

TITLE 8 SOCIAL SERVICES
CHAPTER 314 LONG TERM CARE SERVICES - WAIVERS
PART 5 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED
SERVICES WAIVER

8.314.5.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.314.5.1 NMAC - Rp, 8.314.5.1 NMAC, xx-xx-16]

8.314.5.2 SCOPE: The rule applies to the general public.
[8.314.5.2 NMAC - Rp, 8.314.5.2 NMAC, xx-xx-16]

8.314.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.314.5.3 NMAC - Rp, 8.314.5.3 NMAC, xx-xx-16]

8.314.5.4 DURATION: Permanent.
[8.314.5.4 NMAC - Rp, 8.314.5.4 NMAC, xx-xx-16]

8.314.5.5 EFFECTIVE DATE: xx-xx-16, unless a later date is cited at the end of a section.
[8.314.5.5 NMAC - Rp, 8.314.5.5 NMAC, xx-xx-16]

8.314.5.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.314.5.6 NMAC - Rp, 8.314.5.6 NMAC, xx-xx-16]

8.314.5.7 DEFINITIONS:

A. Activities of daily living (ADLs): Those activities associated with an individual's daily functioning. The basic skills of everyday living such as toileting, bathing, dressing, grooming, and eating and the skills necessary to maintain the normal routines of the day, such as housekeeping, shopping and preparing meals. The term also includes exercising, personal, social and community skills.

B. Adult: An individual who is eighteen (18) years of age or older.

C. Authorized representative: An individual designated by the eligible recipient or his or her guardian, if applicable, to represent the eligible recipient and act on his or her behalf. The authorized representative must provide formal documentation authorizing him or her to access the identified case information for this specific purpose. An authorized representative may be, but need not be, the eligible recipient's guardian or attorney.

D. Child: An individual under the age of eighteen (18). For purpose of Early Periodic Screening, Diagnosis and Treatment (EPSDT) services eligibility, "child" is defined as an individual under the age of twenty-one (21).

E. Clinical Documentation: Sufficient information and documentation that demonstrates the request for developmental disabilities waiver (DDW) services is reasonable, necessary and appropriate based on the service specific DDW clinical criteria established by the department of health (DOH) developmental disabilities support division (DDSD) for adult recipients excluding class members of *Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al*, (757 F. Supp. 1243 DNM 1990). Any relevant supporting information and documentation is acceptable and will be considered by the outside reviewer. Examples of clinical documentation include and are not limited to: the therapy service prior authorization request (TSPAR), behavioral support consultation prior authorization request (BSCPAR), intense medical living service (IMLS) parameter tool, electronic comprehensive health assessment tool (e-Chat), assessments, clinical notes, progress notes, interdisciplinary team (IDT) meeting minutes, etc.

F. Clinical justification: Information and documentation that justifies the need for services based on the eligible recipient's assessed need and the DDW clinical criteria. Based on assessed need, the justification must:

- (1) meet the eligible recipient's clinical, functional, physical, behavioral or rehabilitative needs;
 - (2) promote and afford support to the eligible recipient for his or her greater independence;
- or

(3) contribute to and support the eligible recipient's efforts to remain in the community; to contribute and be engaged in his or her community, and to reduce his or her risk of institutionalization; and

(4) address the eligible recipient's physical, behavioral, social support needs (not including financial support) that arise as a result of his or her functional limitations or conditions, such as: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

(5) relate to an outcome in the eligible recipient's individual service plan (ISP).

G. DDW clinical criteria: A set of criteria established by the DOH that is applied by an outside reviewer to each DDW service when a DDW service is requested for adult recipients excluding a class member of *Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al*, (757 F. Supp. 1243 DNM 1990).

H. Individual service plan (ISP): A treatment plan for an eligible recipient that includes his or her needs, functional levels, intermediate and long range goals statements for achieving his or her goals and specifies responsibilities for the eligible recipient's care needs. The ISP determines the services allocated to the eligible recipient within the DDW allowances.

I. Outside reviewer: An independent third party who conducts a clinical review of all requested DDW services. The outside reviewer will make a written clinical determination on whether the requested supports are clinically justified and will recommend whether the eligible recipient's requested ISP and budget should be approved or denied.

J. Person centered planning: Addresses health and long-term services and support needs in a manner that reflects the eligible recipient's preferences, strengths and goals.

K. Supports Intensity Scale® (SIS): A standardized assessment tool that provides a valid and reliable framework to quantify the support needs of an eligible recipient with developmental disabilities. For the purpose of this rule, SIS includes all refreshed versions of the SIS such as the SIS-A that remain identical in reliability and validity to the original SIS.

L. Waiver: Permission from the centers for medicaid and medicare services (CMS) to cover a particular population or service not ordinarily allowed.

M. Young Adult: An individual between the ages of 18 through 20 years of age who is allocated to the DDW and is receiving specific services as identified in the DOH/DDSD standards and policies. An individual under age 21 is eligible for medical services funded by his or her medicaid providers under EPSDT. Upon the individual's 21st birthday, he or she is considered to be an adult recipient of DDW services.
[8.314.5.7 NMAC -Rp. 8.314.5.7, xx-xx-16]

8.314.5.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.314.5.8 NMAC - Rp, 8.314.5.8 NMAC, xx-xx-16]

8.314.5.9 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES

WAIVER: To help New Mexicans who have an intellectual/developmental disability (I/DD) or a specified related condition to receive services in a cost-effective manner, the New Mexico medical assistance division (MAD) has obtained a waiver from certain medicaid payment and benefit statutes (42 CFR 441.300) to provide home and community-based services (HCBS) to eligible recipients as an alternative to institutionalization. DDW services are intended to enhance, not replace, existing natural supports and other available community resources. Services will emphasize and promote the use of natural and generic supports to address the eligible recipient's assessed needs in addition to paid supports.

[8.314.5.9 NMAC - Rp, 8.314.5.9 NMAC, xx-xx-16]

8.314.5.10 ELIGIBLE PROVIDERS:

A. Health care to medical assistance program (MAP) eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities, and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to MAP eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including New Mexico administrative code (NMAC) rules, billing instructions, utilization review instructions, service definitions and

service standards and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

B. All DDW eligible providers must be approved by DOH or its designee and have an approved MAD PPA and a DOH provider agreement.

C. MAD through its designee, DOH/DDSD, follows a subcontractor model for certain DDW services. The agency, following the DOH/DDSD model, must ensure that its subcontractors or employees meet all required qualifications. The agency must provide oversight of subcontractors and employees to ensure that they meet all required MAD and DOH/DDSD qualifications. In addition, the agency must provide satisfactory oversight of subcontractors and employees to ensure that services are delivered in accordance with all requirements set forth by the DOH/DDSD DDW service definition, all requirements outlined in the DDW services standards, applicable NMAC rules, MAD supplements, and as applicable, his or her New Mexico licensing board's scope of practice and licensure. Pursuant to federal regulations, an agency may not employ or subcontract with the spouse of an eligible recipient or the parent of an eligible recipient under 18 years of age to provide direct care services to the eligible recipient.

D. Qualifications of case management provider agency: A case management provider agency, its case managers, whether subcontractors or employees must comply with Section 10 of this rule. In addition, case management provider agency must ensure that a case manager meets the following qualifications:

- (1) one year of clinical experience, related to the target population; and
- (2) one or more of the following:
 - (a) hold a current social worker license as defined by the New Mexico regulation and licensing department (RLD); or
 - (b) hold a current registered nurse (RN) license as defined by the New Mexico board of nursing; or
 - (c) hold a bachelor's or master's degree in social work, psychology, sociology, counseling, nursing, special education, or a closely related field; and
- (3) comply with all training requirements as specified by DOH/DDSD; and
- (4) have received written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS); and
- (5) does not provide any direct support services through any other type of 1915 (c) Home and Community Based Waiver Program.

E. Qualifications of respite provider agency: A respite provider agency must comply and ensure that all direct support personnel, whether subcontractors or employees, comply with Section 10 of this rule. In addition, respite provider agencies and direct support personnel must:

- (1) comply with all training requirements as specified by DOH;
- (2) have and maintain documentation of current cardiopulmonary resuscitation (CPR) and first aid certification; and
- (3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

F. Qualifications of adult nursing provider agencies: Adult nursing provider agencies must ensure it has subcontractors or employees, including nurses, comply with DOH DDW service definitions, DDW service standards, applicable NMAC rules, MAD billing instructions, utilization review instructions, and supplements, and applicable federal and state laws, rules and statutes. Direct nursing services shall be provided by a New Mexico licensed RN or licensed practical nurse (LPN) and must comply with all aspects of the New Mexico Nursing Practice Act, including requirements regarding delegation of specific nursing function and Section 10 of this rule.

G. Qualifications of therapy provider agency: A therapy provider agency must comply and ensure that each of its therapists including physical therapists (PT), occupational therapists (OT), and speech therapists (SLP), physical therapy assistants (PTA), and certified occupational therapy assistants (COTA), whether a subcontractor or employee complies with Section 10 of this rule.

H. Qualifications for community living supports provider agency: Living supports consist of family living, supported living, and intensive medical living services. A living supports provider agency must

comply with the accreditation policy and all requirements set forth by the DOH, DDW service definitions, all requirements outlined in the DDW service standards and the applicable NMAC rules. A living supports provider agency must ensure that all direct support personnel meet all qualifications set forth by DOH, DDW service standards, and applicable NMAC rules.

(1) A living supports provider agency and direct support personnel must:

- (a) comply with all training requirements as specified by DOH;
- (b) have and maintain documentation of current CPR and first aid certification; and
- (c) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the CCHS.

(2) A family living provider agency must ensure that all direct support personnel, whether a subcontractor or employee, meet all qualifications set forth by DOH and the DDW service standards and the applicable NMAC rules. The direct support personnel employed by or subcontracting with the provider agency must be approved through a home study completed prior to the initiation of services and periodically thereafter as required of the provider agency.

(3) A supported living provider agency must ensure that all direct support personnel meet all qualifications set forth by DOH and the applicable NMAC rules and the DDW service standards. A supported living provider agency must employ or subcontract with at least one licensed RN and comply with the New Mexico Nurse Practicing Act, including requirements regarding delegation of specific nursing functions.

(4) An intensive medical living supports provider agency must employ or subcontract with at least one New Mexico licensed RN who must have a minimum of one year of supervised nursing experience and comply with the New Mexico Nursing Practice Act. An intensive medical living supports provider agency must comply with and ensure RNs, whether subcontractors or employees, comply with Section 10 of this rule. In addition, an intensive medical living supports provider agency and direct support personnel must:

- (a) comply with all training requirements as specified by DOH;
- (b) have and maintain documentation of current CPR and first aid certification; and
- (c) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the CCHS.

I. Qualifications of a customized community supports provider agency: A customized community supports provider agency must comply with and ensure that all direct support personnel comply with Section 10 of this rule. In addition, a customized community supports provider agency and direct support personnel must:

- (1) comply with all training requirements as specified by DOH;
- (2) have and maintain documentation of current CPR and first aid certification; and
- (3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the CCHS.

J. Qualifications of a community integrated employment provider agency: A community integrated employment provider agency must comply with and ensure that all direct support personnel comply with Section 10 of this rule. In addition, a community integrated employment provider agency and direct support personnel must:

- (1) comply with all training requirements as specified by DOH;
- (2) have and maintain documentation of current CPR and first aid certification; and
- (3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the CCHS.

K. Qualifications of a behavioral support consultation provider agency: A behavioral support consultation provider agency must comply with and ensure that all behavioral support consultants, whether subcontractors or employees, comply with Section 10 of this rule.

(1) A provider of behavioral support consultation services must be currently licensed in one of the following professions and maintain that licensure with the appropriate RLD board or licensing authority:

- (a) a licensed mental health counselor (LMHC), or
- (b) a licensed clinical psychologist; or
- (c) a licensed psychologist associate, (masters or Ph.D. level); or
- (d) a licensed independent social worker (LISW) or a licensed clinical social worker; or
- (e) a licensed master social worker (LMSW); or
- (f) a licensed professional clinical counselor (LPCC); or
- (g) a licensed marriage and family therapist (LMFT); or

(h) a licensed practicing art therapist (LPAT); or
(i) Other related licenses and qualifications may be considered with DOH's prior written approval.

(2) Providers of behavioral support consultation services must have a minimum of one year of experience working with individuals with intellectual or developmental disabilities.

(3) Behavioral support consultation providers must participate in training in accordance with the DOH/DDSD training policy.

L. Qualifications of a nutritional counseling provider agency: A nutritional counseling provider agency must comply with and ensure that all nutritional counseling providers, whether subcontractors or employees comply with Section 10 of this rule. In addition, a nutritional counseling provider must be registered as a dietitian by the commission on dietetic registration of the American dietetic association and be licensed by RLD as a nutrition counselor.

M. Qualifications of an environmental modification provider agency: An environmental modification contractor and his or her subcontractors and employees must be bonded, licensed by RLD, and authorized by DOH to complete the specified project. An environmental modification provider agency must comply with Section 10 of this rule. All services shall be provided in accordance with applicable federal, state and local building codes.

N. Qualifications of a crisis supports provider agency: A crisis supports provider agency must comply with and must ensure that direct support personnel, whether subcontractors or employees, comply with Section 10 of this rule. In addition, a crisis supports provider agency and direct support personnel must:

- (1) comply with all training requirements as specified by DOH;
- (2) have and maintain documentation of current CPR and first aid certification; and
- (3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the CCHS.

O. Qualifications for a non-medical transportation provider agency: A non-medical transportation provider agency must comply with Section 10 of this rule. In addition, a non-medical transportation provider agency and direct support personnel must:

- (1) comply with all training requirements as specified by DOH;
- (2) have and maintain documentation of current CPR and first aid certification; and
- (3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the CCHS.

P. Qualifications of a supplemental dental care provider agency: A supplemental dental care provider agency must comply with Section 10 of this rule. A supplemental dental care provider must contract with a New Mexico licensed dentist and dental hygienist who are licensed by RLD. The supplemental dental care provider will ensure that a RLD licensed dentist provides the oral examination; ensure that a RLD licensed dental hygienist provides all routine dental cleaning services; demonstrate fiscal solvency; and function as a payee for the service.

Q. Qualifications of an assistive technology purchasing agent provider and agency: An assistive technology purchasing agent provider and agency must comply with Section 10 of this rule, demonstrate fiscal solvency and function as a payee for this service.

R. Qualifications of an independent living transition service provider agency: An independent living transition service provider agency must comply with Section 10 of this rule, demonstrate fiscal solvency and function as a payee for this service.

S. Qualifications of a personal support technology/on-site response service provider agency: Personal support technology/on-site response service provider agencies must comply with Section 10 of this rule. In addition, personal support technology/on-site response service provider agencies must comply with all laws, rules, and regulations of the federal communications commission (FCC) for telecommunications.

T. Qualifications of a preliminary risk screening and consultation related to inappropriate sexual behavior (PRSC) provider agency: A PRSC provider agency must comply with Section 10 of this rule and all training requirements as specified by DOH. Additionally, the PRSC provider agency must subcontract with or employ the risk evaluator, who at a minimum must be:

- (1) an RLD independently licensed behavioral health practitioner, such as an LPCC, LCSW, or a psychologist; or
- (2) a practitioner who holds a master's or doctoral degree in a behavior health related field from an accredited college or university.

U. Qualifications of a socialization and sexuality education provider agency: A socialization and sexuality education provider agency must comply with Section 10 of this rule. A provider agency must be approved

by the DOH, bureau of behavioral support (BBS) as a socialization and sexuality education provider, and must meet training requirements as specified by DOH. In addition, a socialization and sexuality education provider agency must employ or contract with a provider who has one of the following qualifications for rendering the service:

- (1) a master's degree or higher in psychology;
- (2) a master's degree or higher in counseling;
- (3) a master's degree or higher in special education;
- (4) a master's degree or higher in social work;
- (5) a master's degree or higher in a related field;
- (6) a RN or LPN;
- (7) a bachelor's degree in special education;
- (8) a certification in special education; or
- (9) a New Mexico level three recreational therapy instructional support provider

certification.

V. Qualifications of a customized in-home supports provider agency: A customized in-home supports provider agency must comply with and ensure that direct support personnel, whether subcontractors or employees, comply with Section 10 of this rule. In addition, a customized in-home supports provider agency and direct support personnel must:

- (1) comply with all training requirements as specified by DOH;
- (2) have and maintain documentation of current CPR and first aid certification; and
- (3) have written notification from DOH that he or she does not have a disqualifying

conviction after submitting to the CCHS.

[8.314.5.10 NMAC - Rp, 8.314.5.10 NMAC, xx-xx-16]

8.314.5.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations, rules, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement and the DOH provider agreement. A provider also must meet and adhere to all applicable NMAC rules and instructions as specified in the MAD provider rules manual and its appendices, DDW service standards, DDW service definitions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and the centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

[8.314.5.11 NMAC - Rp, 8.314.5.11 NMAC, xx-xx-16]

8.314.5.12 ELIGIBLE RECIPIENTS: DDW services are intended for an eligible recipient who has a developmental disability limited to an intellectual/developmental disability (I/DD), or a specific related condition. The MAP category of eligibility criteria for DDW services is located in 8.290.400 NMAC.

[8.314.5.12 NMAC - Rp, 8.314.5.12 NMAC, xx-xx-16]

8.314.5.13 RECIPIENT STANDARDIZED ASSESSMENT:

A. DOH shall utilize the Supports Intensity Scale® (SIS) to assess the needs of adult recipients who are on the DD waiver and for those who are newly allocated. The SIS assessment shall be administered at regular intervals, typically after at least 3 annual ISPs, to an eligible recipient who is **17 years of age or older and will be at least 18 years of age** at the time of his or her ISP start date. The SIS quantifies the pattern and intensity of support needs of an eligible recipient with intellectual or developmental disabilities by obtaining information about the needs of each eligible recipient through a standardized assessment process.

B. Supplemental questions are reviewed by the SIS assessor with respondents at the end of each SIS assessment. The SIS assessor records responses provided and the information is included in the results issued. Responses are only applicable when there is extensive support needed (denoted by a "2") on any item in the exceptional medical support needs section of the SIS assessment or on specific items related to severe risk of injury to self or others in the exceptional behavioral support needs section of the SIS assessment. The supplemental questions are related to:

- (1) severe medical risk;
- (2) severe community safety risk - convicted;
- (3) severe community safety risk - not convicted; and
- (4) severe risk of injury to self.

C. The SIS assessment shall be scheduled prior to the eligible recipient's ISP start date so that the interdisciplinary team can receive results and plan services accordingly. An eligible recipient shall be offered options for dates and times to schedule the SIS assessment at least four months prior to the ISP start date.

D. The SIS assessment scheduling process shall include planning for accommodations, education about choice of respondents, and the setting of the time and location.

E. The eligible recipient being assessed is strongly encouraged, but is not required, to be involved in the entire SIS assessment. However, the assessed eligible recipient must at least personally meet the SIS® assessor at the time of the assessment.

F. Not less than two primary qualified respondents, who are usually primary caregivers or direct support professionals in residential and day service programs, must attend the assessment. The eligible recipient being assessed can also be a primary qualified respondent. Primary qualified respondents are not required to have clinical expertise or professional degrees. To qualify as a primary respondent, an individual must have:

- (1) known the eligible recipient for at least three months; and
- (2) recently observed the eligible recipient in one or more settings and for at least several hours per setting; and
- (3) the ability to describe the eligible recipient's support needs.

G. Guardians and close family members are strongly encouraged and welcomed to be involved in the eligible recipient's SIS assessment; however, they need not be qualified as a primary respondent.

H. The attendance of ancillary respondents is optional but encouraged when appropriate. An ancillary respondent is an individual who is typically a medical, behavioral or therapy professional who can provide clinical information that adds perspective particularly for individuals with complex support needs.

I. An eligible recipient may have an attorney present to observe the administration of the SIS assessment. Counsel for an eligible recipient will not participate in or interrupt the administration of the SIS assessment. The state of New Mexico, HSD, DOH, or the SIS assessor is under no obligation to pay any fees or costs associated with the attendance of an attorney at a SIS assessment; such legal fees and costs are solely the responsibility of the eligible recipient or his or her authorized representative.

J. Standard guidelines for administering the SIS assessment and supplemental questions require that:

- (1) the SIS assessor has been trained and certified to provide SIS assessments;
- (2) the SIS assessor provides information to the primary and ancillary respondents about the SIS® assessment process prior to starting the assessment;

- (3) the SIS assessment is conducted face to face;
- (4) the SIS assessor personally meets the eligible recipient at the time of the assessment;
- (5) each question in the SIS assessment is explained to respondents prior to it being scored;
- (6) each question is asked and discussed during the SIS assessment;
- (7) the final score of each question is shared with the respondents; and
- (8) medical and behavioral needs are discussed with the respondents; and
- (9) the SIS assessor be trained in standard administration of the supplemental questions and proper recording of the applicable responses.

K. An eligible recipient or his or her authorized representative may request a SIS reassessment during the eligible recipient's three year SIS assessment cycle when:

- (1) the eligible recipient or his or her authorized representative believes there is a substantial departure from standard guidelines in the administration of his or her SIS assessment; or
- (2) the eligible recipient has experienced a change in his or her condition that results in a significant change to the pattern and intensity of supports needed in one or more life areas.

L. A SIS reassessment, which requires the prior written approval of DOH, must be requested in accordance with the procedures and timelines established by DOH.

M. The DOH uses the SIS as a tool along with other information to place eligible recipients in a New Mexico (NM) DDW group. Each NM DDW group describes individuals with a similar pattern of support needs. The services and supports provided in each NM DDW group are generally appropriate for individuals with similar service and support needs. The NM DDW groups A through G (table is located below) are assigned through the standardized application of decision rules associated with select SIS assessment scores, and when relevant, the supplemental question verification process. The decision rules are applied to any updated versions of the SIS

assessment such as the SIS-A™ in a manner that is consistent with the application of the decision rules to the original SIS assessment in order to assure consistency and fairness across all individuals assessed.

(1) **SIS sum ABE:** Refers to the sum of the standards scores from supports intensity scale (SIS) support needs scale, part A: home living activities; part B: community living activities; and part E: health and safety activities.

(2) The medical support score refers to the total score in SIS assessment subsection titled: “medical support needed”. The total score for this section when using any newer version of the SIS assessment is determined by a scoring protocol to match the original SIS assessment, i.e. additional items in the SIS®-A are treated as sub items of the original SIS item denoted “other”.

(3) Behavioral support score refers to the total score in SIS assessment subsection titled: “behavioral support needed”.

(4) Extraordinary medical risk is determined by verification of positive responses to supplemental questions through a document review by subject matter experts. The verification process is applicable when a respondent meets a certain threshold in responses to supplemental questions which includes receiving extensive support needed (denoted by a “2”) on any item within the exceptional medical support needs section of the SIS assessment. The verification process will not result in lower benefits than would have been assigned through the SIS assessment process.

(5) Dangerousness to others or extreme self-injury risk is determined by verification of responses to supplemental questions through a document review by subject matter experts. The verification process is applicable when a respondent meets a certain threshold in responses to supplemental questions which includes receiving extensive support needed (denoted by a “2”) or on specific items related to severe risk of injury to self or others in the exceptional behavioral support needs section of the SIS assessment. The verification process will not result in lower benefits than would have been assigned through the SIS assessment process.

(6) The verification process will operate as currently conducted until the outside review process is fully operational and will not result in lower benefits than would have been assigned through the SIS assessment process. Once the outside review process is in place, the outside reviewer contractor will perform the functions currently performed in the verification process.

(7) Table identifying decision rules to define the NM DDW groups A through G:

NM DDW groups	SIS sum ABE	medical support score	behavioral support score
A: Mild support needs and low to moderate behavioral challenges	≥ 0 to ≤ 24	≥ 0 to ≤ 6	≥ 0 to ≤ 6
B: Low to moderate support needs and behavioral challenges	≥ 25 to ≤ 30	≥ 0 to ≤ 6	≥ 0 to ≤ 6
C: Mild to above average support needs and moderate to above average behavioral challenges	≥ 0 to ≤ 36	≥ 0 to ≤ 6	≥ 7 to ≤ 10
D: Above average support needs and low to moderate behavioral challenges	≥ 31 to ≤ 36	≥ 0 to ≤ 6	≥ 0 to ≤ 6
E: High support needs and mild to above average behavioral challenges	≥ 37 to ≤ 55	≥ 0 to ≤ 6	≥ 0 to ≤ 10

F: Extraordinary medical challenges	any	≥ 7 to ≤ 32 OR extraordinary medical risk	≥ 0 to ≤ 10
G. Extraordinary behavioral challenge	any	any	≥ 11 to ≤ 26 OR dangerousness to others or extreme self-injury risk

N. Information from the SIS assessment along with other information should be used for person-centered planning. When determining what service the eligible recipient needs, the IDT should consider the DDW group's suggested service packages and proposed budget with the understanding that the focus must always be on the individual's DD waiver support needs that can be clinically justified.
[8.314.5.13 NMAC - Rp, 8.314.5.13 NMAC, xx-xx-16]

8.314.5.14 DDW COVERED WAIVER SERVICES FOR IDENTIFIED POPULATION UNDER 18 YEARS OF AGE:

The DDW program is limited to the number of federally authorized unduplicated eligible recipient (UDR) positions and program funding. All DDW covered services in an ISP must be authorized. DDW services must be provided in accordance with all requirements set forth by DDW service definitions, all requirements outlined in the DDW service standards, and the applicable NMAC rules, supplements and guidance. The DDW covers the following services for a specified and limited number of waiver eligible recipients as a cost effective alternative to institutionalization in an intermediate care facilities for individuals with intellectual disabilities (ICF-IID).

A. **Eligible recipients Age Birth to 18:** The child's level of care assessment is used to determine the annual resource allotment (ARA) within the under 18 years of age category. The service options funded within the ARA allow the family of an eligible recipient, in conjunction with the IDT, the flexibility to choose any or all of these service options in an amount that does not exceed the eligible recipient's ARA. Services funded within the ARA include:

- (1) behavioral support consultation;
- (2) customized community support;
- (3) respite;
- (4) non-medical transportation;
- (5) case management;
- (6) supplemental dental care; and
- (7) nutritional counseling.

B. Services from the under 18 years of age category must be coordinated with and shall not duplicate other services such as the medicaid school-based services program, the MAD early periodic screening diagnosis and treatment (EPSDT) program, services offered through the New Mexico public education department (PED), or the DOH family infant toddler program (FIT).

C. Service options available outside of the ARA include:

- (1) environmental modifications;
- (2) assistive technology;
- (3) personal support technology; and
- (4) socialization and sexuality education.

[8.314.5.14 NMAC - Rp, 8.314.5.14 NMAC, xx-xx-16]

8.314.5.15 DDW COVERED WAIVER SERVICES FOR IDENTIFIED POPULATION 18 YEARS OF AGE AND OLDER:

The DDW program is limited to the number of federally authorized unduplicated eligible recipient (UDR) positions and program funding. All DDW covered services in an ISP must be authorized by DOH. DDW services must be provided in accordance with all requirements set forth by DOH DDW service definition, all requirements outlined in the DDW service standards, and the applicable NMAC rules, supplements and guidance. DDW covers the following services for a specified and limited number of waiver eligible recipients as a cost effective alternative to institutionalization in an intermediate care facilities for individuals with intellectual disabilities (ICF-IID).

A. There are seven NM DDW groups (designated A-G) each of which has a corresponding proposed service package. The proposed service package for each NM DDW group is based on assessed need and consists of a proposed base budget, a proposed professional services budget, and other services budget that make up the total funding authorized in the eligible recipient's ISP. The proposed service package and proposed budget for each of the seven NM DDW groups allows an eligible recipient 18 years of age and older and his or her IDT flexibility to request any covered service and service amount medically necessary to meet his or her needs through the outside reviewer when appropriate clinical criteria are met.

B. H Authorization allows an eligible adult recipient who has extenuating circumstances or extremely complex clinical needs, or both, to receive services beyond what is authorized in their current ISP/budget or to allow exceptions to DOH Standards related to the suggested service package option that corresponds with their NM DDW Group assignment. Services outside of the suggested service package assigned to the corresponding NM DDW group may be authorized for an eligible recipient through the H authorization designation on a permanent basis as deemed appropriate by DOH, or on either a temporary or long-term basis.

(1) A permanent H authorization includes:

(a) an eligible recipient who is included in the class established in the matter of *Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al*, (757 F. Supp. 1243 DNM 1990) is to receive a permanent NM DDW H authorization approval, regardless of his or her NM DDW group assignment. A Jackson class member may receive service types and amounts consistent with those approved in his or her ISP; and

(b) an eligible recipient assigned to NM DDW group A or B who was 55 years of age and older at the time of his or her annual ISP between March 1, 2013 and February 28, 2014 and who had been receiving DDW Supported Living services prior to March 1, 2013 are authorized to continue to use supported living services.

(2) The review process for temporary H authorization (up to 90 calendar days) requests for service is as follows:

(a) the interdisciplinary team (IDT) convenes and determines the need for consideration for a temporary H authorization request by identifying the specific need or service, and number of units necessary;

(b) the IDT is responsible for first completing any prior authorization processes and obtaining the maximum amounts of services suggested within the current NM DDW group assignment;

(c) the case manager submits a H authorization request for services to the regional office (RO);

(d) the RO director or designee makes a determination based on criteria from DOH whether the request meets the definition of extenuating circumstances or extremely complex clinical needs. Once a determination on the review is made, the case manager or an eligible recipient, or his or her authorized representative will be notified of the decision in writing;

(e) if temporary H authorization request for services is approved by DOH, the case manager shall submit a budget revision with the DOH prior authorization to the DOH designee.

(3) The review process for long-term H authorization (greater than 90 calendar days) requests for service is as follows:

(a) the IDT convenes and determines the need for consideration for a long-term H authorization request by identifying the specific need or service and the number of units necessary;

(b) the IDT is responsible for first completing any prior authorization processes and obtaining the maximum amounts of services suggested within the current NM DDW group assignment;

(c) the case manager submits a H authorization request for services to the RO;

(d) the RO director processes the request and sends the request to the RO bureau chief for review. The RO bureau chief makes a determination on the H authorization request by reviewing the following:

(i) the request meets the definition of clinical need, extenuating circumstances, and /or extremely complex clinical needs.

(ii) the options within the eligible recipient's current NM DDW group assignment have been fully explored;

(iii) the individual has significant support needs that are not currently being met;

(iv) evidence of the previous and current ISP year utilization;

(v) medicaid state plan benefits have been exhausted;

(vi) that generic/natural resources to address the extenuating circumstance or complex need have been explored;

(vii) that the nature of the extenuating circumstance or complex need is anticipated to last longer than 90 calendar days, and

(viii) that the individual's need for a long-term H authorization request for services is not exclusively due to a significant change in condition or personal life circumstances that can otherwise be addressed through temporary H authorization request for services needed or pending the request for a SIS reassessment;

(e) DOH makes a determination based on its criteria set by DOH whether the request meets the definition of extenuating circumstances or extremely complex clinical needs; once a determination is made, the case manager and the eligible recipient and his or her authorized representative (if applicable) will be notified of the decision in writing;

(f) if the long-term H authorization request for services is approved by DOH, the case manager shall submit a budget revision with the approved prior authorizations to the DOH designee.

D. When determining what service the eligible recipient needs, the IDT should consider the DDW group's suggested service packages and proposed budget with the understanding that the focus must always be on the individual's DD waiver support needs that can be clinically justified. Services available:

(1) **Case management services:** Case management services assist an eligible recipient to access MAD covered services. A case manager also links the eligible recipient to needed medical, social, educational and other services, regardless of funding source. DDW services are intended to enhance, not replace existing natural supports and other available community resources. Services will emphasize and promote the use of natural and generic supports to address the eligible recipient's assessed needs in addition to paid supports. Case managers facilitate and assist in assessment activities, as appropriate. Case management services are person-centered and intended to support an eligible recipient in pursuing his or her desired life outcomes while gaining independence, and access to services and supports. Case management is a set of interrelated activities that are implemented in a collaborative manner involving the active participation of the eligible recipient, his or her authorized representative, and the entire interdisciplinary team. The case manager is an advocate for the eligible recipient he or she serves, is responsible for developing the ISP and for ongoing monitoring of the provision of services included in the ISP. Case management services include but are not limited to activities such as:

- (a) assessing needs;
- (b) facilitating eligibility determination for persons with developmental disabilities;
- (c) directing the service planning process;
- (d) advocating on behalf of the eligible recipient;
- (e) coordinating service delivery;
- (f) assuring services are delivered as described in the ISP; and
- (g) maintaining a complete current central eligible recipient record (e.g. ISP, ISP budget, level of care documentation, assessments).

(i) Cost-effectiveness is a DDW requirement mandated by federal regulation. The fiscal responsibilities of the case manager include assuring cost containment by preventing the expense of DDW services from exceeding a maximum cost established by DOH and by exploring other options to address expressed needs.

(ii) Case managers must evaluate and monitor direct service through face-to-face visits with the eligible recipient to ensure the health and welfare of the eligible recipient, and to monitor the implementation of the ISP.

(2) **Respite services:** Respite services are a flexible family support service for an eligible recipient. The primary purpose of respite services is to provide support to the eligible recipient and give the primary, unpaid caregiver relief and time away from his or her duties. Respite services include assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills and providing opportunities for play and other recreational activities; community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the eligible recipient to make his or her own choices with regard to daily activities. Respite services will be scheduled as determined by the primary caregiver. An eligible recipient receiving living supports or customized in-home supports (when an eligible recipient is not living with a family member), may not access respite services. Respite services may be provided in the eligible recipient's own home, in a provider's home, or in a community setting of the eligible recipient family's choice. Respite services must be provided in accordance with Section 10 of this rule.

(3) **Adult nursing services:** Adult nursing services (ANS) are provided by a licensed RN or LPN under the supervision of a RN to an eligible adult recipient. Adult nursing services are intended to support the highest practicable level of health, functioning and independence for an eligible recipient. They include direct nursing services and activities related to the nursing oversight of unrelated direct support staff when assisting with health related needs in specific settings.

(a) ANS is available to individuals ages 21 and over who reside in family living; those who receive customized in home supports and those who do not receive any Living Supports. It is available to any eligible recipient who has health related needs that require nursing training, delegation or oversight of direct support staff during participation in customized community supports (individual or small group) and/ or community integrated employment even if Living Supports or CCS- Group are also provided.

(b) ANS is available to individuals ages 18-20 who reside in family living and who are at aspiration risk and desire to have aspiration risk management services. It is also available to individuals who have health related needs that require nursing training, delegation or the oversight of non-related direct support staff during substitute care; customized community supports (individual or small group); community integrated employment or customized in home supports.

(c) There are two categories of adult nursing services:

(i) assessment and consultation services which includes a comprehensive health assessment (including assessment for medication delivery needs and aspiration risk) and consultation regarding available or mandatory services which requires only budgeting; and

(ii) ongoing services, which requires prior authorization and are tied to the eligible recipient's specific health needs revealed in the comprehensive health assessment and prior authorization process.

(4) **Therapy services:** Therapy services are to be delivered consistent with the participatory approach philosophy and two models of therapy services (collaborative-consultative and direct treatment). These models support and emphasize increased participation, independence and community inclusion in combination with health and safety. Therapy services are designed to support achievement of ISP outcomes and prioritized areas of need identified through therapeutic assessment. PT, OT and SLP are skilled therapies that are recommended by an eligible recipient's IDT members and a clinical assessment that demonstrates the need for therapy services. All three therapy disciplines: PT, OT, and SLP will be available to all DD waiver recipients if they and their IDT members determine the therapy disciplines are necessary. Therapy services for an eligible adult recipient require a prior authorization except for his or her initial assessment. A RLD licensed practitioner, as specified by applicable state laws and standards, provides the skilled therapy services. Therapy services for eligible adult recipients must comply with Section 10 of this rule. For an eligible recipient under 21 years of age, he or she accesses covered therapy services through the early and periodic screening, diagnostic and treatment program (EPSDT).

(a) **Physical therapy (PT):** PT is a skilled, RLD licensed therapy service involving the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance, and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy prevents the onset, symptoms and progression of impairments, functional limitations, and disability that may result from diseases, disorders, conditions or injuries. A RLD licensed physical therapy assistant (PTA) may perform physical therapy procedures and related tasks pursuant to a plan of care/therapy intervention plan written by the supervising physical therapist. Therapy services for eligible recipients must comply with Section 10 of this rule.

(b) **Occupational therapy (OT):** OT is a skilled, RLD licensed therapy service involving the use of everyday life activities (occupations) for the purpose of evaluation, treatment, and management of functional limitations. Therapy services for eligible recipients must comply with Section 10 of this rule. Occupational therapy addresses physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being and quality of life. COTAs may perform occupational therapy procedures and related tasks pursuant to a therapy intervention plan written by the supervising OT as allowed by RLD licensure. OT services typically include:

(i) evaluation and customized treatment programs to improve the eligible recipient's ability to engage in daily activities;

(ii) evaluation and treatment for enhancement of an eligible recipient's performance skills;

(iii) health and wellness promotion to the eligible recipient;

(iv) environmental access and assistive technology evaluation and treatment for use by the eligible recipient; and

(v) training/consultation to eligible recipient's family members and direct support personnel.

(c) **Speech-language pathology:** SLP service, also known as speech therapy, is a skilled therapy service, provided by a speech-language pathologist that involves the non-medical application of principles, methods and procedures for the diagnosis, counseling, and instruction related to the development of and disorders of communication including speech, fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction and sensory-motor competencies. Therapy services for eligible recipients must comply with Section 10 of this rule. Speech-language pathology services are also used when an eligible recipient requires the use of an augmentative communication device. For example, SLP services are intended to:

(i) improve or maintain the eligible recipient's capacity for successful communication or to lessen the effects of an eligible recipient's loss of communication skills; or

(ii) treat a specific condition clinically related to an intellectual developmental disability of the eligible recipient; or

(iii) improve or maintain the eligible recipient's ability to safely eat foods, drink liquids or manage oral secretions while minimizing the risk of aspiration or other potential injuries or illness related to swallowing disorders.

(5) **Living supports:** Living supports are residential habilitation services that are individually tailored to assist an eligible recipient 18 years and older who is assessed to need daily support or supervision with the acquisition, retention, or improvement of skills related to living in the community to prevent institutionalization. Living supports include residential instruction intended to increase and promote independence and to support an eligible recipient to live as independently as possible in the community in a setting of his or her own choice. Living support services assist and encourage an eligible recipient to grow and develop, to gain autonomy, become self-governing and pursue his or her own interests and goals. Living support providers take positive steps to protect and promote the dignity, privacy, legal rights, autonomy and individuality of each eligible recipient who receives services. Services promote inclusion in the community and an eligible recipient is afforded the opportunity to be involved in the community and actively participate using the same resources and doing the same activities as other community members. Living supports will assist an eligible recipient to access generic and natural supports and opportunities to establish or maintain meaningful relationships throughout the community. Living supports providers are responsible for providing an appropriate level of services and supports up to 24 hours per day, seven days per week. Room and board costs are reimbursed through the eligible recipient's social security insurance (SSI) or other personal accounts and cannot be paid through the DDW. Living Support services for eligible recipients must comply with Section 10 of this rule. Living supports consists of family living, supported living and intensive medical living as follows.

(a) **Family living:** Family living is intended for an eligible recipient who is assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family living is a residential habilitation service that is intended to increase and promote independence and to provide the skills necessary to prepare an eligible recipient to live on his or her own in a non-residential setting. Family living services are designed to address assessed needs and identified individual eligible recipient outcomes. Family living is direct support and assistance to no more than two eligible recipients furnished by a natural or host family member, or companion who meets the requirements and is approved to provide family living services in the eligible recipient's home or the home of the family living direct support personnel. The eligible recipient lives with the paid direct support personnel. The provider agency is responsible for substitute coverage for the primary direct support personnel to receive sick leave and time off as needed.

(i) **Home studies:** The family living services provider agency shall complete all DOH requirements for approval of each direct support personnel, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the provider agency to conduct home studies shall be approved by DOH.

(ii) **Family living services:** Family living can be provided to no more than two eligible recipients with intellectual or developmental disabilities at a time. An exception may be granted by DOH if three eligible recipients are in the residence, but only two of the three are on the DDW and the arrangement is approved by DOH based on the home study documenting the ability of the family living services provider agency to serve more than two eligible recipients in the residence; or there is documentation that identifies the eligible recipients as siblings or there is documentation of the longevity of a relationship (e.g., copies of birth certificates or social history summary). Documentation shall include a statement of justification from a social worker,

psychologist, and any other pertinent professionals working with the eligible recipients. Family living services cannot be provided in conjunction with any other living supports service, respite, or nutritional counseling

(b) **Supported living:** Supported living is intended for an eligible recipient who is assessed to need residential habilitation to ensure health and safety. Supported living is a residential habilitation service that is intended to increase and promote independence and to provide the skills necessary to prepare an eligible recipient to live on his or her own in a non-residential setting. Supported living services are designed to address assessed needs and identified individual eligible recipient outcomes. The service is provided to two to four eligible recipients in a community residence. Prior authorization is required from DOH for an eligible recipient to receive this service when living alone. Supported living services cannot be provided in conjunction with any other living supports service, respite, or nutritional counseling.

(c) **Intensive Medical Living Services:** An intensive medical living supports agency provides residential supports for an eligible recipient in a supported living environment who requires daily direct skilled nursing, in conjunction with community living supports that promote health and assist the eligible recipient to acquire, retain or improve skills necessary to live in the community and prevent institutionalization, consistent with his or her ISP. An eligible recipient must meet criteria for intensive medical living supports according to DDW service definitions and DDW standards for this service and he or she requires nursing care, ongoing assessment, clinical oversight and health management that must be provided directly by a MAD recognized RN or LPN, see Section 10 of this rule.

(i) These medical needs include: skilled nursing interventions; delivery of treatment; monitoring for change of condition; and adjustment of interventions and revision of services and plans based on assessed clinical needs.

(ii) In addition to providing support to an eligible recipient with chronic health conditions, intensive medical living supports are available to an eligible recipient who meets a high level of medical acuity and require short-term transitional support due to recent illness or hospitalization. This service will afford the core living support provider the time to update health status information and health care plans, train staff on new or exacerbated conditions and assure that the home environment is appropriate to meet the needs of the eligible recipient. Short-term stay in this model may also be utilized by an eligible recipient who meets the criteria that is living in a family setting when the family needs a substantial break from providing direct service. Both types of short-term placements require prior approval from DOH. In order to accommodate referrals for short-term stays, each approved intensive medical living supports provider must maintain at least one bed available for such short-term placements. If the short-term stay bed is occupied, additional requests for short-term stay will be referred to other providers of this service.

(iii) The intensive medical living supports provider will be responsible for providing the appropriate level of supports, 24 hours per day seven days a week, including necessary levels of skilled nursing based on assessed need of the eligible recipient. Daily nursing visits are required; however, a RN or a LPN under a RN's supervision is not required to be present in the home during periods of time when skilled nursing services are not required or when an eligible recipient is out in the community. An on-call RN or LPN, under the supervision of a RN must be available to staff during periods when a RN or a LPN under a RN's supervision is not present. Intensive medical living supports require supervision by a RN, and must comply with Section 10 of this rule.

(iv) Direct support personnel will provide services that include training and assistance with ADLs such as bathing, dressing, grooming, oral care, eating, transferring, mobility and toileting. These services also include training and assistance with instrumental activities of daily living (IADL) including housework, meal preparation, medication assistance, medication administration, shopping, and money management.

(v) The intensive medical living supports provider will be responsible for providing access to customized community support and employment as outlined in the eligible recipient's ISP. This includes any skilled nursing needed by the eligible recipient to participate in customized community support and development and employment services. The intensive medical living provider must arrange transportation for all medical appointments, household functions and activities, and to-and-from day services and other meaningful community options.

(vi) Intensive medical living supports providers must comply with Section 10 of this rule.

(6) **Customized community supports:** Customized community supports consist of individualized services and supports that enable an eligible recipient to acquire, maintain, and improve opportunities for independence, community integration and employment. Customized community supports services are designed around the preferences and choices of each eligible recipient and offer skill training and supports to include:

adaptive skill development; educational supports; citizenship skills; communication; social skills, socially appropriate behaviors; self-advocacy, informed choice; community integration and relationship building. This service provides the necessary support to develop social networks with community organizations to increase the eligible recipient's opportunity to expand valued social relationships and build connections within local communities. This service helps to promote self-determination, increases independence and enhances the eligible recipient's ability to interact with and contribute to his or her community.

(a) Based on assessed needs, customized community supports services may include personal support, nursing oversight, medication assistance or administration, and integration of strategies in the therapy and healthcare plans into the eligible recipient's daily activities.

(b) The customized community supports provider will provide fiscal management for the payment of education opportunities as determined necessary for the eligible recipient.

(c) Customized community supports services may be provided regularly or intermittently based on the needs of the eligible recipient and are provided during the day, evenings and weekends.

(d) Customized community supports may be provided in a variety of settings to include the community, classroom, and site-based locations. Services provided in any location are required to provide opportunities that lead to participation and integration in the community or support the eligible recipient to increase his/her growth and development.

(e) Pre-vocational and vocational services are not covered under customized community supports.

(f) Customized community supports services must be provided in accordance with Section 10 of this rule.

(7) **Community integrated employment:** Community integrated employment provides supports that achieve employment in jobs of the eligible recipient's choice in his or her community to increase his or her economic independence, self-reliance, social connections and ability to grow within a career. Community integrated employment results in employment alongside non-disabled coworkers within the general workforce or in business ownership. This service may also include small group employment including mobile work crews or enclaves. An eligible recipient is supported to explore and seek opportunity for career advancement through growth in wages, hours, experience or movement from group to individual employment. Each of these activities is reflected in individual career plans. Community integrated employment services must not duplicate services covered under the Rehabilitation Act or the Individuals with Disabilities Education Act (IDEA). Compensation shall comply with state and federal laws including the Fair Labor Standards Act. DDW funds (e.g., the provider agency's reimbursement) may not be used to pay the eligible recipient for work. Community integrated employment services must comply with Section 10 of this rule. Community integrated employment consists of job development, self-employment, individual community integrated employment and group community integrated employment models.

(a) **Self-employment:** The community integrated employment provider provides the necessary assistance to develop a business plan, conduct a market analysis of the product or service and establish necessary infrastructure to support a successful business. Self-employment does not preclude employment in the other models. Self-employment may include but is not limited to the following:

- (i) completing a market analysis of product/business viability;
- (ii) creating a business plan including development of a business infrastructure to sustain the business over time, including marketing plans;
- (iii) referring and coordinating with the division of vocational rehabilitation (DVR) for possible funds for business start-up;
- (iv) assisting in obtaining required licenses necessary tax identifications, incorporation documents and completing any other business paperwork required by local and state codes;
- (v) supporting the eligible recipient in developing and implementing a system of bookkeeping and records management;
- (vi) providing effective job coaching and on-the-job training and skill development; and
- (vii) arranging transportation or public transportation during self-employment services.

(b) **Individual community integrated employment:** Individual community integrated employment is job coaching and job development for an employed eligible recipient in integrated community based settings. The amount and type of individual support needed will be determined through vocational assessment including on-the-job analysis. Individual community integrated employment may include, but is not limited to the following:

(i) provide effective job coaching and on-the-job training as needed to assist the eligible recipient to maintain the job placement and enhance skill development; and
(ii) arrange transportation or public transportation during individual community integrated employment services.

(c) **Group community integrated employment:** Group community integrated employment is when more than one eligible recipient works in an integrated setting with staff supports on site. Regular and daily contact with non-disabled coworkers or the public occurs. Group community integrated employment may include but is not limited to the following:

(i) participate with the IDT to develop a plan to assist an eligible recipient who desires to move from group employment to individual employment; and
(ii) provide effective job coaching and on-the-job training as needed to assist the eligible recipient to maintain the job placement and enhance skill development.

(8) **Behavioral support consultation services:** Behavioral support consultation services guide the IDT to enhance the eligible recipient's quality of life by providing positive behavioral supports for the development of functional and relational skills. Behavioral support consultation services also identify distracting, disruptive, or destructive behavior that could compromise quality of life and provide specific prevention and intervention strategies to manage and lessen the risks this behavior presents. Behavioral support consultation services do not include individual or group therapy, or any other behavioral services that would typically be provided through the behavioral health system.

(a) Behavioral support consultation services are intended to augment functional skills and positive behaviors that contribute to quality of life and reduce the impact of interfering behaviors that compromise quality of life. This service is provided by an authorized behavioral support consultant and includes an assessment and positive behavioral support plan development, IDT training and technical assistance, and monitoring of an eligible recipient's behavioral support services.

(b) Behavioral support consultation services must comply with Section 10 of this rule.

(9) **Nutritional counseling services:** Nutritional counseling services include the assessment, evaluation, collaboration, planning, teaching, consultation and implementation and monitoring of a nutritional plan that supports the eligible recipient to attain or maintain the highest practicable level of health. Nutritional counseling services are in addition to those nutritional or dietary services allowed in the eligible recipient's medicaid state plan benefit, or other funding source. This service does not include oral-motor skill development services, such as those services provided by a speech pathologist. Because nutritional counseling is included in the reimbursement rate for living supports, nutritional counseling cannot be billed as a separate service during the hours of living supports. Nutritional counseling services must comply with Section 10 of this rule.

(10) **Environmental modification services:** Environmental modifications services include the purchasing and installing of equipment or making physical adaptations to an eligible recipient's residence that are necessary to ensure the health, welfare and safety of the eligible recipient or enhance his or her access to the home environment and increase his or her ability to act independently.

(a) Adaptations, instillations and modifications include:
(i) heating and cooling adaptations;
(ii) fire safety adaptations;
(iii) turnaround space adaptations;
(iv) specialized accessibility, safety adaptations or additions;
(v) installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;
(vi) installation of trapeze and mobility tracks for home ceilings;
(vii) installation of ramps and grab-bars;
(viii) widening of doorways or hallways;
(ix) modification of bathroom facilities (roll-in showers, sink, bathtub and toilet modification, water faucet controls, floor urinals and bidet adaptations and plumbing);
(x) purchase or installation of air filtering devices;
(xi) purchase or installation of lifts or elevators;
(xii) purchase and installation of glass substitute for windows and doors;
(xiii) purchase and installation of modified switches, outlets or environmental controls for home devices; and

(xiv) purchase and installation of alarm and alert systems or signaling devices.

(b) Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the eligible recipient. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to an eligible recipient's residence or to configure a bathroom to accommodate a wheelchair).

(c) Environmental modification services must be provided in accordance with applicable federal, state and local building codes.

(d) Environmental modification services must comply with Section 10 of this rule.

(11) **Crisis supports:** Crisis supports are services that provide intensive supports by appropriately trained staff to an eligible recipient experiencing a behavioral or medical crisis either within the eligible recipient's present residence or in an alternate residential setting. Crisis support must comply with Section 10 of this rule.

(a) **Crisis supports in the eligible recipient's residence:** These services provide crisis response staff to assist in supporting and stabilizing the eligible recipient while also training and mentoring staff or family members, who normally support the eligible recipient, in order to remediate the crisis and minimize or prevent recurrence.

(b) **Crisis supports in an alternate residential setting:** These services arrange an alternative residential setting and provide crisis response staff to support the eligible recipient in that setting, to stabilize and prepare the eligible recipient to return home or to move into another permanent location. In addition, staff will arrange to train and mentor staff or family members who will support the eligible recipient long-term once the crisis has stabilized, in order to minimize or prevent recurrence of the crisis.

(c) Crisis response staff will deliver such support in a way that maintains the eligible recipient's normal routine to the maximum extent possible. This includes support during attendance at employment or customized community supports services, which may be billed on the same dates and times of service as crisis supports.

(d) This service requires prior written approval and referral from the bureau of behavioral support (BBS). Crisis supports are designed to be a short-term response (two to 90 calendar days).

(e) The timeline may exceed 90 calendar days under extraordinary circumstances, with approval from the BBS in which case duration and intensity of the crisis intervention will be assessed weekly by BBS staff.

(12) **Non-medical transportation:** Non-medical transportation services assists the eligible recipient in accessing other waiver supports and non-waiver activities identified in his or her ISP. Non-medical transportation enables the eligible recipient to gain physical access to non-medical community services and resources promoting the eligible recipient opportunity and responsibility in carrying out his or her ISP activities. This service is to be considered only when transportation is not available through the medicaid state plan or when other arrangements cannot be made. Non-medical transportation includes funding to purchase a pass for public transportation for the eligible recipient. Non-medical transportation provider services must comply with Section 10 of this rule.

(13) **Supplemental dental care:** Supplemental DDW dental care services are provided for an eligible recipient that requires routine oral health care more frequently than the coverage provided under other MAP benefit plans. Supplemental dental care provides one oral examination and one cleaning once every ISP year to an eligible recipient for the purpose of preserving or maintaining oral health. The supplemental dental care service must comply with Section 10 of this rule.

(14) **Assistive technology purchasing agent service:** Assistive technology purchasing agent service is intended to increase the eligible recipient's physical and communicative participation in functional activities at home and in the community. Items purchased through the assistive technology service assist the eligible recipient to meet outcomes outlined in his or her ISP, increase functional participation in employment, community activities, activities of daily living, personal interactions, or leisure activities, or increase the eligible recipient's safety during participation of the functional activity.

(a) Assistive technology services allows an eligible recipient to purchase needed items to develop low-tech augmentative communication, environmental access, mobility systems and other functional assistive technology, not covered through the eligible recipient's medicaid state plan benefits.

(b) Assistive technology purchasing agent providers act as a fiscal agent to either directly purchase, or reimburse team members who purchase devices or materials which have been prior authorized by DOH on behalf of the eligible recipient.

(c) Assistive technology purchasing agent services must comply with Section 10 of this rule.

(15) **Independent living transition services:** Independent living transition services are one-time set-up expenses for an eligible recipient who transitions from a 24 hour living supports setting into a home or apartment of his or her own with intermittent support that allows him or her to live more independently in the community. The service covers expenses associated with security deposits that are required to obtain a lease on an apartment or home, set-up fees or deposits for utilities (telephone, electricity, heating, etc.), and furnishings to establish safe and healthy living arrangements, such as a bed, chair, dining table and chairs, eating utensils and food preparation items, and a telephone. The service also covers services necessary for the eligible recipient's health and safety such as initial or one-time fees associated with the cost of paying for pest control, allergen control or cleaning services prior to occupancy. Independent living transition services must comply with Section 10 of this rule.

(16) **Personal support technology/on-site response service:** Personal support technology/on-site response service is an electronic device or monitoring system that supports the eligible recipient to be independent in the community or in his or her place of residence with limited assistance or supervision of paid staff. This service provides 24-hour response capability or prompting through the use of electronic notification and monitoring technologies to ensure the health and safety of the eligible recipient in services. Personal support technology/on-site response service is available to the eligible recipient who has a demonstrated need for timely response due to health or safety concerns. Personal support technology/on-site response service includes the installation of the rented electronic device, monthly maintenance fee for the electronic device, and hourly response funding for staff that support the eligible recipient when the device is activated. Personal support technology/on-site response services must comply with Section 10 of this rule.

(17) **Preliminary risk screening and consultation related to inappropriate sexual behavior:** PRSC identifies, screens, and provides periodic technical assistance and crisis intervention when needed to the IDTs supporting the eligible recipient with risk factors for sexually inappropriate or offending behavior, as defined in the DDW definitions and DDW standards. This service is part of a continuum of behavioral support services (including behavioral support consultation, and socialization and sexuality services) that promote community safety and reduce the impact of interfering behaviors that compromise quality of life.

(a) The key functions of PRSC are to:

- (i) provide a structured screening of the eligible recipient's behaviors that may be sexually inappropriate;
- (ii) develop and document recommendations of the eligible recipient in the form of a report or consultation notes;
- (iii) develop and periodically review risk management plans for the eligible recipient, when recommended; and
- (iv) provide consultation regarding the management and reduction of the eligible recipient's sexually inappropriate behavioral incidents that may pose a health and safety risk to the eligible recipient or others.

(b) Preliminary risk screening and consultation related to inappropriate sexual behavioral services must comply with Section 10 of this rule.

(18) **Socialization and sexuality education service:** Socialization and sexuality education service is carried out through a series of classes intended to provide a proactive educational program about the values and critical thinking skills needed to form and maintain meaningful relationships, and about healthy sexuality and sexual expression. Social skills learning objectives include positive self-image, communication skills, doing things independently and with others, and using paid and natural supports. Sexuality learning objectives include reproductive anatomy, conception and fetal development, safe sex and health awareness. Positive outcomes for the eligible recipient include safety from negative consequences of being sexual, assertiveness about setting boundaries and reporting violations, expressing physical affection in a manner that is appropriate, and making informed choices about the relationships in the eligible recipient's life. Independent living skills are enhanced and improved work outcomes result from better understanding of interpersonal boundaries, and improved communication, critical thinking and self-reliance skills. Socialization and sexuality education services must comply with Section 10 of this rule.

(19) **Customized in-home supports:** Customized in-home support services is not a residential habilitation service and is intended for an eligible recipient that does not require the level of support

provided under living supports services. Customized in-home supports provide an eligible recipient the opportunity to design and manage the supports needed to live in his or her own home or family home. Customized in-home supports includes a combination of instruction and personal support activities provided intermittently to assist the eligible recipient with ADLs, meal preparation, household services, and money management. The services and supports are individually designed to instruct or enhance home living skills, community skills and to address health and safety of the eligible recipient, as needed. This service provides assistance with the acquisition, improvement or retention of skills that provides the necessary support to achieve personal outcomes that enhance the eligible recipient's ability to live independently in the community. Customized in-home support services must comply with Section 10 of this rule.

[8.314.5.15 NMAC - Rp, 8.314.5.15 NMAC, xx-xx-16]

8.314.5.16 NON-COVERED SERVICES: Only those services listed in the DDW benefit package may be reimbursed through the DDW. Room, board and ancillary services are not covered DDW services. An eligible recipient may access, as medically necessary, all medicaid state plan benefits in addition to his and her DDW services. If the eligible recipient is an enrolled member of a HSD managed care organization (MCO), he or she may access, as medically necessary, the benefits listed in 8.308.9 NMAC.

[8.314.5.16 NMAC - Rp, 8.314.5.16 NMAC, xx-xx-16]

8.314.5.17 INDIVIDUALIZED SERVICE PLAN (ISP): An ISP must be developed by an IDT in consultation with the eligible recipient and others involved in the eligible recipient's care. The ISP is developed using information relevant to the care of the eligible recipient. In developing an ISP, the IDT should consider the DDW Group's suggested services packages and proposed budget with the understanding that the focus must always be on the eligible recipient's support needs that can be clinically justified. The ISP is submitted to DOH or its designee for final approval. DOH or its designee must approve any changes to the ISP; see 7.26.5 NMAC.

A. The IDT must review the eligible recipient's treatment plan every 12 months or more often if indicated. DOH shall provide the eligible recipient, his or her case manager and, as applicable, his or her guardian(s) a DDW planning packet that contains each of the following:

- (1) an informational instructions cover letter;
- (2) notice of right to appeal pursuant to 8.314.5.21 NMAC;
- (3) a copy of the my supports profile report created by DOH for that recipient;
- (4) notice of the proposed DDW group assignment and associated service package;
- (5) notice of the proposed annual budget for the recipient;
- (6) a copy of the DDW group assignment decision rules; and
- (7) any additional information that MAD or DOH/DDSD may determine, from time to time,

to be of assistance to the IDT in creating an ISP.

B. The IDT is responsible for compiling clinical documentation to justify the requested services and budget to the OR for adult recipients excluding class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990).

C. The ISP must contain the following information:

- (1) statement of the nature of the specific needs of the eligible recipient;
- (2) description of the functional level of the eligible recipient;
- (3) statement of the least restrictive conditions necessary to achieve the purposes of treatment of an eligible recipient;
- (4) description of intermediate and long-range goals, with a projected timetable for eligible recipient's attainment and the duration and scope of services;
- (5) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provision for review and modification of the eligible recipient's ISP; and
- (6) specification of responsibilities for areas of care, description of needs, and orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the eligible recipient.

D. Upon completion of the ISP by the IDT, the case manager shall develop a budget to be evaluated in accordance with the Outside Reviewer (OR) process; see section 8.314.5.18(D) NMAC.

E. Upon completion of the ISP by the IDT, the case manager shall develop a budget to be evaluated in accordance with the medicaid TPA review process for child recipients and class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990).

F. All services must be provided as specified in the ISP.

[8.314.5.17 NMAC - Rp, 8.314.5.17 NMAC, xx-xx-16]

8.314.5.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services, including services covered under the DDW, are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made; see 8.310.2 NMAC. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. MAD prior authorization: To be eligible for DDW services, a MAD eligible recipient must require the level of care (LOC) of services provided in an ICF-IID. LOC determinations are made by MAD or its designee. The eligible recipient's person centered ISP must specify the type, amount and duration of services and meet clinical criteria. Certain procedures and services specified in the ISP may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. DOH prior authorization: Certain services are subject to utilization review by DOH.

C. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for MAD services. Providers must verify that individuals are eligible for MAD services, including DDW services or other health insurance prior to the time services are furnished. An eligible recipient may not be institutionalized, hospitalized, or receive personal care option (PCO) services or other HCBS waiver services at the time DDW services are provided, except for certain case management services that are required to coordinate discharge plans or transition of services to DDW services.

D. Outside Review Process: All services for adult recipients excluding class members of *Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al*, (757 F. Supp. 1243 DNM 1990) will be reviewed by an Outside Reviewer (OR) contracted by DOH. The OR will adhere to deadlines set forth in its contract with the DOH. The OR will apply the DDW clinical criteria to make a clinical determination on whether the requested services are needed, and will recommend whether the requested annual budget and ISP should be approved. If the OR approves in whole or part the requested ISP and budget, the OR will send the approved portion of the budget to the medicaid TPA for entry into the medicaid management information system and issue a prior authorization to the case manager. If there is a denial in part or whole, the OR decision must be in writing, identify a list of all documents and input considered by the OR team during its review, and state the reasons for any denial of requested services. The eligible recipient, case manager, and guardian (if applicable) will be provided with this written determination and notice of an opportunity to request a fair hearing as well as an agency review conference.

(1) The eligible recipient, case manager, and guardian (if applicable) may submit to the Outside Reviewer additional information relating to support needs.

(2) The decision of the OR is binding on the State. However, the State may agree to overturn a decision to deny services at a requested agency conference.

E. Reconsideration: Providers who disagree with the denial of a prior authorization request or other review decisions may request a reconsideration. See 8.350.2 NMAC, reconsideration of utilization review decisions.

[8.314.5.18 NMAC - Rp, 8.314.5.18 NMAC, xx-xx-16]

8.314.5.19 REIMBURSEMENT: DDW service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. A DDW provider must follow 8.302.2 NMAC, MAD billing instructions, utilization review instructions, and supplements. Reimbursement to providers of waiver services is made at a predetermined reimbursement rate.

[8.314.5.19 NMAC - Rp, 8.314.5.19 NMAC, xx-xx-16]

8.314.5.20 RIGHT TO A HSD ADMINISTRATIVE HEARING: An eligible recipient may request a HSD administrative hearing to appeal a decision of the Outside Reviewer that is an adverse action against the recipient. Prior to the fair hearing an eligible recipient has the right to an agency review conference. An agency review conference (AC) means an optional conference offered by the DOH to provide an opportunity to informally resolve a dispute over the denial, suspension, reduction, termination or modification of DDW benefits or services. An AC will be attended by the recipient and their authorized representative (if applicable) and by a representative of the DOH. The recipient may also bring whomever he or she wishes to assist during the AC. The AC is optional and shall in no way delay or replace the fair hearing process or affect the deadline for a fair hearing request.

A. An authorized representative means any individual designated by the eligible recipient or his or her guardian, if applicable, to represent the recipient and act on their behalf. The authorized representative must

provide formal documentation authorizing him or her to access the identified case information for this specific purpose. An authorized representative may be, but need not be, the recipient's guardian or attorney.

B. If a resolution is reached through the AC, DOH will issue written notification within seven (7) business days of the AC to the recipient, recipient's guardian (if applicable) and case manager. The case manager will then prepare a budget for submission to the medicaid TPA based on that resolution.

C. Unless the fair hearing request is withdrawn by the recipient or recipient's guardian or lawyer, any requested fair hearing will proceed. At the fair hearing the claimant may raise any relevant issue and present any relevant information that he or she chooses. See 8.352.2 NMAC for a description of a claimant's HSD administrative hearing rights and responsibilities.

D. In addition to the requirements set forth in 8.352.2 NMAC, HSD and DOH shall take such actions as are necessary to assure the presence at the hearing of all necessary witnesses within DOH's control, including, when relevant to a denial of services or when requested by the claimant, the SIS assessor who conducted the assessment at issue, and a representative of the OR with knowledge of the claimant's case and the reason(s) for the denial, in whole or in part, of any requested services.

E. All HSD administrative hearings are conducted in accordance with state and federal law.
[8.314.5.20 NMAC - Rp, 8.314.5.20 NMAC, xx-xx-16]

8.314.5.21 CONTINUATION OF BENEFITS PURSUANT TO A TIMELY APPEAL AND A HSD ADMINISTRATIVE HEARING PROCEEDING: A continuation of an existing DDW benefit or benefits is automatically provided to an eligible recipient claimant pending the resolution of the Outside Review Process and any subsequent fair hearing. The continuation of a benefit is only available to a claimant that is currently receiving the appealed benefits. The continuation of the benefits will be the same as the claimant's current allocation, budget or LOC unless a revision is agreed to in writing by the eligible recipient (or authorized representative) and DOH.
[8.314.5.21 NMAC - Rp, 8.314.5.21 NMAC, xx-xx-16]

HISTORY OF 8.314.5 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives.

ISD-Rule 310.2000, Coordinated Community In-Home Care Services, 3-19-84.

History of Repealed Material:

ISD-Rule 310.2000, Coordinated Community In-Home Care Services, Repealed 1-18-95.

8 NMAC 4.MAD.736.12 - Repealed 9-1-98; and

8 NMAC 4.MAD.736.412 - Repealed 9-1-98.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, Repealed 3-1-07.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver (filed 2-15-07)

Repealed 11-1-12.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver (filed 11-1-12)

Repealed 11-1-12.