DDW Renewal Steering Committee Recommendations

NEW MEXICO DEPARTMENT OF HEALTH

DRAFT

	Primary Column	Topic	Proposals - Focus Groups	Steering Committee Recommendations	DDSD Response
1		Person Centered Planning and Individual Service Plan (ISP)	Look at composition of the IDT, ISP development, then a separate budget meeting	Simplified ISP template (similar to the WI template) with attachments for detail; recommend against a separate budget meeting	DDSD will continue to work through improvements through the Service standards updates
2			Consider ISP Quality Assurance (QA) audit by the Outside Review committee	Recommend against this due to the number of audits already in place and concerns about different entities looking at the ISP in different ways - need agreement among all QA entities about what person centeredness is - consider some of the training be done by self-advocates	Not considering at this time
3			Look at duplication among assessments	Support removing duplication across specialized assessments, particularly the Person Centered Assessment	DDSD will continue to work through improvements through the Service standards updates
4			Look at Pre- ISP meeting process - make this more meaningful	Support keeping this meeting- agree to make it more meaningful - Considerations for verbal and non verbal participants	DDSD will continue to work through improvements through the Service standards updates
5			Other	Add a prompt in the ISP regarding the person learning how to run their own meeting	DDSD will continue to work through improvements through the Service standards updates
6		Emergency Physical Restraint (EPR), Restrictions and Human Rights Committees (HRCs)	Look at establishing Quality Improvement committee and "Supercommittee"	Support for these bodies not as regulatory bodies but as added resources; consider timelines for urgent matters and community member at large as part of the membership	DDSD will continue to work through process details through the Service standards updates
7		Case Management	Implement 24 hours of annual mandatory training for case managers.	Support for training concepts in proposal (ANE, PCP, health and self selection) but recommend reducing the number of hours; also recommend more input from CMAAC and other stakeholders to operationalize this	Reduced to 14 hours; working to use training database to help agencies track; accepting licensure CEUs; attendance at meetings and many self selected training hours;
8			Allow Dual Caseloads for Case Managers	Research why the caseloads were initially separated to understand the concern about allowing dual caseloads- collaborate with Mi Via as they rewrite the standards; cautions about operationalizing this- needs a lot of attention to safeguard the person centerednesss	All waivers updating training in PCP; SW accepting CM agencies in good standing will help with understanding self direction; dual caseloads allowed with no more than 30 DDW clients - 50 across waivers
9		Therapies and Behavior Support Consultants (BSCs)- Telehealth	Extend the usage of telehealth	Support extending the use of telehealth - need standards for the different disciplines	COVID has moved this forward quickly - will be implemented in waiver renewal with considerations and parameters in the standards
10			What are the challenges/barriers to minimizing or preventing fading opportunities?	Not applicable; good discussion that may pertain to the Standards	DDSD will continue to work through improvements through the Service standards updates
11			Consider creation of a targeted Person-Centered Planning training “module”	Not supported	DDSD training unit updating existing modules and online training
12		Remote Personal Support Technology	Change name of service from Personal Support Technology to Remote Personal Support Technology (RPST)	Neutral	Name change put forward
13			Add State or Contract position	Support	On hold due to hiring freeze
14			RPST provider will act as fiscal agent with primary responsibility for payment, tracking, and documentation.	Support	Put forward with addition of opportunities for SFOC for direct tech providers not having to be provider of any RPST. To operationalize, DDSD initiating this idea with SW and hopes to enlist more providers this way
15			Consider changing reimbursement methodology from a percentage of total to a flat rate to better align with provider	Support	No change be to be researched out at this time
16			Other	Add RPST prompt in ISP. Also add AT prompt in the ISP in a place other than health and safety.	To be addressed through ISP template updates which can occur outside of waiver application. Basic elements of ISP template to remain the same
17		Assistive Technology	Increase amount allowed for AT	Support	Increase to $500
18			Allow exception process	Support	Consider more collaboration with HSD to address higher cost items through SME in State plan. Specialized shower chair of particular significance. CSB conducting further research.
19		Non-Medical Transportation	Expand the definition of what the public transportation pass can be used for to include ridesharing services. (Uber/Lyft)	Support	Will pursue in both application and service standards
20			Raise service limit for Nonmedical Transportation Mileage from $750 to $810 to reflect mileage rate change from .41 to .44 cents per mile that was recommended by 2019 PCG rate study.	Support	Will pursue
21			Add exception to mileage limit of $805 for people in rural and frontier counties only.		Needs more research regarding financial impact, unable to finalize a recommendation for waiver application at this time. At this time exception process will not be developed at this time.
22		Family Living-nursing requirements	Should nursing continue to be required in the Family Living Model? Does that requirement as it stands now limit person centeredness and choice (i.e., if you want to be in Family Living you must have a nursing assessment)? Would nursing as an add-on like in CIHS provide more flexibility? Does it pose problems for individuals in FL who need assistance with medication?	Needs more exploration - concerns about increasing flexibility and having safeguards	Due to COVID Public Health emergency will not consider changing at his time

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23		Staying Home when I want to	A Supported Living (SL) aide for someone being at home; an hourly rate with modifier within SL. This is essentially building in some hourly billing options to address the rate-build up that typically assumes 30 hours a week outside of SL care.	Support for aide code across settings (work, community, and home)	Unable to complete financial impact analysis and will not pursue due to impact of rate increase on budget
24			Encourage the use of PST and on call staffing requirements in SL/FL, so people can stay home alone with appropriate planning and supports including weekends and evenings.	Support	Will address further through ISP prompts, CM training opportunities and service standards; also pending targeted rate study results related to study of tiered rates
25		Supporting People with complex mobility and personal care needs	Non-Ambulatory Stipend will continue but not be expanded; Consider the 20K paid annually for this stipend – would use of this amount of money be more efficient/effective leveraging alternative supports like aides, supplemental staffing at critical points in persons day, or DME etc.	Support the need to explore maximizing funding from State Plan and DDW; need more public education and awareness on the potential long-term savings and increased quality of life for people with high needs.	Ongoing study needed
26			Limits in state plan generally don't pay for the more expensive barrier free lifts which allow for one person transfers (Can HSD look at state plan or DDW be extension of state plan?)	Support the need to explore maximizing funding from State Plan and DDW; need more public education and awareness on the potential long-term savings and increased quality of life for people with high needs.	Ongoing study needed
27			Person centered planning for two-person staffing at key times in FL, CIHS; Community Inclusion is looking at leveraging aide scopes to add second person	Support for aide code across settings (work, community, and home)	Unable to complete financial impact analysis and will not pursue due to impact of rate increase on budget
28			Other	The needs of people who are non ambulatory are very differentt -DDSD needs to recognize this in general	Ongoing study needed
29			Other	Explore the cost of moving equipment (track) to a new location (through AT /Env Mod)	Ongoing study needed
30			Look at staffing ratio requirements for SL providers when someone is non ambulatory and receiving Cat 3 and 4 rates?	No Discussion	Pending results of targeted rate study related to tiered rates; may be addressed through service standards
31		Employment	Break out the current monthly CIE Rate into 3 categories/payment rates Job Development, Job Coaching, Long-Term Job Maintenance.	Support. However there was a lot of discussion on this. Some providers support this and the advocate agencies supported this due to increased accountability and the ability to track people's progress. (Some providers expressed concerns about impact of changes to rate structure on cost of doing business.)	Will pursue
32			Highly recommend Association of Community Rehabilitation Educators (ACRE) or Certified Employment Support Professionals (CESP) credentialing for job developers and job coaches. Building the foundation to require at least one of these credentials in the future	Support and also support for tiered rates as an incentive	Will pursue
33			Explore options for redefining Job Aid to be used in general terms for CCS, CIE and other services as needed	Support for aide code across settings (work, community, and home)	Unable to complete financial impact analysis and will not pursue due to impact of rate increase on budget
34		Customized Community Supports	Discontinue CCS-IIBS and revise the CCS-I definition to allow this service to be provided in the community and facility or 75% in the community and 25% in the facility	Support as long as the CCS-I definition is revised as outlined in the proposal. Need to consideror the need for expedited approvals	Will pursue
35			Institute a cap on units and budget for all CCS services. 6240 units is the recommendation for the CCS (a combination of all CCS Services) cap.	Caps are supported as long as there is an exception process	Ongoing study of budget utilization with particular attention on what causes need for high expenditures. Will not pursue caps for each service at this time due to : no standardized assessment, people migrate to cap and need for more analysis about utilization. Decision was made not to institute a CAP on CCS services.
36			3 hours day /15 hours a week in home	Support	Wil pursue through standards
37			Redefine the community inclusion aid	Support for aide code across settings (work, community, and home)	Unable to complete financial impact analysis and will not pursue due to impact of rate increase on budget
38		Service limits	Thoughts on CAP's in general and the methodology utilized	Burden of revision process needs to be addressed- how to fade back in when needed - need flexibility and an exception process; Caps are supported as long as there is an exception process; Past H Authorization (exception process) worked well.	Ongoing study of budget utilization with particular attention on what causes need for high expenditures. Will not pursue caps for each service at this time due to : no standardized assessment, people migrate to cap and need for more analysis about utilization