New Mexico Department of Health
Developmental Disabilities Supports Division
CMS Final Rule Settings Requirements
Supports Waiver Provider Attestation

Provider Name: _____

Provider Representative Name and Title: _____

Do you currently provide waiver services? Yes_____ No_____

If yes, which waiver? _____

Services Provided: _____

1. Do you have a Corrective Action Plan (CAP) approved by DDSD related to Validation Findings for DD Waiver or Mi Via Waiver settings? Yes_____ Date _____ No_____

2. Please initial one item below as applicable:

   _____If **Yes,** I attest that my organization has remediated all issues in the DDSD approved CAP.

   _____If **No**, I attest that my organization was not required to submit a CAP for DDSD approval based on 2019 Validation Findings.

Provider Attestation
Please initial the following:

As the representative of the above agency,

____ I attest that my organization is in full compliance with the Centers for Medicare and Medicaid Services (CMS) Final Rule Settings Requirements which seek to ensure that individuals receiving long-term services and supports through the 1915(c) waiver programs under Medicaid authorities have full access to benefits of community and opportunity to receive services in the most integrated settings appropriate, and to enhance the quality of HCBS and provide protections to participants.

_____ I attest that I have read the following summary of the CMS Final Rule Settings Requirements for Home and Community Based Services (HCBS) Providers:

Any HCBS providers, who offer services in a setting where individuals live and/or receive HCBS, must comply with the following CMS Final Rule requirements:

1) **Providers must ensure that settings are integrated in and support full access of individuals to the greater community including:**
    a. **Providing opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources; and**
    b. **Ensuring that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS.**
2) **Providers must ensure that the individual selects from among setting options including non-disability specific settings and options for a private unit in a residential setting. The provider setting must have person-centered service plans that document the options based on the individual's needs and preferences. For residential settings, the person-centered plan must document options available for room and board.**
3) **Providers must ensure an individual's rights to privacy, dignity and respect, and freedom from coercion and restraint.**
4) **Providers must ensure settings optimize individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.**
5) **Provider must ensure settings facilitate individual choice regarding services and supports, and choice regarding who provides them.**
6) **Providers must ensure tenant protections, privacy, and autonomy for individuals receiving HCBS who do not reside in their own private (or family) home.**

As a Medicaid enrolled HCBS provider you are required to ensure all aspects of the Final Rule are followed. It is recommended that you read the CMS Final Rule in the Federal Register at the following link to review the details of the CMS Final Rule requirements: https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities?utm_campaign=subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=emailZ

____I understand that if my agency is not in full compliance with the CMS Final Rule Settings Requirements that my agency will not be approved to provide Supports Waiver services.

____I understand that if I have questions about any of the CMS Final Rule Settings Requirements I can reference https://nmhealth.org/about/ddsd/diro/kyrc/ and that I can contact DDSD for CMS Final Rule Settings Technical Assistance.

Provider Representative Signature: _____

Provider Representative Printed Name: _____

Date: _____