INDEX

8.314.500 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER

8.314.5.1 ISSUING AGENCY....2
8.314.5.2 SCOPE:. 2
8.314.5.3 STATUTORY AUTHORITY....2
8.314.5.4 DURATION. 2
8.314.5.5 EFFECTIVE DATE. 2
8.314.5.6 OBJECTIVE....2
8.314.5.7 DEFINITIONS: 2
8.314.5.8 MISSION STATEMENT. 2
8.314.5.9 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER. 2
8.314.5.10 ELIGIBLE PROVIDERS 3
8.314.5.11 PROVIDER RESPONSIBILITIES 6
8.314.5.12 ELIGIBLE RECIPIENTS. 6
8.314.5.13 MAP RECIPIENT STANDARDIZED ASSESSMENT 7
8.314.5.14 DDW COVERED WAIVER SERVICES. 8
8.314.5.15 NON-COVERED SERVICES. 19
8.314.5.16 INDIVIDUALIZED SERVICE PLAN (ISP) 19
8.314.5.17 PRIOR AUTHORIZATION AND UTILIZATION REVIEW 19
8.314.5.18 REIMBURSEMENT 20
8.314.5.19 RIGHT TO A HSD ADMINISTRATIVE HEARING. 20
8.314.5.20 CONTINUATION OF BENEFITS PURSUANT TO A TIMELY APPEAL AND A HSD ADMINISTRATIVE HEARING PROCEEDING. 20

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

8.314.5.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.314.5.1 NMAC - Rp, 8.314.5.1 NMAC, 11-1-12]

8.314.5.2 SCOPE: The rule applies to the general public.
[8.314.5.2 NMAC - Rp, 8.314.5.2 NMAC, 11-1-12]

8.314.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.314.5.3 NMAC - Rp, 8.314.5.3 NMAC, 11-1-12]

8.314.5.4 DURATION: Permanent.
[8.314.5.4 NMAC - Rp, 8.314.5.4 NMAC, 11-1-12]

8.314.5.5 EFFECTIVE DATE: November 1, 2012, unless a later date is cited at the end of a section.
[8.314.5.5 NMAC - Rp, 8.314.5.5 NMAC, 11-1-12]

8.314.5.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.314.5.6 NMAC - Rp, 8.314.5.6 NMAC, 11-1-12; A, 2-1-15]

8.314.5.7 DEFINITIONS:

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

B. Individual service plan (ISP): A treatment plan for an eligible recipient that includes the eligible recipient's needs, functional level, intermediate and long range goals, statement for achieving the goals, and specifies responsibilities for the care needs. The ISP determines the services allocated to the eligible recipient within the developmental disabilities waiver (DDW) allowances.

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

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

E. Supports intensity scale (SIS): A standardized assessment tool that provides a reliable framework to quantify the support needs of individuals with developmental disabilities.

F. Waiver: Permission from the centers for medicaid and medicare services (CMS) to cover a particular population or service not ordinarily allowed.
[8.314.5.7 NMAC - N, 11-1-12; A, 6-15-14; A, 2-1-15]

8.314.5.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.314.5.8 NMAC - Rp, 8.314.5.8 NMAC, 11-1-12]

8.314.5.9 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER: To help New Mexicans who have a developmental disability, intellectual disability (ID) 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 (HCBS) to eligible recipients as an alternative to institutionalization.
[8.314.5.9 NMAC - Rp, 8.314.5.9 NMAC, 11-1-12; A, 2-1-15]

8.314.5.10 ELIGIBLE PROVIDERS:

A. Health care to medical assistance program (MAP) eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities, and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to MAP eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including New Mexico administrative code (NMAC) rules, billing instructions, utilization review instructions, service definitions and service standards and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

B. Eligible providers must be approved by the department of health (DOH) developmental disabilities support division (DDSD) or its designee and have an approved MAD PPA as a DDW provider.

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

D. Qualifications of case management agency providers: Case management providers, their case managers, whether subcontractors or employees must comply with Section 10 of this rule. In addition, case management providers must ensure that case managers meet the following qualifications:

(1) one year of clinical experience, related to the target population; and

(2) one of the following:

(a) social worker licensure as defined by the New Mexico regulation and licensing department (RLD); or

(b) registered nurse (RN) licensure as defined by the New Mexico board of nursing; or

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

(3) training requirements as specified by DDSD; and

(4) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

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

(1) comply with all training requirements as specified by DDSD;

(2) have and maintain documentation of current cardiopulmonary resuscitation (CPR) and first aid certification; and

(3) have written notification from DDSD that he or she does not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS).

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

G. Qualifications of therapy provider agencies: Therapy provider agencies must comply and ensure that all therapists including physical therapists (PT), occupational therapists (OT), and speech therapists (SLP), physical therapy assistants (PTAs) and certified occupational therapy assistants (COTAs), whether subcontractors or employees, comply with Section 10 of this rule.

H. Qualifications for community living supports provider agencies: Living supports consist of family living and supported living. Living supports provider agencies must comply with accreditation policy and all requirements set forth by the DDSD, DDW service definition, all requirements outlined in the DDW service standards and the MAD rules. Living supports provider agencies must ensure that all direct support personnel meet all qualifications set forth by DDSD and its DDW service standards and applicable NMAC rules.

(1) Living supports provider agencies and direct support personnel must:

(a) comply with all training requirements as specified by DDSD;

(b) have and maintain documentation of current CPR and first aid certification; and

(c) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the CCHS.

(2) Family living provider agencies must ensure that all direct support personnel, whether subcontractors or employees, meet all qualifications set forth by DDSD and its DDW service standards and the applicable NMAC rules. The direct support personnel employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency.

(3) Supported living provider agencies must ensure that all direct support personnel meet all qualifications set forth by DDSD and the applicable NMAC rules and its DDW service standards. Supported living provider agencies for supporting living services must employ or subcontract with at least one licensed RN and comply with the New Mexico Nurse Practicing Act.

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

(1) comply with all training requirements as specified by DDSD;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the CCHS.

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

(1) comply with all training requirements as specified by DDSD;

(2) have and maintain documentation of current CPR and first aid certification; and

(3) have written notification from DOH that he or she does not have a disqualifying conviction after submitting to the CCHS.

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

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

(a) a licensed mental health counselor (LMHC), or

(b) a licensed clinical psychologist; or

(c) a licensed psychologist associate, (masters or Ph.D. level); or

(d) a licensed independent social worker (LISW); or

(e) a licensed master social worker (LMSW); or
(f) a licensed professional clinical counselor (LPCC); or
(g) a licensed marriage and family therapist (LMFT); or
(h) a licensed practicing art therapist (LPAT).

(2) Other related licenses and qualifications may be considered with DDSD prior written approval.

(3) Providers of behavioral support consultation must have a minimum of one year of experience working with individuals with intellectual disabilities (IID).

(4) Behavioral support consultation providers must receive training in accordance with DOH/DDSD training policy.

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

M. Qualifications of environmental modification provider agencies: Environmental modification contractors and their subcontractors must be bonded, licensed by RLD, and authorized by DDSD to complete the specified project. Environmental modification provider agencies must comply with Section 10 of this rule. All services shall be provided in accordance with applicable federal, state and local building codes.

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

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

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

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

P. Qualifications of supplemental dental care provider agencies: Supplemental dental care provider agencies must comply with Section 10 of this rule. Supplemental dental care providers must contract with New Mexico licensed dentists and dental hygienists who are licensed by RLD, 61-5A-1 et seq., NMSA 1978. The supplemental dental care provider will ensure that a RLD licensed dentist provides the oral examination; ensure that a RLD licensed dental hygienist provides the routine dental cleaning services; demonstrate fiscal solvency; and will function as a payee for the service.

Q. Qualifications of assistive technology purchasing agent providers and agencies: Assistive technology purchasing agent providers and agencies must comply with Section 10 of this rule.

R. Qualifications of independent living transition service provider agencies: Independent living transition service provider agencies must comply with Section 10 of this rule.

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

T. Qualifications of preliminary risk screening and consultation related to inappropriate sexual behavior (PRSC) provider agencies: A PRSC provider agency must comply with Section 10 of this rule and all training requirements as specified by DDSD. Additionally, the PRSC provider agency must have on staff:

(1) a RLD independently licensed behavioral health practitioner, such as counseling and therapy, a social worker, or a psychologist; or

(2) holds a master's or doctoral degree in a behavior health related field from an accredited college or university.

U. Qualifications of socialization and sexuality education provider agencies: Socialization and sexuality education provider agencies must comply with Section 10 of this rule. Agencies must be approved by the DDSD, bureau of behavior supports (BBS) as a socialization and sexuality education provider, and must meet training requirements as specified by DDSD. In addition, socialization and sexuality education provider agencies must have one of the following providers rendering the service:

(1) a master's degree or higher in psychology;
(2) a master's degree or higher in counseling;
(3) a master's degree or higher in special education;
(4) a master's degree or higher in social work;
(5) a master's degree or higher in a related field;
(6) a RLD licensed RN or LPN;
(7) a bachelor's degree in special education; or
(8) hold a certification in special education.

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

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

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

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

[8.314.5.10 NMAC - Rp, 8.314.5.10 NMAC, 11-1-12; A, 6-15-14;A, 2-1-15]

8.314.5.11 PROVIDER RESPONSIBILITIES:

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

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

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HSD, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.; see 8.302.1 NMAC.

[8.314.5.11 NMAC - Rp, 8.314.5.11 NMAC, 11-1-12; A, 6-15-14; A, 2-1-15]

8.314.5.12 ELIGIBLE RECIPIENTS: DDW services are intended for MAP eligible recipients who have developmental disabilities limited to intellectual disability (ID) or a specific related condition. MAP eligibility criteria [~~is~~] are located in 8.290.400.10 NMAC.

[8.314.5.12 NMAC - Rp, 8.314.5.12 NMAC, 11-1-12; A, 2-1-15]

8.314.5.13 MAP RECIPIENT STANDARDIZED ASSESSMENT:

A. DDSD shall utilize the supports intensity scale (SIS) to assess the needs of all adult recipients transitioning into the waiver and of adults who are new allocations into the waiver, and to conduct assessments on each eligible recipient within the third year thereafter. The SIS assessment shall be administered to an eligible recipient who is 17 years of age or older and will be at least 18 years of age at the time of his or her individual service plan (ISP) start date. The SIS quantifies the pattern and intensity of support needs of an eligible recipient with intellectual or developmental disabilities by obtaining information about the needs of each eligible recipient through an assessment process. Supplemental questions related to:

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

B. The SIS assessment shall be scheduled 30-90 calendar days prior to the individual's individual service plan start date and at least three years after the last SIS assessment was conducted so that the interdisciplinary team can receive results and plan services accordingly. Recipients shall be offered options for dates and times to schedule the SIS assessment.

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

D. The individual being assessed is strongly encouraged to be involved in the entire assessment but must at least meet the SIS interviewer.

E. At least two primary respondents who are usually primary caregivers or direct support professionals in residential and day service programs must attend the assessment. The individual being assessed can also be a primary respondent. Primary respondents are not required to have clinical expertise or professional degrees. Qualifications for primary respondents include:

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

F. A guardian or close family member are strongly encouraged and welcomed to be involved, however may not be qualified as a primary respondent.

G. The attendance of ancillary respondents is optional. Typically, medical, behavioral or therapy professionals may serve as ancillary respondents. They can provide clinical information that adds perspective particularly for individuals with complex support needs.

H. Standard guidelines for administering the SIS assessment include:

(1) the SIS assessor is trained and certified to provide SIS assessments;
(2) the SIS assessor provides information to the primary and ancillary respondents about the SIS assessment process prior to starting the assessment;
(3) the SIS assessment is conducted face to face;
(4) the SIS assessor met the individual;
(5) each question in the assessment is explained to respondents prior to it being scored;
(6) each question is asked and discussed during the assessment;
(7) the final score of each question is shared with the respondents; and
(8) medical and behavioral needs are discussed with the respondents.

I. Within an eligible recipient's three year assessment cycle, he or she or the authorized representative may request a new SIS assessment when:

(1) the eligible recipient or his or her authorized representative believes there is a substantial departure from standard guidelines for administering the SIS; and
(2) the eligible recipient has experienced a change of condition that results in a significant change to the pattern and intensity of supports needed to maintain the eligible recipient's health and safety.

J. SIS reassessments must be requested according to procedure and timelines established by DDSD, and require prior written approval of DDSD.

K. The New Mexico (NM) DDW groups A through G are assigned through standardized application of decision rules associated with select SIS scores, and when relevant, the supplemental question verification process.

(1) Medical support score refers to the total score in SIS section 3.A. titled: medical support needed.

(2) Behavior support score refers to the total score in SIS section 3.B. titled: behavioral support needed.

(3) Extraordinary medical risk is determined by verification of positive responses to supplemental questions through a document review by subject matter experts.

(4) Dangerousness to others or extreme self-injury risk is determined by verification of responses to supplemental questions through a document review by subject matter experts.

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

NM DDW groups	SIS sum ABE		Section 3A medical support score	Section 3B behavior support score
A: Mild support needs and low to moderate behavioral challenges	≥ 0 to ≤ 24		≥ 0 to ≤ 6	≥ 0 ≤ to 6
B: Low to moderate support needs and behavioral challenges	≥ 25 to ≤ 30		≥ 0 to ≤ 6	≥ 0 to ≤ 6
C: Mild to above average support needs and moderate to above average behavioral challenges	≥ 0 to ≤ 36		≥ 0 to ≤ 6	≥ 7 to ≤ 10
D: Above average support needs and low to moderate behavioral challenges	≥ 31 to ≤ 36		≥ 0 to ≤ 6	≥ 0 to ≤ 6
E: High support needs and mild to above average behavioral challenges	≥ 37 to ≤ 55		≥ 0 to ≤ 6	≥ 0 to ≤ 10
F: Extraordinary medical challenges	any		≥ 7 to ≤ 32 OR extraordinary medical risk	≥ 0 to ≤ 10
G. Extraordinary behavioral challenge	any		any	≥ 11 to ≤ 26 OR dangerousness to others or extreme self injury risk

L. Information from the SIS assessment should be used for person-centered planning.
[8.314.5.13 NMAC - Rp, 8.314.5.13 NMAC, 11-1-12; 8.314.5.13 NMAC - N, 6-15-14; A, 2-1-15]

8.314.5.14 DDW COVERED WAIVER SERVICES: The DDW program is limited to the number of federally authorized unduplicated eligible recipient (UDR) positions and program funding. All DDW covered services in an individual service plan (ISP) must be authorized and cannot exceed the allowable funding amount associated with the assigned service package. DDW services must be provided in accordance with all requirements set forth by DDSD DDW service definition, all requirements outlined in the DDW service standards and the applicable NMAC rules, supplements and guidance. MAD covers the following services for a specified and limited number of waiver eligible recipients as a cost effective alternative to institutionalization in an intermediate care facilities for individuals with intellectual disabilities (ICF-IID).

A. There are seven NM DDW groups (labeled A-G) each of which has a corresponding service package and budget. The service package for each NM DDW group is based on assessed need and consists of a

base budget, a professional services budget, and other services budget that make up the total funding authorized in the eligible recipient's ISP. The service package for each of the seven NM DDW groups allows an eligible recipient flexibility to choose services to meet his or her needs within the maximum amount allowed in the service package assigned to the corresponding NM DDW group.

B. Covered waiver services by NM DDW group assignments:

NM DDW GROUP	BASE BUDGET ELIGIBILITY	PROFESSIONAL SERVICES
A: Mild support needs and low to moderate behavioral challenges	case management customized in-home supports: independent or family/natural supports including respite day services-including employment, customized community supports	physical therapy, speech therapy, occupational therapy- prioritize one discipline behavior support consultation
B: Low to moderate support needs and behavioral challenges	case management customized in-home supports: independent or family/natural supports including respite day services-including employment, customized community supports	physical therapy, speech therapy, occupational therapy- prioritize one discipline behavior support consultation
C: Mild to above average support needs and moderate to above average behavioral challenges	case management customized in-home supports, family living or supported living: independent or family/natural supports including respite day services- including employment, customized community supports	physical therapy, speech therapy, occupational therapy- prioritize one discipline behavior support consultation, increase to core hours
D: Above average support needs and low to moderate behavioral challenges	case management customized in-home supports, family living or supported living: independent or family/natural supports including respite day services- including employment, customized community supports	physical therapy, speech therapy, occupational therapy- prioritize two disciplines behavior support consultation
E: High support needs and mild to above average behavioral challenges	case management customized in-home supports, family living or supported living: independent or family/natural supports including respite day services-including employment, customized community supports	physical therapy, speech therapy, occupational therapy- three disciplines if clinical criteria met for each discipline behavior support consultation
F: Extraordinary medical challenges	case management customized in-home supports, family living or supported living: independent or family/natural supports including respite, intensive medical living services day services- including employment, customized community supports	physical therapy, speech therapy, occupational therapy- three disciplines if clinical criteria met for each discipline behavior support consultation

G: Extraordinary behavioral challenges	case management customized in-home supports, family living or supported living: family/natural supports including respite day services- including employment, customized community supports, individualized Intensive behavior customized community supports with prior approval	physical therapy, speech therapy, occupational therapy- prioritize two disciplines behavior support consultation, increase to core hours

C. Environmental modifications, preliminary risk screening, and crisis supports require prior authorization from DDSD. Other services in the service standards are available to all NM DDW groups as follows:

(1) environmental modifications every five years with a prior authorization;

(2) personal support technology with a prior authorization;

(3) assistive technology with a prior authorization;

(4) independent living transition;

(5) supplemental dental care, one visit per year;

(6) non-medical transportation, with caps applicable by mileage and passes with a prior authorization;

(7) adult nursing with a prior authorization;

(8) nutritional counseling with a prior authorization;

(9) initial assessments for therapies and behavior support consultation;

(10) preliminary risk screening and consultation related to inappropriate sexual behavior with a prior authorization;

(11) socialization and sexuality education, six classes per lifetime; and

(12) crisis supports with a prior authorization.

D. Group H is reserved for an eligible recipient who has extenuating circumstances or extremely complex needs that may require services that exceed the service package options corresponding to the assigned NM DDW group. Services outside of the maximum amount allowed in the services package assigned to the corresponding NM DDW group may be authorized for an eligible recipient through group H designation on a categorical basis as deemed appropriate by DDSD, on either a temporary (less than 90 calendar days) or long term basis (greater than 90 calendar days).

(1) Categorical group H assignment includes:

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

(b) an eligible recipient assigned to NM DDW group A or B who are 55 or older and who has been receiving DDW supported living prior to March 1, 2013. These eligible recipients may continue to receive supported living services if desired.

(2) The review process for temporary group H requests for service is as follows:

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

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

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

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

(e) if temporary group H request for services is approved by DDSD, the case manager shall submit a budget revision with the DDSD prior authorization to the third party assessor (TPA).

(3) The review process for long term group H requests for service is as follows:

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

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

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

(d) the RO director or designee makes a determination whether the request is appropriate for review by the group H committee for long term group H by verifying:

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

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

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

(iv) that the individual's need for a long term group H request for services is not exclusively due to a significant change in condition that can otherwise be addressed through temporary group H request for services needed outside the current NM DDW group assignment pending the scheduling of a SIS reassessment;

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

(f) if the long term group H request for services is approved by DDSD, the case manager shall submit a budget revision with the approved prior authorizations to the TPA.

E. Services available in service packages:

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

(i) assessing needs; facilitating eligibility determination for persons with developmental disabilities;

(ii) directing the service planning process;

(iii) advocating on behalf of the eligible recipient;

(iv) coordinating service delivery;

(v) assuring services are delivered as described in the ISP; and

(vi) maintaining a complete current central eligible recipient record (e.g. ISP, ISP budget, level of care documentation, assessments).

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

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

(c) Case management services must be provided in accordance with Section 10 of this rule.

(2) Respite services: Respite services are a flexible family support service for an eligible recipient. The primary purpose of respite services is to provide support to the eligible recipient and give the

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

(3) Adult nursing services: Adult nursing services are provided by a licensed RN or LPN under the supervision of a RN to an eligible adult recipient. Adult nursing services are intended to support the highest practicable level of health, functioning and independence for a DDW eligible recipient age 21 and older with a variety of health conditions. The exception is an eligible recipient receiving nursing supports through supported living and intensive medical living services, where such nursing supports are included as part of the living service and addressed within those respective services standards. Any adult nursing service provided during the hours of customized community supports cannot be billed as a separate service because nursing is included in the customized community supports services. There are two categories of adult nursing services: (a) assessment and consultation services which include a comprehensive health assessment and basic nurse consultation of and with an eligible recipient; and (b) ongoing services, which require prior authorization and are tied to the eligible recipient's specific health needs revealed in the comprehensive health assessment. Adult nursing services must comply with Section 10 of this rule.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

summary). Documentation shall include a statement of justification from a social worker, psychologist, and any other pertinent professionals working with the eligible recipients. Family living services cannot be provided in conjunction with any other living supports service, respite, or nutritional counseling.

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

(6) Customized community supports: Customized community supports consist of individualized services and supports that enable an eligible recipient to acquire, maintain, and improve opportunities for independence, community integration and employment. Customized community supports services are designed around the preferences and choices of each eligible recipient and offer skill training and supports to include: adaptive skill development; educational supports; citizenship skills; communication; social skills, socially appropriate behaviors; self-advocacy, informed choice; community integration and relationship building. This service provides the necessary support to develop social networks with community organizations to increase the eligible recipient's opportunity to expand valued social relationships and build connections within local communities. This service helps to promote self-determination, increases independence and enhances the eligible recipient's ability to interact with and contribute to his or her community.

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

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

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

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

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

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

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

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

(i) completing a market analysis of product/business viability;

(ii) creating a business plan including development of a business infrastructure to sustain the business over time, including marketing plans;

(iii) referring and coordinating with the division of vocational rehabilitation (DVR) for possible funds for business start-up;

(iv) assisting in obtaining required licenses necessary tax [~~ID~~] identifications, incorporation documents and completing any other business paperwork required by local and state codes;

(v) supporting the eligible recipient in developing and implementing a system of bookkeeping and records management;

(vi) providing effective job coaching and on-the-job training and skill development; and

(vii) arranging transportation or public transportation during self-employment services.

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

(i) provide effective job coaching and on-the-job training as needed to assist the eligible recipient to maintain the job placement and enhance skill development; and

(ii) arrange transportation or public transportation during individual community integrated employment services.

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

(i) participate with the IDT to develop a plan to assist an eligible recipient who desires to move from group employment to individual employment; and

(ii) provide effective job coaching and on-the-job training as needed to assist the eligible recipient to maintain the job placement and enhance skill development.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

transportation for the eligible recipient. Non-medical transportation provider services must comply with Section 10 of this rule.

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

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

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

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

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

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

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

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

(a) The key functions of PRSC are to:

(i) provide a structured screening of the eligible recipient’s behaviors that may be sexually inappropriate;

(ii) develop and document recommendations the eligible recipient in the form of a report or consultation notes;

(iii) develop and periodically review of risk management plans for the eligible recipient, when recommended; and

(iv) provide consultation regarding the management and reduction of the eligible recipient's sexually inappropriate behavioral incidents that may pose a health and safety risk to the eligible recipient or others.

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

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

(19) Customized in-home supports: Customized in-home support services is not a residential habilitation service and is intended for an eligible recipient that does not require the level of support provided under living supports services. Customized in-home supports provide an eligible recipient the opportunity to design and manage the supports needed to live in his or her own home or family home. Customized in-home supports includes a combination of instruction and personal support activities provided intermittently to assist the eligible recipient with ADLs, meal preparation, household services, and money management. The services and supports are individually designed to instruct or enhance home living skills, community skills and to address health and safety of the eligible recipient, as needed. This service provides assistance with the acquisition, improvement or retention of skills that provides the necessary support to achieve personal outcomes that enhance the eligible recipient's ability to live independently in the community. Customized in-home support services must comply with Section 10 of this rule.

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

(a) These medical needs include:

(i) skilled nursing interventions;

(ii) delivery of treatment;

(iii) monitoring for change of condition; and

(iv) adjustment of interventions and revision of services and plans based on assessed clinical needs.

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

(c) The intensive medical living provider will be responsible for providing the appropriate level of supports, 24 hours per day seven days a week, including necessary levels of skilled nursing

based on assessed need of the eligible recipient. Daily nursing visits are required; however, a RN or a LPN under a RN's supervision is not required to be present in the home during periods of time when skilled nursing services are not required or when an eligible recipient is out in the community. An on-call RN or LPN, under the supervision of a RN must be available to staff during periods when a RN or a LPN under a RN's supervision is not present. Intensive medical living supports require supervision by a RN, and must comply with Section 10 of this rule.

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

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

(f) Intensive medical services must comply with Section 10 of this rule.

[8.314.5.14 NMAC - Rp, 8.314.5.14 NMAC, 11-1-12; 8.314.5.14 NMAC - Rn & A, 8.314.5.13 NMAC, 6-15-14; A, 2-1-15]

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

[8.314.5.15 NMAC - Rp, 8.314.5.15 NMAC, 11-1-12; 8.314.5.15 NMAC - Rn & A, 8.314.5.14 NMAC, 6-15-14; A, 2-1-15]

8.314.5.16 INDIVIDUALIZED SERVICE PLAN (ISP): An ISP must be developed by an IDT in consultation with the eligible recipient and others involved in the eligible recipient's care. The ISP is developed using information relevant to the care of the eligible recipient. The ISP will be developed utilizing the service package available with the individual's NM DDW group. The ISP must comply with Section 10 of this rule. The ISP is submitted to DDSD or its designee for final approval. DDSD or its designee must approve any changes to the ISP; see 7.26.5 NMAC.

A. The IDT must review the eligible recipient's treatment plan every 12 months or more often if indicated.

B. The ISP must contain the following information:

(1) statement of the nature of the specific needs of the eligible recipient;

(2) description of the functional level of the eligible recipient;

(3) statement of the least restrictive conditions necessary to achieve the purposes of treatment of an eligible recipient;

(4) description of intermediate and long-range goals, with a projected timetable for eligible recipient's attainment and the duration and scope of services;

(5) statement and rationale of the treatment plan for achieving these intermediate and long-range goals, including provision for review and modification of the eligible recipient's ISP; and

(6) specification of responsibilities for areas of care, description of needs, and orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the eligible recipient.

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

[8.314.5.16 NMAC - Rp, 8.314.5.16 NMAC, 11-1-12; 8.314.5.16 NMAC - Rn & A, 8.314.5.15 NMAC, 6-15-14; A, 2-1-15]

8.314.5.17 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services, including services covered under the DDW, are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made,

or after payment is made; see 8.310.2 NMAC. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

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

B. DDSD prior authorization: Certain services are subject to utilization review by DDSD, including group H requests.

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

D. Reconsideration: Providers who disagree with the denial of a prior authorization request or other review decisions may request a reconsideration; see 8.350.2 NMAC.

[8.314.5.17 NMAC - Rp, 8.314.5.17 NMAC, 11-1-12; 8.314.5.17 NMAC - Rn & A, 8.314.5.16 NMAC, 6-15-14; A, 2-1-15]

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

[8.314.5.18 NMAC - N, 11-1-12; 8.314.5.18 NMAC - Rn & A, 8.314.5.17 NMAC, 6-15-14; A, 2-1-15]

8.314.5.19 RIGHT TO A HSD ADMINISTRATIVE HEARING: MAD has established a process to determine if an individual is eligible to request a HSD administrative hearing. Once the individual requests a HSD administrative hearing, the individual is referred to as a claimant. MAD has also established a process for an individual or the individual's authorized representative to request a HSD administrative hearing when an adverse action is intended or has been taken by MAD, its utilization review (UR) contractor or designee against the individual. See 8.352.2 NMAC for a detailed description of a claimant's HSD administrative hearing rights and responsibilities.

[8.314.5.19 NMAC - N, 11-1-12; 8.314.5.19 NMAC - Rn & A, 8.314.5.18 NMAC, 6-15-14; 2-1-15]

8.314.5.20 CONTINUATION OF BENEFITS PURSUANT TO A TIMELY APPEAL AND A HSD ADMINISTRATIVE HEARING PROCEEDING: A continuation of an existing DDW benefit is provided to an eligible recipient claimant when he or she requests a continuation of the benefit through MAD, its UR contractor or its designee as directed on the claimant's notice of action within 10 calendar days of the mailing of the MAD, its UR contractor or its designee's notice of action. MAD, its UR contractor or it designee's notice of action will include information on the rights to the continued benefit and on the claimant responsibility for repayment if the HSD administrative hearing decision is not in his or her favor. The continuation of a benefit is only available to a claimant that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the claimant's current allocation, budget or LOC unless a revision is agreed to in writing by the DDW claimant (or authorized representative) and DDSD. See 8.352.2 NMAC for a detailed description of a claimant's HSD rights to the continuation of the eligible recipient claimant's benefit.

[8.314.5.20 NMAC - Rn, & A, 8.314.5.19 NMAC, 6-15-14; A, 2-1-15]

HISTORY OF 8.314.5 NMAC:

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

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

History of Repealed Material:

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

8 NMAC 4.MAD.736.12 - Repealed 9-1-98; and
8 NMAC 4.MAD.736.412 - Repealed 9-1-98.
8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, Repealed 3-1-07.
8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, filed 2-15-07 is repealed effective 11-1-12