



DISABILITY RIGHTS NEW MEXICO

1720 Louisiana Blvd. NE, Suite 204 • Albuquerque, New Mexico 87110

TEL/TTY: (505) 256-3100 • FAX: (505) 256-3184

State-wide Toll Free 1-800-432-4682

WEBSITE: www.drn.org • EMAIL: info@drnm.org

James Jackson, Executive Director

Promoting and Protecting the Rights of Persons with Disabilities

SUMMARY OF MAJOR CHANGES COMING TO THE DD WAIVER PROGRAM BASED ON SETTLEMENT OF THE WALDROP LITIGATION

June 8, 2015

Settlement Resolves Lawsuit

An agreement approved by federal District Judge Judith Herrera on May 29, 2015, has resolved the Waldrop et al. vs. Human Services Department et al. lawsuit that was filed in 2014 by Disability Rights New Mexico (DRNM), The Arc of New Mexico, and 8 individuals and their guardians. The lawsuit challenged reductions in services in the Developmental Disabilities Waiver program and violations of due process. The federal court will retain jurisdiction of the case for two years to assure that the state complies with the agreement.

The settlement allows people to regain access to residential services, therapies, and day services that had been denied or limited in the current ("old") system.

Under the agreement, the state will continue to use the Supports Intensity Scale (SIS) to assess the needs of participants in the DD waiver program. The SIS score will be used to put each participant into one of several groups, and each group will have a *suggested* service package and a proposed annual budget. Under the "old" system, the group assignment put a cap on the allowable budget and a clear limit on services available. However, under the new agreement, there will be no cap on the individual's budget or service plan. The SIS assessment will be a planning tool to be used by a participant's Interdisciplinary Team (IDT), along with other information, to develop a service plan and budget based on individual need, no matter what the group assignment is.

The agreement restores a person-centered approach to the DD waiver program, allowing each participant to get the services they need – no more, but no less. If services recommended by the IDT are limited or denied - through a new independent professional review process - participants will have a meaningful opportunity to appeal that decision.

As a result of the agreement, there will be important changes in the short run, and major changes in the long run to the DD Waiver program. This document summarizes these changes. All waiver participants (including those in the Mi Via version of the waiver) should have already received a joint letter from the state and the advocacy groups about the agreement. In the future, participants will receive additional written information from the state.

Important changes that are happening NOW

- Waiver participants who experienced a loss or reduction in residential or day services after November 2012, due to implementation of the SIS-based system, will have an opportunity to get those services back. They will receive an explanation about this opportunity, with a form to complete and return no later than July 31, 2015. Participants will use the form to indicate whether they want to restore their previous services or to continue to receive their current services. If they decide to restore the lost services, they will be able to keep those services until their next annual individual service plan (ISP) is developed. That new service plan may or may not include such services, depending upon whether they are clinically justified.
- The current limitation on access to therapy services is being withdrawn by the state. If an individual's IDT determines that there is clinical justification, participants can receive OT, PT, and Speech therapy regardless of which SIS group they are in.
- Individuals whose ISP review date is on or before Oct. 31, 2015, will go through the current service planning process based on their SIS group. However, regardless of which SIS group they are in, they will have the opportunity to apply for residential services and additional day services through the state's "Group H" process if their IDT determines that such services are clinically justified. This application can be initiated by the participant as well as the case manager.
- The current "verification" process - whereby Department of Health staff review the SIS group assignment - will continue until the new system (described below) is put in place. However, the verification process can only be used to increase services available to a DD Waiver participant, and cannot be used to reduce recommended services.

The new service planning system effective Nov. 1, 2015

- Use of the SIS
 - The SIS assessment will be used for all new participants in the DD waiver, and every three (3) years for continuing participants.
 - Before the SIS is conducted, waiver participants/guardians will receive a letter that explains the assessment process. This will include notice that the outcome of the SIS could result in reduction in services, and that the participant has due process rights to challenge any reduction if that occurs. There will be web site links to resources for more information about the SIS.
 - When the SIS is performed, persons who know the participant well should be involved in the assessment. The participant will be allowed to have an attorney present, at the participant's expense, but the attorney can only observe and not participate in the assessment.
 - The score on the SIS assessment will result in assignment to a group. Each group will include persons with similar levels of disability. For each group there will be a suggested service package and a proposed annual budget. However, these are not binding and cannot be used to cap the participant's services or budget, as they were in the old system.
 - A new SIS (re-assessment) may be requested if there has been a significant change in circumstances or if there were serious problems with the way the initial SIS was conducted.
- IDT and service planning
 - After the SIS is completed, the participant and case manager will receive a Planning

Packet. This will contain the SIS assessment results and related materials; the group assignment based on the SIS score; the suggested service package and proposed budget based on the group assignment; instructions for the next steps in the planning process; information on how to request a new SIS; and notice of the right to appeal denials or limitations of services.

- The participant's Interdisciplinary Team (IDT) will meet to develop an annual individual service plan (ISP). The SIS assessment is to be used as a planning tool by the IDT, which can and should also consider other evaluations, records and information about the individual. The focus will be on whatever supports and services that are available through the waiver program, that the individual needs, and that can be **clinically justified** based on the SIS assessment and all other information available to the team, regardless of the individual's group assignment.
- Annual budget
 - When the ISP has been completed by the IDT and agreed to by the participant/guardian, the case manager will develop an annual budget based on the services and supports called for in the ISP. There is no arbitrary limit to the amount of the budget. The case manager will submit the proposed budget and the proposed service plan developed by the IDT to the Outside Review process.
- Outside Review
 - The Outside Review is an entirely new process in the DD Waiver program. It is anticipated that the Outside Review program will be operated by an independent agency under contract to the state, and will use a number of qualified individuals as Outside Reviewers.
 - Each proposed service plan and budget will be reviewed by an Outside Reviewer, who will operate independently of the Department of Health and the Human Services Department. The Outside Reviewer will be a professional in the field of developmental disabilities who will make an independent judgment about the clinical justification for the plan. The Outside Reviewer may approve a plan completely, approve parts of a plan and reject others, or reject a plan in its entirety. The Outside Reviewer must give a clear, written explanation and justification for any denial or reduction of services. The Outside Reviewer's decision will serve as the state's official decision on the services and budget for each participant.
 - All services that are approved by the Outside Reviewer must be made available to the participant.

Dispute Resolution and Appeals

- Agency conference
 - The settlement agreement requires the Department of Health (DOH) to offer an informal process that may resolve disputes over denial, suspension, reduction or termination of waiver benefits or services. At an agency conference, a DOH representative meets with the participant/guardian and/or a representative of their choice to seek an acceptable resolution. The agreement gives this DOH representative the authority to overturn an adverse decision of the Outside Reviewer and approve the requested services and budget - something that DOH had no power to do in the old system. But the DOH representative will not be able to limit or deny a service that was already approved by the Outside Reviewer.

- The process is optional and may not be used to delay a Fair Hearing if one is requested.
- Fair Hearing
 - A Medicaid Fair Hearing is an administrative hearing, conducted by an Administrative Law Judge (ALJ), through the Fair Hearings Bureau of HSD. It is available to challenge any denial, suspension, reduction or termination of waiver benefits or services. This would include any benefit or service recommended by the IDT but denied or limited by the Outside Review.
 - A request for a Fair Hearing must be filed within 90 days of any notice of a denial, suspension, reduction or termination of benefits.
 - A participant may use the Fair Hearing to raise any issue related to the denial, suspension, reduction or termination of benefits. Under the old system, participants could only challenge the way in which a SIS was conducted and not the loss of services that might result from the SIS.
 - The participant and his/her representative, if any, have the opportunity in a Fair Hearing to introduce additional evidence relevant to the situation.
 - If the participant requests a Fair Hearing within the 90 day time limit, **any benefits the person is then receiving will continue until a decision on the appeal is made.**
 - The participant has a right to be represented by his or her own attorney, or to be accompanied by or represented by a friend, family member or other person of the participant's choice.
 - If the state uses the SIS assessment as evidence in the hearing to justify the denial or limitation of services, the state must arrange for the SIS assessor to be present and subject to cross examination. This was not available under the old system.
 - If the state uses the decision of the Outside Reviewer as evidence in the hearing, the state must arrange for a representative of the Outside Reviewer to be present and subject to cross examination.
 - After the Fair Hearing is completed, the ALJ will issue a decision based on the hearing, and provide a copy of the decision to the state and to the participant.
 - As with all Medicaid Fair Hearings, the state's final decision is made by the Director of the Medical Assistance Division (MAD), who can either approve or reject the decision of the ALJ.
 - If the final decision is in favor of the state and against the participant, the participant has the right to appeal that decision in state district court.
- Appeal to District Court
 - A decision that goes against the participant may be appealed through a legal action in state district court. Any such appeal must be filed within 30 days of receipt of the decision issued by the MAD Director.

FOR MORE INFORMATION:

Disability Rights New Mexico: (505) 256-3100 Info@drnm.org