State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
DEVELOPMENTAL DISABILITIES HOME AND
COMMUNITY-BASED SERVICES WAIVER-ELIGIBILITY

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY
The Human Services Department (the Department), Medical Assistance Division (MAD), is proposing amendments to 8.314.5 NMAC, *Developmental Disabilities Home and Community-Based Services Waiver,* and to 8.290.400 NMAC, *Medicaid Eligibility for Home and Community-Based Services Waiver(Categories 090, 091, 092, 093, 094,095 and 096), Recipient Policies,* and 8.290.600 NMAC, *Benefit Description,* to change the definition of eligible recipients, specifying the definition of developmental disability and attributable disorders/conditions, bringing conformity to the definition contained in the renewal of the New Mexico Developmental Disabilities Home and Community Services Waiver as approved by the Center for Medicare and Medicaid Services (CMS), made effective 07/01/2011.

If implemented as proposed, the following changes to the regulations will have the following effect: clarifying language and removing old definitions of mental retardation and specific related conditions. The definition of developmental disability is made specific for the related condition of autistic disorder (as described in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders/DSM-IV TR), excluding asperger syndrome. In keeping with the report and recommendations of the Small Business-Friendly Task Force published 4/1/2011, the proposed rules provide clarification of the definition for eligibility for the developmental disability waiver program and is not more stringent than federal requirements.

VI. REGULATIONS
These proposed regulation changes will be contained in 8.314.5 NMAC, 8.290.400 NMAC, and 8.290.600 NMAC of both the Medical Assistance Program Policy Manual and Eligibility Manual. This register and the proposed changes are available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad/registers/2011. If you do not have Internet

access, a copy of the regulations may be requested by contacting the Medical Assistance Division at 827-3157.

VII. EFFECTIVE DATE

The Department proposes to implement these regulations effective April 1, 2012.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed regulations will be held at 1:00 p.m. on Thursday, February 9, 2012 in the ASD conference room, Plaza San Miguel, 729 St. Michael's Dr., Santa Fe, NM.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the Medical Assistance Division upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Sidonie Squier, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 p.m. on February 9, 2012. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Barbara.watkins@state.nm.us .

X. PUBLICATIONS

Publication of these regulations approved by:

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SIDONIE SQUIER, SECRETARY
HUMAN SERVICES DEPARTMENT

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

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 27-2-12 et. seq. (Repl. Pamp. 1991).~~] See NMSA 1978 27-2-12 et seq.
[8.314.5.3 NMAC - Rp, 8.314.5.3 NMAC, 3-1-07; A, 4/1/12]

8.314.5.8 MISSION STATEMENT: [~~The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of HSD/MAD program eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.~~] 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.
[8.314.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 5/1/02; A, 12/1/10; A, 4/1/12]

8.314.5.9 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER: To help New Mexicans who have a developmental disability, mental retardation or a specified related condition to receive services in a cost-effective manner, the New Mexico medical assistance division (MAD) has obtained a waiver of certain federal regulations to provide home and community-based services waiver (HCBSW) programs to recipients as an alternative to institutionalization. See Section 2176 of the Omnibus Budget Reconciliation Act of 1981, codified at 42 CFR 441.300 Subpart G. The developmental disabilities waiver (DDW) annual resource allotment (ARA) allows the individual to utilize flexible combinations of services that are of benefit to them up to the maximum of their available ARA. The utilization of an ARA offers the individual more flexibility in choosing and receiving desired services. [~~The ARA is the individual's annual funding resource for DDW services for their individualized service plan (ISP) year with the exception of community living services, environmental modifications, tier III crisis service, and outlier services.~~] The ARA is the individual's annual funding resource for DDW services for their individualized service plan (ISP) year with the exception of living supports services, environmental modifications, and crisis supports services. Exceptions to the ARAs for additional therapy hours, behavior support consultation, or [~~supported~~] or community integrated employment services are subject to approval by the department of health, developmental disabilities supports division (DOH/DDSD) and in accordance with the DOH/DDSD DDW service definitions and standards. This part describes DDW eligible providers, covered waiver services, service limitations, general reimbursement methodology, and services for recipients determined to have developmental disabilities.
[8.314.5.9 NMAC - Rp, 8.314.5.9 NMAC, 3-1-07; A, 4/1/12]

8.314.5.10 ELIGIBLE PROVIDERS:

A. Eligible providers must be approved by the DOH/DDSD or its designee and have an approved medicaid provider agreement with MAD. Eligible providers who contract with DOH/DDSD for more than $100,000. must be accredited in accordance with the DOH/DDSD accreditation policy.

B. Individual providers participate as employees or contractors of agencies, except as otherwise, recognized by this policy. Providers may subcontract only with individuals who are qualified and must follow the general contract provisions for subcontracting. Agencies may not employ or subcontract direct care personnel who are the spouse or parent, if a minor child, of the individual served pursuant to 42 CFR Section 440.167 and CMS state medicaid manual section 4480-D. For professionals governed by various licensing boards (nurses, social workers, counselors, psychologists, physical therapists, physical therapy assistants (PTAs), occupational therapists, certified occupational therapy assistants (COTAs), speech pathologists, clinical fellows, etc.), [~~contact the appropriate licensing body for information regarding the applicable licensure~~] professionals participating with the provision of DD waiver program services must have a current license and verification with the appropriate professional licensing body will determine the applicable licensure status.

C. Once enrolled, providers receive instruction on how to access medicaid and other medical assistance provider program policies, billing instructions, utilization review instructions, and other pertinent material from MAD and DOH/DDSD. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. To be eligible for

medical assistance program reimbursement, providers are bound by the provisions of the provider participation agreement.

D. **Qualifications of case management agency providers:** Case management providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards. Case management providers must possess the following qualifications:

(1) one year clinical experience, related to the target population; [~~and~~]

(2) one of the following:

(a) social worker licensure as defined by the NM board of social work examiners; or

(b) registered nurse licensure as defined by the NM board of nursing; or

(c) bachelor's degree in social work, counseling, nursing, special education, or closely related field.

E. **Qualifications of personal support service providers:** Personal-support service providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.

(1) Personal support service providers must complete a 40 hour personal support service training program and participate in ongoing training at a minimum of 10 hours per year after the first year.

(2) Personal support providers must be accredited by an agency identified by DOH/DDSD, DDW service standards.

(3) Personal support service staff must possess [~~a~~] current CPR and first aid certification.

F. **Qualifications of respite providers:** Respite providers must meet all qualifications as set forth by the DOH/DDSD, DDW definitions and service standards. Respite providers must complete a 40 hour training program and participate in ongoing training at a minimum of 10 hours per year, after the first year.

G. **Qualifications of private duty nursing providers:** Private duty nursing providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards. Direct nursing services are provided by individuals who are currently licensed as registered or licensed practical nurses by the New Mexico state board of nursing. Nurses must have a minimum of one year of supervised nursing experience, in accordance with the New Mexico Nursing Practice Act. Eligible agencies must be licensed home health agencies, licensed or certified rural health clinics, community programs or individual contractors.

H. **Qualifications of therapy providers:** Physical, occupational, and speech therapists, PTAs and COTAs must meet all qualification criteria in accordance with the DOH/DDSD, DDW service definitions and standards. Physical, occupational and speech therapists, PTAs and speech clinical fellows must possess a therapy license in their respective field, from the New Mexico regulation and licensing department. COTAs must possess an occupational therapy assistant certification from the New Mexico regulation and licensing department.

I. **Qualifications for community living service providers:** There are three types of community living services. Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.

(1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.

(2) Supported living service providers must meet the qualifications for residential facility staff in accordance with the DOH/DDSD, DDW service definitions and standards.

(3) Independent living service providers must meet the qualifications for residential facility staff in accordance with the DOH/DDSD, DDW service definitions and standards.

J. **Qualifications of adult day habilitation providers:** Adult day habilitation providers must meet all qualifications as set forth by the DOH/DDSD, DDW service definitions and standards.

[~~K. **Qualifications of community access providers:** Community access service providers must meet all qualifications as set forth by the DOH/DDSD, DDW service definitions and standards.~~]

[~~L.~~] K. **Qualifications of supported employment providers:** Supported employment providers must meet the minimum qualifications as set forth by the DOH/DDSD, DDW service definitions and standards.

[~~M.~~] L. **Qualifications of behavior support consultation providers:** Behavior support consultation providers must meet all qualifications as set forth by the DOH/DDSD, DDW definitions and service standards.

(1) Providers of behavior support consultation services must possess qualifications in at least one of the following areas: licensed psychiatrist, licensed clinical psychologist, licensed psychologist associate, (masters or Ph.D. level), a licensed independent social worker (LISW), licensed master social worker (LMSW), licensed professional clinical counselor (LPCC), licensed professional counselor (LPC), a licensed psychiatric nurse

(MSN/RNCS), NM licensed marriage and family therapist (LMFT), NM licensed practicing art therapist (LPAT). Other related licenses and qualifications may be considered with DOH/DDSD prior written approval.

(2) Providers of behavior support consultation must have a minimum of one year of experience working with persons with developmental disabilities. All behavior support consultants must maintain current New Mexico licensure with their professional field licensing body.

[~~N.~~] M. **Qualifications of nutritional counseling providers:** Nutritional counseling providers must meet all qualification criteria in accordance with the DOH/DDSD, DDW service definitions and standards. Nutritional counseling providers must be registered as dietitians by the commission on dietetic registration of the American dietetic association.

[~~O.~~] N. **Qualifications of environmental modification providers:** Environmental modification providers must be a licensed contractor authorized by the State of New Mexico to complete the specified project. Environmental modification providers must meet all qualification criteria in accordance with the DOH/DDSD, DDW service definitions and standards.

[~~P.~~] O. **Qualifications of personal planning facilitation providers:** Personal planning facilitation providers must meet all qualifications as set forth by the DOH/DDSD, DDW definitions and service standards.

~~Q.~~] P. **Qualifications of goods and service providers:** Goods and services providers must meet all qualifications as set forth by the DOH/DDSD, DDW definitions and service standards.

[~~R.~~] Q. **Qualifications of [~~tier III~~] crisis support providers:** [~~Tier III~~] Crisis support providers must meet all qualifications as set forth by the DOH/DDSD, DDW definitions and service standards.

[~~S.~~] R. **Qualifications for non-medical transportation providers:** Non-medical transportation providers must meet all qualifications as set forth by the DOH/DDSD, DDW definitions and service standards.
[8.314.5.10 NMAC - Rp, 8.314.5.10 NMAC, 3-1-07; A, 4/1/12]

8.314.5.12 ELIGIBLE RECIPIENTS: [~~DDW services are limited to individuals who meet the definition of developmental disability and mental retardation or specific related conditions as determined by the DOH/DDSD in accordance with approved DDW criteria, including the following. The individual has a severe chronic disability, other than mental illness, that:~~

~~A. is attributable to a mental or physical impairment, including the result from trauma to the brain, or a combination of mental and physical impairments;~~

~~B. is manifested before the person reaches the age of twenty-two years;~~

~~C. is expected to continue indefinitely;~~

~~D. results in substantial functional limitations in three or more of the following areas of major life activity:~~

~~(1) self-care;~~

~~(2) receptive and expressive language;~~

~~(3) learning;~~

~~(4) mobility;~~

~~(5) self-direction;~~

~~(6) capacity for independent living; and~~

~~(7) economic self-sufficiency;~~

~~E. reflects the person's need for a combination and sequence of special, interdisciplinary or generic care treatment or other support and services that are of life-long or extended duration and are individually planned and coordinated;~~

~~F. have mental retardation or a specific related condition; related conditions are limited to cerebral palsy, autism (including asperger syndrome), seizure disorder, chromosomal disorders (e.g. downs), syndrome disorders, inborn errors of metabolism, and developmental disorders of brain formation; and~~

~~G. who meet the intermediate care facility for the mentally retarded (ICF/MR) level of care criteria in accordance with 8.313.2 NMAC.~~] DDW services are intended for individuals who have developmental disabilities limited to mental retardation (MR) or a specific related condition as determined by the DOH/DDSD. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated. The individual must also require the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR), in accordance with 8.313.2 NMAC.

A. The definition for mental retardation is as follows: mental retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.. General intellectual functioning is defined as the results obtained by assessment

with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.

(1) significantly sub-average is defined as approximately IQ of 70 or below;

(2) adaptive behavior is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group; and

(3) the developmental period is defined as the period of time between birth and the 18th birthday.

B. The definition for specific related condition is as follows: an individual is considered to have a specific related condition if he/she has a severe chronic disability, other than mental illness, that meets all of the following conditions:

(1) is attributable to cerebral palsy, seizure disorder, autistic disorder (as described in the fourth edition of the diagnostic and statistical manual of mental disorders), chromosomal disorders (e.g. Down) syndrome disorders, inborn errors of metabolism, or developmental disorders of the brain formation;

(2) results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires treatment or services similar to people with mental retardation;

(3) is manifested before the person reaches age 22 years;

(4) is likely to continue indefinitely; and

(5) results in substantial functional limitations in three or more of the following areas of major life activity:

(a) self-care;

(b) receptive and expressive language;

(c) learning;

(d) mobility;

(e) self-direction;

(f) capacity for independent living; and

(g) economic self-sufficiency.

[8.314.5.12 NMAC - Rp, 8.314.5.12 NMAC, 3-1-07; A, 4/1/12]

8.314.5.13 COVERED WAIVER SERVICES: This medicaid waiver covers the following services for a specified and limited number of waiver recipients as a cost effective alternative to institutionalization in an ICF-MR. The program is limited to the number of federally authorized unduplicated recipient (UDR) positions and program funding.

A. **Case management services:** Case management services are person-centered and intended to support individuals pursuing their desired life outcomes by assisting them in accessing supports and services necessary to achieve the quality of life that they desire, in a safe and healthy environment. Case management services assist participants in gaining access to needed DDW, medicaid state plan services, and needed medical, social, educational and other services, regardless of the funding source for the services to which access is needed. Case management services include but are not limited to activities such as: assessing needs; facilitating eligibility determination for persons with developmental disabilities; directing the service planning process; advocating on behalf of the individual; coordinating service delivery; assuring services are delivered as described in the individualized service plan (ISP); and maintaining a complete current central client record (e.g. ISP, ISP budget, level of care documentation, assessments).

(1) Cost-effectiveness is a waiver program requirement mandated by federal policy. The fiscal responsibilities of the case manager include assuring cost containment by preventing the expense of waiver services from exceeding a maximum cost established by DOH and by exploring other options to address expressed needs. Case management services are intended to assist individuals to enable, not replace, existing natural supports and other available community resources in collaboration with waiver services.

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

(3) Case management services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

B. **Personal support services:**

Individuals receiving personal support services live in the community, in their own home or in the home of their family. Personal support/companion services assist the individual with activities of daily living while providing companionship to acquire, maintain or improve social interaction skills in the community or at the job site. Personal support services duties include accompanying the individual to community events and activities of interest to the

individual; assistance at the individual's place of employment; and assistance at the individual's home. Legal guardians or natural family members who meet DOH/DDSD requirements must be approved by DOH/DDSD to provide personal support services. Personal support services may include performing and/or assisting the individual with the following:

(1) household services, cleaning, laundry, meal preparation and assistance, support service that promote the recipient's independence (appointments, shopping and/or errands, extension of skilled therapy services, individualized exercise program);

(2) individual care services (hygiene/grooming, oral care with intact swallowing reflux, nail care, perineal care, toileting), minor maintenance of assistive device(s), skin care prevention/maintenance, and mobility assistance (ambulation and transfer);

(3) individuals requiring the assistance for their individualized bowel and bladder program must be determined to be medically stable; a personal support direct care provider must demonstrate competency to perform individualized bowel and bladder programs.

(a) An individualized bladder program may include the following tasks: straight in and out catheterization; changing of catheter bag; application and care of external catheter; care of indwelling catheter; individualized crede bladder massage if appropriate; care of indwelling catheter; irrigation of indwelling catheter with medicated or non-medicated solutions; and insertion and care of suprapubic catheter.

(b) An individualized bowel program may include the following tasks: insertion of medicated or non-medicated suppositories; digital stimulation; enemas; manual impaction removal; and ostomy care, including irrigations, changing, cleaning of bags and skin care;

(4) assist individuals with self-administration of medication, including prompting and reminding; this must be accomplished in accordance with the New Mexico Nursing Practice Act;

(5) assist the recipient with eating as determined by the interdisciplinary team; the recipient must have an intact swallowing reflux in order to receive assistance; in the instance where the recipient requires tube feeding, the personal support attendant must be trained and supervised by a registered nurse or this task may be delegated to the personal support attendant as governed by the New Mexico Nursing Practice Act;

(6) personal support services can be provided with respite services, adult day habilitation, or individual, group and customized supported employment as long as the combination is deemed appropriate in the ISP and is not provided for the same hours of the same day;

(7) personal support services cannot be included in the ISP in combination with any community living support service (i.e. family living, supported living or independent living); in addition, personal support services may not be provided to recipients by their spouses or to minor recipients by their parents; other family members may be covered as personal support services providers only if the following requirements are met:

(a) the family member meets the qualifications for providers of care;

(b) there are strict controls to assure that payment is made to the family member only in return for specific services rendered; and;

(c) there is adequate written justification as to why the family member is the only available provider of care (e.g. a lack of other qualified providers in the geographic area);

(8) personal support-services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

C. **Respite care services:** Respite is a flexible family support service. The primary purpose of respite is to provide support to the individual and give the primary, unpaid caregiver time away from their duties. The respite care provider assists the individual in activities of daily living to promote the individual's health and safety, as well as maintain a clean and safe environment. Respite will be scheduled as determined by the primary caregiver. Respite services can be included in the ISP with personal support, adult day habilitation, individual, group and customized supported employments and community access as long as the services are not provided for the same hours of the same day with the exception of therapies and case management. Respite services cannot be provided for individuals receiving supported or independent living services. Respite may be provided in the client's own home, in a provider's home or in a community setting of the family's choice. Respite services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

D. **Private duty nursing:** Private duty nursing services are provided by registered nurses or licensed practical nurses to adults. Nursing intervention are activities, procedures and treatments provided to treat a physical condition, physical illness or chronic physical disability. Activities, procedures and treatments may include, but not be limited to: health assessment; aspiration precautions; bowel management; feeding tube management; health education; health screening; infection control; medication management; medication administration; nutrition management; oxygen management; seizure management; seizure precautions; self-care assistance, skin care;

teaching of prescribed medication; weight management; wound care; and staff supervision of such activities, procedures and treatment. (Children receive this service through the medicaid early periodic screening, diagnosis and treatment [EPSDT] program.)

(1) Nursing services may be combined with other services, except as specified below.

(a) Nursing services cannot be included in the ISP for individuals receiving a community living service;

(b) Because nursing is included in the adult day habilitation rate, any nursing provided during the hours of adult day habilitation cannot be billed as a separate service.

(2) Private duty nursing services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

E. **Therapy services for adults:** Therapy services include physical therapy, occupational therapy and speech and language therapy. Based on therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group setting.

(1) **Individual integrated therapy:** Individual integrated therapy services are provided within the natural context of an individual's life (i.e. home, day habilitation site, vocational site or community locations). Consultative services may be provided at ISP planning meetings. This model does not include services provided in an isolated, non-integrated manner unless a direct skilled therapy service is provided and applied to a functional activity/routine in collaboration with a caregiver during the same session.

(2) **Individual clinical therapy:** Individual clinical therapy services are provided in a clinic setting such as in a therapist's office or when services are delivered in an isolated, non-integrated manner. A clinical context would include any location that an individual would not otherwise visit, if they did not have a therapy appointment.

(3) **Group integrated therapy:** Group integrated therapy services are delivered in a group with a ratio of two or three individuals to one therapist designed to benefit the individuals involved due to a group context. The context of the group must reflect the context of a naturally occurring activity/routine i.e., yoga group instruction; social interaction; leisure activity; etc.

(4) **Group clinical therapy:** Group clinical therapy services are delivered in a clinical setting, in a group with a ratio of two or three individuals to one therapist designed to benefit the individuals involved due to a group context. A clinical setting would include any location that an individual would not otherwise visit, if they did not have a therapy appointment.

(5) **Physical therapy:** Physical therapy is a skilled therapy service performed by a licensed physical therapist or a licensed physical therapist assistant (PTA) under the supervision of a licensed physical therapist. Services include 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 activities: increase, maintain or reduce the loss of functional skills; treat a specific condition clinically related to an individual's developmental disability; or support the individual's health and safety needs. Activities include the identification, implementation or training of therapeutic strategies to support the individual and their family or support staff in efforts to meet the individual's ISP vision and goals.

(6) **Occupational therapy:** Occupational therapy is a skilled therapy service performed by a licensed occupational therapist or certified occupational therapy assistant (COTA) under the supervision of a licensed occupational therapist. Occupational therapy services include diagnosis, assessment and management of functional limitations intended to assist adults to regain, maintain, develop and build skills that are important for independence, functioning and health. Occupational therapy services typically include: customized treatment programs to improve one's ability to perform daily activities; comprehensive home and job site evaluations with adaptation recommendations; performance of skills assessments and treatment; assistive technology recommendations and usage training; and guidance to family members and caregivers. Occupational therapy services: increase, maintain or reduce the loss of functional skills; treat specific conditions clinically related to an individual's developmental disability; or support the individual's health and safety needs. Activities include the identification, implementation or training of therapeutic strategies to support the individual and their family or support staff in efforts to meet the individual's ISP desired outcomes and goals. Based on therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group setting.

(7) **Speech therapy:** Speech therapy is a specialized therapy service performed by a licensed speech language pathologist or a speech clinical fellow under the supervision of a licensed speech language pathologist. Speech therapy services include the diagnosis, counseling and instruction related to the development and disorders

of communication including speech fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction, oral phyaryngeal or laryngeal, or sensory motor competencies. Speech language pathology is also used when an individual requires the use of an augmentative communication device. Services are intended to improve or maintain the individual's capacity for successful communication, to lessen the effects of the individual's loss of communication skills, or to improve or maintain the individual's ability to eat foods, drink liquids, and manage oral secretions with minimal risk of aspiration, other potential injuries or illnesses related to swallowing disorders. Activities include identification, implementation and training of therapeutic strategies to support the individual and their family or support staff in efforts to meet the individual's ISP vision and goals. Based on therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group setting.

(8) Providers of therapy services must prepare progress notes and reports as required by the DOH or designee, including analysis of data, progress, effectiveness of strategies and significant events in the individual's life which may impact progress. Physical, occupational, and speech therapy services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

F. **Therapy services for children:** Therapy services include physical therapy, occupational therapy and speech and language therapy. Based on therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group setting.

(1) **Individual integrated therapy:** Individual integrated therapy services are provided within the natural contexts of an individual's life (i.e. home, day habilitation site, vocational site, community locations). Consultative services may be provided at ISP planning meetings. This model does not include services provided in an isolated, non-integrated manner unless a direct skilled therapy service is provided and applied to a functional activity/routine in collaboration with a caregiver during the same session.

(2) **Individual clinical therapy:** Individual clinical therapy services are provided in a clinic setting such as in a therapist's office or when services are delivered in an isolated, non-integrated manner. A clinical context would include any location that an individual would not otherwise visit, if they did not have a therapy appointment.

(3) **Group integrated therapy:** Group integrated therapy services are delivered in a group with a ratio of two or three individuals to one therapist designed to benefit the individuals involved due to a group context. The context of the group must reflect the context of a naturally occurring activity/routine i.e. yoga group instruction; social interaction; leisure activity; etc. One therapist can bill for no more than three individuals regardless of the number of participants.

(4) **Group clinical therapy:** Group clinical therapy services are delivered in a clinical setting, in a group with a ratio of two or three individuals to one therapist designed to benefit the individuals involved due to a group context. A clinical setting would include any location that an individual would not otherwise visit, if they did not have a therapy appointment. One therapist can bill for no more than three individuals regardless of the number of participants.

(5) **Physical therapy for children:** Services are delivered by a licensed physical therapist to provide services not covered by the state plan under medicaid EPSDT requirements, nor through an individualized education program (IEP) through the public schools. Services include: physical therapy interventions that are used to promote participation in community integration activities as defined in the DDW service standards; adaptation of exercise equipment and associated training for family members or other support persons to promote ongoing fitness of the child; assessment for appropriate environmental modifications in the home as described in the DDW service standards; recommendations for equipment, techniques or therapy interventions to increase family or caregiver ability to provide support for the child's comfort and conveniences; interventions for children with swallowing disorders to prevent aspiration in accordance with the team approach described in the DOH/DDSD aspiration prevention policy and procedures, as appropriate to the therapist's scope of practice; coordination with other therapists serving the child through EPSDT or the public schools or with other disciplines on the child's DDW interdisciplinary team; and associated evaluation, assessment and training of the child, family or other caregivers related to the above activities.

(6) **Occupational therapy for children:** Services are delivered by a licensed occupational therapist to provide services not covered by the state plan under medicaid EPSDT requirements, nor through an IEP through the public schools. Services include: occupational therapy interventions that are used to promote participation in community integration activities as defined in the DDW service standards; adaptation of exercise equipment and associated training for family members or other support persons to promote ongoing fitness of the child; assessment for appropriate environmental modifications in the home as described in the DDW service standards; recommendations for equipment, techniques or therapy interventions to increase family or caregiver ability to provide support for the child's comfort and conveniences; interventions for children with swallowing disorders to

prevent aspiration in accordance with the team approach described in the DOH/DDSD aspiration prevention policy and procedures, as appropriate to the therapist's scope of practice; coordination with other therapists serving the child through EPSDT or the public schools or with other disciplines on the child's DDW interdisciplinary team; and associated evaluation, assessment and training of the child, family or other caregivers related to the above activities. Based on therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group setting.

(7) **Speech and language pathology for children:** Services are delivered by a licensed speech language pathologist to provide services not covered by the state plan under medicaid EPSDT requirements, nor through an IEP through the public schools. Speech language services: interventions to promote participation in community integration activities as defined in the DDW service standards; interventions for children with swallowing disorders to prevent aspiration in accordance with the team approach described in the DOH/DDSD aspiration prevention policy and procedures, as appropriate to the therapist's scope of practice; recommendations for equipment, techniques or therapy interventions to increase family or caregiver ability to facilitate; coordination with other therapists serving the child through EPSDT or the public schools or with other disciplines on the child's DDW interdisciplinary team; and associated evaluation, assessment and training of the child, family or other caregivers related to the above activities. Based on therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group setting.

G. [~~**Community living services**~~**]** **Living support services:** [~~Community living~~] Services are intended to provide persons with the assistance and support needed in a home environment in order to increase or maintain an individual's capacity for independent functioning, self-determination, interdependence, productivity and integration in the community. Community living services are only available for individuals for whom no other residential or support options are clinically appropriate to meet the needs of the individual. Community living services must be justified by the IDT as the only service which can meet the needs of the individual.

(1) This service includes personal support, and nutritional counseling [~~and nursing supports~~] and, therefore, personal support nutritional counseling [~~and private duty nursing~~] services may not be included in an ISP for an individual receiving [~~community~~] living support services. Respite services cannot be provided to individuals receiving supported or [~~independent~~] shared living services. Room and board costs are reimbursed through the individual's SSI or other personal accounts and cannot be paid through the waiver service.

(2) This service is available to individuals 18 years of age or older.]

(3) This service may be available to individuals under 18 years of age in extraordinary circumstances and are approved by the DOH/DDSD Director on a case-by-case basis. [~~Community living~~] Living support services for individuals under 18 years of age may not be provided by legally responsible individuals.

(4) Legally responsible individuals (i.e. spouses or parents of minor children) may not be paid for any services that they would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness.

(5) This medicaid waiver covers the following three living supports services. Each of these services is a distinct service and must be billed in accordance with DDSD of the DOH standards:

(a) **Family living services**: These services may be furnished by a companion, surrogate, foster or natural family member who has been studied and approved to provide family living in the individual's home or the home of the family living provider. Legal guardians or natural family members who meet the DOH/DDSD requirements must be approved by DOH/DDSD to provide family living services.

(i) Family living can be provided to no more than two individuals with developmental disabilities in the home environment at a time.

(ii) The direct support provider must be present when the individual is in the home, as described in the ISP or other coverage specified below.

(iii) The direct support provider is responsible for services up to 24 hours per day as described in the ISP, but does not include time when an individual is in an employment, school, adult habilitation or other day program. Twenty-four hour support includes coverage in the residential setting during times when the individual is unable to attend other scheduled services [~~and/or~~] or activities due to reasons beyond their control (e.g. illness). The direct support provider is responsible for arrangements for back-up supports and staffing. The person(s) providing back-up supports and staffing must be listed with and meet the requirements of the provider agency.

(iv) The provider agency is responsible for providing on-call emergency staffing coverage. The 24 hour per day requirement may be met through the emergency on-call system, when necessary. If the individual requires emergency staffing services, those services must reach the individual within 60 minutes.

(v) Family living direct support providers must complete all DOH/DDSD requirements for approval, including completion of a home study, and compliance with all relevant policies, procedures, standards, requirements and training.

(vi) Substitute care is available to individuals receiving family living services.

(vii) Family living cannot be included in the ISP for individuals receiving any other living support service.

(viii) The family living direct support provider may be a single person, couples, roommates, companions, friends, and natural family members. The direct support provider may not be the spouse of the individual served. Family members providing direct supports to the recipient with developmental disabilities must meet all the requirements for approval and ongoing service provision as other family living direct support providers.

(ix) Family living services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

(b) **Supported living services:** Supported living services are provided in a home setting to four or fewer individuals. This service model can only be accessed by individuals for whom all other residential services are clinically inappropriate and is documented in the ISP. Supported living services must be available up to 24 hours per day, as determined by the IDT, but does not include time when an individual is in an employment, school, adult habilitation or other day program. Supported living is not an appropriate model for individuals needing less than 340 hours of face-to-face service and support per month. Twenty-four hour staff support includes coverage in the residential setting during times when persons are unable to attend other scheduled services and/or activities due to reasons beyond their control (e.g. illness). Additional residential staff support may also be available in an emergency through an on-call system. If the individual requires on-call services, those services must reach the individual within 60 minutes. Supported living provider services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

(c) **Independent living services:** Independent living services are individual intervention and support services promoting a more independent environment and life style. Independent living supports are only provided in the individual's home and community in groups of three or fewer individuals with developmental disabilities. Individuals must be at least 18 years of age. Staff support is available as needed and is furnished on a planned periodic schedule of less than 24 hours per day as required in the ISP. Unscheduled staff support may be available through an on-call system. If the individual requires on-call services, those services must reach the individual within 60 minutes. Independent living is reimbursed at two levels based on the number of support hours needed. Providers serving individuals requiring at least 20 but less than 100 hours of support per month will be reimbursed at level II rates. Individuals requiring 100 or more hours per month will receive level I funding. Independent living cannot be included in the ISP for individuals receiving any other community living service. Independent living services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.]

H. **Community inclusion services**: Community inclusion services provide individuals with connection to and membership in the same community life that is desired and chosen by the general population. This includes: purposeful, meaningful and equitably paid work; sustained opportunity for self-empowerment and personal relationships; skill development in natural settings; and social, education and community membership activities that are specified in the individual's ISP. Community inclusion services also assist the individual to develop skills and relationships that reduce dependence on paid, specialized services. Community inclusion services include the following: [~~community access,~~] supported employment and adult habilitation.

(1) Community inclusion services support measurable individual progress as specified in the ISP including the individual's personal definition of a meaningful day. The outcome of community inclusion services is that the individual becomes an integral part of his community in the manner desired by the individual.

(2) Community inclusion providers must be provided in accordance with the DOH/DDSD DDW services definitions and standards.

(3) Community inclusion services include the following:

[~~(a) **Community access services:** Community access services are designed to promote maximum participation in community life, support individuals in achieving their desired outcome, promote self-advocacy, and enhance a participant's ability to control his environment through focused teaching of adaptive skills, self-help and socialization skills. These services may be used by adults and children. For children and youth, the objective of the community access services is to support the family in understanding and promoting his child's development. This service promotes the acquisition and retention of skills necessary for the child to participate successfully in family and community life as well as future employment. Community access services addresses the~~

~~child's development in natural settings with age appropriate strategies of self-help, cognitive, physical/motor, communication, and social skills; potentially reducing dependence on specialized supports.~~

~~(i) Community access services may be provided in a group (not to exceed three persons), or individual arrangement as outlined in the ISP. Services must accommodate non-traditional hours (e.g., evenings) as outlined in the ISP. Services are to be provided in integrated environments that enhance the person's contribution to the community and increase independence.~~

~~(ii) Community access cannot replace, supplant, or duplicate services included in community living services.~~

~~(iii) Community access services can be provided with any other service, as long as the combination is deemed appropriate in the ISP and as long as the services are not provided for the same hours of the same day, except for therapies or case management.~~

~~(iv) Community access services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.~~

~~(b)~~] (a) **Supported employment services:** Supported employment services are intended to provide ongoing supports, as needed for persons seeking or maintaining community based employment for which compensation, if it is covered work, would be made in compliance with the Fair Labor Standards Act (FLSA) and New Mexico labor laws. Supported employment services may be conducted in a variety of settings, in which most persons employed do not have disabilities. Activities are designed to increase or maintain the individual's skills and independence; and may include job development, job placement, and job coaching. Individuals are eligible for DD waiver supported employment services insofar as the service is not otherwise available or appropriate under a program funded under the Rehabilitation Act of 1973, VI-C funds available through the division of vocational rehabilitation, New Mexico public education department (as amended, 1992). DOH will require reporting on supported employment services as specified in the DDSD of the DOH DDW service definitions and standards. Waiver services included in this category are individual supported employment, group supported employment and customized supported employment.

[~~(c)~~] (b) **Group supported employment:** Group supported employment provides onsite supervision of persons with developmental disabilities working as part of a group in a community-based employment setting, including employment by the provider agency, which promotes opportunities for integration with non-disabled people. Supervision and support is usually furnished on a continual basis as scheduled by the provider or may include full or part-time supervision by the employer.

(i) Reimbursement to the recipient must be at prevailing hourly wage with regard to productivity and in compliance with the Federal Fair Labor Standards Act. Wages are to be commensurate with the hourly wages or salaries of those performing the same or similar work.

(ii) Group supported employment services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

(iii) Group supported employment services can be provided with any other service, as long as the combination is deemed appropriate in the ISP and as long as the services are not provided for the same hours of the same day; however, therapy services are reimbursable when provided simultaneously.

[~~(d)~~] (c) **Individual supported employment:** Individual supported employment offers one-to-one support to participants placed in jobs in the community and support is provided at the work site as needed for the individual to learn and perform the job. Participants must have the opportunity for integration into work settings where most of the people in the work setting are not disabled. Individual supported employment may include competitive jobs in the public or private sector and self-employment. The service delivery model for individual supported employment includes a job coach, job developer and personal support companion. Providers must document time spent on allowable activities on behalf of the individuals and include at least two face-to-face contacts with the individual each month in order to receive reimbursement.

(i) Supervision and supports are furnished in response to the individual's needs and preferences. Full time support may be needed at the beginning of employment. The fading of support is required in accordance with the ISP supported employment fading plan as the recipient stabilizes in the job. A fading plan must include supports and training needed for a specified period of time at a defined level or degree. The plan will specify natural supports available to the recipient and will address related training for the employer's staff who will be providing the supports. The provider agency will furnish coordination activities including assistance in arranging transportation, job development and job placement.

(ii) Reimbursement to the recipient must be paid at prevailing hourly wages with regard to productivity and in compliance with the Federal Fair Labor Standards Act.

(iii) Supported employment services are described in the ISP and must be provided in accordance with the DOH/DDSD DDW service definitions and standards. Individual supported employment services can be provided with any other service, as long as the combination is deemed appropriate in the ISP and as long as the services are not provided for the same hours on the same day; however, therapy services are reimbursable when provided simultaneously.

[~~(e)~~] (d) **Self-employment:** Self-employment services assist the individual to gain self-employment or engage in other entrepreneurial initiatives. The service delivery model for self-employment services includes a business consultant and a personal support companion if needed. The business consultant assists the individual with the development of a business plan; location of business loans and leverage of other financial resources; marketing, advertising, obtaining a business license, permits, tax registration and other legal requirements for a business enterprise; and with banking services, financial management and the development and maintenance of information management systems necessary for business operations. Self-employment services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

[~~(f)~~] (e) **Intensive supported employment:** Intensive supported employment offers individual's one-to-one job coaching for employed individuals in integrated community based settings. Intensive supported employment is intended for individuals who need 1:1 job support (face-to-face) 32 or more hours per month.

I. **Adult habilitation services:** Adult habilitation services are designed to meet the needs of individuals 18 years of age or older. The service consists of daily functional and purposeful activities, including choice-making and community membership, specified by the IDT members that relate to his desired outcomes, objectives, interests and skills that leads to a reduction of dependence on paid, specialized services. The objective of adult habilitation services is to support measurable individual progress toward ISP specified outcomes, as well as, to meet the individual's personal definition of a meaningful day. Adult habilitation services include participation in adult education; identification of community resources and connections; development of pre-vocation skills; opportunities to pursue hobbies and recreation, leisure or other interests; transportation during adult habilitation services; personal care and activities of daily living; assistance with self-administration of medication; reminding, observing, monitoring of medication and pharmacy needs; and medication administration. When individuals receive compensation in adult habilitation settings, the compensation shall comply with the Fair Labor Standards Act and code of federal regulations. Medicaid funds (e.g. the provider agency's reimbursement) may not be used to pay the individual for work.

(1) Adult habilitation services that are segregated (e.g. center-based or sheltered work) are time limited as determined by the IDT to support movement to more appropriate, integrated, and age appropriated options such as employment.

(2) Personal support, nutritional counseling and nursing supports are included in adult day habilitation services. Therefore, personal support, nutritional counseling and private duty nursing services may not be included as separate billable services in the ISP for the time period in which the individual is receiving adult habilitation services.

(3) Adult habilitation services must take place outside of the individual's residence or any other residential setting unless approved as an exception by DOH/DDSD in accordance with the DOH/DDSD DDW service standards.

(4) Adult habilitation services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

J. **Behavior support consultation services:** Behavior support consultant services consist of functional support assessments, positive behavioral support plan development, training and support coordination for an individual and their IDT related to behaviors that compromise an individual's quality of life. Factors that compromise an individual's quality of life include behaviors that: interfere with forming and maintaining relationships, integrating into the community, or completing activities of daily living; or pose a health and safety risk to the individual or others. Providers of behavior support consultation services must prepare progress notes and reports as required by DOH or its designee, including progress, effectiveness of strategies and significant events in the individual's life, which may impact progress. Behavior support consultation services must be provided in accordance with the DDSD DDW service definitions and standards.

K. **Nutritional counseling services:** Nutritional counseling is designed to meet unique food and nutrition needs presented by persons with developmental disabilities. 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 [~~community~~] living support services and [~~adult day habilitation~~] nutritional counseling cannot be billed as a separate service during the hours of [~~community~~] living supports or [~~day~~

~~habilitation~~]. Nutritional counseling services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

L. **Outlier services:** Outlier services cover individuals recognized as having extreme medical needs or behavioral issues requiring services of a frequency, duration, and intensity that surpass those described in other covered DDW services. Outlier services reimburse providers for those few individuals that meet outlier services criteria. Reimbursement is only available after approval has been given by the DOH/DDSD or its designee. Outlier residential services are available only to individuals who receive supported living services. Outlier habilitation services are available to only individuals in adult habilitation. The outlier services are intended to meet the needs of individuals with severe chronic needs. Individuals with short term acute support needs are covered within the existing rates or through supports available through the regular medicaid state plan package. Individuals with extraordinary need fit into one of two categories: 1) high medical necessity or; 2) behavioral outlier.

(1) **High medical necessity outlier:** To be considered for the high medical necessity outlier rate of reimbursement, individuals must first meet the definition for high medical necessity. Individuals who meet the definition for high medical necessity may qualify for the outlier services and corresponding funding if the frequency, duration, and intensity of staff supports greatly surpass those described in service definitions rates and the following conditions and criteria are met. High medical necessity is defined as a chronic physical condition, including brain disorders, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following:

(a) there is a life threatening condition characterized by frequent periods of acute exacerbation which require frequent medical supervision, [~~and/or~~] or physical consultation and which in the absence of such supervision or consultation, would require hospitalization;

(b) the individual requires frequent time consuming administration of specialized treatments which are medically necessary and will be required for more than 30 days; and

(c) the individual is dependent on medical technology such that without the technology a reasonable level of health could not be maintained; examples include: ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen.

(2) **High medical necessity criteria:**

(a) All requests for high medical necessity outlier funding must be in writing and must be accompanied by written documentation that meets the definition for high medical necessity.

(b) The IDT will initiate the request for outlier funding.

(c) The IDT will gather all pertinent reports and documentation and ensure timely submission to the DOH/DDSD by the provider.

(d) Documentation for high medical necessity outlier funding will be submitted by the provider to DOH/DDSD or its designee for review and approval.

(e) Staffing ratios must be submitted for the habilitation or residential setting as applicable to the request. This information will be used when determining the need for additional enhanced support hours for an individual with an intense staffing need.

(f) Documentation must show the number of hours necessary to meet the individual's needs, in relation to the total number of hours of staff time available within the setting.

(g) In order for the request to be considered for outlier funding the number of hours of enhanced support hours must exceed 360 hours per month within the residential setting; except in the situation where the hours of enhanced supports are nursing hours, an equivalent amount of enhanced support hours may be considered.

(h) In order for the request to be considered for outlier funding the number of hours of enhanced support hours must exceed 84 hours per month within the habilitation setting; except in situations where the number of hours of enhanced supports are nursing hours, then an equivalent amount of enhanced support hours may be considered.

(i) All generic resources must be identified and accessed prior to requesting outlier funding. The request must be accompanied by documentation of successful or unsuccessful attempts at accessing generic resources.

(j) Documentation must include a signed attending physician's evaluation report which documents the individual's medical status as it relates to the high medical necessity definition and a signed detailed nursing plan that outlines all procedures to be completed and indicates why the staffing within the setting must include the enhanced hours.

(k) The ISP incorporates a detailed nursing plan which specifically addresses the individual's condition, needs and outlines the duties of additional or specialized staff.

(l) Outlier rates will be approved for a specified number of days per year not to exceed the annual waiver billing limits. Each approval will not exceed 180 days.

(3) **Behavioral outlier:** To be considered for the behavioral outlier rate of reimbursement individuals must exhibit frequent or regular episodes of behavior that is historical, chronic, and predictable. Examples include suicidal behavior, self injurious behavior, physical aggression towards others with intent to cause injury, disruption of most activities which requires intensive staff attention, personal withdrawal from all contact with staff and others, dangerous elopement, or serious criminal activities that are dangerous to others or to the recipient (e.g., rape, manslaughter, battery). Individuals who meet the definition for behavioral outlier may qualify for the outlier services and corresponding funding if the frequency, duration, and intensity of staff supports greatly surpass those described in the service definitions and the following conditions and criteria are met.

(4) **Behavioral criteria:**

(a) All requests for outlier funding must be in writing and must be accompanied by written documentation from an appropriate mental health professional (psychiatrist, psychologist, neurologist) that addresses the chronic care criteria that meets the definition of behavioral outlier.

(b) The IDT will initiate the request for outlier funding.

(c) The IDT will gather all pertinent reports and documentation and ensure timely submission by the provider to the DOH/DDSD or its designee.

(d) Documentation for behavioral outlier funding will be submitted by the provider to the DOH/DDSD or its designee for review and approval.

(e) Staffing ratios must be submitted for the habilitation or residential setting, as applicable to the request. This information will be used when determining the need for additional enhanced support hours for an individual with an intense staffing need.

(f) Documentation must show the number of hours necessary to meet the individual's needs, in relation to the total number of hours of staff time available within the setting.

(g) In order for the request to be considered for outlier funding the number of hours of enhanced support hours must exceed 360 hours per month within the residential setting.

(h) In order for the request to be considered for outlier funding the number of hours of enhanced support hours must exceed 84 hours per month within the habilitation setting.

(i) All generic resources must be identified and accessed prior to requesting outlier funding. The request must be accompanied by documentation of successful or unsuccessful attempts at accessing generic resources.

(j) Documentation must include the psychiatric/neurological/ psychological evaluation report which documents the individual's mental health/health status as it relates to the behavioral outlier definition; and provides justification for the use of additional or specialized staffing.

(k) The psychiatric/neurological/psychological evaluation must be completed by a professional who is not employed by the agency providing supported living or adult habilitation services.

(l) Individuals being considered for behavioral outlier funding must have a current active behavior support plan that outlines the specific duties of additional staff; and the plan is intensively monitored by the behavior support consultant.

(m) The behavior plan must be in compliance with the DOH/DDSD DDW policy governing the process of behavioral support service planning for persons with developmental disabilities.

(n) The ISP specifically addresses the individual's condition, needs and outlines the daily responsibilities of additional or specialized staff.

(o) Outlier rates will be approved for a specified number of days per year not to exceed the annual waiver billing limits. Each approval will not exceed 180 days.

M. **Environmental modification services :** Environmental modifications services include the purchase and installation of equipment or making physical adaptations to an individual’s residence that are necessary to ensure the health, welfare and safety of the individual or enhance the individual’s access to the home environment [~~and increase the individual’s ability to act independently~~]. Adaptations include: the installation of ramps and grab-bars; widening of doorways or hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; purchase or installation of lifts or elevators; modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modification, water faucet controls, floor urinals and bidet adaptations and plumbing); turnaround space adaptations; specialized accessibility, safety adaptations or additions; installation of trapeze and mobility tracks for home ceilings; purchase or installation of automatic door openers or door bells, and voice-activated, light-activated, motion-activated and electric devices; fire safety adaptations; purchase and installation of air filtering devices; heating and cooling adaptations; the purchase and

installation of glass substitute for windows and doors; purchase and installation of modified switches, outlets or environmental controls for home devices; and purchase and installation of alarm and alert systems or signaling devices.

(1) No duplicate adaptations modifications or improvements shall be approved regardless of the payment source. Home modifications, adaptations, or improvements cannot be part of new construction. Adaptations, modifications, improvements or repairs to the existing homes, which are not of direct medical or remedial benefits to the individual, and automobile/vehicle retrofitting shall not be approved. Such non-beneficial adaptations, or improvements include, that are not limited to carpeting, roof repair, central air conditioning, furnace replacement, remodeling bare rooms and other general household repairs.

(2) An occupational therapist shall assess the individual's needs and the effectiveness of the requested environmental modification and submit a written recommendation to the case manager that is consistent with DOH/DDSD DDW service standards. If an occupational therapist is not available, the services of a physical therapist or other qualified individual approved by DOH/DDSD may be substituted. A complete report specifying how the environmental modification would contribute to the individual's ability to remain in or return to his home, and how the modification or improvements would increase the individual's independence and decrease the need for other services such as personal support, must be completed on a DOH/DDSD approved form. The report must be completed and submitted to the environmental modification provider and DOH/DDSD for approval before the contractor can be authorized to begin construction. This evaluation must be submitted to DOH/DDSD with the prior authorization request (PAR).

(3) All services must be provided in accordance with applicable federal, state and local building regulations, standards and codes.

(4) The environmental modification provider must ensure that proper design criteria are addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction or remodeling services, provide administrative and technical oversight of construction projects, provide consultation to family members, waiver providers and contractors concerning environmental modification projects to the individual's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan.

(5) Environmental modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects.

(6) Each environmental modification must be:

(a) documented with written recommendations from a qualified professional that specifies the model and type of equipment;

(b) deemed medically necessary by a physician or appropriate licensed professional;

(c) approved by DOH/DDSD in accordance with written policy including defined qualifying criteria prior to start of adaptations;

(d) documented as not otherwise available as a medicaid state plan service;

(e) completed by a DOH approved modification provider that has a GB-2 class construction license.

(7) Environmental modification services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

(8) Exclusions are those adaptations or improvements to the home that are of general and standard enhanced features for the home, such as partitioning a room, landscaping, and so forth, not adaptations for special needs and disability conditions.

N. **Personal planning facilitation:** Personal planning facilitators will work with individuals to select a method for this person-centered enhanced planning activity. The results will be incorporated into the individual's individual service plan (ISP). The facilitator will work with the individual to identify the individuals they wish to invite to the personal planning event. The purpose is to generate a more thorough understanding of the individual's background, preferences, dreams, life goals, natural supports, and to foster creative thinking about how to support the individual to achieve their dreams beyond what occurs in a typical ISP planning process.

O. **Goods and services:** Goods and services replace the stipend provided to the individual or family available in community access. Goods and services include services, supports or goods that enhance opportunities to achieve outcomes related to living arrangements, relationships, inclusion in community activities and work so long as the items or services meet the following requirements:

(1) the item or service is not covered by the medicaid state plan or DD waiver services;

(2) the item or service is designed to meet the individual's non-covered functional, medical or social needs and advances the desired outcomes in his ISP;

(3) the item or service is not prohibited by federal and state statutes and regulation;

(4) one or more of the following additional criteria are met:

(a) the item or service would increase the individual's functioning related to the disability;

(b) the item or service would increase the individual's safety in the home environment; or

(c) the item or service would decrease dependence on other medicaid-funded services;

(5) examples of this service may include the purchase of non-medical transportation, memberships to support community inclusion, and education materials.

P. [~~**Tier III**~~**] Crisis supports:** [~~Tier III~~] Crisis supports are services that provide intensive supports by appropriately trained staff to an individual experiencing a behavioral or medical crisis via one of the following models:

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

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

(3) Crisis supports must be prior authorized by the DOH/DDSD office of behavioral services. Crisis supports must be authorized in 14 to 30 calendar day increments, typically not to exceed 90 calendar days. In situations requiring crisis supports in excess of 90 calendar days, the DOH/DDSD director must approve such authorization upon submittal of a written plan to transition the individual from crisis supports to typical menu of DDW services.

Q. **Non-medical transportation:** Non-medical transportation assists the individual in accessing other waiver supports and non-waiver activities identified in the individual service plan (ISP). Non-medical transportation enables individuals to gain physical access to non-medical community services and resources promoting individual opportunity and responsibility in carrying out ISP activities. This service is to be considered only when transportation is not available through the state medicaid plan or when other arrangements cannot be made. Non-medical transportation includes funding to purchase a pass for public transportation for the individual. Non-medical transportation provider services must be provided in accordance with the DOH/DDSD DDW service definitions and standards.]

R. **Supplemental dental care:** Supplemental dental care provides one routine oral examination and cleaning to individuals on the waiver for the purpose of preserving [~~and/or~~] or maintaining oral health. Supplemental dental care provided on the waiver is for individuals that require routine cleaning more frequently. Supplemental dental care includes an oral examination and a routine dental cleaning.

(1) The supplemental dental care provider will ensure that a licensed dentist per New Mexico regulation and licensing provides the oral examination; ensure that a dental hygienist certified by the New Mexico board of dental health care provides the routine dental cleaning services; demonstrate fiscal solvency; and will function as a payee for the service.

(2) The supplemental dental care service must be provided in accordance with the DOH/DDSD DDW service definitions and standards.

[8.314.5.13 NMAC - Rp, 8.314.5.13 NMAC, 3-1-07 A, 4-1-11; A, 4/1/12]

TITLE 8 SOCIAL SERVICES
CHAPTER 290 MEDICAID ELIGIBILITY - HOME AND COMMUNITY-BASED SERVICES WAIVER (CATEGORIES 090, 091, 092, 093, 094, 095 AND 096)
PART 400 RECIPIENT POLICIES

8.290.400.3 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 27-2-12 et. seq. (Repl. Pamp. 1991).~~] See NMSA 1978 27-2-12 et seq.
[2/1/95; 8.290.400.3 NMAC - Rn, 8 NMAC 4.WAV.000.3, 5/1/02; A, 4/1/12]

8.290.400.9 HOME AND COMMUNITY-BASED SERVICES WAIVER - Category 090, 091, 092, 093, 094, 095, 096: The human services department (HSD) is the single state agency designated to administer the medicaid program in New Mexico. The department of health (DOH) and the human services department are charged with developing and implementing home and community-based services waiver (HCBSW) to medicaid applicants/recipients who meet both financial and medical criteria for an institutional or nursing facility level of care. Provision of these services under a waiver allows applicants/recipients to receive the care required at home at less cost than in an institution. The services to be furnished under the waiver must be cost-effective. This means the aggregate cost of care must be an amount less than the cost of maintaining individuals in institutions at the appropriate level of care. The types of services for which medicaid recipients are eligible vary based on the individual waiver. See medical assistance division program manual for the standards for individual waiver of covered services and program rules for all waiver services. The following sections contain the eligibility rules for all waiver services.
[2/1/95; 8.290.400.9 NMAC – Rn, 8 NMAC 4.WAV.400 & A, 5/1/02; A/E, 12-1-06; A, 11/1/07; A, 4/1/12]

8.290.400.10 BASIS FOR DEFINING THE GROUP: Eligibility for applicants/recipients who apply for waiver services is determined as if he were actually institutionalized, although this requirement has been waived. Entry into some of the waiver programs may be based upon the number of unduplicated recipient positions (UDRs) (i.e., slots). Some waiver categories require individuals to be placed on a central registry. The individual waiver program manager is responsible for notifying ISD when an individual is allocated into a waiver program.

A. **Disabled and elderly (D&E) waiver:** The disabled and elderly, now referred to as the coordination of long term-services (CoLTS) waiver, identified as categories 091 (elderly), 093 (blind) and 094 (disabled) was approved effective July 1983, subject to renewal. To qualify as disabled or blind for the purposes of this waiver, disability or blindness must have been determined to exist by the disability determination contractor (DDC). To qualify as an elderly person for purposes of this waiver, the applicant/recipient must be 65 years of age or older. Applicants/recipients must also meet both the financial and non-financial eligibility requirements and meet the medical level of care for nursing facility services.

B. **[~~Developmentally disabled~~] Developmental disabilities (DD) waiver:** The developmental disabled waiver identified as category 096 was approved effective July 1984, subject to renewal. This waiver is designed to furnish services to applicants/recipients who meet the definition of a developmental disability and mental retardation or specific related condition as determined by the department of health and the [~~DDC~~] developmental disabilities supports division (DDC) in accordance with the approved DD waiver criteria[~~, including the following:~~

~~(1) the individual has a developmental disability, defined as a severe chronic disability, other than mental illness, that:~~

~~(a) is attributable to a mental or physical impairment, including the result of trauma to the brain, or a combination of mental and physical impairments;~~

~~(b) is manifested before the person reaches the age of 22 years;~~

~~(c) is expected to continue indefinitely;~~

~~(d) results in substantial functional limitations in three or more of the following areas of major life activity:~~

~~(i) self-care;~~

~~(ii) receptive and expressive language;~~

~~(iii) learning;~~

~~(iv) mobility;~~

~~(v) self-direction;~~

~~(vi) capacity for independent living; and~~
~~(vii) economic self-sufficiency; and~~
~~(e) reflects the person's need for a combination and sequence of special or interdisciplinary treatment, generic or other support and services that are of lifelong or extended duration and are individually planned and coordinated.~~
~~(2) The individual also has mental retardation or a specific related condition, limited to cerebral palsy, autism (Asperger syndrome), seizure disorders, chromosomal disorders (e.g. downs), syndrome disorders, inborn errors of metabolism, and developmental disorders of brain formation~~].
Developmental disabilities waiver services are intended for individuals who have developmental disabilities limited to mental retardation (MR) or a specific related condition as determined by the department of health/developmental disabilities supports division. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated. The individual must also require the level of care provided in an intermediate care facility for the mentally retarded (ICF-MR), in accordance with 8.313.2 NMAC.
(1) The definition for mental retardation is as follows: Mental retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
(a) General intellectual functioning is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning.
(b) Significantly sub-average is defined as approximately IQ of 70 or below.
(c) Adaptive behavior is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group.
(d) The developmental period is defined as the period of time between birth and the 18th birthday.
(2) The definition for specific related condition is as follows: An individual is considered to have a Specific Related Condition if she/he has a severe chronic disability, other than mental illness, that meets all of the following conditions:
(a) is attributable to cerebral palsy, seizure disorder, autistic disorder (as described in the fourth edition of the diagnostic and statistical manual of mental disorders), chromosomal disorders (e.g. Down), syndrome disorders, inborn errors of metabolism, or developmental disorders of the brain formation;
(b) results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires treatment or services similar to people with mental retardation;
(c) is manifested before the person reaches age 22 years;
(d) is likely to continue indefinitely; and
(e) results in substantial functional limitations in three or more of the following areas of major life activity:
(i) self-care;
(ii) receptive and expressive language;
(iii) learning;
(iv) mobility;
(v) self-direction;
(vi) capacity for independent living; and
(vii) economic self-sufficiency.
(3) The individual must also require the level of care provided in an intermediate care facility for the mentally retarded (ICF-MR), and meet all other applicable financial and non-financial eligibility requirements.
C. **Medically fragile (MF) waiver:** The medically fragile (MF) waiver identified as category 095 was established effective August, 1984 subject to renewal. To be eligible for the medically fragile waiver, an applicant/recipient must meet the level of care required for admission to an intermediate care facility for the mentally retarded (ICF/MR), and meet all other applicable financial and non-financial eligibility requirements.
(1) To qualify for the MF waiver an individual must:
(a) have a developmental disability, developmental delay, or be at risk for developmental delay as determined by the DDC, and
(b) be diagnosed with a medically fragile condition prior to the age of 22, defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary, and which is characterized by one or more of the following:

(i) a life threatening condition characterized by reasonably frequent periods of acute exacerbation, which require frequent medical supervision or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(ii) frequent, time-consuming administration of specialized treatments, which are medically necessary;

(iii) dependency on medical technology such that without the technology a reasonable level of health could not be maintained; examples include, but are not limited to, ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen; and

(iv) periods of acute exacerbation of a life-threatening condition, the need for extraordinary supervision or observation, frequent or time-consuming administration of specialized treatments, dependency on mechanical (life) support devices, and developmental delay or disability.

D. **Acquired immunodeficiency syndrome (AIDS) and AIDS related condition (ARC) waiver:** The acquired immunodeficiency syndrome (AIDS) and AIDS related condition waiver designated as category 090, was established effective July 1987, subject to renewal. This waiver serves applicants/recipients diagnosed with AIDS/ARC. Applicants/recipients must require [~~institutional~~] nursing facility level of care and meet all other applicable financial and non-financial eligibility requirements.

E. **Brain injury (BI) under the mi via waiver:** Brain injury services are only available through the mi via waiver, and are designated as category 092. The mi via waiver, administered by the ALTSD, is effective December 1, 2006 and is subject to renewal. To qualify for purposes of this waiver, the applicant/recipient must be under 65 years of age at the time of approval, meet all other applicable financial and non-financial eligibility requirements and have a brain injury. Brain injury is defined as an injury to the brain of traumatic or acquired origin resulting in total or partial functional disability or psychosocial impairment or both. Additional criteria include the following:

(1) the term applies to open and closed head injuries caused by: an insult to the brain from an outside physical force; anoxia; electrical shock; shaken baby syndrome; toxic and chemical substances; near-drowning; infections; tumors; or vascular lesions;

(2) BI may result in either temporary or permanent, partial or total impairments in one or more areas including, but not limited to: cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem solving; sensory perception and motor abilities; psychosocial behavior; physical functions; information processing; and speech;

(3) the term "brain injury" does not apply to injuries that are congenital, degenerative, induced by birth trauma or neurological disorders related to the aging process, or chemically caused brain injuries that are a result of habitual substance abuse; the BI participant must have a documented BI diagnosis, as defined by the state; a list of applicable international classification of disease (ICD9) codes can be obtained from ALTSD or HSD/MAD; and

(4) individuals who require nursing facility level of care.

[2/1/95; 3/15/96; 8.290.400.10 NMAC – Rn, 8 NMAC 4.WAV.402 & A, 5/1/02; A/E, 12-1-06; A, 11/1/07; A, 3/15/12]

TITLE 8 SOCIAL SERVICES
CHAPTER 290 MEDICAID ELIGIBILITY - HOME AND COMMUNITY-BASED SERVICES WAIVER (CATEGORIES 090, 091, 092, 093, 094, 095 AND 096)
PART 600 BENEFIT DESCRIPTION

8.290.600.3 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 Sections 27-2-12 et. seq. (Repl. Pamp. 1991).~~] See NMSA 1978 27-2-12 et seq.
[2/1/95; 8.290.600.3 NMAC - Rn, 8 NMAC 4.WAV.000.3, 5/1/02; A, 4/1/12]

8.290.600.10 BENEFIT DETERMINATION: Application for the waiver programs is made using the "application/redetermination of eligibility for medical assistance of aged, blind, and disabled individuals" (form MAD 381). Upon notification by the appropriate program manager that an unduplicated recipient (UDR) is available for waiver services, applicants are registered on the ISD2 system. Applications must be acted upon and notice of approval, denial, or delay sent out within [~~30~~] 45 days from the date of application, or within [~~60~~] 90 days if a disability determination is required from the DDC. The applicant/recipient must assist in completing the application, may complete the form himself, or may receive help from a relative, friend, guardian, or other designated representative. To avoid a conflict of interest, a case manager or any other medicaid provider may not complete the application or be a designated representative.

A. **Representatives applying on behalf of individuals:** If a representative makes application on behalf of the applicant/recipient, that representative will continue to be relied upon for information regarding the applicant's/recipient's circumstances. The ISD worker will send all notices to the applicant/recipient in care of the representative.

B. **Additional forms:** The following forms are also required as part of the application process:

(1) the applicant/recipient or representative must complete and sign the primary freedom of choice of case management agency form at the time of allocation; and

(2) the applicant/recipient or representative must sign the applicant's statement of understanding at the time waiver services are declined or terminated.

C. **Additional information furnished during application:** The ISD worker provides an explanation of the waiver programs, including, but not limited to, income and resource limits and possible alternatives, such as institutionalization. The ISD worker refers potentially eligible applicants/recipients to the social security administration to apply for supplemental security income (SSI) benefits. If a disability decision by the DDC is required, but has not been made, the ISD worker must follow established procedures to refer the case for evaluation.
[2/1/95; 1/1/97; 8.290.600.10 NMAC - Rn, 8 NMAC 4.WAV.620 & A, 5/1/02; A, 11/1/07; A, 4/1/12]

8.290.600.14 CHANGES IN ELIGIBILITY: If the recipient ceases to meet any of the eligibility criteria, the case is closed following provision of advance notice as appropriate. See 8.200.430.9 NMAC and following subsections for information about notices and hearing rights.

A. **Non-Provision of Waiver Services:** To continue to be eligible for waiver services, an applicant/recipient must be receiving waiver services, EPSDT or salud managed care services, other than case management, [42 CFR Section 435.217]. Following initial approval, a waiver recipient must be in waiver services within 90 days of the approval. At any time ongoing, [~~If~~] if waiver services are no longer being provided (e.g., a suspension) and are not expected to be provided for 60 consecutive days, the recipient is **ineligible** for the waiver category and the case must be closed after appropriate notice is provided by the ISD worker.

B. **Admission to a Hospital, Nursing Facility, or Intermediate Care Facility for the Mentally Retarded (ICF-MR):** If a waiver recipient enters an acute care hospital, a nursing facility, or an ICF-MR and remains for more than 60 consecutive days, the waiver case must be closed and an application for institutional care medicaid must be processed. The recipient is not required to complete a new application if the periodic review on the waiver case is not due in either the month of entry into the institution or the following month. If the waiver recipient is institutionalized within less than 60 consecutive days and still receives waiver services within that time frame, the waiver case is not closed and an application for institutional care medicaid need not be processed.

C. **Reporting changes in circumstances:** The primary responsibility for reporting changes in the recipient's circumstances rests with the recipient or representative. At the initial eligibility determination and all on-going eligibility redeterminations, the ISD worker must explain the reporting responsibilities requirement to the applicant/recipient or representative and document that such explanation was given. In the event that waiver

services cease to be provided, the case manager or the waiver program manager (or designee) must immediately notify the income support division office of that fact by telephone. The telephone call is to be followed by a written notice to the ISD worker.

[2/1/95; 1/1/97; 8.290.600.14 NMAC - Rn, 8 NMAC 4.WAV.630 & A, 5/1/02; A, 11/1/07; A, 4/1/12]