TRANSITION PLAN

For Complying with the CMS Home- and Community-Based Services Medicaid Rule

FOR THE STATE OF NEW MEXICO

The CMS-approved New Mexico transition plan can be found at:
https://www.medicaid.gov/sites/default/files/2023-09/nm-transition-plan-hcbs.pdf

New Mexico did not request a Corrective Action Plan.

SITE-SPECIFIC ASSESSMENTS

The Centers for Medicare & Medicaid Services (CMS) required states to conduct validated, site-specific assessments of all provider-owned or controlled settings.

Types of Settings/ Residents and Funding Authorities	The New Mexico Human Services Department's Medical Assistance Division (MAD) provides HCBS under the following four programs: • 1915(c) Mi Via Waiver • 1915(c) Developmental Disabilities Waiver • Section 1115 Centennial Care Demonstration Waiver (Community Benefit) • 1915(c) Medically Fragile Waiver Settings involved in the State Transition Plan: • Congregate community day programs • Community centers • Adult day programs • Community business and other community places of employment • Provider operated facility-based settings • Provider-owned and provider-controlled homes • Assisted living facility
Compliant/Non-Compliant	<u>DD Waiver Non- Residential Settings:</u> Fully compliant: 0 Compliance with modifications: 246 Cannot comply: 0 Will submit evidence for the application of Heightened Scrutiny: 0 <u>Mi Via Waiver Non-Residential Settings:</u> Fully compliant: 0 Compliance with modifications: 41 Cannot comply: 0 Will submit evidence for the application of Heightened Scrutiny: 0 <u>DD Waiver Residential Settings:</u>

	Fully compliant: 0
	Compliance with modifications: 448
	Cannot comply: 0
	Will submit evidence for the application of Heightened Scrutiny: 0
	<u>Mi Via Waiver Residential Settings:</u>
	Fully compliant: 0
	Compliance with modifications: 213
	Cannot comply: 0
	Will submit evidence for the application of Heightened Scrutiny: 0
	<u>Centennial Care Non-Residential Settings:</u>
	• Fully compliant: 21
	  ○ Adult Day Health/Customized Community Supports: 18
	  ○ Employment Supports: 3
	• Compliant with modifications: 0
	• Cannot comply: 0
	• Will submit evidence for the application of Heightened Scrutiny: 0
	<u>Centennial Care Residential Settings:</u>
	• Fully compliant: 69
	  ○ Adult Day Health/Customized Community Supports: 69
	  ○ Employment Supports: 0
	• Compliant with modifications: 0
	• Cannot comply: 0
	• Will submit evidence for the application of Heightened Scrutiny: 0

Reasons for Non-Compliance	Reasons for noncompliance were not stated for all waivers and setting type; however, areas that need to be addressed for the DD waiver include: 1. Individual rights listed comprehensively in some service standards but absent or minimally noted in other service standards; 2. Silence about provider responsibilities to ensure rights and protection; 3. Silence about the setting location within the community and about personal choice of setting, among all options particularly non disability specific settings; 4. Silence about requirements to ensure the setting does not have the effect of isolating individuals receiving Medicaid HCBS from the

	broader community of individuals not receiving Medicaid HCBS especially when the service is intended for groups; 5. Silence about personal control of schedules; 6. Silence about conflict of interest in service planning by paid DD Waiver providers; 7. Over emphasis of service coordination among DD Waiver providers and under emphasis of coordination of natural supports and other non-disability specific community-based options, over emphasis on group settings and under emphasis on promoting individual choice within day programs; and 8. Silence about choice group make-up for services provided in groups.
Transition plans	The State completed a systematic statewide review of its waiver applications, applicable waiver program standards, and applicable NMACs for each of its HCBS programs against the requirements set forth in the HCBS Final Rule. Additionally, for Centennial Care the review also included assessment of the Centennial Care contract, the Special Terms and Conditions (STCs), the provider application, and the MCO policy manual. Provider self-assessment surveys were delivered to determine compliance with the Final Rule. Validation activities such as on-site assessments and desk reviews were conducted to classify and verify level of compliance. Technical assistance was provided to work on remediation. Should a setting be presumed institutional, the State may decide to submit a heightened scrutiny evidence packet to CMS. For settings unable to comply, the provider will be unenrolled from the program and participants will be relocated to a compliant setting. Once providers are compliant with all applicable requirements in the HCBS Waiver Rule, the state will continue to engage in ongoing monitoring of the settings.

SETTINGS PRESUMED INSTITUTIONAL

CMS presumes some settings have qualities that are institutional or isolating in nature. These settings must go through a heightened scrutiny review by CMS.

CMS presumes the following types of settings have institutional or isolating qualities:

- *Category 1: Located in a hospital, nursing facility, or other institutional setting.*
- *Category 2: Located adjacent to a public hospital, nursing facility, or other institutional setting.*
- *Category 3: Have the effect of isolating people from the broader community.*

% Presumed Institutional (No. of Residents Affected)	There were zero settings that were determined to fall under Heightened Scrutiny.
Type of Setting/Residents	Not applicable.

Reason for Presumption	Not applicable.
Heightened Scrutiny Process	Had there been settings in the Heightened Scrutiny category, which there were not, HSD would have submitted them to CMS for a heightened scrutiny review. Any identified settings presumed to be non- HCBS (i.e., settings that were institutional or isolating in nature) but that HSD believed, supported through validation, were appropriate settings for HCBS and that had the qualities of HCBS settings would also have been submitted to CMS. The state would have made those determinations and then submitted the Heightened Scrutiny package to CMS. Should a state be unable to overcome presumption, participants will be relocated.
NON-COMPLIANCE COMMUNICATION	
% Cannot/Will Not Comply (No. of Residents Affected)	There are no settings that cannot/will not comply.
Type of Setting/Residents	Not applicable.
Reason for Determination	Not applicable.
Communication Strategy	The state would have ensured that reasonable notice and due process was provided to anyone needing to transition. The State or, in the case of Centennial Care the managed care organization (MCO), would have sent a formal notification letter to individuals, no less than 90 calendar days prior to relocation that outlined the specific reason for the relocation and the due process procedure and timeline available to the individual and, if applicable, his/her guardian. The State/MCO would have also sent the provider a notification letter no less than 90 calendar days prior to relocation indicating the intent to relocate the individual. The letter would have directed the provider to participate with the State, MCO, and other entities, as appropriate, in activities related to relocating the individual. The individual and provider notifications would have been sent simultaneously to ensure both parties were made aware at the same time of the need to relocate the individual.
Assistance to Residents?	In the event an individual needed to transition to a new provider (residential or non-residential), the case manager/care coordinator or consultant/support broker would work with the individual to ensure continuity of care including educating the individual about the process, timeframes and due process rights. Through the person-centered planning process, case managers/care coordinators and consultants/support brokers would have ensured that individuals made

	an informed choice from alternative provider settings that complied with the Final Rule. As applicable, the individual's case manager/care coordinator or consultant/support broker would have ensured that all services were in place in advance of the individual's relocation and then monitored the transition to ensure successful placement and continuity of services. This would have included increased monitoring before and after transition, updating the participant's plan of care as needed, and tracking the success of the transition. Specifically, individuals and their guardians, if applicable, would conduct an onsite review of the individual's new setting prior to the individual's relocation. Case managers/care coordinators and consultants/support brokers would have touched base with individuals as part of regularly scheduled visits to monitor the success of the transition.
ONGOING MONITORING	

Monitoring Procedures	• MCOs are responsible for monitoring ongoing provider compliance in Centennial Care for all HCB settings. MCOs verify continued compliance of current providers with the HCB settings requirements as part of the MCO credentialing/re-credentialing process. MCOs have developed tools to monitor settings for all Community Benefit members as required in their contracts with HSD. Beginning in January 2023, tools will be reviewed on an annual basis by HSD and updated by the MCOs as needed to ensure compliance with HCBS settings criteria.
	• The MCOs will continue their on-going monitoring efforts that include:
	  o Provider/setting training activities;
	  o Provider network collaboration;
	  o Weekly meetings with Conduent, the Self-Directed HCBS (SDCB) fiscal management agency; and
	  o Monthly meetings with SDCB support broker agencies
	• All Community Benefit members receive at least one comprehensive needs assessment (CNA) per year.
	• MCOs monitor their own activities through supervisor chart audits, focused care plan audits conducted by care coordination managers, and review of member grievances by senior leaders. HSD monitors the MCOs through oversight of MCO communications to members and providers, the monthly LTC workgroup with HSD and MCOs, HSD staff attendance at MCO HCBS settings trainings, HSD monitoring of member complaints and grievances and MCO reporting to HSD.

	• The DOH will continuously monitor settings compliance through the State's provider enrollment process. • For Mi Via, the DOH and Human Services Department, Medical Assistance Division (HSD/MAD) will monitor and approve settings compliance through monitoring activities that may include face to face visits at settings, participant complaints, fair hearing requests, vendor attestations, approved by the DOH for each setting per agency, waiver quality assurance monitoring activities, and Service and Support Plan (SSP) reviews. • Ongoing monitoring for all programs will also include, as appropriate: • Regular provider communication on specific, identified issues; • Training for new and existing providers on HCB settings requirements and CMS and State expectations; • Education and outreach to participants on relevant issues; and • HSD collaboration with DOH to ensure ongoing monitoring efforts.
Quality Assurance Measures	More information about quality assurance measures can be found in New Mexico's Jan 1st submission here.