for Employment’s Project Search and the Special Services Program at Eastern New Mexico University Roswell (ENMUR). Both programs target individuals with intellectual or developmental disorders who recently graduated high school, focusing on connecting these individuals with employment opportunities or training.

Chart 39. Number of Waiver Participants Receiving Employment Services



Source: DOH

Project Search is an international program currently implemented in all but five states. Nationally, Project Search leads to higher employment rates. In New Mexico, Project Search is a collaboration between DDS, the Division of Vocational Rehabilitation, high schools, a supported employment agency and a local business. The program, in four cities around the state, is a one-year internship for students, which prepares them for integrated employment. As of March 19, 36 youth successfully completed the program in FY18. More than half the individuals participating in Project Search are on the waiver or the central registry. The University of New Mexico Center for Development and Disability (UNM CDD) tracks Project Search outcomes, finding on average 69 percent of individuals who participated in the program were employed 18 months after graduating.

The Special Services Program at ENMUR may lead to better outcomes for individuals with low intensity intellectual or developmental disabilities. The Special Services Program offers various programs, each taking a year to complete, and students can graduate with a certificate after completing one, with the option of returning to complete others. The Special Services Program serves students from New Mexico and surrounding states, with 45 percent of students from New Mexico in 2015. Of the 28 students who graduated from the program in 2014, 79 percent are working, with 68 percent working in their chosen career field (Appendix I). This is much higher than the state average of 30 percent, mentioned above. However, these data should be interpreted with caution because these numbers decreased in 2015 to 28 percent (similar to the state average) and data for more recent years was unavailable.

Recommendations

The Department of Health should:

- Use the key performance indicator framework to examine more client-centered outcome information;
- 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;
- Continue to collect and examine employment outcome data while including additional information such as the number of individuals including employment as a goal and client acuity to make the data more interpretable; and
- Continue to collaborate with Project Search and reinitiate discussions with ENMUR Special Services Program to direct DD waiver clients towards these promising employment programs.

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

The state has reached a critical juncture in the 31-year-old Jackson lawsuit, which has cost DOH over \$40 million since FY13.

The Jackson class-action lawsuit was originally filed against the state of New Mexico in 1987 over violations of federal law in state-operated facilities for individuals with developmental disabilities and the rights of the residents of those facilities. Beginning in 1990, the court issued a series of orders requiring the state to correct constitutional and statutory violations at the facilities. After the state closed its last facility in 1997, it continued to be subject to court oversight under the Joint Stipulation on Disengagement (JSD). Since then, numerous court hearings, filings, and judgments have led to additional corrective plans and a complex array of over 300 obligations with which the state must demonstrate compliance in order to disengage from the lawsuit. As of 2018, the lawsuit remains an active case in federal court and the source of ongoing negotiations between the state and plaintiffs regarding the state's responsibilities to class members as they receive services in community settings.

Table 16. Summary of Outstanding Jackson Obligations

Issue Area	Number of Items Remaining
Health	52
Safety	63
Supported Employment	67
Integrated and Meaningful ISPs	19
Correction of ISP Deficiencies	9
Day Services	17
Vocational Rehabilitation	8
Continuous Improvement	10
Items Potentially in Dispute	
Quality Enhancement	99
Incident Management	25
Supported Employment	17
Case Management	19

Note: Obligations based on three separate court documents and agreements: The Joint Stipulation on Disengagement and Plan of Action (1997), Appendix A (2005), and the Remedial Plan/Revised Table IV (2015). Source: DOH

Activities the state is to undertake span a range of identified issue areas, including health, safety, supported employment, individual service plans (ISPs), incident management, and quality enhancement. As of February 2018, there were approximately 245 activities outstanding, with as many as 160 additional items in dispute. The exact number of specific activities and obligations the state must comply with is still a subject of the litigation because the court has indicated the state may still be subject to certain older items the state believes to have been superseded by newer requirements. Table 16 summarizes these obligations.

Specific activities for the state to complete range from the relatively straightforward to the complex and prescriptive. For example, Safety Objective S1.1.2 in the 2015 Remedial Plan contains one activity requiring DOH to provide educational information about detecting abuse, neglect, and exploitation to providers, physicians, clinicians, families, guardians, and law enforcement. Health Objective H1.2, however, consists of five specific activities laying out how DOH is to ensure that nurses routinely monitor class members' health needs, including responsibilities of nurses to train and meet with direct support workers based on changes in participant needs, and document and update participant healthcare plans accordingly. Two court-appointed officials, the Jackson Community Monitor and the Jackson Compliance Administrator, oversee the state's progress in complying with these obligations. The full remedial plan has been included in Appendix J.

Recent developments have led to the state pursuing two separate courses of action with respect to the Jackson case. First, the state is preparing new legal arguments to resolve the lawsuit following a ruling by the

U.S. Court of Appeals for the Tenth Circuit in January 2018. The appeals court remanded the case to the district court and ordered it to be reheard under a narrower set of criteria. Specifically, the district court is to examine whether there are sufficient changed circumstances to warrant ongoing court oversight of the state, whether there is an ongoing violation of clients' rights under federal law, and whether the state's programs and actions to ensure those rights are sustainable. The federal district court has scheduled a status conference to take place in January 2019.

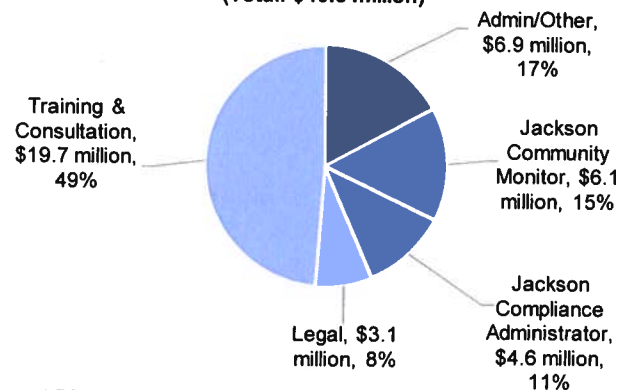
Second, New Mexico must continue to abide by the existing system of court oversight and compliance until the district court reaches a decision under the Tenth Circuit's framework. Representatives from the state continue to meet triannually with plaintiffs' counsel, the Jackson Community Monitor, the Jackson Compliance Administrator, and the court to discuss steps toward disengagement, with monthly meetings focusing on specific issues related to health, safety, and employment of class members. The state's services to class members are still subject to review by the Community Monitor.

DOH has spent over \$40 million on costs related to the Jackson lawsuit since FY13, not including services to class members. The various consent decrees and court orders arising from the Jackson class action lawsuit require the state to engage in and bear the costs of a variety of actions and meet numerous conditions on behalf of members of the class. Total spending by DOH on these activities amounted to \$40.3 million between FY13 and FY18, above and beyond the services delivered to clients under the waiver itself. These costs include portions of general fund appropriations of \$4 million in FY16 and \$1 million in FY17 specifically for compliance and disengagement activities for the Jackson and Waldrop lawsuits. This amount does not include attorney fees paid to legal counsel contracted through the Risk Management Division of the General Services Department.

Nearly half (49 percent) of Jackson-related spending since FY13 was for training and consultation, largely consisting of training and technical assistance for providers of services to Jackson clients or for initiatives that were spurred by requirements of the Jackson litigation. For example, the state funds contracts for consultants on sexuality risk screening and behavioral support activities that began due to Jackson lawsuit requirements.

The largest single Jackson-related contracts are for two court-appointed officials: the Jackson Community Monitor and the Jackson Compliance Administrator. The Community Monitor conducts oversight of the state's treatment of class members, while the Compliance Administrator reviews the state's progress on complying with court mandates and has authority to approve requests for disengagement of specific compliance items. Together, these two compliance components have amounted to \$10.7 million since FY13, or about 27 percent of total Jackson-related costs of \$40.3 million. Administrative and other costs amount to 17 percent, while legal costs paid by DOH totaled 8 percent (Chart 40). Some of these costs, particularly those for training and consultation, include activities with a reach beyond just Jackson Class Members, such as the training database administered by the UNM Center for Development and Disability (UNM CDD). While the state would not have incurred these costs without the

Chart 40. Breakdown of DOH Spending Related to Jackson Litigation, FY13-FY18
(Total: \$40.3 million)



Source: LFC analysis of DOH data

Jackson litigation, it is not possible to further break down these systemwide costs specifically to identify which portions are directly attributable to Jackson Class Members.

These costs continue even as the number of Jackson Class Members decreases. As of the CY04 Community Practice Review, there were 411 Jackson Class Members, compared to 299 at the end of CY13 and 253 in April 2018. Since FY13, the above costs have resulted in an average additional cost to the system of roughly \$24.4 thousand per Jackson Class Member or \$1,400 per client for all DD Waiver and Mi Via participants, beyond the cost of regular services received under the waiver.

DOH estimates the average service cost per client for Jackson Class Members at \$122.9 thousand in FY17, about 56 percent higher than the average cost per client for all DD Waiver participants. Higher costs for Jackson Class Members are due in part to strict limitations on reductions in service levels under the court order, as well as natural increases due to aging and higher levels of need.

The state could serve approximately 140 additional clients for the same amount it spends in Jackson-related compliance costs. In FY17, DOH spent approximately \$7.5 million on Jackson-related costs not including regular waiver services for class members. According to DOH, many of these costs, including certain contracts for training, therapy consultation services, and others, would likely continue even if Jackson ended immediately in order to ensure continuation of policies implemented during and because of the litigation.

Based on this, LFC staff conservatively estimate approximate savings of \$3.2 million in general fund spending if the state were no longer subject to costs most directly attributable to Jackson compliance. These costs include the Community Monitor and Compliance Administrator, as well as certain consultation contracts and legal fees. If, in the absence of these costs, DOH were able to redirect this amount entirely to client services under the waiver, New Mexico would have been able to use it as the Medicaid state share to draw down an additional \$11.1 million in federal funding for client services. This would have allowed the state to serve an additional 141 waiver clients in FY17, at the average statewide cost per client of \$78,575.

Figure 4. Scenario If Jackson Compliance Costs Were Redirected to Services (Based on FY17 Spending)



Source: LFC analysis of DOH and CMS-372 data

DOH has made progress on streamlining the DD Waiver system to incorporate Jackson obligations, but administrative complexities still complicate service delivery and system performance.

In March 2018, DD Waiver providers began delivering services under a single set of standards for all clients, including Jackson Class Members and non-Jackson clients. Prior to March 2018, services to Jackson Class Members were governed by DDS's 2007 provider standards, while services to all other waiver participants were subject to standards originally adopted in 2012. This bifurcated structure created significant administrative complexities for providers. However, while the inclusion of Jackson Class Members under a unified set of standards should allow providers to better plan for service needs and staff training, the standards specify certain minimum levels of service for Jackson Class Members that are greater than or different from those for other waiver participants. For example, Jackson clients receive at least two case management visits monthly, compared to a minimum of one for other adult participants.

Additionally, the requirements of the court-mandated Individual Quality Review (IQR) process include numerous tasks that can be both time- and labor-intensive. These include file reviews, on-site interviews of class members, and other ancillary tasks related to the ongoing monitoring of Jackson Class Member services and status. Under the DD Waiver provider standards, providers must furnish all requested documentation during the IQR and participate in all on-site reviews and interviews throughout the process.

Multiple regional offices and providers interviewed by LFC staff indicated they do not formally track the amount of time spent on these tasks, but that it is significant and may result in overtime. Several providers also indicated to LFC staff that the substantial documentation requirements of serving Jackson Class Members have led to fatigue and burnout among direct care workers, and data from the UNM CDD training database indicates turnover among providers of services to Jackson Class Members was 37 percent in FY17, compared to 24 percent for non-Jackson providers. While the IQR calendar is announced in advance each year to give DDS and provider personnel in each region adequate time to prepare, certain aspects are unpredictable because the specific sample of Jackson Class Members reviewed in each region changes annually.

There does not appear to be any research into the effects of heavy administrative workloads on the care of individuals with developmental disabilities. However, research into the effects of heavy administrative task requirements, such as documentation of records, billing and insurance reporting, and regulatory compliance functions, on physicians and nursing home staff has found the demands of such tasks can reduce face-to-face time with patients and reduce provider administrators' ability to supervise direct care.

DOH plans to bring the Jackson community review process in-house, but its ability to leverage this opportunity for enhanced performance monitoring is complicated. In the 2018 General Appropriation Act, DOH received a FY18 supplemental appropriation of \$269.3 thousand and a base increase of \$538.7 thousand in FY19 to begin transitioning the Jackson IQR into the Division of Health Improvement (DHI). Currently, the IQR conducts annual reviews of a sample of Jackson Class Members in each of the five

As of March 2018, Jackson Class Members and all other waiver participants are served under a single set of standards.

Providers of services to Jackson Class Members experienced higher turnover in FY17 than those without Jackson clients.

DDSD regions under the supervision of the Jackson Community Monitor. These reviews evaluate the extent to which providers and the state are delivering services in accordance with court orders and report findings and recommendations to the court. Under the proposed structure, state employees, rather than reviewers contracted by the Community Monitor, will conduct the reviews of class members and providers. However, the Community Monitor retains oversight of the process and the authority to approve staff assigned to the IQR.

The extent to which the state will be able to integrate IQR data with its existing data collection systems in DHI and DDSD is unclear. The IQR's methodology for collecting information is prescribed by the court and is disputed in some respects by DOH, especially as regards employment of Jackson Class Members. Specifically, DOH's position is that the current formula used by the IQR to score employment outcomes does not incorporate adequate consideration of whether a Jackson Class Member wishes to work. Because of these differences, data collected through the IQR is not necessarily comparable to data collected through DDSD and DHI's regular processes. Alterations to what data is collected by the IQR and how it is collected by DHI would require agreement between the Jackson parties and approval by the court before they could be implemented.

Recommendations

Assuming continuation of court oversight in the Jackson case, the Department of Health should:

- Provide triannual reports to the Legislature on the status of disengagement from outstanding obligations;
- Continue to seek approval from the court to adapt Individual Quality Review methodology to align with existing and in-development DDSD and DHI data collection procedures and performance measures, with an emphasis on client outcomes applicable to the entire DD waiver system; and
- Direct DDSD to work with providers and its regional offices to develop a plan to identify and minimize the areas of greatest administrative burden due to Jackson documentation requirements, while still fulfilling those requirements to the satisfaction of the community monitor and the court.



Department of Health Response to the LFC Evaluation of the DD and Mi Via Waivers

The DDSO operates the Developmental Disabilities and Mi Via waiver programs (hereafter referred to as the DD Waivers) through a joint powers agreement between the Department of Health (DOH) and the Human Services Department (HSD). The DD Waivers are home and community-based services that provide long term care. The DD and Mi Via Waiver programs provide an array of services to support individuals with intellectual and developmental disabilities to live successfully in their community, become more independent and reach their personal goals. DDSO also works with children at risk for developmental delay or disability and their families.

The LFC review evaluated the traditional DD and Mi Via Waivers and provided findings and recommendations. DDSO has also internally been reviewing a number of the factors to prepare to propose possible alternative and more cost-effective solutions. The current DD Waiver was approved for 5 years effective July 1, 2016, so the DOH and HSD will be seeking waiver renewal again in 2021. This evaluation report, along with past task force reports, internal data, external data to include; information from the ACQ, provider organizations and litigation, as well as other resources and experiences will be useful tools in planning for the next renewal period.

For ease of reading, the DOH response primarily focused on highlighting areas from the Key Findings and Recommendations from the full report.

The LFC found that the DD Waiver is costing more per client, even as enrollment declines.
The Department agrees that per client costs are rising.

The Department is studying cost containment strategies aimed at reducing the average cost per client. In 2010, DDSO faced similar challenges to address rising cost of program cost and average cost per person for the traditional DD Waiver. To address the rising cost and to address the waiting list in 2010, DDSO implemented cost containment efforts and redesigned the DD traditional Waiver.

Specifically, in 2012 DDSO implemented the use of the Supports Intensity Scale (SIS) based on a recommendation outlined in the LFC audit report from 2010 and developed a resource allocation system using data generated by the SIS. The SIS is a standardized valid and reliable assessment that provides a framework to quantify the support needs of people with intellectual and developmental disabilities. The goal of the resource allocation system was to create a system that is fair and equitable, allocate resources based on need so people with similar needs receive the same allocation of resources.

After the first full year of implementing the SIS and resource allocation system, the average cost per person decreased to \$67,065 in FY14 compared to \$73,334 in FY12.

DDSO efforts to implement the use of the SIS and resource allocation system were met with strong opposition from advocates, families, providers, Jackson Plaintiffs, the Court overseeing the Jackson litigation, and legislators which eventually resulted in litigation known as the Waldrop lawsuit. That litigation was eventually settled.

Department of Health Response to the LFC Evaluation of the DD and Mi Via Waivers

As a result of the Waldrop Settlement Agreement, the resource allocation system was replaced with the Outside Reviewer (OR) and clinical criteria to justify services. The OR was implemented in 2015 and the SIS was discontinued in 2016. These required changes have contributed to the rising cost of the DDW since FY15. For example, the average cost per person increased from \$67,065 in FY14 to approximately \$88,000 in FY18.

Given this history, it is evident that the DOH understands the growing costs of the waiver system and has made efforts to address those. Any future waiver design to address the rising cost of the waivers, will take a collective effort. Any changes to the Waiver should be considered in light of the potential impact on current and future enrollees and the possibility of litigation based on changes.

Recommended changes to impact the rising costs will inevitably have to consider implementing a valid assessment tool and resource allocation methodology. Based on program expenditures for the DD waiver, 88% of the cost for the DD Waiver is related to residential and day services. Residential services are 24 hours a day, 365 days a year. The third highest DD Waiver expenditures are therapy and behavior support consultation services. Cost containment strategies should focus on these service types.

Since New Mexico closed the institutions in the 1990's, the DD and Mi Via Waivers are the only programs specifically for individuals with intellectual and developmental disabilities available to provide long term support in the community. This creates an overwhelming demand for the services provided in these waiver programs. Any changes to availability or eligibility for individual services will require a collective effort and large-scale changes to eligibility or otherwise should be made, if possible, via statutory amendment and must at any rate be supported by HSD and approved by the Centers for Medicare and Medicaid Services (CMS).

The LFC believes that Mi Via, the self-directed waiver, is driving cost increases of the state's developmental disability programs.

The Department disagrees that Mi Via is driving cost increases for the DD programs. Pursuant to federal law, self-directed waiver programs are required to be more cost effective than traditional waiver programs, and this is true for the NM Mi Via Program. Even though the expenditures for the Mi Via Waiver have increased, the number of individuals enrolled in Mi Via has also increased from 192 in FY 12 to 1, 461 in FY 18.

To address a recommendation of the 2013 Senate Memorial 20 report, DDS has prioritized increasing the attractiveness of the Mi Via Waiver and has been a national leader in promoting self-direction. Key motivators for choosing the Mi Via Waiver over the traditional waiver include more autonomy and choice in selecting providers and staff, and more control over their program and supports.

The Mi Via budgets are capped based on age of the participant, although in some individual cases additional funding may be approved. Participants are using up to 90% of their approved budgets. This high percentage of utilization is a prime factor impacting the average cost per person. The Department does acknowledge the availability of additional funding and the range of rate (the

Department of Health Response to the LFC Evaluation of the DD and Mi Via Waivers

amount of money a participant can pay their staff) criteria in the Mi Via Waiver could be strengthened as a possible cost containment measure.

The LFC indicates that other states are more cost effective in delivering services for the developmentally disabled population.

The Department agrees that other states have mechanisms to control costs for services provided to individuals with intellectual and developmental disabilities. Each state is given the flexibility to determine what services and amounts of service it will provide. Many states have moved to a managed care model, and most states use a standardized assessment tool and resource allocation. Additionally, approximately 30 states have supports waivers which are designed to complement unpaid supports that are provided to individuals with IDD by family and other natural supports. DDS should review how other states determine who qualifies for the waiver including how they define intellectual and developmental disability.

Currently, the DD Waiver offers a comprehensive array of services with few limitations. The range of services and limits to those services are being explored internally at DDS. The initial thoughts have been to look at cost containment measures which would result in the reduction of some services and service amounts provided under the waiver. Home and community-based services, such as our waivers, are options afforded to the states.

The Department recognizes the need to implement program reform and best practices to align with what is occurring across the nation. This would entail ensuring the waivers are cost effective, fair and equitable, while also addressing the waiting list. It is essential that future program changes are made in partnership with all stakeholders across state agencies and the waiver system.

DOH is improving the management of the DD Waiver Waiting List, but needs to do more to predict future needs and service capacity.

The Department agrees with this finding.

DDS is considering using a standardized assessment tool for people on the waiting list to assess need and better predict future funding and program needs. DDS is also exploring the point in time a determination is made from the date of the registration.

However, approximately 65% of the people on the Waiting List are enrolled in Centennial Care and are eligible for the Community Benefits that Centennial Care offers.

The Department was allocated \$2 million in the 2018 legislative session to reduce the waiting list. DDS has begun the allocation of 70 people from the wait list into services effective July 2018. It is the Department's plan to expend the \$2 million in support of removing people from the wait list.

LFC found that DOH's current assessment and budget allocation process lacks standardization and contributes to rising annual client budgets.

The Department agrees with this finding. The impact of the Waldrop litigation and the discontinuation of the Supports Intensity Scale (SIS) in 2015 is a factor in the rising annual budgets. The Waldrop Settlement Agreement established the implementation of the Outside

Department of Health Response to the LFC Evaluation of the DD and Mi Via Waivers

Review process, clinical criteria and the allowance for requesting service levels in any amount. CMS requires the use of assessment tools.

New Mexico has used different assessment tools in the past. The SIS was one such tool. The Department is not opposed to a standardized tool. We will contact other states and see what is being successfully used, although most commonly used is the SIS. This will require working with stakeholders and developing support and understanding for a decision that will be in the programmatic and financial interest of the state.

Improved oversight is necessary to mitigate risk to waiver participants and public funds.

The Department agrees that oversight is part of any Continuous Quality Improvement. The Department strongly disagrees that there is no oversight from DOH of Mi Via providers. Oversight requirements are outlined in the approved waiver and service standards. Those standards may be found at <https://nmhealth.org/publication/view/policy/3381/>. With respect to Mi Via services provided by any employee, contractor, vendor or other community-based waiver service agency having a provider agreement with DOH, any suspected abuse, neglect, exploitation, suspicious injury, environmental hazard, eligible recipient death must be reported to the CYFD/CPS or DOH/DHI/IMB for the eligible recipient under 18 years or to IMB for eligible recipients age 18 years or older. See Sections 27-7-14 through 27-7-31 NMSA 1978 (Adult Protective Services Act) and in Sections 32A-4-1 through 32A-4-34 NMSA 1978 (Child Abuse and Neglect Act).

Monitoring client services is a shared responsibility between waiver participants, family members and consultants and is not the sole responsibility of the EOR.

Although the Employee of Record (EOR) is currently a volunteer position, DDS will consider adding an EOR as a required service at the next renewal in 2020.

Data collection offers DOH an opportunity to improve performance management and client outcomes.

The Department agrees that data informs decisions. DD Waiver service providers have always been required to report on CMS performance measures as part of their provider agreements with DDS. This year, DDS has implemented 3 Key Performance Indicators (KPI) based on Quality Management Bureau, Incident Management Bureau, the Jackson Individual Quality Review and the Centers for Medicare and Medicaid Services 2014 Final Settings Rule that will be reported on by all providers of DD Waiver services. DDS specifically identified these three KPI to assist the State in analyzing and developing more client centered outcomes. The KPI are: [1] The percent of Individual Service Plans (ISPs) that are implemented as written; 2) the percent of appointments attended as recommended by medical professionals (physician, nurse, practitioner or specialist) and 3) the percent of individuals accessing Customized Community Supports in a non-disability specific setting. The directive to add these three KPI is included in Chapter 22 of the DDS Standards and the language of the KPI was circulated to the field on March 5, 2018. Guidance to the field continues regarding this new initiative. These 3 KPI are expected to be collected in addition to other performance indicators selected by provider agencies as part of their overall service delivery approach. Data will be available and reported to the Department in quarter 3 of FY 2019.

Department of Health Response to the LFC Evaluation of the DD and MI Via Waivers

DDSD is in the final stages of issuing a Request for Proposals to select a vendor to develop a Client Data Management System that will allow the Division access to the types of data that will allow tracking of client outcomes and system performance.

Employment

DDSD is proud to continue to exceed the national average for employment for individuals with Intellectual/Developmental Disabilities (I/DD). While New Mexico performs higher than the national average, there are several states that have implemented policies and initiatives that prioritize employment and have improved outcomes. A database was created with the assistance of the University of Massachusetts Employment Leadership Network in 2015. DDSD implemented an Employment First policy in 2017 after researching the steps those high performing states took to achieve better employment outcomes. The Employment First Policy establishes competitive integrated employment as the preferred service over other day service options for all working age adults.

DDSD agrees that Project Search and ENMU-R have promising employment programs for those individuals who qualify for their programs. DDSD is excited to report that through their work with Partners for Employment at UNMCDD, there are currently 5 Project Search sites in New Mexico with plans to secure 8 in FY 19.

The Department agrees that the Eastern New Mexico University – Roswell (ENMU-R) Special Services Program is a value-based asset for some individuals with I/DD who seek employment. Efforts to partner with ENMU-R in the past have been unsuccessful. The business model utilized by the University does not include becoming a Medicaid provider as this would require that the University program accept any Medicaid eligible applicant. ENMU-R does have a strong special services program and DDSD will continue to promote the ENMU-R program as an option outside the Medicaid employment system.

DDSD will continue to utilize their data as well as the new KPI that relates to the amount of time spent in community integrated settings, which includes employment related services and supports.

In addition to the database, the KPI and Project Search, DDSD has embarked on promising practices intended to increase interest and participation in employment for individuals with I/DD. In partnership with the UNM Center for Developmental Disability and the Division of Vocational Rehabilitation, DDSD has launched a comprehensive, multi- year training plan to address the diverse training needs of employment support professionals in New Mexico. While employment professionals are the primary target of the training plan, the trainings should also meet the needs of other important stakeholders, such as individuals with disabilities, their families and guardians, case managers, advocates and providers.

Transition to Employment Grant

The Transition to Employment Grant is designed to provide opportunities for employment to individuals who might not otherwise have access to employment supports. The program is intended to give individuals who are preparing to exit/graduate from high school or have recently exited or graduated from high school the opportunity to receive supports for community employment as adults. Individuals who are between the ages of 17 and 25 are eligible for this

Department of Health Response to the LFC Evaluation of the DD and Mi Via Waivers

program. This grant was developed through Senate Memorial 20, which provides funding for efforts that reduce the wait time between school and adult services. The individual must be on the Department of Health/Developmental Disabilities Supports Division Central Registry. Individuals who are already receiving services through the Developmental Disabilities (DD) Waiver or the Mi Via Waiver are not eligible for this program.

The Transition to Employment program will fund up to 10 hours per month of Follow-Along supports and/or up to \$460 for transportation supports to/from work.

WORK EXPERIENCE GRANT PROGRAM

In 2015, DDSDD launched the Work Experience Grant Program. Individuals with I/DD who are interested in community employment are now able to apply for grant funding in collaboration with their supported employment agency. There are three design models for this program. They are: Trial Work Opportunity, Community-Based Situational Assessment, and Microenterprise start-up. The Work Experience Grant program can be accessed to cover funding for wages and workers' compensation insurance for individuals in the Trial Work Opportunity and the Community-Based Situational Assessment models. The Microenterprise model is designed to cover business start-up costs that cannot be obtained through other means.

Informed Choice Project

The Informed Choice Initiative uses Discovery strategies and techniques to help individuals and their team to determine if the individual is interested in integrated competitive employment customized community inclusion activities, or both. Outcomes of this project include:

- To assist agencies in making the system change
- Provide customized services to the individuals they represent.

The expectation of the project is to focus on selected agencies that are interested in making systems change that will incorporate Discovery strategies in assisting individuals in making informed choices related to how they spend their time.

Qualified Provider Project

DDSDD worked with National Subject Matter Expert Linda Rolfe to establish new expectations for providers related to quality outcomes by updating the Developmental Disabilities Waiver provider application. DDSDD partnered with 7 Supported Employment agencies to pilot the new requirements to determine whether the assumptions that DDSDD developed based on national and local data are sound.

The pilot has been completed and the results are being shared with other bureaus within DDSDD to improve the overall provider application.

Abuse, Neglect and Exploitation Investigations

The Division of Health Improvement continually works to improve processes and recently began specific measures to address the timeliness of the investigative process. Specifically, the Division has identified the need to look at that issue from a variety of different angles to include: the investigative process itself; what has to be done to close an investigation, who has to review it; how that review is happening; staffing; how many employees we have, how long they stay, how they are trained and special projects like OverTime and contract assistance.

Department of Health Response to the LFC Evaluation of the DD and Mi Via Waivers

New Mexico has made progress on resolving the Jackson lawsuit, but it remains a significant cost driver for the entire DD system.

The Department agrees that we are making progress on the Jackson litigation and that it is a high cost-driver for the state and as a result for the DD Waiver providers. The Jackson litigation is both an administrative burden and a cost driver. DDS D meets at least monthly in smaller groups, as well as tri-annually, with the Court, Court experts and Plaintiffs' counsel to clarify expectations on the Remedial Plan. This continued court involvement in how the state hires staff and conducts investigations impacts the timeliness, cost and independence by which the state can run its DD system.

The positive response from the 10th Circuit in January 2018, indicating federal oversight of the class should terminate if there are no ongoing constitutional or federal statutory violations, is encouraging. DDS D hopes that the approaching trial will finally bring resolution to this protracted litigation, which will allow the state the autonomy to run its programs and services without interference, which in turn will bring funds back into services and away from litigation costs.

In the meantime, DDS D could provide the Legislature with the Jackson Quarterly Reports that are required under the Court Orders. This report has been significantly structured by the Jackson Compliance Administrator, but DDS D and DHI use it to demonstrate their ongoing efforts to meet the objectives and evaluative components of the current Remedial Plan.

DHI continues to work on the viability of the recently developed Individual Quality Review. While it remains a Jackson only tool today, DHI is open to the recommendation that the IQR be adapted to measure DDS D performance measures that apply to the entire waiver population.

Finally, DDS D has made efforts in the past to minimize areas of greatest administrative burden through a project titled "Reduce the Burden". DDS D agrees that continuing to address Jackson documentation requirements is essential to supporting providers.

Conclusion

The Department will continue to carefully consider the findings and recommendations included in the report to help inform future actions. The Department is thankful that the state of New Mexico is committed to improving its system for providing services and supports for its citizens with intellectual and developmental disabilities. We will continue to work toward making program and cost-containment improvements while at the same time maintaining the high-quality services provided to our New Mexican citizens, and we look forward to doing that in partnership with the LFC and other important stakeholders.

Appendix A: Evaluation Objectives, Scope, and Methodology

Evaluation Objectives.

- Evaluate the cost-effectiveness of DD Waiver services;
- Examine client outcomes and quality measures; and
- Review the costs and impact of the Jackson and Waldrop litigations on the delivery of DD Waiver services.

Scope and Methodology.

- Analyzed DD Waiver and Mi Via financial and claims data to identify cost drivers and trends;
- Analyzed DDS Central Registry data;
- Reviewed performance measure documentation from DDS and DHI;
- Met with DOH and HSD staff, DD Waiver and Mi Via providers, case managers, and consultants;
- Interviewed stakeholders including advocacy organizations, provider groups, the Outside Review team, and Jackson lawsuit plaintiff and defendant representatives and the Jackson Community Monitor;
- Reviewed DD Waiver and Mi Via documents, reports, and publications, including provider standards;
- Reviewed relevant New Mexico and federal statutes, rules, and regulations; and
- Reviewed publications, studies, and documents on DD Waiver programs in other states, including costs, outcomes, and best practices.

Evaluation Team.

Brian Hoffmeister, Lead Program Evaluator
 Maria Griego, Program Evaluator
 Dr. Sarah Dinces, Program Evaluator

Authority for Evaluation. LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conferences. The contents of this report were discussed with the Deputy Secretary of the Department of Health, the Director of the Developmental Disabilities Supports Division, and their staff on July 10, 2018.

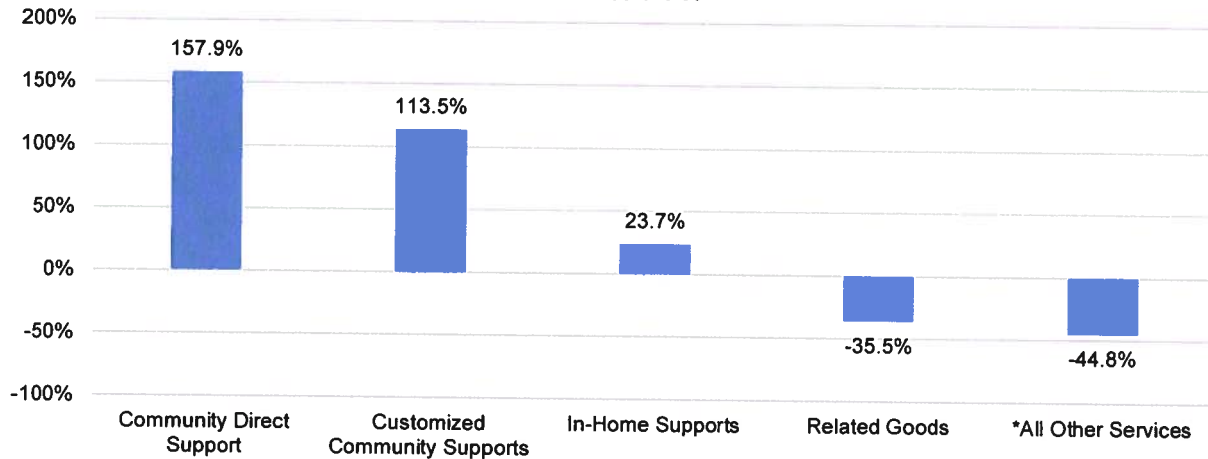
Report Distribution. This report is intended for the information of the Office of the Governor, the Department of Health, the Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.



Charles Sallee
 Deputy Director for Program Evaluation

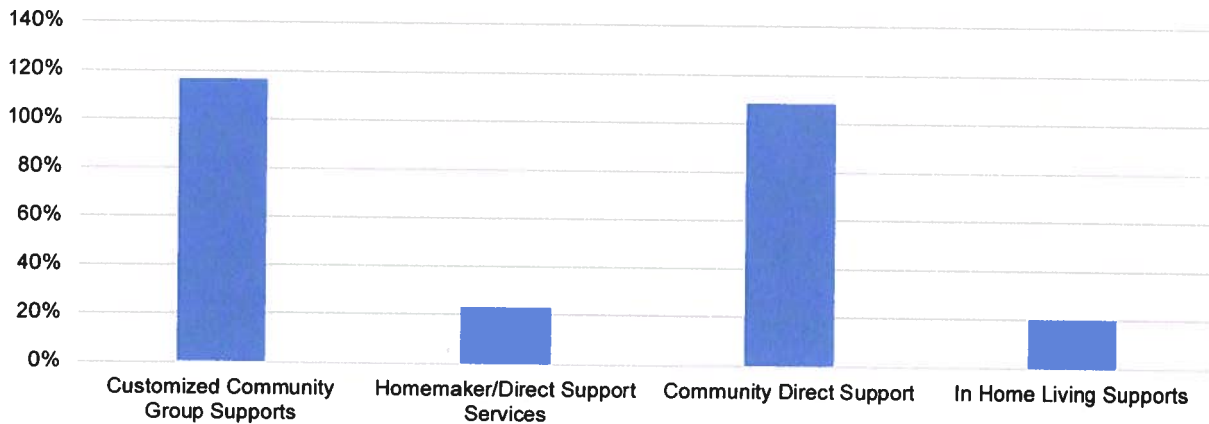
Appendix B: Mi Via Service Cost per Client and Utilization Rate Changes Between FY12 and FY17

**Mi Via Largest Cost per Client Changes by Service
FY12 to FY17**



Note: All Other Services includes physical, occupational, and speech/language therapies. Based on state fiscal year.
Source: LFC Analysis of HSD Data

**Living and Community Support Utilization Increases
FFY12-FFY17**



Note: Based on federal fiscal year.
Source: LFC Analysis of HSD Data

Appendix C: Waiver Services Offered in States Without Institutions

Comparison of DD Waiver Services Offered by States Without DD Institutions																				
State	Cost per Client (2014)	Case Management	Residential Services: Independent/Family	Residential Services: Supported Living	Personal Care/Chore Services (Standalone)	Supported Employment/Job and Career Planning	Day Habilitation/Community Integration	Nursing	Behavioral Supports/Consultation	Nutritional Counseling	Therapy Services (PT/OT/SLP)	Assistive/Personal Support Technology	Crisis Supports/Intervention	Environmental Modification	Transition Services	Non-Medical Transportation	Dental Care	Respite	Other Wellness Services	Family/Caregiver Training
District of Columbia	\$102,203																			
West Virginia	\$78,509																			
Alaska	\$76,124																			
Maine	\$73,030																			
Minnesota	\$65,749																			
New Mexico	\$61,375																			
Alabama	\$58,052																			
Michigan	\$52,914																			
New Hampshire	\$42,466																			
Haw aii	\$40,375																			
Indiana	\$34,700																			
Oregon	\$6,567																			

	Service is offered under an HCBS waiver
	Service is offered under an HCBS waiver, with caveats (see notes)
	Service is not offered under an HCBS waiver

Source: Cost data from 2014 CMS-372 forms; Service data from each state's current HCBS waiver documents

Notes:

- Rhode Island and Vermont are excluded from this table because they do not have a 1915(c) HCBS waiver. Certain individuals with IDD are a discrete eligibility group for services under a comprehensive section 1115 demonstration waiver in these states. Vermont's 1115 waiver includes a component consisting of "HCBS waiver-like services" for designated populations including persons with DD.
- New Mexico includes personal care services as part of its residential benefits, but not as a standalone billable service.
- New Mexico and DC include socialization and/or sexuality education as billable services that are grouped with behavioral supports for purposes of this analysis.
- Alaska, Minnesota, and Oregon include meals or special dietary benefits as available waiver services.
- DC bundles transportation with certain living categories, such as Supported Living and In-Home Supports; DC also includes companion services as a standalone benefit, and nutritional counseling and sexuality education as part of a larger array of wellness services that include various types of health education and counseling services.
- DC, Indiana, and New Hampshire include art, music, and recreational therapy as available billable services that are grouped with behavioral supports for purposes of this analysis.
- Hawaii offers therapy, behavioral, and nutritional consultation and training for caregivers, but not direct therapy services under its waiver.
- Indiana includes nursing only as a component of respite and wellness coordination services, but not as a standalone billable service. Indiana's Family Supports Waiver includes a standalone Personal Assistance and Care benefit, and the Community Integration and Habilitation Waiver includes a separate benefit for rent and food for in-home caregivers.
- Maine's waiver includes physical therapy, occupational therapy, and speech and language therapy for maintenance of existing abilities; evaluative and rehabilitative therapy is included in the State Plan. Case management is also included in the State Plan.
- Michigan includes transportation bundled in with various other services.
- NH includes behavioral counseling and other therapy services bundled under "Specialty Services."
- Oregon offers Targeted Case Management for participants of multiple waivers under a separate 1915(b)(4) waiver. Oregon residential services are provided under the State Plan. The Supports waiver offers a Special Diets benefit.

Appendix D: Fiscal Integrity Measures Used in Vermont

VT Developmental Disabilities Services Annual Report

State Fiscal Year 2017

FISCAL INTEGRITY

The fiscal stability of the service system is dependent upon skillful and frugal management and sufficient resources to meet the needs of Vermonters with developmental disabilities.

Developmental Disabilities Services emphasize cost effective models and maximization of federal funds to capitalize on the resources available. A wide range of home and community-based services (HCBS) are available under the 1115 Global Commitment to Health Medicaid Waiver. In FY 2017, HCBS accounted for 96% of all DDSD appropriated funding for Developmental Disabilities Services, which means Vermont's Developmental Disabilities Services system leverages a high proportion of federal funds.

State Oversight of Funds

As noted in the FY 2015 – FY 2017 State System of Care Plan, AHS is committed to providing high quality, cost-effective services to support Vermonters with developmental disabilities within the funding available and to obtain value for every dollar appropriated by the Legislature. Guidance regarding the utilization of funding is provided through regulations, policies and guidelines, including the following⁴³:

- *Vermont State System of Care Plan for Developmental Disabilities Services*
- *Regulations Implementing the Developmental Disabilities Act of 1996*
- *Medicaid Manual for Developmental Disabilities Services*

The Department performs a variety of oversight activities to ensure cost-effective services, including, but not limited to:

- Verifying eligibility of applicants.
- Reviewing and approving requests for new developmental disabilities caseload funding for new and existing consumers through Equity and Public Safety Funding Committees.
- Requiring at least an annual periodic review/assessment of needs for individuals receiving services.
- Reviewing and approving funding for plans which include shared funding from Children's Personal Care Services, High Technology Home Care Services⁴⁴, Department for Children and Families, Department of Mental Health and Department of Corrections.
- Assisting agencies in filling openings in previously funded group home vacancies.
- Providing technical assistance to agencies regarding use of home and community-based services funding.

⁴³ The *State System of Care Plan* and *Regulations* were being updated in FY 17 with effective dates of 10/1/17. The *Medicaid Manual* was also being updated in FY 17 with an effective date of 11/1/17. These documents can be found on the Developmental Disabilities Services Division website by clicking on Frequently Used Documents.

⁴⁴ Children's Personal Care Services and High Technology Home Care Services that are blended with developmental disabilities home and community-based services are called Unified Support Plans (USPs).

- Performing Quality Services Reviews which determine whether services and supports are of high quality and cost effective.
- Completing bi-annual reviews of high cost budgets.
- Allocating and monitoring funds to DA/SSAs within funds appropriated by the Legislature.
- Requiring corrective action plans, including repayment of funds, when errors in use of funds are discovered.
- Monitoring utilization of Flexible Family Funding, Family Managed Respite, Bridge Program and other fee-for-service state plan Medicaid funding and making adjustments, as needed.
- Reviewing and approving home and community-based services on a monthly basis for all individuals with developmental disabilities served by DA/SSAs and who self-manage and family-manage services.
- Reviewing required financial operations data (submitted monthly by DA/SSAs).
- Reviewing required financial operations budgets of DA/SSAs prior to each state fiscal year.
- Working collaboratively to address any problems with use of funds identified by the Medicaid Program Integrity Unit and the Attorney General's Medicaid Fraud and Abuse Unit.
- Reviewing Medicaid claims data in the HCBS program to track billing rates submitted by DA/SSAs to DAIL, and approved rates and assure compliance (through billing adjustments) when required.
- Conducting reviews of paid claims to ensure consistency with authorized rates and funding rules in the System of Care Plan and Medicaid Manual for DDS.

Increased Fiscal Monitoring

The Department continues to follow up on the recommendations of the 2014 State Auditor's Report on the Department's oversight of provider agencies. The Department has begun to conduct reviews of paid claims and services delivered. The Department is working with the providers to develop a new service delivery and payment model that will ensure that consumers receive needed services and allow for streamlined procedures and enhance transparency and accountability for DDS funds. This is an ongoing project that will also include consumers and other stakeholders in its design.

Appendix E: Providers of High Cost Services by County, FY18

Number of providers for high cost services by county

County	Customized In-home Supports	Living Supports Family Living	Living Supports Intensive Medical	Living Supports Supported Living	Behavioral Support Consultation	Occupational Therapy	Physical Therapy	Speech Therapy
Bernalillo	23	25	5	22	24	14	8	20
Catron	2	3	NA	1	0	0	0	0
Chaves	5	6	2	2	5	1	0	1
Cibola	5	7	0	3	3	0	0	2
Coffax	2	2	0	1	2	0	1	0
Curry	5	5	2	2	2	0	0	2
De Baca	1	1	1	1	NA	0	0	0
Dona Ana	12	11	NA	9	3	2	2	1
Eddy	3	3	1	1	3	0	0	1
Grant	6	7	NA	3	1	1	0	0
Guadalupe	1	2	1	1	2	0	0	1
Harding	0	1	0	0	2	0	0	0
Hidalgo	2	3	NA	0	1	0	0	0
Lea	3	4	NA	0	3	0	0	2
Lincoln	3	4	NA	1	2	0	0	1
Los Alamos	5	4	0	0	3	2	2	4
Luna	5	6	NA	2	3	0	0	0
McKinley	5	6	NA	4	3	0	0	1
Mora	7	7	0	3	4	2	1	2
Otero	7	8	NA	4	3	0	0	0
Quay	1	1	NA	1	1	0	0	0
Rio Arriba	7	6	0	0	5	3	2	3
Roosevelt	2	4	1	1	3	0	0	1
San Juan	6	6	0	3	1	1	0	1
San Miguel	8	10	0	2	5	0	1	2
Sandoval	19	20	2	9	19	6	5	10
Santa Fe	10	10	1	4	7	3	2	6
Sierra	6	7	NA	0	3	0	0	1
Socorro	7	7	0	0	3	1	1	1
Taos	4	6	NA	1	3	3	1	2
Torrance	12	13	1	6	6	1	0	3
Union	1	1	0	1	2	0	0	0
Valencia	19	20	2	9	18	5	0	6
Average	6	7	1	3	5	1	1	2
Percent w/o service*	3%	0%	67%	21%	6%	58%	67%	30%

Source: DOH secondary freedom of choice website: <http://sfoc.health.state.nm.us/>; Accessed on April 30 and May 1 2018* NA listed when the service category was not included for the county

Appendix F: Counties Receiving Incentive Rates

County	Region	Therapies	Behavioral Support Consultation	Preliminary Risk Screening and Consultation	Socialization and Sexuality Education
Bernalillo	Metro			x	
Sandoval	Metro		x	x	x
Torrance	Metro			x	x
Valencia	Metro			x	x
Cofax	NE	x	x	x	x
Harding	NE	x	x	x	x
Los Alamos	NE		x	x	x
Mora	NE	x	x	x	x
Rio Arriba	NE	x	x	x	x
San Miguel	NE	x	x	x	x
Santa Fe	NE			x	
Taos	NE	x	x	x	x
Union	NE	x	x	x	x
Cibola	NW	x	x	x	x
McKinley	NW	x	x	x	x
San Juan	NW	x	x	x	x
Chaves	SE	X		x	x
Curry	SE	x	x	x	x
De Baca	SE	x	X	x	x
Eddy	SE	x	x	x	x
Guadalupe	SE	x	X	x	x
Lea	SE	x	x	x	x
Lincoln	SE	x	X	x	x
Quay	SE	x	x	x	x
Roosevelt	SE	x	x	x	x
Catron	SW	x	x	x	x
Dona Ana	SW	x		x	
Grant	SW	x		x	x
Hidalgo	SW	x	x	x	x
Luna	SW	X		x	x
Otero	SW	x		x	x
Sierra	SW	X	x	x	x
Socorro	SW	x	x	x	x

Source: DOH

Appendix G: Mi Via Scorecard

Self Directed Waiver Best Practice Scorecard for New Mexico

Measures Provide or Assure:		
Best Practice	Done in New Mexico?	Explanation
Structure Measures:		
Fair Assessment of Need	?	Needs assessed by third party with unclear criteria
A fair and ample budget	✓	Clients' budget is determined by a third party based on need although additional clarity would be beneficial
Fair and Affordable Provider Rates	✓	Provider rate range set by state and clients negotiate with providers directly
Effective Provider Pay	?	Providers are paid by Conduent however we have anecdotal regarding providers not being paid timely
Information and Training	?	Clients need to provide training for staff. If employ an agency, training is left up to the agency.
Person Centered Planning	✓	Client has large role in budget and service package
A Stable and Qualified Workforce	?	NM has high provider turnover rates and the qualifications to be a Mi Via Provider are loose
Support quality is measured and assured	?	The state does not assess or measure provider quality
Public Transparency	?	Little information is available regarding services available and limited TA is available from regional offices.
Process Measures		
Individuals feel heard	✓	Waiver is person centered
Information exchange is adequate, not burdensome	?	Providers have complained about paperwork for themselves and the client.
Cultural Competency	✓	Client can choose employees and there diverse providers statewide
Individuals control their budget	✓	Clients receive a budget amount and can spend the money as they choose
Individuals choose providers	✓	Clients have control over who they hire with no oversight from the state and limited oversight from consultants
Money and supports are portable	✓	Money and supports are not contingent on where client is within the state but may vary based on provider availability in a region.
Supports meet changing needs	✓	Clients can be reassessed as needed so budgets and services can be changed to reflect current need.
Supports are available in a crisis	?	No available information has shown this is true for Mi Via
Community resources are utilized	✓	Family supports are often utilized for Mi Via participants, however the quality of these supports is not examined by the state
Peer support is available	?	No available information has shown there is peer support for individuals on the waiver

New Mexico's Score = 10/19

Source: Adapted from HSRI, Vorderer et al., 2009

Appendix H: Minnesota Self Directed Waiver Assessment

Minnesota Department of Human Services



Assessment Domains

SELF-DIRECTION

About this Domain (Self-Direction)

To assess the individual's interest in participating in self-directed series such as:

- PCA Choice
- Consumer Support Grant (CSG)
- Consumer Directed Community Supports (CDCS)
- Family Support Grant (FSG)

Self-Direction

The State of Minnesota has some programs that give people the opportunity to have more control over the services and supports they receive. The following questions in this section are to get an idea of how much help you might need if you decided to participate in one of the State's self-directed support programs.

The following 3 questions are only displayed for individuals age 18 and older:

Can this person identify their own needs?

- No
- Yes

Can this person direct and evaluate caregiver/PCA task accomplishments?

- No
- Yes

Can this person provide and/or arrange for their health and safety?

- No
- Yes

Is the person participating in the Alternative Care Program, home and community based waivers, MN managed care programs, PCA, FSG, HHA and/or PDN services?

- Participating and plan to continue participating
- Participating and plan to transition to CSG
- Not participating

Is the person participating in the Brain Injury (BI) Waiver, Community Alternative Care (CAC) Waiver, Community Alternatives for Disabled Individuals (CADI) Waiver, Consumer Support Grant, Developmental Disabilities (DD) Waiver, or Personal Care Assistance?

- Participating and plan to continue participating
- Participating and plan to transition to FSG
- Not participating

Is the person able to direct and purchase their own care and supports or have a family member, legal representative or other authorized representative available to purchase, arrange and direct care on their behalf?

- No
- Yes

Information provided about:

- CSG
- FSG
- CDCS
- PCA Choice

Comments: _____

Is the person interested in having more control over the services and supports received?

- No
- Yes

Comments: _____

Assessor Conclusions about the Person's Capacity for Independent vs. Supported Self-Direction

- Very little or no support needed for self-direction
- Can self-direct with support

Explain: _____ *(Displays when this option is checked)*

- Needs another person to direct their services

Explain: _____ *(Displays when this option is checked)*

- Don't have enough information to reach a conclusion
- Not applicable

Explain: _____ *(Displays when this option is checked)*

Does the person and/or their representative, if applicable, agree with your conclusion?

- No

Explain: _____ *(Displays when 'No' is checked)*

- Yes

Notes/Comments: _____

Self-Direction has been assessed? *(Displays for reassessment only)*

- Yes



Referrals & Goals (Self-Direction)

What is important to the individual?

Referrals Needed:

- County/Tribe Social Services _____ *(Displays if checked)*
- Disability Linkage Line (1-866-333-2466) _____ *(Displays if checked)*
- Managed Care Organization _____ *(Displays if checked)*
- MNHelp.info _____ *(Displays if checked)*
- Ombudsman _____ *(Displays if checked)*
- Senior Linkage Line (1-800-333-2433) _____ *(Displays if checked)*
- Other **Specify:** _____ *(Displays when 'Other' is checked)*
- Other **Specify:** _____ *(Displays when 'Other' is checked)*

Assessed Needs and Support Plan Implications

Referrals & Goals (Self-Direction) have been assessed? *(Displays for reassessment only)*

Yes

Appendix I: Eastern New Mexico University Roswell Special Services Program Outcomes Data, 2013-2015

Performance Data

	Total number of students enrolled	Number of students from NM	Percent of students from NM	Total number of students with DD	Percent of students with DD	Students from NM with DD	Percent of students from NM with DD
2013	67	31	46%	59	88%	28	90%
2014	54	21	39%	47	87%	18	90%
2015	55	25	45%	47	85%	23	92%

Success Data

	Is graduate working?	Is graduate working in their career field?	How many hours is graduate working?	What is the graduate's hourly wage?	Is the graduate living independently? Or in a supported environment?	Is the graduate continuing their education?
2013	79% 15/19	60% (9/15)	21.7 hours/week (average)	\$7.90 hourly wage (average)	Independent: 58% Supported: 42%	2% (4/23)
2014	79% (19/24)	68% (13/19)	22.4 hours/week (average)	\$8.25 hourly wage (average)	Independent: 46% Supported: 54%	29% (10/34)
2015	28% (13/28)	85% (11/13)	22.8 hours/week (average)	\$7.60 hourly wage (average)	Independent: 32% Supported: 68%	40% (19/47)

Source: ENMUR

Appendix J: Jackson Remedial Plan (Revised Table IV) as of January 2018

Table IV “Jackson Remedial Plan”
HEALTH PLAN
<p>GOAL 1: Consistent, informed and effective healthcare coordination.</p> <p>GOAL 2: Early identification of deteriorating health.</p> <p>GOAL 3: Provide a reliable available form of targeted technical assistance to providers of supported employment based on all provider reviews.</p> <p>GOAL 4: Competent and consistent care in line with recommendations and good practice.</p>
<p><i>Health Objective H1.1</i> Expectations for healthcare coordination are appropriate as evidenced by well-defined roles and responsibilities that are carried out and measured at the provider, region and state level.</p> <p>H1.1a The Department of Health (DOH) must define health care coordination roles and responsibilities at the provider, regional, and state levels in DOH policies, procedures, and standards.</p> <p>H1.1b The DOH must disseminate the definitions referred to in H1.1a to all pertinent providers.</p> <p>H1.1c The definitions of healthcare coordination roles and responsibilities must contain measurable performance indicators so that the DOH can assess whether the assigned responsibilities are carried out at the provider, regional, and state levels.</p> <p>H1.1d The DOH must annually evaluate the performance of healthcare coordination roles and responsibilities consistent with the measurable performance indicators through the use of the health field survey tool or other appropriate tools.</p> <p>H1.1e The DOH must take prompt action to address healthcare coordination performance that does not meet the measurable performance indicators.</p>
<p><i>Health Objective H1.2</i> Nurses routinely monitor Jackson Class Members’ individual health needs through (1) oversight, (2) communication with DSP (Direct Support Professionals), and (3) corrective actions in order to implement the Jackson Class Members’ health plans, to ensure that the Jackson Class Members’ health needs are being met, and to timely respond to changes in Jackson Class Members’ health status.</p> <p>H1.2a Defendants must ensure that each JCM’s healthcare needs, conditions, and risk factors are accurately documented in the JCM’s healthcare record.</p> <p>H1.2b DSP and their supervisors must receive training by nurses in order to competently and correctly implement each JCM’s healthcare plan.</p> <p>H1.2c Nurses must visit each JCM in accordance with DOH requirements.</p> <p>H1.2d Nurses must meet with DSP’s as needed based upon the JCM’s ECHAT acuity level and any significant change in health status to monitor the individual.</p> <p>H1.2e Defendants must ensure prompt revision of a JCM’s healthcare plan if there is a change in the JCM’s health status.</p>
<p><i>Health Objective H1.3</i> Teams use accurate health records for Jackson Class Members.</p>

H1.3a Defendants must monitor the accuracy of each JCM's health record, including the JCM's current healthcare plans.

H1.3b Each JCM's "Therap eCHATS" ("Electronic Comprehensive Assessment Tool") must be updated within 45 days before an IDT (Interdisciplinary Team) Meeting at which the JCM's annual ISP (Individual Service Plan) is created.

Health Objective H1.4 Teams (including the individual) have information (education, consultant and technical assistance) needed to achieve goals stated in individual Healthcare Plans, MERPs [Medical Emergency Response Plans], CARMPs [Comprehensive Aspiration Risk Management Plans] and written direct support instructions as appropriate to the individual.

H1.4a Upon request, DDS will assist IDTs to identify professionals with specialized skills to provide needed information, consultation, and technical assistance. DDS will inform IDTs of the availability of DDS's assistance.

H1.4b Each JCM must have access to healthcare professionals with specialized skills, as needed.

Health Objective H1.5 Identified health needs for Jackson Class Members, including daily medical considerations, are addressed in individualized healthcare plans, MERPs, CARMPs, and written direct support instructions as appropriate to the Jackson Class Members. Healthcare plans are reviewed and promptly modified in response to changes in health status.

H1.5a Defendants must prepare quarterly reports on a sample of the JCMs to monitor the accuracy of the JCMs' individual healthcare record.

H1.5b Defendants must take action to correct inaccuracies in the JCMs' individual healthcare record.

Health Objective H1.6 Current and complete information is provided to the healthcare professionals treating or evaluating the individual.

H1.6a Healthcare professionals, who treat or evaluate a JCM, must have a copy of the JCM's accurate "Health Passport."

H1.6b DOH will revise and distribute the Health Passport policy and procedure clearly stating that it is the DDW provider's responsibility to provide, in all settings, the accurate and up to date Health Passport and Physicians Consultation form to treating health care professionals.

H1.6c A JCM's provider must ensure a JCM's current healthcare information is provided to treating and evaluating health care professionals and the case manager must verify that through review of the Physician Consultation Form.

Health Objective H1.7 The team assures recommendations from healthcare professionals are reviewed with the individual and guardian in a manner that supports informed decision making and [are] either implemented, or documented in a Decision Consultation Form if recommendation is declined.

H1.7a A JCM's IDT must ensure that a healthcare professional's recommendations and assessments (1) are promptly communicated to the nurse, guardian, DSP, and entire healthcare team, as needed, and (2) are implemented, unless the individual or their healthcare decision maker declines the healthcare professional's recommendations by completing a Decision Consultation Form.

H1.7b A JCM's healthcare records must accurately identify and reflect any recommendations and assessments of the JCM's treating and evaluating healthcare professionals.

H1.7c Defendants, through appropriate personnel, e.g., provider agencies and case managers, must ensure that a healthcare professional's recommendations are implemented within the prescribed timeframe.

H1.7d The JCM's Case Manager must complete a Decision Consultation Form, as appropriate, for use by the JCM's healthcare professionals. The Decision Consultation Form must be kept in the JCM's healthcare records

Health Objective H1.8 Each Jackson Class Member will receive the Jackson Class Member's medications (1) in the doses prescribed, (2) in the manner and frequency prescribed, and (3) at the times prescribed.

H1.8a Defendants must monitor the accuracy of administration of prescription medications to each JCM.
H1.8b Defendants must take prompt action to correct any failure to properly administer medications to a JCM in accordance with prescriptions.

Health Objective H2.1 Jackson Class Members receive age appropriate preventive/early detection screening/immunizations for health risk factors.

H2.1a The DOH must publish and promote routine preventive and early detection healthcare screening standards guidelines that are consistent with national standards and adjustable for the age and the specific condition of each JCM.

H2.1b Each JCM must receive routine preventive screening and immunizations consistent with the national standards unless the JCM, in conjunction with the JCM's guardian and primary healthcare provider, makes an informed choice to reject the recommended screening and immunization standards.

Health Objective H3.1 Jackson Class Members receive increased intensity of services during acute episodes or illnesses.

H3.1a A nurse's monitoring, including nursing assessments and oversight, must increase during a JCM's acute episodes or illnesses.

H3.1b Prompt face to face visits by a Nurse must occur upon a JCM's significant change of condition unless the Nurse directs and the JCM receives care from a Healthcare Practitioner, from urgent care or from emergency services. This visit will include a nursing assessment, monitoring and management of JCMs acute illness or episodes. If the JCM receives care from a Healthcare Practitioner, from urgent care or from emergency services the nurse will promptly assess the JCM at the conclusion of the care.

H3.1c In each individual case where a Nurse fails to comply with DOH requirements regarding significant health status change, the provider will report the failure to IMB. IMB will investigate and take appropriate action and DOH will review patterns and trends via the health field tool and identify nurse performance issues, and will take corrective action.

Health Objective H3.2 Direct Service Personnel/supervisors are able to identify subtle signs of change/acute symptoms.

H3.2a The DOH must issue healthcare guidelines for use by healthcare provider staff about the timely identification of and response to changes in the health status of a JCM so that a JCM does not experience unnecessary pain, loss of optimal function, or regression. The DOH may develop "fact sheets" that define a specific health condition, related signs and symptoms, and recommended actions, or the DOH may develop other pertinent policies and procedures that provide the required guidance.

H3.2b Each JCM's healthcare plans and MERP's must contain individual specific information on how provider agency staff can identify subtle signs of change or acute symptoms.

H3.2c DSP and supervisors must receive and must complete appropriate training on how to timely identify signs of change or acute symptoms in a JCM.

H3.2d DSP and supervisors must promptly notify the nurse and document any acute symptoms and any signs of change in a JCM's health status.

Health Objective H3.3 When informed of signs of change in health status (including chronic and acute pain) agency nurses take immediate action.

H3.3a The pertinent DDW agency nurse must implement pain management strategies for addressing a JCM's chronic and acute pain.

H3.3b The DOH or pertinent agency must communicate these effective pain management strategies to the JCM's treating healthcare professionals.

H3.3c: The DDW Agency Nurse will evaluate the effectiveness of pain management strategies and record the effectiveness in nursing notes or on the MAR. If needed, the JCM's healthcare record will be promptly updated.

H3.3d Nurses must identify and must respond to signs of a JCM's chronic and acute pain and must take prompt action to reduce or to eliminate the JCM's pain.

Health Objective H3.4 When an individual is receiving healthcare in an out of home setting, critical health and functional information will be provided and the individual's existing adaptive equipment that can be used in that setting will be offered.

H3.4a The DOH must develop and must implement a procedure to ensure communication of a JCM's need for existing AT, adaptive equipment and supports to an out-of-home provider.

H3.4b The out-of-home provider must receive a JCM's Health Passport, along with information concerning the JCM's mobility, comfort, safety, and sensory items within 24 hours of the JCM's placement with an out-of-home provider.

H3.4c The necessary adaptive supports already used by a JCM must be offered to the out-of-home provider within 24 hours of the JCM's placement with an out-of-home provider.

Health Objective H3.5 When a JCM is receiving healthcare in an out-of-home setting, the IDT will plan for a smooth transition back to the JCM's home as soon as medically feasible.

H3.5a The JCM's case managers, Agency Nurses and pertinent Regional Office staff will meet promptly to plan for a JCM's safe discharge.

H3.5b The JCM's e-CHAT and other healthcare records must be promptly updated by appropriate healthcare providers to indicate healthcare and adaptive supports that the JCM received from the out-of-home provider in order to ensure a safe and smooth transition back to the JCM's home.

Health Objective H4.1 Competent personnel (nurses, DSP, front line supervisors, ancillary providers, and case managers), who have received and passed competency based training related to prevention and early identification, provide services to Jackson Class Members. (Ashton #6, 7, 8)

H4.1a The parties and the JCA must develop a mandatory competency based training program.

H4.1b Nurses, DSP, front-line supervisors, ancillary providers, and case managers must satisfactorily complete the mandatory competency based training program.

H4.1c The DOH must independently measure compliance by nurses, DSP, front-line supervisors, ancillary providers, and case managers with mandatory competency based training.

H4.1d The DOH must take prompt remedial action for nurses, DSP, frontline supervisors, ancillary providers, and case managers who are found deficient in the mandatory competency based training.

H4.1e Nurses, DSP, front-line supervisors, ancillary providers, and case managers must receive information specific to Ashton #6, 7, and 8, as outlined in the Health Communications Matrix.

Health Objective H4.2 IDTs provide for the changing health supports class members need as they age including advanced care planning and have access to palliative care consistent with their individual needs.

H4.2a Case managers and agency nurses must provide up-to-date information and resources to JCMs and their guardians about advanced care planning and palliative or end-of-life care so that the JCMs and their guardians can make informed choices.

H4.2b The DOH must identify, and must document on an annual basis in the pertinent healthcare records, those JCMs who want advanced care planning, including palliative care, and those JCMs who decline advanced care planning.

H4.2c The DOH must provide advanced care planning and palliative care to those JCMs who choose to have advanced care planning and palliative care.

Health Objective H4.3 Quality Assurance information is used to improve health outcomes.

H4.3a. The DOH must use existing quality assurance information and tools – including the measurements found in the CPR (Community Practice Review), Out-of-Home Placement, Emergency Services Utilization, ANE (Abuse, Neglect, and Exploitation) Reporting, and Provider QA (Quality Assurance) Reports to identify gaps in the healthcare services to JCMs and to improve healthcare outcomes to JCMs.

SAFETY PLAN

GOAL 1: The recommendations from the JCA’s report on the incident management system prepared by Eva Kutas are implemented. Incidents of abuse, neglect and exploitation are timely reported, professionally investigated, and needed corrective actions are promptly implemented and sustained.

GOAL 2: Deaths are reviewed in a timeframe consistent with DOH policy by a team of qualified, independent healthcare professionals and relevant administrative personnel. Detailed findings and recommendations, as appropriate are issued and recommendations from the MRC and corrective actions are implemented. Deaths are reviewed as a learning opportunity to improve quality at the individual, program and systems level. Incidents, deaths and significant events are documented and analyzed, root causes are identified and deficiencies are adequately remediated.

GOAL 3: The quality of services, settings, and supports provided by community agencies are evaluated at least annually through the Community Practice Review and at other intervals as appropriate, through provider reviews; any deficiencies are identified, corrective actions are taken and sustained on an individual, program and regional basis.

GOAL 4: Prompt and effective action is taken with respect to provider agencies where serious incidents, deaths, patterns of incidents or of significant events or serious programmatic deficiencies have been identified, in order to protect class members, to reduce the risk of future harm and to ensure that quality services and supports are provided.

GOAL 5: Establish measurable indicators of quality and develop an integrated data collection system that collects, analyzes, and employs information from multiple sources to ensure that these quality indicators are met, the safety of Jackson Class Members is protected, and quality services are provided for Jackson Class Members.

Safety Objective SI.1.1 Define “Abuse, Neglect and Exploitation” (ANE) consistent with New Mexico Statutory Adult Protective Services (APS) definitions. Disengaged on February 11, 2016. See Doc 2095

S1.1a The DOH must promulgate revised regulations that define ANE consistent with APS definitions.
(DISENGAGED)

Safety Objective SI.1.2 Provide educational information about how to detect ANE.

S1.2a The DOH must develop and must provide annually educational information to providers, physicians, clinicians, families, guardians, and law enforcement about detecting ANE.

Safety Objective SI.1.3 The individuals listed in POA [Plan of Action] CIMS B [Community Incident Management System] [regional coordinators, agency coordinators, direct contact staff, DD[S] D staff, case managers, agency executive staff, IMB investigators, agency IMCs, agency direct service staff] will receive the training described in the Eva Kutas Recommendations #7 and #8 and will pass a formal test of the individuals’ knowledge and understanding of IMB provider policy requirements.

S1.3a All current and new staff as listed in POA CIMS B and the DDS staff (Regional Directors, Assistant Regional Office Bureau Chief, and the DDS Training Unit) must successfully complete DHI’s competency based training on ANE from a DHI Trainer or a DHI approved trainer that incorporates the principles of adult learning as described in Kutas Recommendations # 7 and #8 before working alone with JCMs and their guardians.

S1.3b. All current and new staff in POA CIMS B and the DDS staff must demonstrate a knowledge and understanding of the training received in S1.3a and S1.3b by passing a formal test.

S1.3c. All current and new staff listed in POA CIMS B and the DDS staff must receive refresher competency based training on an annual basis.

Safety Objective SI.1.4 ANE is reported immediately. Disengaged. See Doc. 2140 dated 2/16/17.

S1.4a The DOH must maintain a toll-free 24 hour, 7 days a week, telephone number to receive reports of ANE.

S1.4b The DOH must communicate to its staff and the providers who have contact with JCMs that ANE of JCMs must be reported immediately.

S1.4c IMB must formally document reports of ANE of JCMs and must take corrective action when ANE is not reported immediately.

(DISENGAGED)

Safety Objective SI.1.5. Providers will take immediate action to develop a safety plan after an allegation of ANE to protect the alleged victim(s) during the course of an investigation. Disengaged. See Doc. 2141 dated 2/16/17.

S1.5a Providers for JCMs must immediately develop, with IMB approval and monitoring, an Immediate Action and Safety Plan (IASP) in all cases of reported ANE.

S1.5b The DOH must monitor providers for compliance with IASPs and must take corrective action as needed.

(DISENGAGED)

Safety Objective S1.1.6 Severity of the alleged ANE dictates the investigation response. JCA Disengagement Determination Received on 3/1/17.

S1.6a The DOH must establish a priority of investigation responses consistent with the applicable policy and severity guidelines which requires investigative responses be three hours or less for emergencies, 24 hours or less for Priority 1 incidents, and 5 days or less for Priority 2 incidents.

(DISENGAGED)

Safety Objective S [Kutas] 1.2.1 Competent ANE Investigators conduct professionally adequate investigations.

S2.1a ANE Investigators must pass Core Competency and Field Training before conducting investigations of ANE.

S2.1b The JCM Supervisory Review Tool must be used to assess an ANE investigation in every case of ANE.

S2.1c ANE investigations must not be closed until they meet the standards of the Supervisory Review Tool, which verifies whether the investigation meets the standard for professionally adequate investigations.

S2.1d The DOH must review ANE intake and investigation quality, consistent with the Kutas quality indicators, on a quarterly basis.

Safety Objective S [Kutas] 1.3.1 Consistent with the IGA (Inter-Governmental Agreement), IMB will be the primary authority for ANE investigations. Disengaged. See Doc. 2141 dated 2/16/17.

S3.1a The DOH must promulgate administrative rules that delineate the IMB's responsibilities as they relate to the IMB's primary authority to conduct ANE investigations.

S3.1b The DOH must monitor the provider's compliance with these administrative rules on a quarterly basis and must promptly correct any deficiencies.

(DISENGAGED)

Safety Objective S [Kutas] 1.4.1 Provide information regarding ANE reports/investigations to designated stakeholders. Disengaged. See Doc. 2147 dated 6/29/17.

S4.1a The DOH must provide timely information regarding ANE reports, investigations, and findings to JCMs, stakeholders (families, guardians, providers, case managers), and other individuals or staff who need that information to ensure the safety of JCMs.

S4.1b The reporter of ANE must receive information from the DOH about the status of the ANE report and any findings.

S4.1c Notification of substantiation of ANE reports must comply with New Mexico Administrative Code 7.1.14.12 (Notification of Investigation Results).

(DISENGAGED)

Safety Objective S [Kutas] 1.5.1 Risk of ANE is reduced when individual/systems issues are identified and preventive] and remedial measures are taken.

S5.1a When there is substantiated ANE, Defendants must take immediate preventive and remedial action at the individual and provider levels and if indicated at the systems level.

S5.1b When there is substantiated ANE, the case manager must ensure that identified health and safety risks for a JCM are addressed and remediated.

S5.1c Providers and regional office staff must review ANE investigations and findings to determine if responses to substantiated ANE are timely, effective, and sustained.

S5.1d When there is substantiated ANE, the JCM's IDT must meet as required by NMAC and pertinent information about the ANE investigation and the ANE report must be properly documented, including in the IDT meeting minutes for purposes of reducing and preventing ANE.

Safety Objective S [Kutas] 1.6.1 Use ANE information to improve health/safety.

S6.1a The DOH must implement the IMB database to identify patterns concerning ANE at the individual, program, and systems levels.

S6.1b Quarterly, the DHI and DDS must examine IMB data and must identify patterns of ANE, indicated, for example, by multiple reports of ANE by providers or JCMs, by substantiated cases of ANE, by use of emergency services in response to ANE, and by out-of-home placements resulting from ANE.

S6.1c The DOH must disseminate at least annually, to providers and stakeholders, information about ANE, including patterns of ANE, identified "systems" issues concerning ANE, and identified causes and contributing factors of ANE.

Safety Objective S2.1 All deaths are reviewed and a root cause analysis is done of preventable deaths. The findings from the root cause analysis will be used to strategically reduce the likelihood of preventable deaths.

S2.1a Qualified independent healthcare professionals must timely review and report to the Mortality Review Committee (MRC) on all JCM deaths. Relevant administrative personnel must timely report to the MRC and review all JCM deaths.

S2.1b The DOH must provide autopsy reports and independent healthcare professionals' reports of JCMs' deaths to the Mortality Review Committee (MRC), promptly after their receipt that then reviews and analyzes all JCM deaths, and makes findings and recommendations.

S2.1c The DOH must identify and take appropriate actions in response to the MRC's findings and recommendations.

S2.1.d The DOH mortality review process must be consistent with the components in the General Accounting Office Mortality Review Report, GAO-08-529, as tailored for New Mexico's population and demographics.

S2.1e In response to analysis of JCMs' deaths and the mortality review process, in the case of preventable deaths the DOH must identify root causes of the JCM deaths and must remediate identified deficiencies so as to reduce the likelihood of preventable deaths.

Safety Objective S3.1 Establish and use indicators to measure quality of DD [Developmentally Disabled] Services in New Mexico.

S3.1a The DOH must establish "DD key indicators" at the individual, program, and systems levels that guide programs and services for JCMs.

S3.1b The DOH must ensure that the DD key indicators are present in the DDW provider agreements, DDW (Developmentally Disabled Waiver) standards, and the QMB (Quality Management Bureau) review tool.

S3.1c Through the use of the CPR, QMB and other JCM data, the DOH will identify and document whether the JCM's preferences and needs, with respect to gaining skills, increasing independence, and participating in integrated community activities are met.

S3.1d The DOH and providers must respect a JCM's informed choices for program development and services to meet the JCM's preferences and needs.

S3.1e Providers must use information from the DD key indicators, the CPR, and the JCM to promptly correct deficiencies in programs and services and to improve practice.

Safety Objective S3.2 Community Practice Reviews are provided by competent personnel as evidenced by reviewers who have passed competency based training.

S3.2a Community Practice Reviewers must satisfactorily complete mandatory competency-based training as identified by the Community Monitor before independently participating in the CPR.

S3.2b The Community Monitor must approve Community Practice Reviewers and Case Judges.

S3.2c The Community Monitor must determine the CPR sampling methodology, protocol instrument, reviewers' guidelines, scoring, and evidence used to assess compliance with the elements of the CPR, consistent with related requirements in the JSD (Joint Stipulation on Disengagement)

Safety Objective S3.3 Implement the CPR.

S3.3a The DOH must annually conduct the CPR consistent with the Community Monitor's existing sampling methodology, protocol instrument, reviewers' guidelines, scoring, and evidence.

S3.3b The Community Monitor must issue individual, regional, and statewide reports that contain the Community Monitor's findings and recommendations.

S3.3c The DOH must continue to provide adequate resources to support the implementation of the CPR for purposes of demonstrating sustainability.

Safety Objective S3.4 Use the findings from the CPR to improve services for class members and to improve the system of services for Jackson class members.

S3.4a DDSD must work with service providers and case management agencies that have "repeat findings" of deficiencies or problems to improve and sustain improvement with respect to the identified deficiencies or problems.

S3.4b The DDSD and providers must use the 2013–2015 CPR findings and recommendations.

S3.4c DDSD must meet with providers that have high health risk-related findings and providers that have the highest number or 2013–2015 CPR findings of deficiencies to improve those providers' services to JCMs.

S3.4d Defendants must identify actions taken in response to the 2013–2015 CPR findings and ensure that deficiencies are remedied.

Safety Objective S3.5 Competency based training is provided based in part on analysis of identified deficiencies from the CPR through the DDSD required trainings and to specific entities as appropriate.

S3.5a DDSD must evaluate CPR findings to identify deficiencies in its required competency-based training.

S3.5b Using its evaluation of CPR findings, the DDSD must modify existing competency-based training or must provide additional competency-based training to address identified deficiencies.

S3.5c When training is needed to address identified deficiencies, competency based training must be provided to address deficiencies.

Safety Objective S3.6 Use information from the CPR in an integrated manner to inform program development and management for class members.

S3.6a DOH must develop, modify, and manage the service system for JCMs based on identified correlations in the CPR information and other JCM data.

S3.6b DDS must file semi-annual reports identifying program development and implementation.

Safety Objective S3.7 Regulatory program reviews are completed by staff who have received and passed competency based training specific to their QMB roles and responsibilities.

S3.7a DHI/QMB staff must receive competency-based training for evaluating programs that serve JCMs.

S3.7b DHI/QMB staff must satisfactorily complete competency-based training before evaluating programs and providers that serve JCMs.

Safety Objective S3.8 Regulatory review of CM [case management] agencies by the QMB, will include a review of essential services as determined by professional assessments and IDT decisions of individual needs and preferences.

S3.8a QMB must identify and must review the essential services that should be provided to JCMs, consistent with IDT decisions and determinations by medical professionals, therapists, and nutritional experts.

S3.8b QMB must modify its CM data to reflect the identified essential services for JCMs.

S3.8c QMB must review CM agencies on an annual basis, using quality indicators consistent with the DDS 2006 Case Management Manual Resource Guide and DDS Service Standards, to ensure essential services are being provided to JCMs.

Safety Objective S4.1 Examine current Quality Assurance and Quality Improvement processes and activities intended to safeguard Jackson Class Members and to improve the quality of provider performance in relation to Jackson Class Members. Take steps to increase transparency, accountability, and effective remediation. Establish measurable indicators that are consistent with the pertinent standards that address the quality of provider performance.

S4.1a Using stakeholder input, DDS will analyze its quality assurance and quality improvement systems and will modify these systems accordingly to improve the quality of services and of provider performance for JCMs.

S4.1b The DOH must annually evaluate the quality of providers' services and must promptly issue "provider report cards" that use measurable indicators to identify strengths, deficiencies, and remediation plans of the providers.

S4.1c The DOH must allow public access to the provider report cards

S4.1d Clear, current and specific information about available provider services will be available to the public as part of the Provider Selection Guide.

S4.1e The DOH must review a provider more frequently in cases where there is evidence that the provider has an increased number of deficiencies or increasingly serious deficiencies.

Safety Objective S4.2 DOH response is proportionate to the seriousness of the contractor's alleged substandard performance when corrective action is not effectively implemented.

S4.2a Defendants must identify a provider's deficiencies in cases where the contractor failed to effectively implement corrective action.

S4.2b Defendants must take remedial action proportional to the seriousness of the substandard performance by a provider that fails to effectively implement an identified corrective action.

Safety Objective S5.1 Providers will use the identified performance indicators as part of their agency quality assurance system to improve quality.

S5.1a The DOH must establish measurable quality indicators, including (1) implementation of a QA/QI (Quality Assurance/Quality Improvement) Plan, (2) implementation of ISPs, (3) analysis of General Events Reports data, (4) compliance with Caregivers Criminal History Screening requirements, (5) compliance with Employee Abuse Registry requirements, (6) compliance with DDS training requirements, (7) patterns of reporting incidents, and (8) results of improvement actions taken in Quarters, at the individual, program, and systems levels.

S5.1b The DOH must communicate these required measurable quality indicators to providers.

S5.1c Providers must use the required measurable quality indicators to improve the quality of their services to JCMs.

S5.1d The DOH must determine providers' compliance in using the measurable quality indicators through the use of QMB surveys.

Safety Objective S5.2 Use significant events reported through GER (General Events Reporting) -- including use of emergency services, falls, medication errors, and law enforcement incidents -- to support DD system management, that includes responses to significant events.

S5.2a Defendants must use the GER information to identify the JCMs most at risk, to inform providers and regional staff of JCMs most at risk, and to request the development and implementation of prevention plans specific to a JCM's identified risks.

S5.2b Defendants must provide DDSQI with significant event information found in electronic reporting through Therap GER for use by members of the joint DDS and DHI Significant Events Committee in program development and improvement.

S5.2c The DOH must (1) analyze significant event information, (2) identify trends in provider performance, (3) intervene, and evaluate the effectiveness of the intervention.

Safety Objective S5.3 Implement a responsive and effective case management system as evidenced by the provision of needed supports and services

S5.3a Case managers must demonstrate that they know the current strengths, needs, preferences, and medical conditions of each JCM they serve and the JCM's ISP must address these factors.

S5.3b Case Managers must ensure that each JCM's ISP is properly implemented.

S5.3c Case Managers must identify significant risks, needed supports, and unmet needs for each JCM; must convene the IDT promptly whenever a JCM is at risk or a JCM's needs are not being fully addressed; must ensure DOH if the IDT is unable to adequately meet a JCM's needs.

S5.3d The DOH must monitor and evaluate the performance of each case management agency on an annual basis and must use its evaluation to determine whether the case management agency should be enrolled as a DD Waiver provider.

Safety Objective S5.4 Develop and implement an effective, integrated DD Strategic Information Management System.

S5.4a The DOH must evaluate its information management system's ability to use information related to JCMs in an integrated manner.

S5.4b The DOH must ensure that the "ad-hoc reports pulled from HSD's MMIS" are available from DDS.

S5.4c Defendants must evaluate the usefulness and gaps in the above described data collection system and must modify or update the system where practicable.

SUPPORTED EMPLOYMENT PLAN:

GOAL 1: People who want to work will work.

GOAL 2: Every class member will have access to a quality network of providers throughout the state. Providers who cannot achieve work goals are eliminated.

GOAL 3: Provide a reliable available form of targeted technical assistance to providers of supported employment based on all provider reviews.

GOAL 4: Assist class members to have meaningful lives.

Supported Employment Objective SE 1.1 Achieve an annual increase of Jackson Class Members working “at criteria,” in accordance with information gathered regarding the Jackson Class Members’ abilities and desires to be employed, and the guardians’ positions on employment of the Jackson Class Members. Defendants must provide technical, supported employment assistance to the Jackson Class Members and support for teams to assist all qualified and willing Jackson Class Members to obtain “at criteria” employment.

SE1.1a Defendants must obtain current statistics on JCMs who are not working at criteria, but who wish to work and are capable of working at criteria, provided the JCMs’ guardians support working at criteria.

SE1.1b Defendants must provide technical vocational assistance and support through job developers and job coaches for all JCMs identified in SE1.1a.

SE1.1c Defendants must achieve an annual increase in the number of JCMs working at criteria, consistent with SE1.1a.

SE1.1d Defendants must provide technical assistance to JCMs and their teams to obtain jobs for JCMs consistent with the federal definition of Supported Employment.

Supported Employment Objective SE 1.2 Defendants will increase the number of qualified providers statewide in order to increase the number of Jackson Class Members earning minimum wage or better, and to increase the average number of hours per week worked by Jackson Class Members. Defendants will develop a plan with time lines to provide quality supported employment at criteria to all priority class members who are determined to be appropriate for work.

SE1.2a Defendants must develop a written strategy and process to recruit and retain qualified employment providers for all JCMs who wish to and are able to work at criteria, with their guardians’ consent.

SE1.2b Defendants must provide a current written list of qualified employment providers to JCMs and their guardians.

SE1.2c Defendants must use the list of qualified employment providers to increase the number of JCMs earning minimum wage or better and to increase the number of hours per week worked by JCMs.

SE1.2d Defendants must create and must disseminate a timeline with target dates for the employment at criteria of all JCMs who wish to work, who can work, and who have the consent of the guardians to work at criteria.

SE1.2e Defendants must maintain and must report annual statistics on the number of (1) JCMs who wish to work at criteria, (2) JCMs who can work at criteria with their guardians’ consent, and (3) JCMs who are working at criteria. Defendants must correlate these annual statistics with the target dates in the timeline.

Supported Employment Objective SE 1.3 Personnel who develop or implement career development plans will receive and pass competency based training based on DDW standards on career development planning.

SE1.3a Defendants must develop competency based training on DDW standards for career development planning.

SE1.3b Personnel must have satisfactorily passed competency based training on DDW standards for career development planning before providing career development planning to JCMs and their guardians.

Supported Employment Objective SE 1.4 Increase capacity to create traditional and non-traditional paths to employment.

SE1.4a The DDS Deputy Director must develop an approved action plan to deploy an SE expert or experts to work with qualified employment providers to increase the number of traditional and non-traditional employment opportunities for JCMs to work at criteria.

SE1.4b Defendants, through Partners for Employment, must deliver customized employment training to qualified employment providers in reference to employment of JCMs at criteria.

SE1.4c Defendants must use funding available through the IGA for the development of JCMs' vocational assessment profiles (VAPs).

SE1.4d Defendants must demonstrate through annual statistics that they have increased the capacity to provide traditional paths for employment of JCMs at criteria.

Supported Employment Objective SE 1.5 Individual records (including ISPs) of Jackson Class Members will contain accurate employment plans that include information about the Jackson Class Members' desires to work, the Jackson Class Members' skills for existing jobs, and whether the guardians want the Jackson Class Members to work.

SE1.5a Defendants, through appropriately trained personnel, must update each JCM's ISP with a current and accurate employment plan, including information about the JCM's employment goals and whether the JCM wishes to work, has skills for existing work, seeks traditional or nontraditional work, and has the guardian's consent to work.

Supported Employment Objective SE 1.6 When there is a change in an individual's life that impacts their employment status, the team will meet within 10 days and take action to minimize the disruption to the class member's employment.

SE1.6a Defendants must have a system in place to minimize the disruption to a JCM's employment when a JCM suffers a "life change" (hospitalization, significant health status change, relocation to another city, loss of employment).

SE1.6b Defendants must promptly document any life change for a JCM in appropriate forms, including Case Management Site Visit Forms and IDT Meeting minutes.

SE1.6c The JCM's team must meet within ten (10) days of a JCM's life change to take appropriate actions to minimize a disruption in the JCM's employment.

Supported Employment Objective SE2.1 Qualified regional providers will be available in each region for each individual seeking employment.

SE2.1a Defendants must develop a process to produce a list of qualified employment providers in all regions of the State for JCMs who seek employment.

SE2.1b Defendants must create written standards that qualified employment providers must meet, including standards addressing employment goals for JCMs.

SE2.1c Qualified employment providers that do not meet Defendants' standards must be placed on probation for a period not to exceed six (6) months. If a qualified employment provider does not meet Defendants' standards by the end of the probationary period, Defendants must eliminate that employment provider from the list.

SE2.1d Defendants must ensure that JCMs in every region of the State have some choice of qualified employment providers. Defendants need not provide qualified employment providers in regions of the State where there are no JCMs who seek employment.

Supported Employment Objective SE2.2 Defendants will implement the Employment First Policy that explicitly sets forth the role and importance of employment, as well as expectations for employment, in a Jackson Class Member's life.

SE2.2a The DOH must develop and must implement an Employment First Policy consistent with professionally accepted standards of practice that apply to a JCM.

SE2.2b The Employment First Policy must set forth in writing the role and importance of employment for a JCM and a JCM's expectation of employment.

SE2.2c The DOH must make available to a JCM and the JCM's family and guardian information on how to obtain vocational assistance, vocational assessment, assistance for non-traditional employment, and DVR services.

Supported Employment Objective SE2.3 Clarify what the employment first principle means in terms of day-to-day practice for all stakeholders (people with disabilities, family members, providers, guardians, advocates, case managers, DDS, DVR, Partners for Employment).

SE2.3a Defendants must communicate to stakeholders, including pertinent agency personnel, the meaning of New Mexico's Employment First Policy as it relates to day-to-day practice and assistance to JCMs and their guardians.

SE2.3b Defendants must communicate information about New Mexico's Employment First Policy through formal training sessions, delivery of written materials, or other outreach efforts.

SE2.3c Defendants must use the proposed Communication Matrix—which contains columns indicating audience size, frequency of event, method of communication, key message delivered, and date of communication—to identify communications about New Mexico's Employment First Policy.

Supported Employment Objective SE2.4 Identify quality employment providers based on employment outcome data.

SE2.4a Defendants must measure qualified employment providers through employment outcome data that includes each JCM's name, start and end date of each job, employer of record, wages earned, hours worked, and summary of qualified employment providers' assistance.

Supported Employment Objective SE2.5 Review CPR and other employment data. Analyze data and use the resulting information annually to help make improvements to the employment system and improve provider performance.

SE2.5a Defendants, in consultation with the Jackson Employment Expert, must maintain and must analyze current employment data and the CPR.

SE2.5b Defendants, through the Statewide Supported Employment Lead will use the resulting information to enhance employment outcomes for individual JCMs and the employment system.

Supported Employment Objective SE2.6 Increase the number of qualified providers statewide. Qualified providers are defined as those that get people jobs in the community, maintain jobs and help individuals with career advancement.

No need for evaluative component per court order.

Supported Employment Objective SE2.7 CMs will demonstrate competence in facilitating IDTs regarding employment outcomes for class members. Competence will be demonstrated by passing competency based training regarding DOH employment policies.

SE2.7a DOH, in consultation with the Jackson Employment Expert, must provide competency-based training for all JCM case managers.

SE2.7b DOH must identify JCM case managers who have not passed the competency-based training and must take appropriate actions until the case managers are successful.

Supported Employment Objective SE2.8 DOH will disseminate information to CM[s], Providers and IDTs regarding strategies for overcoming identified barriers to employment and will promote use of the RORI system by CMs, providers and IDTs to seek assistance from DOH when they encounter obstacles related to employment. DOH will review and use the information from the RORIs at least annually.

SE2.8a The DOH must collect annual data and information useful in identifying barriers to employment and in developing strategies for overcoming barriers to employment for JCMs. The data and information may include CPRs, RORIs, and input from JCMs, JCMs' families and guardians, case managers, providers, DDSD personnel, DVR personnel, and advocates.

SE2.8b The DOH must disseminate the information addressed in SE2.8a to case managers, providers, JCMs, guardians, and IDTs.

SE2.8c The DOH must collect RORI information on an annual basis and must promote RORI use to identify barriers that JCMs encounter in obtaining employment.

Supported Employment Objective SE2.9 Qualified employment providers have capacity to do individualized job development.

SE2.9a Defendants must provide adequate training for providers that are unable to perform the individualized job development.

Supported Employment Objective SE2.10 Qualified employment providers have the capacity to provide individualized job supports to JCMs.

SE2.10a For JCM's who need job supports, Defendants will ensure qualified supported employment providers can supply the required job supports.

Supported Employment Objective SE2.11 Provider agencies use outcome data to improve practice.

SE2.11a Defendants must identify outcome data related to employment of JCMs that will assist provider agencies to improve their services to JCMs. That data may include information concerning provider agencies

that are successfully developing jobs for JCMs at criteria or above criteria, provider agencies that are successfully supporting JCMs in maintaining community based jobs at criteria or above criteria, and provider agencies that are enabling JCMs to work more hours, receive higher wages, and obtain greater levels of social integration.

SE2.11b Defendants must disseminate to provider agencies annual outcome data that Defendants deem helpful for use by provider agencies to improve services to JCMs.

SE2.11c Provider agencies must use “the required QA/QI agency plan in regard to ISP implementation specific to Supported Employment.”

Supported Employment Objective SE3.1 Defendants will inform employment providers where to refer Jackson Class Members for a complete, person-centered vocational assessment, and employment providers will understand the requisite elements of a person-centered vocational assessment as defined by Defendants.

SE3.1a Defendants must identify appropriate tools, e.g., the “Assessment Toolkit,” for employment providers, including information about where to refer JCMs for a complete person-centered vocational assessment.

SE3.1b Defendants must develop training on how to use the Assessment Toolkit, and DDS Supported Employment Coordinators and other pertinent staff must receive that training.

SE3.1c Defendants must provide training to employment providers on how to use the Assessment Toolkit.

SE3.1d Defendants must inform employment providers that they may schedule follow-up meetings with Defendants about the use of the Assessment Toolkit.

Supported Employment Objective SE3.2 IDTs are informed about the importance of accommodations to increase independent performance in the workplace.

SE3.2a IDTs, case managers, and qualified employment providers must complete competency based training regarding the importance of accommodations, supports, and assistive technology for a JCM so as to maximize a JCM’s independent performance in the workplace.

SE3.2b IDTs, case managers, and qualified employment providers must understand, through training and written communications, the availability of accommodations, supports, and assistive technology for use by a JCM in the workplace.

SE3.2c Defendants must document the transmittal of information about the importance of accommodations and supports for a JCM to IDTs, case managers, and qualified employment providers.

Supported Employment Objective SE3.3 Use the statewide employment institute to provide training and technical assistance to the field to advance employment opportunities for class members.

SE3.3a The DOH and University of New Mexico must have a formal agreement that requires Partners for Employment to respond to requests for employment information and consultation.

SE3.3b Partners for Employment must provide training, technical assistance, information, and support to employment providers, JCMs and their families and guardians, and the IDTs in order to advance employment opportunities for JCMs.

SE3.3c Defendants must report quarterly the requests for information about employment, training, technical assistance, consultation, and support made to Partners for Employment that it provided regarding JCMs.

SE3.3d Defendants quarterly reports must disclose Partner’s for Employment’s success in assisting the advancement of employment opportunities for JCMs. When feasible, the reports will include quantitative information.

Supported Employment Objective SE3.4 DDSD will provide technical assistance to teams as requested for individuals whom they support to access employment opportunities.

SE3.4a DDSD must identify necessary technical assistance and information to provide to IDTs and JCMs and their guardians for purposes of responding to JCMs' employment inquiries and issues.

SE3.4b DDSD must respond to inquiries about employment opportunities and provide appropriate job-related technical assistance and information that may include job coaching, mentoring, and problem solving to IDTs and JCMs and their guardians.

Supported Employment Objective SE3.5 Defendants, through UNM/CDD Partners for Employment will provide training for people with disabilities, family members, providers, guardians, advocates, case managers, DDSD and DVR consistent with the Employment First Principle. Preparing disengagement

Supported Employment Objective SE3.6 Defendants will provide training to employment providers and case managers on evidence based practices in Supported Employment.

Supported Employment Objective SE3.7 Defendant(s) will work with Partners for Employment (formerly known as Employment Institute) to maintain an ongoing learning collaborative.

SE3.7a Defendants must continue to fund and support Partners for Employment in accordance with an active formal agreement between DDSD and UNM, pertinent state procurement rules, and funding appropriated by the state legislature.

SE3.7b The Partners for Employment program is intended to provide a learning collaborative that enhances employment opportunities for JCMs.

SE3.7c Defendants must annually evaluate the outcomes and efficacy of Partners for Employment as the program relates to employment services for JCMs.

SE3.7d Defendants must communicate the results of the annual evaluation with Partners for Employment.

Supported Employment Objective SE4.1 Class members are able to explore community work experiences including job sampling, trial work experiences and volunteering.

SE4.1a Defendants must identify JCMs who wish to do job sampling, trial work, or volunteering, provided the JCMs have their guardians' consent to do this type of work.

SE4.1b Defendants must identify processes that encourage job sampling, trial work experience, and volunteer opportunities for JCMs identified in SE4.1a.

SE4.1c Defendants must communicate processes identified in SE4.1b to JCMs and their guardians, IDTs, case managers, and qualified employment providers.

SE4.1d Defendants must ensure that there are qualified employment providers in each region that will afford opportunities for job sampling, trial work experiences, and volunteer opportunities for JCMs identified in SE4.1a.

Supported Employment Objective SE4.2 Decrease the amount of time class members spend in congregated, segregated settings for persons with D/D and work with IDTs to promote participation in community activities and generic resources that are comparable to those used by non-disabled persons of the same age.

SE4.2a Defendants must identify JCMs who are in “congregated, segregated settings for persons with D/D” and who do not wish to be in these settings.

SE4.2b For those JCMs identified in SE4.2a, Defendants must take steps to decrease the amount of time the JCMs spend in congregated, segregated settings, provided the JCMs’ guardians agree.

SE4.2c Defendants must provide education and competency-based training to IDTs and pertinent personnel concerning the importance of having JCMs participate in integrated community activities and reducing the time spent by JCMs in congregated, segregated settings.

SE4.2d Defendants must annually identify and monitor those JCMs who wish to reduce time spent in congregated segregated settings and those JCMs who spent reduced hours in congregated, segregated settings.

<p>OUTCOME E ISP: People will receive appropriate services / supports through integrated and meaningful ISP’s</p>	<p>SEE ABOVE-Page 1 of this document. PLAN OF ACTION Activities Remaining</p>
<p>Individual Service Planning</p> <p>OUTCOME C: Identify and correct ISP deficiencies, both individual and systemic, using the community audit information</p>	
<p>OUTCOME K ASSISTIVE TECHNOLOGY: People will have access to appropriate Assistive Technology</p>	<p>DISENGAGED</p>
<p>Assistive Technology</p> <p>OUTCOME A: Enhance and expand the Assistive Technology Initiative statewide.</p>	
<p>2005 Appendix A to the Plan of Action</p> <p>MEANINGFUL DAY SERVICES</p>	<p>SEE ABOVE Page 1 of this document. APPENDIX A Activities Remaining</p>

<p>2005 Appendix A to the Plan of Action DIVISION OF VOCATIONAL REHABILITATION</p>	<p>SEE ABOVE-Page 2 of this document. APPENDIX A Activities Remaining</p>
<p>1998 Audit Recommendations</p>	<p>DISENGAGED 12/14/15 Doc. 2076 Disengaging the 1998 Audit</p>
<p>JSD Continuous Improvement</p>	<p>ISP JSD Paragraph 35 Metro: Total Program Adequate: DISENGAGED Doc. 2069 Adequate Use of Generic Services</p> <p>Person Integrated Into Community</p> <p>Southeast:</p> <p>Total Program Adequate: Doc. 2074 Plaintiffs Opposed Response, Doc. 2077 Reply in Support of the Motion to Disengage</p> <p>Southwest:</p> <p>Person Integrated into Community</p> <p>Behavioral Supports JSD Paragraph 36</p> <p>Northeast:</p> <p>Behavior Services Integrated into ISP</p> <p>Northwest:</p> <p>Behavior Services Integrated into ISP</p> <p>Southeast:</p> <p>Person Receive Behavior Services</p> <p>Southwest:</p> <p>Behavior Services Integrated into ISP</p> <p>Supported Employment JSD Paragraph 37</p> <p>Metro: Have Career Development Plan</p>

	<p>Person Receive Employment Services</p> <p>Northeast:</p> <p>Have Career Development Plan</p> <p>Person Receive Employment Services</p> <p>Southwest:</p> <p>Have Career Development Plan</p> <p>Person Receive Employment Services</p>
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Appendix K: DD and Mi Via Waiver Key Service Definitions

DD WAIVER	
LIVING SUPPORTS	
SUPPORTED LIVING SERVICES	Supported Living is intended for individuals who are assessed to need residential habilitation to ensure health and safety. Supported Living services are designed to address assessed needs and identified individual outcomes. Supported Living providers are responsible for providing an appropriate level of services and supports twenty-four (24) hours per day, seven (7) days per week.
FAMILY LIVING SERVICES	Family Living is intended for individuals who are assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family Living is direct support and assistance to individuals residing in the home of a natural or host family member.
CUSTOMIZED IN-HOME SUPPORTS	Customized In-Home Supports provide individuals the opportunity to design and manage the supports needed to live in their own home or their family home. It is not a residential habilitation service and is intended for individuals that do not require the level of support provided under Living Supports services.
COMMUNITY-BASED SUPPORTS	
CUSTOMIZED COMMUNITY SUPPORTS	
MI VIA WAIVER	
LIVING SUPPORTS	
HOMEMAKER/DIRECT SUPPORT	Homemaker/Direct Support Services are provided on an episodic or continuing basis to assist the participant with activities of daily living, performance of general household tasks, provide companionship to acquire, maintain, or improve social interaction skills in the community and enable the participant to accomplish tasks he/she would normally do for him/herself if he/she did not have a disability. Homemaker/Direct Support services are provided in the participant's own private home and in the community, depending on the participant's needs and choice.
IN-HOME SUPPORTS	In-home Living Supports are individually designed services and/or supports that are related to the participant's qualifying condition or disability. These services enable the participant to live in his/her apartment or house or family home that is owned or leased, in the community of his/her choice, for the purpose of preventing institutionalization.
COMMUNITY-BASED SUPPORTS	
COMMUNITY DIRECT SUPPORT SERVICES	Community Direct Support Services deliver supports that assist the participant to identify, develop, nurture and maintain community connections. Community Direct Support also assists the participant to maintain community connections and access social, educational, recreational and leisure activities in the community.
CUSTOMIZED COMMUNITY GROUP SUPPORTS	Customized Community Group Supports can include participation in congregate community-based day programs and community centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive

Source: DOH DD Waiver and Mi Via Waiver Service Standards

