

Developmental Disabilities (DD) Waiver Service Standards

Effective Date: April 1, 2007



Developmental Disabilities Supports Division

<http://www.health.state.nm.us/ddsd>

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GENERAL AUTHORITY

The following Laws and standards, policies and procedures governing the provision of services under the Developmental Disabilities Medicaid Waiver include, but are not limited to:

The Centers for Medicare and Medicaid Services (CMS) Requirements for Home and Community Based Services Waivers;

CMS Rulings such as decisions of the Administrator, precedent final opinions, orders and statements of policy and interpretation;

Health Insurance Portability and Accountability Act (HIPAA) of 1996, including the CMS Administrative Simplification Provisions;

New Mexico Human Services Department (HSD) Medicaid Policy Manual for Developmental Disabilities Home & Community Based Services Waiver (8.314.5);

HSD Medicaid Program Policy Manual;

HSD Medicaid Billing Instructions for the Disabled and Elderly, Medically Fragile, HIV/AIDS, and Developmental Disabilities Waivers (8.314 BI);

HSD Medical Assistance Division Provider Participation Agreement (MAD 335);

Fair Labor Standards Act of 1938 (FLSA), as amended 29 USC §201 et seq.; 29 CFR Parts 510 to 794;

Pharmacy Act (Chapter 61, Article 11 NMSA 1978)

New Mexico Nursing Practice Act, Chapter 61, Article 3, New Mexico Statute Authority (NMSA);

Certified Medication Aide Rules – Title 16, Chapter 12, Part 5 New Mexico Administrative Code (NMAC)

The DDS Home and Community Based Waiver Provider Agreement;

HSD/DOH Medicaid Waiver Case Management Code of Ethics;

DOH/DDS Service Plans for Individuals with Developmental Disabilities Living in the Community (7.26.5 NMAC);

DOH/DDS Rights of Individuals with Developmental Disabilities Living in the Community (7.26.3 NMAC);

DOH/DDS Client Complaint Procedures (7.26.4 NMAC);

DOH/DDS Requirements for Developmental Disabilities Community Programs (7.26.6 NMAC);

DOH/DDSD (Appendix A) Individual Transition Planning Process (7.26.7 NMAC);

DOH/DDSD (Appendix B) Dispute Resolution Process (7.26.8 NMAC);

DOH/DHI Statewide Incident Management System Policies and Procedures;

DDSD [formerly Developmental Disabilities Division (DDD) and Long Term Services Division (LTSD)] Policies, Procedures, Director's Releases, Interpretive Memos, Guidelines or other current published rules including, but not limited to DDSD Policies and Procedures, including:

- DDSD Policies and Procedures for Centralized Admission and Discharge Process for New Mexicans with Disabilities (DDD-CST-150, 1992);
- DDSD Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities;
- DDSD Policy Governing the Training Requirements for Case Management Staff Serving Individuals with Developmental Disabilities Served Through the DD Waiver;
- DDSD Policy for Behavioral Support Service Provision;
- DDSD Medication Assessment and Delivery Policy and Procedure;
- DDSD Policy on Accreditation of Providers;

DOH/DHI Caregivers Criminal History Screening Requirements (7.1.9 NMAC);

DHI/DOH Quality Management System and Review Requirements for Provider Agencies of Community Based Services (7.14.2 NMAC);

DOH/DHI Employee Abuse Registry (7.1.12 NMAC);

DOH/DHI Requirements for Home Health Agencies (7.28.2 NMAC);

DOH/DDSD Requirements for Family Infant Toddler Early Intervention Services (7.30.8 NMAC);

Individuals with Disabilities Education Act (IDEA), Part C;

Education Department General Administrative Regulations (EDGAR);

Incident Reporting, Intake Processing and Training Requirements for Providers of Community Based Services (7.1.13 NMAC) effective 2/28/2006 (renumbered and replaced and repealed 7.14.3 NMAC);

DOH/DHI Statewide Mortality Review Policy and Procedures;

State and Local regulations for operating a business

DEFINITIONS

- A. ANNUAL** means the twelve (12) month period covered by an individual service plan, except where otherwise stated.
- B. ANNUAL RESOURCE ALLOTMENT. (ARA)** means a service category with a corresponding funding limit that is based on an individual's age, level of care and residential status. The annual resource allotment service categories are:
- (1) Children's Services;
 - (2) Young Adult Services;
 - (3) Young Adult Community Living Support Services for individuals receiving any 24-hour residential services;
 - (4) Adult Services;
 - (5) Adult Community Living Supports Services for individuals receiving any 24-hour residential services;
- C. BEHAVIORAL SUPPORT CONSULTATION.** means a service that includes a comprehensive functional assessment of an individual's behaviors; development, implementation and management of the positive behavioral supports assessment and plan; and behavioral consultation and training provided to the individual's interdisciplinary team (IDT) members.
- D. CAREER DEVELOPMENT PLAN.** means the completed vocational profile plus the strategic plan for employment for a specific individual, which may be included in the ISP action plan for the Work/Learn life area.
- E. CASE MANAGER.** means the individual responsible for service coordination for individuals with developmental disabilities on the Medicaid Developmental Disabilities Waiver. The Case Manager is external to, and independent from, all other direct services provided to the individual.
- F. CHILD.** except in the context of Early Periodic Screening Diagnosis and Treatment (EPSDT) services eligibility "child," means an individual under the age of eighteen (18). For purposes of EPSDT service eligibility, "child" means an individual under the age of twenty-one (21).
- G. CHRONIC MEDICAL CONDITIONS.** means frequent or persistent medical diagnoses that require long-term health care management.
- H. CLINICAL NECESSITY CRITERIA.** means the developmental, physical or behavioral health conditions establishing and justifying a service. All individuals receiving services from the Medicaid Developmental Disabilities Waiver program must have a developmental disability and meet admission criteria for an intermediate care facility for the mentally retarded (ICF/MR) which shall include:
- (1) A developmental disability consistent with the Centers for Medicare and Medicaid Services (CMS) approved state eligibility criteria, and which may occur in combination with:
 - (a) Pathological or disabling disease processes as recognized in the medical professional community, and/or

- (b) Emotional, psychological, and psychiatric processes with associated behavioral factors that substantially interfere with daily living as identified by appropriate behavioral health professionals.
 - (2) The above developmental, physical or behavioral health conditions are potentially amenable to treatment, accommodation, rehabilitation, or amelioration through proposed services as supported through research and/or clinical practice;
 - (3) Proposed treatment, accommodation, rehabilitation, or amelioration services are derived from objective assessments by authorized professionals;
- I. COMMUNITY.** means a group of people with a common characteristic or interest living together within a larger society.
- J. COMMUNITY INCLUSION SERVICES.** means support services that provide individuals with access to and participation in activities and functions of community life.
- K. COMMUNITY INTEGRATION.** means access to and participation in all aspects of typical community activities and functions of community life that are used by the general population and that are meaningful to the individual. Community integration includes: accessing community resources, and/or spending time in the community without the presence of paid staff, spending time in the community with non-disabled and unpaid individuals, and/or building and maintaining relationships with family members, friends, neighbors, peers and acquaintances.
- L. COMMUNITY LIVING SUPPORTS.** means individualized levels of assistance in a residential setting in order to increase, maintain or promote the individual's capacity for independent functioning, self-determination, self-advocacy, interdependence, productivity and integration in the community.
- M. CONSULTATION.** means various forms of technical assistance or information (e.g., positive behavioral supports, coaching, training or advisement) to the individual, family members, provider agencies, other IDT members or to natural supports and community members.
- N. CRISIS PREVENTION/INTERVENTION PLAN.** means an individualized procedural plan that describes actions to be taken in the event of a medical or behavioral situation that requires immediate intervention by the direct care staff in order to avert a crisis, and criteria for seeking emergency services.
- O. DEPARTMENT.** means the New Mexico Department of Health.
- P. DDS.** means the Developmental Disabilities Supports Division, New Mexico Department of Health.
- Q. DHI.** means the Division of Health Improvement, NM Department of Health.
- R. DIRECT SERVICE PERSONNEL.** means persons directly responsible for the provision of specified services to the individual with developmental disabilities. Direct

service personnel are paid to provide the face-to-face delivery of a service to the individual.

- S. ENHANCED STAFFING HOURS.** means the hours of direct service staff that exceed the hours used to form a reimbursement rate for Supported Living Services or habilitation on the basis of a rate-setting cost analysis.
- T. ENVIRONMENTAL MODIFICATIONS.** means the physical adaptations to the residence which are of direct medical or remedial benefit to the individual to ensure his or her health and safety or which would enable the individual to function with greater independence in the residence.
- U. ENVIRONMENTAL MODIFICATION PROVIDER AGENCY.** means the licensed contracting entity that constructs the environmental modification.
- V. EPSDT.** means Early Periodic Screening Diagnosis and Treatment program under Medicaid that mandates certain services to children under the age of 21 who are Medicaid eligible.
- W. FACE-TO-FACE.** means providing direct services in the physical presence of an individual with developmental disabilities, or in specific instances, the family of a child with developmental disabilities.
- X. FAMILY LIVING SERVICES.** means a twenty-four (24) hour Community Living Support provided to eligible individuals with developmental disabilities in their homes or in the residence of the direct service provider. Family Living Services are provided using a non-shift staffing model in which the individual is supported as part of a family unit. The Family Living Services direct service provider shall not be the spouse of the individual served.
- Y. GENERIC SUPPORTS.** means supports that are not specific to, or specifically designed for people with developmental disabilities.
- Z. HEALTH ASSESSMENT TOOL.** means an instrument used to identify individual health related concerns, which need to be addressed in the individual service planning process.
- AA. HEALTH CARE COORDINATOR.** means the designated individual on the interdisciplinary team who monitors and arranges for health care services for an individual in accordance with these standards.
- AB. HEALTH CARE PLAN.** means a document developed by a licensed nurse that identifies the individual's health care needs, measurable health related goals, and specific activities to be implemented by licensed nurses, direct care staff, caregivers or other members of the interdisciplinary team to address identified health care needs and goals.
- AC. HIGH MEDICAL NECESSITY.** means an acute or chronic health status, including brain disorders that result in a dependency on medical care for which daily skilled (nursing) intervention is medically necessary.

- AD. IDEA.** means Individuals with Disabilities Education Act and relates to federal requirements for special education services through public schools.
- AE. INDIVIDUAL.** means a person who is eligible for or being served by the Developmental Disabilities Waiver Program.
- AF. INDEPENDENT LIVING SERVICES.** means Community Living Support for residential services on a less than twenty-four (24) hour basis designed to support the attainment, improvement and retention of skills necessary to achieve personal desired outcomes that enhance the individual's ability to live in his or her community as specified in the individual service plan.
- AG. IDT MEMBERS.** means the interdisciplinary team as defined in 7.26.5 NMAC.
- AH. ISP.** means an individualized service plan, as defined in 7.26.5 NMAC.
- AI. IMMEDIATE FAMILY MEMBER.** means father (includes natural or adoptive or foster father, father-in-law, stepparent), mother (includes natural or adoptive or foster mother, mother-in-law, stepparent), brother (includes half-brother, step-brother), sister (includes half-sister, step-sister), son or daughter, step-son or step-daughter, adoptive or foster son or daughter, natural grandfather, and natural grandmother and spouse relationship to the individual.
- AJ. INTEGRATED WORK SETTING.** means settings in which non-disabled individuals are co-workers, or an individual has consistent and regular opportunities for interacting with non-disabled individuals.
- AK. INTERN.** means an individual holder of an advanced degree or candidate for an advanced degree, participating in a practicum program approved by and under supervision of a university program.
- AL. LIFE THREATENING MEDICAL CONDITIONS.** means conditions that have associated potential to cause cardiopulmonary arrest or respiratory arrest leading to cardiac arrest.
- AM. LOC.** means level of care determined by score on the level of care abstract that is based upon supporting functional and psychosocial assessments. The level of care is one criterion used to determine the amount of funds available to an individual through his or her ARA. The level of care abstract is also part of the Level of Care packet used to verify the individual's medical eligibility for Developmental Disabilities Waiver services.
- AN. MAD.** means the Medical Assistance Division, New Mexico Human Services Department.
- AO. MEANINGFUL DAY.** means individualized access for individuals with developmental disabilities to support their participation in activities and functions of community life that are desired and chosen by the general population. The term "day" does not exclusively denote activities that happen between 9:00 a.m. to 5:00 p.m. on weekdays. This includes: purposeful and meaningful work; substantial and sustained opportunity for optimal health, self empowerment and personalized relationships; skill development and/or maintenance; and social, educational and community inclusion activities that are directly

linked to the vision, goals and desired personal outcomes documented in the individual's Individual Service Plan. Successful Meaningful Day supports are measured by whether or not the individual achieves his/her desired outcomes as identified in the individual's Individual Service Plan, as documented in daily schedules and progress notes. Each Meaningful Day activity should help move the individual closer to a specified outcome identified in his/her ISP.

- AP. MEDICAL ADVERSE EVENTS.** means omission of medical care or implementation of medical treatment outside of physician orders or treatment plan, which lead to an exacerbation of clinical condition or injury.
- AQ. NATURAL FAMILY MEMBER.** means an individual related by blood or adoption to include: mother, father, brother, sister, aunt, uncle, grandmother, grandfather, son, or daughter.
- AR. NATURAL SUPPORTS.** means supports, not funded under the Developmental Disabilities Medicaid Waiver or other publicly funded developmental disabilities program that assist the individual and facilitate his or her integration into the community. Natural supports may be planned, facilitated, or coordinated in partnership with a Developmental Disabilities Waiver Provider Agency.
- AS. NON-MEDICAL HEALTH CARE.** means assistance with minor health needs such as first aid for minor cuts and scrapes, using menstrual supplies, or hygiene to promote health (e.g., nail cutting, denture cleaning).
- AT. NURSE.** means a registered nurse (RN) or licensed practical nurse (LPN) that is currently licensed by the New Mexico Board of Nursing.
- AU. OUTLIER SERVICES.** means services provided to individuals with severe physical, behavioral, or medical diagnoses requiring services of a frequency, duration, and intensity that exceed those described in other Developmental Disabilities Waiver Services.
- AV. PARENT.** means the natural or adoptive mother or father, or stepmother, stepfather.
- AW. PARTICIPATORY APPROACH.** means a method of service delivery based on therapeutic and assistive technological support to effectuate physical interaction or communication within the individual's environment. The participatory approach asserts that no one is too severely disabled to benefit from assistive technological and other supports that promote participation in life activities.
- AX. PERSONAL HOME.** means the primary residence of the individual that is owned, leased or rented (in whole or in part) by the individual.
- AY. PERSONAL SUPPORT SERVICES.** means assistance with activities of daily living while providing companionship to acquire, maintain or improve social interaction skills.
- AZ. POSITIVE BEHAVIORAL SUPPORTS ASSESSMENT.** means the process and result of conducting positive behavioral evaluation procedures, including observation of an individual, interview of an individual and others who support the individual, and

includes a functional assessment of behaviors and all other evaluative procedures as outlined in the DDS/Office of Behavioral Services (OBS) Practice Guidelines.

- BA. POSITIVE BEHAVIOR SUPPORTS PLAN.** means a supportive intervention plan tailored to the identified behavioral needs of the individual and developed from the positive behavioral supports assessment. The plan represents a holistic approach to providing positive behavior supports interventions and is consistent with existing policies and the DDS/OBS Practice Guidelines.
- BB. PRELIMINARY RISK SCREENING.** means a consultative interview of an individual who has a recent incident of engaging in sexually inappropriate and/or offending behavior. The screening is used to identify and assess risk factors for re-offending behaviors, to determine whether further assessment is warranted and to identify educational and risk management strategies.
- BC. PRIMARY CAREGIVER.** means the parent or surrogate parent of a child or the person providing day-to-day care of an adult with developmental disabilities.
- BD. PROVIDER AGENCY.** means a private entity that has entered into a contract or Provider Agency agreement with the DOH or that is certified by the DOH for the purpose of providing supports and services to individuals with developmental disabilities. The Provider Agency may be a corporation, or sole proprietor or other legal business entity.
- BE. PROGRESS REPORT.** means the written summary of a specific service provided that documents an individual's status, identifies factors that impact the individual's progress, and provides recommendations for future Interdisciplinary Team planning considerations.
- BF. QUARTERLY.** means every three months beginning with the effective date of the annual ISP unless otherwise specified.
- BG. RESIDENCE.** means a single home or any contiguous dwelling with separate entrances, or in a dwelling within the line of vision (allowing for an adjacent mobile home or cottage within close proximity) in which one or more served individuals live continuously and for whom there are designated, paid staff or other direct support Provider Agencies in that setting.
- BH. RESPITE.** means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.
- BI. SELF-ADVOCACY.** means that individually or in groups, people with disabilities speak or act on behalf of themselves, others or on behalf of issues that affect people with disabilities.
- BJ. SUBSTITUTE CARE.** means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider.
- BK. SUPPORT.** means the assistance to an individual that may or may not include a paid service.

- BL. SUPPORT CONSULTANT.** means a licensed professional approved by DDSD/OBS to provide Behavioral Support Consultation services.
- BM. SUPPORTED LIVING SERVICES.** means a Community Living Support service provided in a single residence setting to four (4) or fewer individuals.
- BN. SUPPORT SERVICES.** means activities and assistance (clinical, physical and social) provided to the individual that lead to achievement of his or her vision, and that address individual needs to activities of daily living and safety.
- BO. STAFF TO INDIVIDUAL RATIO.** means the number of individuals an employed staff member or subcontractor is responsible for in terms of caseload, stated as a full-time equivalent in relation to number of individuals.
- BP. TIMELY IMPLEMENTATION OF HEALTHCARE ORDERS.** means immediately for emergency medications or orders, eight (8) hours for initiation of urgent care medication and orders, initiation of prescription pain medication or first antibiotic dose, and twenty-four (24) hours for initiation of routine medications and orders.
- BQ. TIMELY MEDICAL ASSESSMENT.** means the amount of time taken to perform assessment so that a good healthcare outcome is achieved for an individual. Emergency situations require that an individual be assessed immediately either by calling 911 or by transport to an emergency room. Urgent situations require that a nurse, physician, or other appropriate healthcare practitioner assess an individual within eight (8) hours. Routine situations require that a nurse, physician or other appropriate healthcare practitioner see the individual as soon as an appointment can be scheduled.
- BR. UR (ALSO LISTED AS NMMUR).** means the utilization review agent of the Human Services Department who may perform such functions as authorizing budgets and Levels of Care; a contract entity with the authority to determine medical necessity and approve Individualized Service Plans (ISPs).
- BS. VOLUNTEER.** means an unpaid individual who carries out service or support activities under the direction of a DD Waiver provider agency.

CHAPTER 1 INTRODUCTION

These standards apply to all services provided through the Medicaid Home and Community Based Services Waiver programs for individuals with developmental disabilities. These standards interpret, and further enforce the New Mexico Human Services Department (HSD), Medicaid Policy Manual for Developmental Disabilities Home and Community Based Services Waiver (8.314.5) and the Centers for Medicare and Medicaid Services (CMS) requirements for Home and Community Based Services Waivers. Under no circumstances may a parent (or guardian) receive payment for services delivered to their minor child under age eighteen (18). Also, under no circumstances may any individual receive payment for services delivered to their spouse.

These standards are effective April 1, 2007, and address each service covered by the Developmental Disabilities (DD) Waiver as renewed in 2006, as well as personnel requirements for people employed by or subcontracting with agencies providing services, known herein as the Provider Agency. The Developmental Disabilities Support Division (DDSD) of the Department of Health (DOH) has established these standards to guide service delivery and promote the health and safety of individuals served by DD Medicaid Waiver Provider Agencies. All Provider Agencies that enter into a contractual relationship with DOH to provide Developmental Disabilities Waiver Services shall comply with all applicable standards herein set forth.

These standards acknowledge that many individuals and the families of children served on the DD Waiver programs have the ability to direct his or her own services and supports. However, planning is required to occur through an Interdisciplinary Team (IDT) process, in accordance with the Service Plans for Individuals with Developmental Disabilities Living in the Community (7.26.5 NMAC). Within the IDT process, these standards promote self-determination through flexibility regarding types and amounts of service provided. In addition, new service options to promote community integration for adults with developmental disabilities and services designed specifically for children and their families are available to address each individual's unique Individual Service Plan (ISP) requirements.

I. PROVIDER AGENCY ENROLLMENT PROCESS.

- A. Applications.** All Provider Agency applications, for initial renewal to provide services, shall be made using a Developmental Disabilities Medicaid Waiver Provider enrollment application packet issued by the DOH. The DOH and the Medical Assistance Division of the Human Services Department provide all of the forms. The application shall be dated and signed by an individual authorized to represent the Provider Agency. Provider Agencies requesting to amend their existing provider agreement must submit an amendment form issued by DOH with required supporting documentation.
- B. Issuance.** The DOH will not issue an agreement unless and until the applicant has supplied all information requested by the DOH.
- C. Types of Provider Agency Agreements.** The DOH may authorize any one of the following agreements:
 - (1) A Provider Agency agreement issued for a single fiscal year period that has met all requirements for the provision of a specific service or services;

- (2) Extended agreement to extend the term of an expiring agreement for a term not to exceed one-hundred-twenty (120) days, at DOH discretion; no more than two consecutive extended agreements may be issued;
- (3) Multi-year agreement issued for up to three years to a Provider Agency that has met all requirements for the provision of services and is in excellent standing with the DOH; and
- (4) An amended Provider Agency agreement when there is an addition or deletion of any service or service region.

D. Scope of DDSA Agreement.

- (1) The agreement is issued only for the individual(s) or entity named in the application and may not be transferred or assigned;
- (2) The agreement is required to state any applicable restrictions, including but not limited to designated services to be provided, geographical regions, and any other limitations that the DOH considers appropriate and necessary; and
- (3) A Provider Agency shall fully comply with all requirements and restrictions of the agreement;
- (4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite;

E. Provider Agency Renewal Application. A Provider Agency shall submit a renewal application or proposal on forms provided by the DOH at least forty-five (45) calendar days prior to expiration of the current approval or as requested by the DOH.

F. Provider Agency Report of Changes in Operations.

- (1) The Provider Agency shall notify the DOH in writing of any changes in the disclosures required in this section within ten (10) calendar days. This notice shall include information and documentation regarding such changes as the following: any change in the mailing address of the Provider Agency; and any change in executive director, administrator, name, and classification of any services provided.

G. Automatic Expiration of Provider Agency Agreement. The agreement contract automatically expires at midnight on the day indicated on the approval as the expiration date, unless sooner renewed, extended, suspended or revoked, or:

- (1) On the day a Provider Agency discontinues operation;

- (2) On the day a Provider Agency is sold, leased, or otherwise changes ownership;
- (3) On the day a Provider Agency changes to a location outside the DOH's region in which the Provider Agency is approved to provide services.
- (4) On the day specified in the notice given by provider agency or HSD as required by the Medicaid Provider Agreement (MAD 335).

H. Program Flexibility. If the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects conflicts with requirements, then prior written approval from the DOH shall be obtained. Such approval shall provide for the terms and conditions under which the exception is granted. The applicant or Provider Agency is required to submit a written request and attach substantiating evidence supporting the request to the DOH.

I. Continuous Quality Management System. Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The Continuous Quality Improvement Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the Continuous Quality Improvement Plan shall address how the agency will collect, analyze, act on data and evaluate results related to:

- (1) Individual access to needed services and supports;
- (2) Effectiveness and timeliness of implementation of Individualized Service Plans;
- (3) Trends in achievement of individual outcomes in the Individual Service Plans;
- (4) Trends in medication and medical incidents leading to adverse health events;
- (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;
- (6) Quality and completeness documentation; and
- (7) Trends in individual and guardian satisfaction.

II. PROVIDER AGENCY REQUIREMENTS. The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff,

whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.

A. General Requirements.

- (1) All Provider Agencies are required to have a current business license issued by state, county or city government and shall comply with all applicable federal, state, and Waiver standards, policies and procedures regarding support services.
- (2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDS policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.
- (3) Appropriate planning should take place with all included IDT members to facilitate a smooth transition of persons with developmental disabilities to alternate environments or services. Individual choices should be given every consideration possible. Department of Health policies must be adhered to during this process as per the provider's contract.

B. Provider Agency Policy and Procedure Requirements. All Provider Agencies, in addition to requirements under each specific service standard shall at a minimum develop, implement and maintain, at the designated Provider Agency main office, documentation of policies and procedures for the following:

- (1) Coordination of Provider Agency staff serving individuals within the program which delineates the specific roles of agency staff, including expectations for coordination with interdisciplinary team members who do not work for the provider agency;
- (2) Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated; and
- (3) Agency protocols for disaster planning and emergency preparedness.

C. Provider Agency Financial Records and Accounting. Each individual served will be presumed able to manage his or her own funds unless the ISP documents justified limitations or supports for self-management, and where appropriate, reflects a plan to increase this skill. All Provider Agencies shall maintain and enforce written policies and procedures regarding the use of the individual's SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual.

D. Provider Agency Case File for the Individual. All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be

provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:

- (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;
- (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);
- (3) Progress notes and other service delivery documentation;
- (4) Crisis Prevention/Intervention Plans, if there are any for the individual;
- (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;
- (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and
- (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.
- (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:
 - (a) Complete file for the past 12 months;
 - (b) ISP and quarterly reports from the current and prior ISP year;
 - (c) Intake information from original admission to services; and
 - (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.

E. Medication Delivery. Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDS Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.

- (1) All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals shall be licensed by the Board of Pharmacy, per current regulations.
- (2) When required by the DDS Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:
 - (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;
 - (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;
 - (c) Initials of the individual administering or assisting with the medication;
 - (d) Explanation of any medication irregularity;
 - (e) Documentation of any allergic reaction or adverse medication effect; and
 - (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.
- (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;
- (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;
- (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;

F. Nurse Delegation. The provider agency must develop and implement policies and procedures that actively support nurses' professional responsibilities regarding delegation as defined in the New Mexico Board of Nursing Rules, including but not limited to initial and ongoing assessment of each direct care staff's skill level, providing initial and ongoing training and performing ongoing monitoring of the direct care staff implementing delegated tasks. Delegation must be documented and may be rescinded at any time the nurse determines that the direct care staff is unable to safely perform the delegated task.

G. Transportation. Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, with comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDS guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following topics:

- (1) Drivers' requirements,
- (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions,
- (3) Vehicle maintenance and safety inspections,
- (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures,
- (5) Emergency Plans, including vehicle evacuation techniques,
- (6) Documentation, and
- (7) Accident Procedures.

III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION.

A. General. All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.

B. Billable Units. The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:

- (1) Date, start and end time of each service encounter or other billable service interval;
- (2) A description of what occurred during the encounter or service interval; and
- (3) The signature or authenticated name of staff providing the service.

C. Individual Progress Reports. The Provider Agency shall prepare progress reports for each individual receiving a service at intervals specified for the

specific service as delineated in these standards and in the individual's ISP. All such reports shall include the name of the individual served and the date of the report on each page of the document and the author shall sign all reports.

D. Records Retention. All records pertaining to services provided to an individual shall be maintained for at least six (6) years from the date of creation, until ongoing audits are settled, or until involvement of the state attorney general is completed in regard to settlement of any claim, whichever is longer.

E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.

(1) Documentation of nursing assessment activities:

(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:

- (i) Community living services provider agency;
- (ii) Private duty nursing provider agency;
- (iii) Adult habilitation provider agency;
- (iv) Community access provider agency; and
- (v) Supported employment provider agency.

(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.

(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first.

(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change

requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDS Medication Assessment and Delivery Policy).

- (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as *subjective* information including the individual complaints, signs and symptoms noted by staff, family members or other team members; *objective* information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.
- (2) Health related plans:
- (a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.
 - (b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.
 - (c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.
 - (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.
- (3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):
- (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.

- (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.
 - (c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.
 - (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.
 - (e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.
 - (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.
 - (g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.
 - (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.
- (4) General Nursing Documentation:
- (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.
 - (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.

F. Sanitation. When services are provided in a setting under the management of the Provider Agency that delivers Community Living or Community Inclusion services, the environment shall be maintained in a functional, sanitary, and safe condition. Any Provider Agency that prepares and serves food to individuals or allows individuals to prepare and eat meals while in the Provider Agency setting shall meet the following requirements:

- (1) Equipment and utensils shall be kept clean and in good repair; and
- (2) Food shall be stored, prepared, distributed and served under sanitary conditions that prevent spoilage or contamination.

G. Quarterly Reports of Service Location. All Provider Agencies shall include in their quarterly report to the DDS Regional Office, documentation that fully discloses the physical location of individuals who are currently receiving services operated by or under the primary supervision of the Provider Agency. The Provider Agency shall include the following:

- (1) The physical address of each service location; and
- (2) The Provider Agency contact for each location.

IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL. The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.

A. Communicable Diseases. Provider agencies shall develop and implement written policies for control of communicable diseases that ensure that employees and volunteers with symptoms or signs of communicable disease or infected skin lesions shall not be permitted to work unless authorized in writing to do so by a physician or other qualified health professional.

B. Volunteers. Provider agencies shall not use volunteers prior to ensuring that a system exists for the effective orientation, training, and supervision necessary to protect the health and safety of individuals served. Natural supports listed as such in an individual's ISP are not considered volunteers for the purposes of this standard.

C. Orientation and Training Requirements. Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:

- (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and
- (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.

D. Criminal History Screening. All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.9 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

E. DOH and Provider Agency Conflict of Interest. In order to avoid conflict of interest, a Provider Agency shall not employ or subcontract with any DOH or MAD employee who works in any program or bureau having oversight responsibility for services covered by these Standards. The DOH or Human Services Department will make a determination of conflict of interest.

F. Qualifications for Direct Service Personnel. The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:

- (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times;
- (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;
- (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual;
- (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and
- (5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.

- (6) Report required personnel training status to the DDS Statewide Training Database as specified in DDS policies as related to training requirements as follows:
 - (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDS Statewide Training Database within the first ninety (90) calendar days of providing services;
 - (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and
 - (c) Quarterly personnel update reports sent to DDS Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.

G. Supervision Requirements.

- (1) Employees who supervise direct service personnel shall meet the following requirements:
 - (a) Be twenty-one (21) years of age or older and shall possess a high school diploma or G.E.D;
 - (b) Have a minimum of one-year experience working with individuals with developmental disabilities or related field; OR a degree in a related field may substitute for experience;
 - (c) Meet the qualifications specified in the DDS Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators;
 - (d) Provide, at a minimum of once every thirty (30) calendar days, a supervisory residence visit and a face-to-face interview with the individual served which documents the safety of the service and the quality of care provided in the individual case record; and
 - (e) Arrange regular staff meetings and training programs.
- (2) Any agency providing Personal Care that is licensed as a Home Health Care Agency pursuant to the New Mexico Department of Health, Health Facility Licensing and Certification Bureau (7.28.2 NMAC) is exempt from these personnel standards.

V. DEPARTMENT OF HEALTH INSPECTIONS AND SANCTIONS FOR NON-COMPLIANCE.

- A. Quality Assurance Reviews.** All Provider Agencies shall permit the DOH to review the quality of care and services in accordance with Quality Management System and Review Requirements for Provider Agencies of Community-Based Services (7.14.2 NMAC).

B. On-Site Inspections. All Provider Agencies shall submit to and cooperate with announced and unannounced inspection or survey and complaint investigations conducted by the DOH in order to receive or maintain a DDS Waiver agreement and/or a contract with the DOH. The Provider Agency shall give the DOH immediate or reasonable access to all records required by these standards. The Provider Agency shall permit the DOH to have private interviews with individuals and staff.

- (1) Frequency and Type of Inspections: An inspection or survey may occur at the discretion of the DOH and may be triggered by an event including but not limited to any one of the following:
 - (a) Prior to the issuance of an agreement and/or contract;
 - (b) Prior to the annual renewal of an agreement and/or contract;
 - (c) Upon complaint or allegation of violation of these standards;
 - (d) When there has been a change in ownership of the Provider Agency;
 - (e) When necessary to determine correction of cited deficiencies, compliance with a directed Plan of Correction or a Provider Agency generated Plan of Correction, or satisfaction of conditions placed on agreement and/or contract;
 - (f) Through routine monitoring of the Provider Agency's quarterly reports assessing the effectiveness of service delivery based on the selected performance indicators established from the requirements within these standards; and
 - (g) Anytime the DOH has probable cause to believe a Provider Agency has violated a regulation or provision of these standards.
- (2) Retaliation Prohibition: The DOH will accept complaints from any party regarding suspected violation of these standards. The Provider Agency shall not retaliate against any staff, individual or his or her representative for filing a complaint or allegation. All complainants have immunity from civil or criminal liability when the complaint is made in good faith. Any violations noted during a complaint investigation will be reported to the Provider Agency in writing.
- (3) Enforcement Procedures:
 - (a) After inspection, a report of findings will be sent to the Provider Agency if the inspection or survey identifies any failure to comply with these standards. A report of findings may be accompanied by a directed Plan of Correction.
 - (b) The Provider Agency shall complete a Plan of Correction to correct each deficiency, sign and date the plan certifying that the plan will be

implemented, and return the plan to the DOH within ten (10) working days of receipt of any statement of deficiency. The plan will include detailed action steps and timelines for improvement. DDSO will verify implementation of the plan within the stated timelines.

C. Sanctions. Failure to correct any deficiency(s) or to file a Plan of Correction with the DOH may lead to the immediate imposition of sanctions or penalties as described in paragraph (2) below:

- (1) The DOH will make the final determination regarding whether a Plan of Correction is acceptable and when it has been adequately implemented.
- (2) Grounds for Sanctions: The DOH is authorized to immediately impose one or more sanctions when any one of the circumstances listed below are present:
 - (a) Operating without appropriate licensure;
 - (b) Impeding or interfering with the enforcement of standards governing the agreement and/or contract of a Provider Agency, or giving false information in connection with the enforcement of these standards;
 - (c) Failure to cooperate with DOH surveyors or inspectors;
 - (d) Failure to submit a Plan of Correction within ten (10) working days after receipt of a report of findings;
 - (e) Failure to take timely corrective action in accordance with a Plan of Correction or a directed plan of correction;
 - (f) Failure to comply with applicable laws or standards; and
 - (g) Failure to comply with DDSO performance expectations based on the requirements established within these standards.
- (3) Interventions and Sanctions: The DOH is authorized to immediately impose one or more of the following sanctions when any one of the circumstances listed above are present and the DOH determines that a sanction is necessary and appropriate to ensure compliance with these standards and to protect the individuals receiving services:
 - (a) The Provider Agency may be directed to immediately stop all new admissions regardless of payment source or to admit only those individuals the DOH approves of until such time as it determines that corrective action has been taken;
 - (b) The DOH may issue a directed Plan of Correction; and
 - (c) The DOH may impose a financial penalty upon a Provider Agency.
- (4) Financial Penalties: Financial penalties may be imposed when:

- (a) There is any failure to comply with a state regulation or Provider Agency agreement or contract requirement where that failure poses an immediate threat of death to an individual;
 - (b) There is any failure to comply with applicable regulation where that failure to comply poses a substantial probability of serious mental or physical harm to an individual or individuals;
 - (c) The occurrence of a repeated deficiency that poses a substantial risk to the health or safety to individual or individuals; and
 - (d) The occurrence of a repeated deficiency that infringes on an individual's rights.
- (5) Assessment of Penalties: If the DOH assesses financial penalties, an assessment of penalties will be issued. The assessment shall describe each violation committed by the Provider Agency, the regulation, contract or agreement that has been violated, and the duration of the violation. If the Provider Agency does not contest the imposition or amount of the penalty, the Provider Agency shall pay within thirty (30) calendar days of receipt of the assessment of the penalty. If the Provider Agency disagrees with the imposition or amount of the penalty, the Provider Agency shall notify the DOH within ten (10) calendar days of receipt of the assessment of penalties. The DOH will schedule an informal conference to resolve the dispute, and a written decision based on this conference will be provided. If the Provider Agency is still dissatisfied with the written decision, a DOH administrative hearing may be requested.
- (6) Other sanctions for failure to comply may include:
- (a) DOH may refuse to issue or renew agreement and/or contract to operate;
 - (b) DOH may termination of the Provider Agency's DD Waiver Agreement and /or contract;
 - (c) When upon investigation, conditions are found which, in the opinion of the DOH, immediately endanger the health or safety of the individuals living in or attending the Provider Agency's services, the DOH may request that court suspend the agreement and/or contract on an emergency basis;
 - (d) Mandated DDS Regional Office Intervention (review of other DDS services, directed technical assistance, required training);
 - (e) Review by DHI;
 - (f) Withholding of payment;

- (g) Reduction in term of the agency's DD Waiver Provider Agreement;
and
 - (h) Referral to the DOH Internal Review Committee for substandard performance.
- (7) The DOH may petition the Court to appoint a receiver to operate a Provider Agency's program in the following situations:
- (a) When the Provider Agency intends to close but has not arranged at least thirty (30) calendar days prior to closure for the orderly transfer of its residents;
 - (b) When an emergency exists that threatens the health, safety, security or welfare of residents; and
 - (c) When the Provider Agency is in substantial or habitual violation of the standards of health, safety or individual care established under state or federal standards to the detriment of the welfare of the individuals.

CHAPTER 2
ANNUAL RESOURCE ALLOTMENTS AND SERVICE CATEGORIES

I. ANNUAL RESOURCE ALLOTMENT SERVICES. The annual resource allotment service provides flexible service access, and expedites the timely provision of age appropriate services. Each individual is placed in a service category with a corresponding funding limit known as the Annual Resource Allotment (ARA). The ARA is based on an individual's age, level of care (LOC) and residential status.

A. Annual Resource Allotment Service Categories include:

- (1) Children's Category for individuals, ages birth – 18;
- (2) Young Adult Category for individuals, ages 18 – 21;
- (3) Young Adult Community Living Supports Category for individuals, ages 18 - 21 receiving any 24-hour residential services;
- (4) Adult Category for individuals, ages 22 and over; and
- (5) Adult Community Living Supports Category for individuals, ages 22 and over receiving any 24-hour residential services.

II. SCOPE OF SERVICES FUNDED BY THE ARA.

A. Annual Resource Allotment Option. Each service shall be provided in accordance with the corresponding DD Waiver standards, and applicable DDSD policies. The total budget for the selected services may not exceed the Annual Resource Allotment. The individual, in conjunction with the IDT members, may choose any or all of the following services in accordance with his or her age and residential status (ARA category):

- (1) Behavioral Support Consultation;
- (2) Community Inclusion Services (Supported Employment, Community Access and Adult Habilitation);
- (3) Personal Plan Facilitation;
- (4) Occupational Therapy (with limitations for children);
- (5) Physical Therapy (with limitations for children);
- (6) Personal Support Services (with limitations);
- (7) Speech Therapy (with limitations for children);
- (8) Goods and Services (up to \$1,000.00 per year);
- (9) Nutritional Counseling;

- (10) Non-Medical Transportation;
- (11) Respite;
- (12) Case Management;
- (13) Private Duty Nursing (with limitations for children);
- (14) Supplemental Dental Care; and

B. Service Options Funded in addition to the ARA.

- (1) Environmental Modifications;
- (2) Community Living Supports (for individuals age 18 or older and only with prior approval from the Medicaid Utilization Review Agent);
- (3) Therapy Exceptions (for individuals age 21 or older);
- (4) Supported Employment Exceptions (for individuals age 18 or older); and
- (5) Tier III crisis (for individuals age 18 or older).

C. Limitations and Restrictions. An exception to the ARA for additional units of therapy services and supported employment services is allowed in accordance with these Standards. Therapy exceptions in excess of 58 hours per year (or 72 hours for the first year) and Supported Employment exceptions require prior approval by DDS. Case Management Assessment (i.e., upon initial allocation to the DD Waiver), Community Living Support Services, Outlier Services, and Environmental Modification are funded outside of the ARA. Community Living Support Services and Outlier Services require pre-approval by the Medicaid Utilization Review (NMMUR) agent. Environmental Modifications and Tier III crisis serviced require prior written approval by DDS.

The ARA may be prorated for the individuals in a non-residential ARA who change to a Community Living Supports (e.g., Supported Living, Independent Living, Family Living) during the ISP year. This adjustment will be based on the percentage of the funding used within the non-residential ARA, up to the date that Community Living Supports begin.

III. CHILDREN'S CATEGORY ARA.

A. General Services from the Children's Category. Services from the children's category are only available to individuals from birth to the age of eighteen (18). At the annual ISP meeting during the year in which the individual turns eighteen, he or she may choose to continue with services from the Children's Category until the next regular ISP date, or he or she may choose to transition to the Young Adult Category.

Individuals may use any amount of a single service, or select a variety of services to occur at different times of the year, e.g., more intensive services during school

breaks. Services from the Children's Category shall be coordinated with and not duplicate other services such as the Medicaid School Based Services Program or the Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) Program and/or the New Mexico State Department of Education public schools or the New Mexico Department of Health Family Infant Toddler Program. Services may be provided in any location appropriate to the service, including a community setting. The Case Manager is required to assist the family in accessing services from other payment sources.

The child's Level of Care (LOC) is used to determine the Annual Resource Allotment (ARA) within the Children's Category. The family, the Case Manager and the other IDT members are responsible for using the ARA to support achievement of the individual's ISP desired outcomes and to support the family to care for the child at home.

The amount of reimbursement for each service is a fixed amount, indicated as a flat fee, fifteen (15) minute, hourly, daily, monthly or per item/event units based on each specific service definition and as specified in the HSD/MAD billing instructions and DD Waiver rate table. The number of units across all services shall be budgeted so as not to exceed the ARA. The child's family may shift the amount or number of units, as well as drop and add units throughout the year, to accommodate changing needs. Revisions to the ISP are approved by the Case Management Provider Agency. If the individual uses all the funding in the ARA prior to the end of the ISP year, funding for services will terminate until the beginning of the next ISP year.

- B. Case Management Services in the Children's Category.** Case Management Services are funded through the ARA and shall be provided a minimum of four (4) times per ISP year. However, the family of an eligible child may choose to have Case Management services up to the 12 unit annual cap. Case Management will be provided in accordance with the corresponding DD Waiver Standards and applicable policies for Case Management. When a family chooses less than 12 units (months) of case management service, the family assumes responsibility for the quality assurance and service utilization tracking functions typically performed by the Case Manager during those months when case management has not been included in the ISP budget. Medically necessary services are covered through the state plan under EPSDT, therefore, Case Management may be the only service listed in the ISP for children if that is the only waiver service desired.
- C. Service Options funded with the ARA.** The individual, in conjunction with the IDT, may choose any or all of the following service options, however the total budget for the selected services may not exceed the Annual Resource Allotment. Each service must be provided in accordance with the corresponding DD Waiver regulations, standards, and applicable DDSD policies:
- (1) Behavior Support Consultation;
 - (2) Community Access;
 - (3) Occupational Therapy (limited and when not covered by EPSDT or IDEA);

- (4) Physical Therapy (limited and when not covered by EPSDT or IDEA);
- (5) Personal Support Services (limited and when not covered by EPSDT);
- (6) Respite;
- (7) Speech Therapy (limited and when not covered by EPSDT or IDEA);
- (8) Non-Medical Transportation;
- (9) Case Management;
- (11) Goods and Services;
- (12) Personal Plan Facilitator;
- (13) Supplemental Dental Care; and
- (14) Nutritional Counseling.

The only service available outside of the ARA for children under age 18 is the Environmental Modification Service.

IV. YOUNG ADULT CATEGORY SERVICES AND ARA.

- A. Young Adult Services.** Services from the Young Adult Category are available to individuals, ages 18 to 22, who do not receive DD Waiver Community Living Supports. An individual may utilize any amount of a single service, or select a variety of services to occur at different times of the year, e.g., be of greater intensity during school breaks. Services from the Young Adult Category shall be coordinated with other services such as Medicaid School Based Services Program or the Medicaid EPSDT Program, and/or the New Mexico State Department of Education Public School Program and or New Mexico State Department of Education Division of Vocational Rehabilitation services. Services, except where restricted under a specific service standard, may be provided in any location, including a community setting, the individual's residence or the residence of others involved with the individual.

The Annual Resource Allotment (ARA) for any combination of services from the Young Adult Category is determined by the individual's level of care (LOC). This ARA may be budgeted to provide one or more services, in addition to Case Management. The ARA funds one ISP year (twelve months) of service. This does not mean that the allotment shall be budgeted in amounts equal to one-twelfth of the ARA. An annualized plan, with variable amounts of services, is required to be developed and budgeted according to the individual's needs, e.g., more intensive services during school breaks. The individual, family/guardian, the Case Manager and the other IDT members are responsible for using the ARA to support the achievement of ISP desired outcomes and to support the family to care for the child.

The amount of reimbursement for each service is a fixed amount, indicated as a flat fee, fifteen (15) minute, hourly, daily, monthly or per item/event units based on each specific service definition and as specified in HSD/MAD billing instructions and DD Waiver rate tables. The number of units across all services shall be budgeted so as not to exceed the ARA. An individual may shift the amount or number of units, as well as drop and add units throughout the year, to accommodate changing needs. Revisions to the ISP may be approved by the Case Management Provider Agency. If the individual uses all the funding in the ARA prior to the end of the ISP year, funding for services will terminate until the beginning of the next ISP year.

B. Services in the Young Adult Category. At the annual ISP meeting, during the same year in which an individual turns twenty one (21), he or she may choose to continue with services from the Young Adult Category until the next regular ISP date, or the individual may choose to transition to the Adult Category.

- (1) Case Management is funded with the ARA. Twelve (12) monthly units per year of Case Management are required for individuals utilizing the Young Adult Category. Case Management will be provided in accordance with DD Waiver Standards and applicable DDS policies for Case Management.
- (2) Young Adult Service Options Funded with the ARA: Each service shall be provided in accordance with the corresponding DD Waiver Standards, and applicable DDS policies. The total budget for the selected services may not exceed the Annual Resource Allotment. The individual, in conjunction with the IDT members, may choose any or all of the following service options:
 - (a) Community Inclusion Services (Supported Employment, Community Access, Adult Habilitation);
 - (b) Behavioral Support Consultation;
 - (c) Occupational Therapy (with limits for individuals under age 21);
 - (d) Physical Therapy (with limits for individuals under age 21);
 - (e) Personal Support Services (with limits for individuals under age 21);
 - (f) Respite;
 - (g) Speech Therapy (with limits for individuals under age 21);
 - (h) Nutritional Counseling;
 - (i) Goods and Services;
 - (j) Personal Plan Facilitation;
 - (k) Case Management;

- (l) Non-Medical Transportation;
 - (m) Supplemental Dental Care; and
 - (n) Private Duty Nursing (with limits for individuals under age 21).
- (3) Services Funded in Addition to the ARA:
- (a) Environmental Modifications;
 - (b) Outlier Services (Adult Habilitation Only);
 - (c) Therapy Exceptions (only if over age 21);
 - (d) Supported Employment Exceptions; and
 - (e) Tier III Crisis.

V. YOUNG ADULT COMMUNITY LIVING SUPPORTS CATEGORY ARA.

- A. General Services from the Young Adult Community Living Supports Category.** Services from the Young Adult Community Living Supports category are available to individuals, ages 18 to 22, who are receiving DD Waiver Community Living Services. At the annual ISP meeting during the year in which an individual turns twenty-one, he or she may choose to continue with services from this category until the next regular ISP date or the individual may choose to transition to the Adult Community Living Supports Category. Services from the Young Adult Community Living Supports Category Services shall be coordinated with other services such as the Medicaid School Based Services Program, and/or the Medicaid EPSDT Program, or the New Mexico State Department of Education Public School Program or New Mexico State Department of Education Division of Vocational Rehabilitation services. The Case Manager is responsible for assisting families in accessing these payment sources for services. Service, except where restricted under a specific service standard, may be provided in any location, including a community setting, the individual's home or the residence of others involved with the individual. A Young Adult may access the Adult ARA if he or she is in a Community Living Services and not enrolled in the public school system.

The Annual Resource Allotment (ARA) for any combination of services from the Young Adult Community Living Supports Category is determined by individual's level of care (LOC). This ARA may be budgeted to provide one or more services, in addition to Case Management. The ARA funds one ISP year (twelve months) of service. This does not mean that the allotment shall be budgeted in amounts equal to one-twelfth of the ARA. An annualized plan, with variable amounts of services, shall be developed and budgeted according to the individual's needs, e.g., more extensive services during school breaks. The

individual, the Case Manager and the other IDT members are responsible for using the ARA to support achievement of ISP goals.

The amount of reimbursement for each service is a fixed amount, indicated as a flat fee, fifteen (15) minute, hourly, daily, monthly or per item/event units based on each specific service definition and as specified in HSD/MAD billing instructions and DD Waiver rate tables. The number of units across all services shall be budgeted so as not to exceed the ARA. Revisions to the ISP for use of the Annual Resource Allotment are approved by the Case Management Provider Agency. If the individual uses all the funding in the ARA prior to the end of the ISP year, funding for services will terminate until the beginning of the next ISP year.

B. Services in the Young Adult Community Living Supports Category.

- (1) Case Management. Case Management is funded with the ARA. Twelve monthly units of Case Management are required for individuals utilizing the Young Adult Community Living Category. Case Management will be provided in accordance with the corresponding DD Waiver Standards and applicable DDS policies for Case Management.
- (2) Service Options Funded with the ARA. Each service shall be provided in accordance with the corresponding DD Waiver standards and applicable DDS policies. The total budget for the selected services may not exceed the Annual Resource Allotment. The individual, in conjunction with the IDT members, may choose any or all of the following service options:
 - (a) Community Inclusion (Supported Employment, Community Access, Adult Habilitation);
 - (b) Personal Plan Facilitation;
 - (c) Behavioral Support Consultation;
 - (d) Non-Medical Transportation;
 - (e) Occupational Therapy (with limits for individuals under age 21);
 - (f) Physical Therapy (with limits for individuals under age 21);
 - (g) Speech Therapy (with limits for individuals under age 21);
 - (h) Goods and Services;
 - (i) Supplemental Dental Care;
 - (j) Case Management; and
 - (k) Respite (for Family Living only).

- (3) Service Options in Addition to the ARA Based on Clinical Necessity:
 - (a) Environmental Modifications;
 - (b) Community Living Services;
 - (c) Outlier Services;
 - (d) Therapy Exceptions (only if over age 21);
 - (e) Supported Employment Exceptions; and
 - (f) Tier III Crisis.

VI. ADULT CATEGORY ARA.

- A. General Services from the Adult Category.** Services from the Adult Category are available to individuals age 22 or older who do not receive DD Waiver Community Living Services. Services from the Adult Category Services are required to be coordinated with other services such as the New Mexico Human Services Department Medicaid SALUD!, or Medicaid fee for service, or New Mexico State Department of Education, Division of Vocational Rehabilitation services. Services, except where restricted under a specific service standard, may be provided in any location, including a community setting, the individual's home or the residence of others involved with the individual.

The ARA may be budgeted to provide one or more services, in addition to Case Management. The ARA funds one ISP year (twelve [12] months) of service. This does not mean that the allotment shall be budgeted in amounts equal to one-twelfth of the ARA. An annualized plan, with variable amounts of services, are required to be developed and budgeted according to the individual's needs. The individual, the Case Manager and the other IDT members are responsible for using the ARA to support the achievement of ISP desired outcomes.

The amount of reimbursement for each service is a fixed amount, indicated as a flat fee, fifteen (15) minute, hourly, daily, monthly or per item/event unit based on each specific service definition and as specified in HSD/MAD billing instructions and DD Waiver rate tables. The number of units across all services shall be budgeted so as not to exceed the ARA. Revisions to the ISP for use of the Annual Resource Allotment are approved by the Case Management Provider Agency. If the individual uses all the funding in the ARA prior to the end of the ISP year, funding for services will terminate until the beginning of the next ISP year.

- B. Services in the Adult Category.**

- (1) Case Management: Case Management is funded with the ARA. Twelve (12) monthly units per year of Case Management are required in accordance with the corresponding DD Waiver Standards and applicable DDS policies for Case Management.

- (2) Service Options Funded with the ARA: Each service shall be provided in accordance with the corresponding DD Waiver Standards and applicable DDS policies. The total budget for the selected services may not exceed the Annual Resource Allotment. In addition to the mandatory 12 units of Case Management, the individual, in conjunction with the IDT members, may choose any or all of the following service options:
 - (a) Community Inclusion (Supported Employment, Community Access Adult Habilitation);
 - (b) Behavioral Support Consultation;
 - (c) Goods and Services;
 - (d) Occupational Therapy;
 - (e) Physical therapy;
 - (f) Personal Plan Facilitation;
 - (g) Personal Support Services;
 - (h) Private Duty Nursing;
 - (i) Speech Therapy;
 - (j) Nutritional Counseling;
 - (k) Respite;
 - (l) Non-Medical Transportation; and
 - (m) Supplemental Dental Care.
- (3) Service Options Funded in Addition to the ARA:
 - (a) Environmental Modifications;
 - (b) Outlier Services (Adult Habilitation only);
 - (c) Therapy Exceptions (only if over age 21);
 - (d) Supported Employment Exceptions; and
 - (e) Tier III Crisis.

VII. ADULT COMMUNITY LIVING SUPPORTS CATEGORY AND ARA.

- A. Services from the Adult Community Living Supports Category.** Services from the Adult Community Living Supports Category are available to individuals

age 22 or older who are receiving DD Waiver Community Living Services. Services from the Adult Community Living Supports Category are required to be coordinated with other services that are the responsibility of the New Mexico Human Services Department and the New Mexico Public Education Department, Division of Vocational Rehabilitation. Services, except where restricted under a specific service standard, may be provided in any location, including a community setting, the individual's residence or the residence of others involved with the individual.

The Annual Resource Allotment (ARA) for any combination of services from the Adult Community Living Supports Category is determined by individual's level of care (LOC). This ARA may be budgeted to provide one or more services, in addition to Case Management. The ARA funds one ISP year (twelve months) of service. This does not mean that the allotment shall be budgeted in amounts equal to one-twelfth of the ARA. An annualized plan, with variable amounts of services, are required to be developed and budgeted according to the individual's needs. The individual, the Case Manager and the other IDT Members are responsible for using the Annual Resource Allotment to support the achievement of ISP goals.

The amount of reimbursement for each service is a fixed amount, indicated as a flat fee, fifteen (15) minute, hourly, daily, monthly or per item/event units based on each specific service definition and as specified in HSD/MAD billing instructions and DD Waiver rate tables. The number of units across all services shall be budgeted so as not to exceed the ARA. An individual may shift the amount or number of units, as well as drop and add units throughout the year, to accommodate changing needs. Revisions to the ISP may be approved by the Case Management Provider Agency. If the individual uses all the funding in the ARA prior to the end of the ISP year, funding for services will terminate until the beginning of the next ISP year.

B. Services in the Adult Community Living Supports Category.

- (1) Case Management: Case Management is funded with the ARA. Twelve (12) monthly units of Case Management are required for individuals utilizing the Adult Community Living Category. Case Management will be provided in accordance with the corresponding DD Waiver Standards and applicable DDSD policies for Case Management.
- (2) Service Options Funded with the ARA. Each service shall be provided in accordance with the corresponding DD Waiver standards, rules and applicable DDSD policies. The total budget for the selected services may not exceed the Annual Resource Allotment. In addition to the mandatory 12 units of Case Management, the individual, in conjunction with the IDT, may choose any or all of the following service options:
 - (a) Community Inclusion (Supported Employment, Community Access, Adult Habilitation);
 - (b) Goods and Services;

- (c) Personal Plan Facilitation;
 - (d) Behavioral Support Consultation;
 - (e) Occupational Therapy;
 - (f) Physical Therapy;
 - (g) Speech Therapy;
 - (h) Respite (for Family Living only);
 - (i) Supplemental Dental Care; and
 - (j) Non-Medical Transportation.
- (3) Service Options Funded in Addition to the ARA:
- (a) Environmental Modifications;
 - (b) Community Living Services;
 - (c) Outlier Services;
 - (d) Therapy Exceptions (only if over age 21);
 - (e) Supported Employment Exceptions; and
 - (f) Tier III Crisis.

CHAPTER 3
BEHAVIORAL SUPPORT CONSULTATION SERVICES

- I. BEHAVIORAL SUPPORT CONSULTATION SERVICES.** Behavioral Support Consultation services promote self-advocacy and are to be delivered in an integrative, collaborative manner in accordance with the IDT to support the individual. Behavioral Support Consultation includes a comprehensive positive behavioral supports assessment of an individual's behaviors, development, implementation and management of the Positive Behavior Supports Plan, behavioral support consultation and training provided to the individual's IDT.

The Support Consultant shall develop strategies to assist the IDT members in providing supports consistent with individuals' action plans as identified in the ISP. Positive Behavior Supports Plan shall:

- (1) Specifically identify and document the interventions in relation to the ISP;
and
- (2) Address daily routines and activities in all relevant settings.

Behavioral Support Consultants providing services under the DD Waiver will practice a consultative training model of service. This requires the involvement of the direct support staff to the maximum extent possible in the implementation of behavioral goals. The Support Consultant will initially be very active in designing, implementing and training the Positive Behavior Supports Plan and collecting data to determine the effectiveness of the plan.

- II. SCOPE OF BEHAVIORAL SUPPORT CONSULTATION SERVICE.** Behavioral Support Consultation shall include, but is not limited to, the following scope of services:

- A.** A comprehensive positive behavior supports assessment including a functional assessment of behavioral issues, leading to a Positive Behavior Supports Plan that enables the IDT members and direct support staff to support the individual in all settings;
- B.** Annual revisions to the Positive Behavior Supports Assessment and Positive Behavior Supports Plan based on DDS Practice Guidelines;
- C.** A Crisis Prevention/Intervention Plan, PRN psychotropic medication plans or Risk Management Plan when applicable;
- D.** Providing recommendations to guide the IDT members in making adaptations to environments to meet the needs of the individual;
- E.** Monthly monitoring of the individual's progress in various setting through direct observation, staff interviews, and data collection. If the individual is in residential services through the DD Waiver, the individual shall be seen at his or her residence at least once per month. The Support Consultant shall document his or her visit in either the residential or day habilitation program log;

- F. Attending and consulting at the annual ISP or any other IDT meetings convened for service planning that have implications for Behavioral Support Consultation either in person or by conference call;
- G. Training IDT members and all relevant personnel, including direct support staff on the implementation of the individual's Positive Behavior Supports Plan, and if applicable, Crisis Prevention/Intervention, PRN Psychotropic, and/or Risk Management Plan(s) and data collection procedures;
- H. Providing families, guardians, IDT members, and direct support staff with materials or other relevant information needed to effectively implement the Positive Behavior Supports Plan;
- I. Consulting as required with IDT members, guardians, family, and direct support personnel; and
- J. Attending a Provider Agency Human Rights Committee meeting either in person or by conference call, for individuals on the Support Consultant's caseload.

III. BEHAVIORAL SUPPORT CONSULTATION SERVICE REQUIREMENTS.

- A. **Behavioral Support Consultation Service Criteria.** Behavioral Support Consultation services are determined by the IDT and are to be recorded on the ISP. The IDT determines the need for Behavioral Support Consultation services when current supports prove to be ineffective, based on any one the following criteria:
 - (1) The individual's activities of daily living are significantly interrupted by challenging behavior;
 - (2) The individual is at risk of exclusion from typical community settings, services, and supports;
 - (3) The current supports for the individual inadequately address the health and safety of the individual, support staff, community members, companions or friends;
 - (4) The current supports for the individual inadequately address a significant risk of loss to property; and
 - (5) The individual's current living arrangements and supports are in jeopardy of being reduced or discontinued.
- B. **ISP Criteria for Behavioral Support Consultation.** Behavioral Support Consultation services shall be recorded in the ISP. The ISP criteria for Behavioral Support Consultation services shall include, but is not limited to, the following service criteria:
 - (1) Provide strategies and skill training necessary for effective support for the individual to achieve a meaningful and stable life within the community in which he or she lives;

- (2) Guide the IDT members in assessing the individual in improving or maintaining adaptive behaviors.
- (3) Guide the IDT members in assessing, predicting, preventing, and intervening in behaviors that are likely to:
 - (a) Interfere with the individual's ability to carry out day-to-day activities;
 - (b) Put the individual at risk for exclusion from typical community settings, services, and supports; and
 - (c) Put the individual at risk of harm to his or her health and safety or the health and safety of others.
- (4) Promote the health and safety of the individual;
- (5) Limit the need for psychotherapeutic medication; and
- (6) Allow for the individual to live and work in the least restrictive environment.

IV. BEHAVIORAL SUPPORT PROVIDER AGENCY REQUIREMENTS.

A. Support Consultant Reporting Requirements. Support Consultant reporting requirements shall include, but are not limited to, the following standards:

- (1) The Support Consultant is responsible for the timely submission of the following information to core members of the individual's IDT and to the DDS Office of Behavioral Services. Each document submitted is required to be clearly labeled and signed by the author.
- (2) Documentation that shall be submitted to the core members of the individual's IDT includes: current Positive Behavior Supports Assessment, Positive Behavior Supports Plan, and Crisis Prevention/Intervention, PRN Psychotropic and Risk Management Plan(s), if appropriate upon completion.
- (3) Documentation that shall be submitted to the individual's case manager includes:
 - (a) Current Positive Behavior Supports Assessment, Positive Behavior Supports Plan, and Crisis Prevention/Intervention, PRN Psychotropic and Risk Management Plan(s), if appropriate upon completion; and
 - (b) Four quarterly progress reports to include the date, time, duration and location of consultation visits and activities, documentation regarding the individual's progress and recommendations to the individual's IDT members. The quarterly reports will be due 30 calendar days following the end of each quarter coinciding with each individual's ISP cycle.

- (4) Documentation that shall be submitted to DDS Office of Behavioral Services includes:
 - (a) Current Positive Behavior Supports Assessment, Positive Behavior Supports Plan, and Crisis Prevention/Intervention, PRN Psychotropic and Risk Management Plan(s), if appropriate upon completion;
 - (b) Four quarterly progress reports to include the date, time, duration and location of consultation visits and activities, documentation regarding the individual's progress and recommendations to the individual's IDT members. The quarterly reports will be due 30 calendar days following the end of each quarter coinciding with each individual's ISP cycle.
 - (c) Individual progress notes, if requested;
 - (d) Human Rights Committee annual approval for any Positive Behavior Supports Plan or Crisis Prevention/Intervention Plan that requires Human Rights Committee review; and
 - (e) Any Crisis Prevention/Intervention and/or PRN Psychotropic Medication Plan(s) that includes any use of physical restraint, law enforcement intervention, and/or PRN psychotropic medication. The current Positive Behavior Supports Assessment and Positive Behavior Supports Plan shall clearly delineate the rationale for the use of physical restraint, law enforcement intervention and/or PRN psychotropic medication and how their use is integrated with Positive Support strategies.
- (5) The Behavioral Support Consultation Provider Agency is required to submit the following information to DDS Office of Behavioral Services:
 - (a) Initial or revised Provider Agency policies related to provision of Behavioral Support Consultation services;
 - (b) Quarterly updates of a list of all DD Waiver participants served;
 - (c) Quarterly updates to the list of names and telephone numbers of Provider Agency Support Consultants, including subcontractors, employees, and interns;
 - (d) Quarterly documentation of all trainings attended by any employee, subcontractor or intern of the agency;
 - (e) Quarterly documentation of the name of the supervisor and all supervision given by Provider Agency to subcontractors or employees; and
 - (f) Quarterly documentation of the name of the supervisor and supervision given by Provider Agency to interns, individuals with temporary licenses or special category subcontractors/employees.

B. Behavioral Support Consultation Planning and Reporting Documentation.

These requirements shall apply to all service options for Behavioral Support Consultation:

- (1) **Positive Behavior Supports Assessments:** Individual written assessments are to be conducted on at least an annual basis, except in cases in which there has been a change in the status of either the individual by the Behavioral Support Consultation Provider Agency or Support Consultant. These exceptions will require a revision of the assessment, which additionally includes a revised functional supports assessment.
- (2) **Positive Behavior Supports Plan:** The Positive Behavior Supports Plan shall be developed at least annually, or revised as needed if there is a change in the status of the individual, Behavioral Support Consultation Provider, or Support Consultant. If DDS/D determines that there is a need to revise the Positive Behavior Supports Plan or assessment, the provider shall make the revisions within thirty (30) calendar days. If health and safety issues have been identified by DDS/D, the plan shall be revised and staff training on the revisions shall occur within ten (10) calendar days.
- (3) **Implementation of the Positive Behavior Supports Plan:** The Support Consultant shall provide IDT members, including direct support staff, with training, materials or other relevant information needed to successfully implement the Positive Behavior Supports Plan. This includes staff training for any ongoing data collection or provider reporting required by the Positive Behavior Supports Plan and all other related plans (Crisis Prevention/Intervention, PRN Psychotropic, or Risk Management Plans).
- (4) **Crisis Prevention/Intervention Plan:** When the individual's needs exceed the techniques and interventions that are enumerated in the Positive Behavior Supports Plan, a Crisis Prevention/Intervention Plan shall be developed. All staff shall be trained on the Crisis Prevention/Intervention Plan within ten (10) calendar days of plan development. The Crisis Prevention/Intervention Plan shall be reviewed and modified at least annually based on changes in the individual's status, or as deemed necessary by the Support Consultant or IDT or at the request of DDS/D/OBS. If a revision to the Crisis Prevention/Intervention Plan is requested by DDS/D/OBS, the plan shall be revised and staff training on the revisions shall occur within ten (10) calendar days.
- (5) **Quarterly Reporting:** Quarterly reports initially shall be prepared and submitted according to the individual's Positive Behavior Supports Plan cycle. Thus, the first quarterly report will cover the time period following the start of the Behavioral Support Consultation services with that particular agency up until the three (3) month period ends following its inception, and shall continue quarterly in this manner until the individual's annual assessment is due. Thereafter quarterly reports shall follow the individual's ISP cycle. Quarterly reports shall include information regarding the Behavioral Support Consultation services provided to the individual during the quarter, consultation regarding the individual's goals, progress toward the goals, any significant behavioral incidents and/or life-

changing circumstances that may have affected the individual, and recommendations to the individual's IDT.

C. Support Consultant Qualifications.

- (1) All Support Consultants shall possess one or more of the following qualifications:
 - (a) New Mexico Licensed Psychiatrist;
 - (b) New Mexico Licensed Psychologist or Psychologist Associate;
 - (c) New Mexico Licensed Independent Social Worker (LISW);
 - (d) New Mexico Licensed Master Social Worker (LMSW);
 - (e) New Mexico Licensed Clinical Counselor (LPCC);
 - (f) New Mexico Licensed Professional Counselor (LPC);
 - (g) New Mexico Licensed Marriage and Family Therapist (LMFT);
 - (h) New Mexico Licensed Practicing Art Therapist (LPAT);
 - (i) New Mexico Licensed Master Degree Psychiatric Nurse (MSN/RNCS);
 - (j) New Mexico Licensed Mental Health Counselor (LMHC); and
 - (k) Other related licenses and qualifications with DDS/OBS prior written approval.
- (2) Support Consultants shall have a minimum of one year of clinical experience or caseload history of working with individuals with developmental disabilities.
- (3) Professional Development: Within the first six (6) months of becoming a Support Consultant, all new Support Consultants will take the first day of the "2 Day Person-Centered Planning in New Mexico" course and the "Positive Behavior Support Strategies" course offered by DDS. Additionally, during this same time period all new Support Consultants will take "Beyond the ABC's: An Introduction to Positive Behavioral Supports" course offered by DDS/OBS. Also, within the first year, new Support Consultants will take "Introduction to Sexuality for Persons with Developmental Disabilities" and "Participatory Communication and Choice Making" courses offered by DDS. Thereafter, Behavioral Support Consultants shall attend a minimum of two DDS identified trainings per year and shall participate in any mandated trainings identified by DDS. Prior approval from OBS is required if Support Consultants attend training offered outside of DDS if they want that training to count toward the training requirements.

- (4) All Behavioral Support Consultation Provider Agencies are required to report required personnel training status to the DDS Statewide Training Database as follows:
 - (a) Initial comprehensive personnel status report (name, date of hire, identification number category) on all required personnel to be submitted to DDS Statewide Training Database within the first ninety (90) calendar days of providing services; and
 - (b) Quarterly personnel update reports sent to DDS Statewide Training Database to reflect new hires, terminations, or agency position changes, and name changes.
- (5) Exceptions to Qualifications:
 - (a) DDS may approve Behavioral Support Consultants with a temporary license from the specific New Mexico Licensing Board for a period of one (1) year. The temporary license and a Supervision Plan shall be submitted to the DDS and approved prior to the Support Consultant providing services. The permanent New Mexico license shall be obtained within one year and submitted to DDS.
 - (b) An academic intern from an accredited university may provide Behavioral Support Consultation under the supervision of a current qualified DD Waiver Behavioral Support Consultant with prior written DDS approval. A copy of the signed academic supervision agreement between the University, the supervising support consultant and the academic intern shall be submitted to DDS to acquire approval. Academic intern agreements shall be approved annually not to exceed two (2) years. The Provider Agency shall also present a Supervision Plan for the intern prior to the intern providing services.
 - (c) A combination of relevant education, internship, and familial or volunteer experience may be used as a substitution for caseload history or clinical experience in certain exceptional circumstances with prior written DDS approval. This exception category requires direct supervision from an OBS Behavioral Specialist, OBS Clinical Director, OBS Director, or OBS Behavioral Consultant. OBS supervision will occur a minimum of once per month in conjunction with supervision provided by the Provider Agency until the individual gains one full year of clinical experience with individuals who have a developmental disability.
 - (d) Licensed Support Consultants who have not met clinical caseload requirements may, with prior written approval from DDS, provide Behavioral Support Consultation under a detailed written Supervision Plan with a currently qualified DD Waiver Support Consultant. No services will be provided under this arrangement unless and until approval from DDS is obtained.

- (6) Supervision Requirements: Each exception category listed in section C (4) requires a written Supervision Plan. The Supervision Plan shall include the following requirements:
 - (a) One (1) hour of supervision to every 10 individual contact hours;
 - (b) A minimum of half (50 percent) of the supervision occurs as face-to-face supervision;
 - (c) A minimum of half (50 percent) of the supervision occurs on an individual basis;
 - (d) Documentation to address clinical issues, service issues, and review of case progress notes, assessments, and plans;
 - (e) Supervisor countersign all assessments, plans and quarterly reports; and
 - (f) Submit supervision plan to OBS every three (3) months.

D. Behavioral Support Consultation Service Reimbursement.

- (1) Billable Unit: A Billable unit is one quarter hour (15-minute increment).
- (2) Prior authorization from DDS is required for all units billed beyond the ARA as an approved exception for Behavioral Support Consultation. In order to request exception units for this service, the individual must first have spent at least \$6,000 for a combination of therapy and behavioral support consultation services within their ARA budget. For those with approved exceptions, the total of Behavioral Support Consultation units within the ARA plus exception units may not exceed 416 units (104 hours) per ISP year.
- (3) The Integrated Behavioral Support Consultation rate may be billed for interventions within the licensed Support Consultant's scope of service when those services are provided in the natural contexts of an individual's life (such as residence, day habilitation site, vocational site, community locations or at IDT/ISP planning meetings).
 - (a) When a direct skilled therapy is provided in a "pull-out model" within a natural context, the Integrated Behavioral Support Consultation rate may be billed if the intervention is applied to a functional activity/routine in collaboration with a caregiver at some point during that Behavioral Support Consultation session.
 - (b) Attendance at specialized appointments (doctors, dentists, orthotists, clinics, and employers, etc.) even in clinical settings can be billed under the Integrated Behavioral Support Consultation rate.
 - (c) IDT meetings may be billed under the Integrated Behavioral Support Consultation rate.

- (d) Functional evaluations/assessments that are conducted in natural contexts may be billed under the Integrated Behavioral Support Consultation rate.
- (4) The Individual Consultation rate may be billed for interventions within the licensed Support Consultant's scope of service when those interventions are provided in a clinic setting (such as a clinic or Support Consultant's office) or when services are delivered in an isolated, non-integrated manner, even within natural contexts of an individual's life (such as residence, day habilitation site, vocational site, or community locations).
- (a) The Individual Consultation rate includes individual-specific development of the Positive Behavior Supports Assessment, Positive Behavior Supports Plan, ISP Strategies and Quarterly Reports.
 - (b) Consultation performed away from the IDT member meeting context and away from the site of a specialized appointment.
 - (c) The Individual Consultation Rate within the scope of service may include writing of plans, training of staff and didactic training for the Support Consultant as it pertains to certain individuals on the Support Consultant's caseload.
- (5) Billable Activities:
- (a) Activities listed in Scope of Behavioral Support Consultation Services;
 - (b) Positive Behavior Supports Assessments:
 - (i) Ten (10) hours of Behavioral Support Consultation Services can be billed for development of a comprehensive Positive Behavior Supports Assessment annually;
 - (ii) A portion of the assessment hours shall be conducted and billed as Integrated Behavioral Support Consultation services (direct observation of the individual in all settings); and
 - (iii) All hours used for written preparation of the assessment is billed at the Individual Consultation rate.
 - (c) Positive Behavior Supports Plan:
 - (i) Up to ten (10) hours of Behavioral Support Consultation services can be billed annually for development of a Positive Behavior Supports Plan; and
 - (ii) Positive Behavior Supports Plan development is billed at the Individual Consultation rate.

- (d) Quarterly Report Preparation: a maximum of twenty-four (24), fifteen-minute units (six hours total), can be billed annually for preparation of quarterly reports at the Individual Consultation rate.
- (e) A total of 26 hours is usually the maximum amount per ISP year that can be billed for the combined activities of assessment, preparation of the Positive Behavior Supports Plan, and preparation of quarterly reports. Up to an additional 10 hours of assessment may be billed when a second assessment is required because Behavioral Support Consultation Services were started part way through the ISP year but the initial assessment date is more than 90 days prior to the assessment which is due two weeks prior to the annual ISP meeting. If the initial assessment is current within 90 days at the time the annual assessment is due, the initial assessment should just be updated based upon quarterly progress report information rather than a second assessment being completed within the same ISP year.
- (f) Collaborative Consultation Sessions: Each Behavioral Support Consultant who is collaboratively providing consultation services to an individual in the same setting (or by video or teleconference) at the same time may bill for the period of direct participation.
- (g) School activities related to the provision of Behavioral Support Consultation shall include:
 - (i) Attendance at Individual Education Plan meetings that occur at a child's school;
 - (ii) Positive Behavior Supports Plan training for school personnel, collaboration with school personnel on a cross-environment Positive Behavior Supports Plan;
 - (iii) Limited direct observation for the purposes of assessment and ongoing monitoring; and
 - (iv) All Behavioral Support Consultation school activities are not to exceed fifteen (15) hours (sixty [60] units) per year.
- (h) Up to fifteen (15) hours (sixty units) per year to perform and prepare written report for a Preliminary Risk Screening. Behavioral Support Consultants must be trained and approved by the Office of Behavioral Services prior to performing a Preliminary Risk Screening.
- (i) DDS approved training: A Support Consultant may bill for one hour of training he or she attends for each individual on his or her caseload for whom the content of the training is appropriate. Under no circumstances may a Support Consultant bill for more than five individuals for any training attended or for more hours than the length of the training (e.g., if the training lasts for three hours, billing cannot be submitted for more than three hours of training, no matter how many individuals there are on the Support Consultant's caseload). If

the training is not offered by DDS, OBS prior approval of the training is required. The case records for any individuals for whom training is billed shall reflect attendance at the training and how the training relates to services for that individual.

- (4) Non-Billable Activities:
 - (a) Non-therapeutic visits;
 - (b) Travel to and from site of any billable service;
 - (c) Supervision;
 - (d) Preparation of billing statement;
 - (e) Training activities for Support Consultants that are not sponsored by DDS or which the Support Consultant does not have prior approval from OBS;
 - (f) Consultation and behavioral management services that are the responsibility of the LEA (Local Educational Provider Agency) under IDEA Part B; and
 - (g) Behavioral Support Consultation that occurs within a school setting except for those activities listed above (see Billable Activities).

CHAPTER 4
CASE MANAGEMENT SERVICES

- I. CASE MANAGEMENT SERVICES.** Case Management services are person-centered and intended to support an individual in pursuing his or her desired outcomes by facilitating access to supports and services. Case Management is a set of interrelated activities that are implemented in a collaborative manner involving the active participation of the individual and/or his or her designated representative (e.g., guardian). Case Management services are intended to assist the individual to use natural supports and other available resources in addition to DD Waiver services. The Case Manager serves as an advocate for the individual. The Case Manager is also responsible for assuring that DD Waiver services in the budget do not exceed any maximum unit or the Annual Resource Allotment (ARA) established by the Department of Health (DOH).
- II. SCOPE OF CASE MANAGEMENT SERVICES.** Case Management shall include, but is not limited to, the following services:
- A.** Facilitate eligibility determination for the DD Waiver and other types of services;
 - B.** Organize and facilitate the service planning process in accordance with the regulation Service Plans for Individuals with Developmental Disabilities Living in the Community [7.26.5 NMAC];
 - C.** Assist the IDT members to explore alternatives to DD Waiver services and assist in the development of complementary or supplemental supports, including other publicly funded programs, community resources available to all citizens and natural supports within the individuals' community;
 - D.** Coordinate and monitor service delivery, including assuring services are delivered as described in the ISP and are provided in a safe and healthy environment;
 - E.** Through a formal, ongoing monitoring process, evaluate and document quality, effectiveness and appropriateness of services and supports;
 - F.** If concerns are identified and unresolved by the Case Manager or service Provider Agency in a timely manner, the Case Manager will report the concern in writing to the respective DDS Regional Office and/or DHI as appropriate;
 - G.** Arrange for information about supported employment to be shared with the individual, in a manner consistent with the DDS Employment First Principle, to insure the individual can make an informed choice;
 - H.** Develop and monitor utilization of ARA budgets;
 - I.** Timely submission of revisions to the ARA budget, if needed;
 - J.** Coordinate and/or advocate for the revision of services when desired outcomes are not achieved;

- K.** Inform the individual of his or her rights and responsibilities at least annually, and promote informed decision-making;
- L.** Promote self-advocacy;
- M.** Advocate on behalf of the individual, as needed;
- N.** Monitor the health and safety of the individual;
- O.** Maintain a current and complete primary record for individual's DD Waiver services as specified in DDS policy;
- P.** Complete and approve Level of Care (LOC) packets as outlined in this standard;
- Q.** Approve the ISPs and the Waiver Review Form (MAD 046) as outlined in this standard;
- R.** Assure that the IDT members develop targeted, realistic desired outcomes and action plans with measurable action steps and that the ISP is cost effective; and
- S.** Meet with the individual, and family/guardian if applicable, and describe the optional Personal Plan Facilitation service available to supplement the individual service plan process. If requested, assist the individual in obtaining this service through the Freedom of Choice process.
- T.** Assure individuals obtain all services through the Freedom of Choice process.

III. CASE MANAGEMENT SERVICE REQUIREMENTS.

A. Case Management Allocation Activities.

- (1) At the time of allocation, DDS will notify the individual of allocation status and initiate the Primary Freedom of Choice process to select a case management agency; and
- (2) The Case Management Provider Agency, within five (5) working days of notification of selection under the Primary Freedom of Choice, will assign a Case Manager to work with the individual to complete the initial assessment process. Also, within those five (5) working days, the Case Manager will call the individual and set a time for their first meeting.
- (3) The Case Manager will keep the Central Registry Unit (CRU) informed on progress with allocation activities in accordance with Central Registry Unit procedures.

B. Case Management Assessment Activities. Assessment activities shall include but are not limited to the following requirements:

- (1) Complete and compile the elements of the Long Term Care Assessment Abstract (LTCAA) packet to include:

- (a) LTCAA form (MAD 378);
 - (b) Comprehensive Individual Assessment (CIA);
 - (c) Current physical exam and medical/clinical history;
 - (d) Norm-referenced adaptive behavioral assessment; and
 - (e) A copy of the Allocation Letter (initial submission only).
- (2) Prior to service delivery, obtain a copy of the Medical Assistant Worker (MAW) letter to verify that the county Income Support Division (ISD) office of the Human Services Department (HSD) has completed a determination that the individual meets financial and medical eligibility to participate in the DD Waiver program.
 - (3) Provide a copy of the MAW letter to service providers listed on the ISP budget (MAD 046).

C. Review and Approval of the LTCAA by the New Mexico Medicaid Utilization Review (NMMUR) Agent.

- (1) The Case Manager will submit the LTCAA packet to the NMMUR agent for review and approval. If it is an initial allocation, submission shall occur within 60 days from the date the DDS receives the individual's allocation letter for the DD Waiver. For re-determinations, submission shall occur between 45 days and 30 days prior to the ISP expiration date.
- (2) Prior to service delivery, the NMMUR agent shall approve:
 - (a) All initial LTCAAs;
 - (b) Any LTCAAs that result in a change in the level of care for the individual; and
 - (c) Any re-admit LTCAAs to the DD Waiver.
- (3) In addition to initial allocations, the NMMUR agent reviews and approves the LTCAA every three years for individuals on the Waiver.
- (4) The Case Manager shall respond to NMMUR within specified timelines when the LTCAA packet is returned for corrections or additional information.

D. Case Management Review and Approval of the LTCAA. Case Management Provider agencies shall ensure that Case Managers conduct a complete and comprehensive LOC review for the intervening two years that the NMMUR is not required to review and approve the LTCAA. The comprehensive LOC shall include:

- (1) A new LTCAA;

- (2) A new history and physical;
- (3) An update to the Client Individual Assessment (CIA); and
- (4) A review of the norm-referenced adaptive behavioral assessment (current within three years), to determine if it still reflects the individual's functional level. If yes, the assessment shall be filed with the current LOC packet, and if not, it shall be re-administered. During these two years, it is the responsibility of the Case Manager to send a copy of the approved LOC to the appropriate ISD office for the individual's annual reassessment of Medicaid eligibility. Case Management Provider Agencies shall review a sample of LTCAAs at least annually to verify accuracy and appropriateness of the eligibility determination.

E. Individualized Service Planning and Approval.

- (1) Individualized service planning is developed through a person-centered planning process in accordance with the rule governing ISP development (7.26.5 NMAC). A person-centered planning process shall be used to develop an ISP that includes:
 - (a) Realistic and measurable desired outcomes for the individual as identified in the ISP which includes the individual's long-term vision, summary of strengths, preferences and needs, desired outcomes and an action plan and is:
 - (i) An ongoing process, based on the individual's long-term vision, and not a one-time-a-year event; and
 - (ii) Completed and implemented in response to what the IDT members learn from and about the person and involves those who can support the individual in achieving his or her desired outcomes (including family, guardians, friends, providers, etc.).
- (2) The Case Manager will ensure the ongoing assessment of the individual's strengths, needs and preferences and use this information to inform the IDT members and guide the development of the plan.

F. Case Manager ISP Development Process.

- (1) The Case Manager meets with the individual in advance of the ISP meeting in order to enable the person to review current assessment information, prepare for the meeting, plan to facilitate or co-facilitate the meeting if the individual wishes and to ensure greater and more informed participation.
- (2) The Case Manager will discuss and offer the optional Personal Plan Facilitation service to the individual to supplement the ISP planning process; if selected, the Case Manager will assist in obtaining this service through the FOC process. This service is funded within the individual's ARA.

- (3) The Case Manager convenes the IDT members and a service plan is developed in accordance with the rule governing ISP development (7.26.5 NMAC).
- (4) The Case Manager will advise the individual of his or her rights and responsibilities related to receipt of services, applicable federal and state laws and guidelines, DOH policies and procedures pertaining to the development and implementation of the ISP, confidentiality, abuse, neglect, exploitation, and appropriate grievance and appeal procedures. In addition, the Case Manager shall provide the individual and/or guardian with a copy of the Case Management Code of Ethics at this time.
- (5) The Case Manager will clarify the individual's long-term vision through direct communication with the individual, and if needed, through communication with family, guardians, friends and support providers and others who know the individual. Information gathered shall include, but is not limited to the following:
 - (a) Strengths;
 - (b) Capabilities;
 - (c) Preferences;
 - (d) Desires;
 - (e) Cultural values;
 - (f) Relationships;
 - (g) Resources;
 - (h) Functional skills in the community;
 - (i) Work interests and experiences;
 - (j) Hobbies;
 - (k) Community membership activities or interests;
 - (l) Spiritual beliefs or interests; and
 - (m) Communication and learning styles or preferences to be used in development of the individual's service plan.
- (6) Case Managers shall operate under the presumption that all working age adults with developmental disabilities are capable of working given the appropriate supports. Individuals will be offered employment as a preferred day service over other day service options. It is the responsibility

of the Case Manager and all IDT members to ensure that employment decisions are based on informed choices.

- (a) The Case Manager shall verify that all Jackson Class members who express an interest in work or who have employment-related desired outcome(s) in the ISP have an initial or updated vocational assessment that has been completed within the preceding twelve (12) months.
- (b) In cases when employment is not an immediate desired outcome, the ISP shall document the reasons for this decision and develop employment-related goals within the ISP that will be undertaken to explore employment options (e.g., volunteer activities, career exploration, situational assessments, etc.) This discussion related to employment issues shall be documented within the ISP or on the DDS Decision Justification form.
- (c) In the context of employment, informed choices include the following:
 - (i) Information regarding the range of employment options available to the individual
 - (ii) Information regarding self-employment and customized employment options
 - (iii) Job exploration activities including volunteer work and/or trial work opportunities
- (7) The Case Manager will ensure discussion on Meaningful Day activities for the individual in the ISP meeting, and reflect such discussion in the ISP “Meaningful Day Definition” section.
- (8) When a recipient of DD Waiver services has a HAT score of 4, 5, or 6, medical consultation shall be obtained for service planning and delivery, including the ISP and relevant Health Care and Crisis Prevention/Intervention Plans. Medical consultation may be from a Provider Agency Nurse, Primary Care Physician/Practitioner, Regional Office Nurse, Continuum of Care Nurses or Physicians including his or her Regional Medical Consultant and/or RN Nurse Case Manager.
- (9) For new allocations, the Case Manager will submit the ISP to NMMUR only after a MAW letter has been received, indicating the individual meets financial and LOC eligibility.
- (10) The Case Manager, with input from each Provider Agency, shall complete the Individual Specific Training Requirements section of the ISP form listing all training needs specific to the individual.
- (11) The Case Manager shall complete the initial ISP development within ninety (90) days as required by DDS.

G. Secondary Freedom of Choice Process.

- (1) The Case Management Provider Agency will ensure that it maintains a current Secondary Freedom of Choice (FOC) form that includes all service providers offering services in that region.
- (2) The Case Manager will present the Secondary FOC form to the individual or authorized representative for selection of direct service providers.
- (3) At least annually, at the time rights and responsibilities are reviewed, individuals and guardians served will be reminded that they may change providers at any time, as well as change types of services. At this time, Case Managers shall offer to review the current Secondary FOC list with individuals and guardians served. If they are interested in changing, a new FOC shall be completed.

H. Case Management Approval of the MAD 046 Waiver Review Form and Budget.

- (1) Case Management Providers are authorized by DDS to approve ISPs and budgets (including initial, annual renewals and revisions) for all individuals except as noted in section I of this chapter. This includes approval of support plans and strategies as incorporated in the ISP.
- (2) The Case Manager shall complete the MAD 046 Waiver Review Form and deliver it to all provider agencies within three (3) working days following the ISP meeting date. Providers will have the opportunity to submit corrections or objections within five (5) working days following receipt of the MAD 046. If no corrections or objections are received from the provider by the end of the fifth (5) working day, the MAD 046 may then be submitted as is to NMMUR. (Provider signatures are no longer required on the MAD 046.) If corrections/objections are received, these will be corrected or resolved with the provider(s) within the timeframe that allow compliance with number (3) below.
- (3) The Case Manager will submit the MAD 046 Waiver Review Form to NMMUR for review as appropriate, and/or for data entry at least thirty (30) calendar days prior to expiration of the previous ISP.
- (4) The Case Manager shall respond to NMMUR within specified timelines whenever a MAD 046 is returned for corrections or additional information.

I. The NMMUR Agent Approval of the MAD 046 Waiver Review Form.

- (1) The NMMUR agent shall approve the MAD 046 Waiver Review Form for clinical necessity designed for the following services:
 - (a) Any initial Community Living Service (Supported Living, Independent Living and Family Living);

- (b) A change from a less restrictive to a more restrictive Community Living Service; with Independent Living being the least restrictive option, and Supported Living as the most restrictive option;
- (c) Outlier services;
- (d) When a third party review is requested by DOH; and
- (e) Awake Supported Living Services.

J. Case Manager Monitoring and Evaluation of Service Delivery.

- (1) The Case Manager shall use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual as specified in the ISP.
- (2) Monitoring and evaluation activities shall include, but not be limited to:
 - (a) Face-To-Face Contact: A minimum of twelve (12) face-to-face contact visits annually (1 per month) is required to occur between the Case Manager and the individual served as described in the ISP; an exception is that children may receive a minimum of four visits per year;
 - (b) Jackson Class members require two (2) face-to-face contacts per month, one of which occurs at a location in which the individual spends the majority of the day (i.e., place of employment, habilitation program) and one at the person's residence;
 - (c) For non-Jackson Class members who receive Community Living Services, at least every other month, one of the face-to-face visits shall occur in the individual's residence;
 - (d) For adults who are not Jackson Class members and who do not receive Community Living Services, at least one face-to-face visit per quarter shall be in his or her home;
 - (e) If concerns regarding the health or safety of the individual are documented during monitoring or assessment activities, the Case Manager shall immediately notify appropriate supervisory personnel within the Provider Agency and document the concern. If the reported concerns are not remedied by the Provider Agency within a reasonable, mutually agreed period of time, the concern shall be reported in writing to the respective DDS Regional Office and/or the Division of Health Improvement (DHI) as appropriate to the nature of the concern. Unless the nature of the concern is urgent, no more than fifteen (15) working days shall be allowed for remediation or development of an acceptable plan of remediation. This does not preclude the Case Managers' obligation to report abuse, neglect or exploitation as required by New Mexico Statute.

- (f) Service monitoring for children: When a parent chooses fewer than twelve (12) annual units of case management, the Case Manager will inform the parent of the parent's responsibility for the monitoring and evaluation activities during the months he or she does not receive case management services,
- (g) It is appropriate to conduct face-to-face visits with the individual both during the time the individual is receiving a service and during times the individual is not receiving a service. The preferences of the individual shall be taken into consideration when scheduling a visit. Visits may be scheduled in advance or be unannounced visits depending on the nature of the need in monitoring service delivery for the individual.
- (h) Communication with IDT members: Case Managers shall facilitate and maintain communication with the individual or his or her representative, other IDT members, providers and other relevant parties to ensure the individual receives maximum benefit of his or her services. Case Managers need to ensure that any needed adjustments to the service plan are made, where indicated. Concerns identified through communication with teams that are not remedied within a reasonable period of time shall be reported in writing to the respective regional office and/or the Division of Health Improvements, as appropriate to the concerns.

IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS.

A. Case Management Provider Agency Qualifications.

- (1) The Case Management Provider Agency shall have a current business license issued by the state, county or city government if required by any of these government entities.
- (2) The Case Management Provider Agency shall comply with all applicable federal, state, and Waiver regulations and policies and procedures regarding case management.

B. Case Management Administrative Requirements.

- (1) Fiscal Requirements
 - (a) Case Management Provider Agencies shall establish and maintain separate financial reporting and accounting activities that are in accordance with state requirements. Case Management Provider Agencies shall have an established automated data system for financial and program reporting purposes.
- (2) Programmatic Requirements
 - (a) Case Management Provider Agencies shall have an established system for tracking key steps and timelines in establishing eligibility, service planning, budget approval and distribution of records to IDT Members.

- (b) Case Management Provider Agencies shall maintain a local telephone answering system during off hours that indicates regular office hours and required response time of not more than forty-eight (48) hours.
- (c) Case Management Provider Agencies shall maintain at least one (1) office that meets Americans with Disabilities Act (ADA) accessibility requirements in each geographic region served by the Provider Agency that includes:
 - (i) A 24-hour local telephone answering system. The case management agency must return all calls not later than 5:00 p.m. the following business day; The answering system must indicate regular office hours and expected response time by the end of the following business day.
 - (ii) An operational fax machine;
 - (iii) Internet and e-mail access for every Case Manager employed by the Provider Agency or with whom he or she is contracted;
 - (iv) Primary client records for each individual served by the Provider Agency that are stored on site, in compliance with HIPAA requirements;
 - (v) A meeting room that can accommodate IDT Members meetings comfortably;
 - (vi) An area where a Case Manager may meet privately with an individual;
 - (vii) A separate physical space and entrance, if the office is connected to a residence;
 - (viii) Exceptions to the above may be granted in writing by DDS based on circumstances and needs of the service system. Requests for such exceptions shall be submitted to the Statewide Coordinator of the Case Management Unit of DDS in writing with appropriate justification.
- (3) Case Management Provider Agencies and their staff/contractors are required to adhere to all requirements communicated to them by DDS, including attendance at mandatory meetings, mandated trainings and technical assistance sessions.
- (4) Case Management Provider Agencies receiving a provider number after the effective date of these service standards shall have and maintain a minimum of three full time equivalent Case Manager positions, including a supervisor, in order to assure proper oversight and coverage. Existing Provider Agencies are required to comply with this requirement by February 1, 2007. Exceptions to this staffing requirement may be granted

in writing by DDS D based on circumstances and needs of the service system. Requests for such exceptions shall be submitted to the Statewide Coordinator of the Case Management Unit of DDS D in writing with appropriate justification that addresses how the agency will assure adequate back up coverage and quality assurance functions.

C. **Quality Assurance Requirements.** Case Management Provider Agencies will use an Internal Quality Assurance and Improvement Plan that must be submitted to and reviewed by the Statewide Case Management Coordinator, that shall include but is not limited to the following:

- (1) Case Management Provider Agencies are to:
 - (a) Use a formal ongoing monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual. This protocol shall be written and its implementation documented.
 - (b) Assure that reports and ISPs meet required timelines and include required content.
 - (c) Conduct a quarterly review of progress reports from service providers to verify that the individual's desired outcomes and action plans remain appropriate and realistic.
 - (i) If the service providers' quarterly reports are not received by the Case Management Provider Agency within fourteen (14) days following the end of the quarter, the Case Management Provider Agency is to contact the service provider in writing requesting the report within one week from that date.
 - (ii) If the quarterly report is not received within one week of the written request, the Case Management Provider Agency is to contact the respective DDS D Regional Office in writing within one business day for assistance in obtaining required reports.
 - (d) Assure at least quarterly that Crisis Prevention/Intervention Plans are in place in the residence and at the Provider Agency of the Day Services for all individuals who have chronic medical condition(s) with potential for life threatening complications and/or who have behavioral challenge(s) that pose a potential for harm to themselves or others.
 - (e) Assure at least quarterly that a current Health Care Plan (HCP) is in place in the residence and day service site for individuals who receive Community Living or Day Services and who have a HAT score of 4, 5, or 6. During face-to-face visits and review of quarterly reports, the Case Manager is required to verify that the Health Care Plan is being implemented.
 - (f) Assure that Community Living Services are delivered in accordance with standards, including responsibility of the IDT Members to plan

for at least 30 hours per week of planned activities outside the residence. If this is not possible due to the needs of the individual, a goal shall be developed that focuses on appropriate levels of community integration. These activities do not need to be limited to paid supports but may include independent or leisure activities appropriate to the individual.

- (g) Perform annual satisfaction surveys with individuals regarding case management services. A copy of the summary is due each December 10th to the respective DDS Regional Office, along with a description of actions taken to address suggestions and problems identified in the survey.
 - (h) Maintain regular communication with all providers delivering services and products to the individual.
 - (i) Establish and implement a written grievance procedure.
 - (j) Notify appropriate supervisory personnel within the Provider Agency if concerns are noted during monitoring or assessment activities related to any of the above requirements. If such concerns are not remedied by the Provider Agency within a reasonable mutually agreed period of time, the concern shall be reported in writing to the respective DDS Regional Office and/or DHI as appropriate to the nature of the concern. This does not preclude Case Managers' obligations to report abuse, neglect or exploitation as required by New Mexico Statute.
 - (k) Utilize and submit the "Request for DDS Regional Office Intervention" form as needed, such as when providers are not responsive in addressing a quality assurance concern. The Case Management Provider Agency is required to keep a copy in the individual's file.
- (2) Case Managers and Case Management Provider Agencies are required to promote and comply with the Case Management Code of Ethics:
- (a) Case Managers shall provide the individual/guardian with a copy of the Code of Ethics when Addendum A is signed.
 - (b) Complaints against a Case Manager for violation of the Code of Ethics brought to the attention of DDS will be sent to the Case Manager's supervisor who is required to respond within 10 working days to DDS with detailed actions taken. DDS reserves the right to forward such complaints to the IRC.

D. Case Manager Requirements for Reports and Distribution of Documents.

- (1) Case Managers will provide reports and data as specified/requested by DDS within the required time frames.

- (2) Case Managers shall provide copies of the ISP to the Provider Agencies listed in the budget, and the individual and guardian (if applicable) within 14 days of ISP approval;
- (3) Case Managers shall provide copies of the ISP to the respective DDS Regional Offices within 14 days of ISP approval.
- (4) Copies of the ISP given to providers, the individual and guardians shall include any related ISP minutes, provider strategies, individual specific training required, client rights and responsibilities, and revisions, if applicable.
- (5) At times, recommendations for further evaluations, screenings, diagnostics and/or treatments may be made to the IDT Members by various healthcare staff, consultants, various audit tools, the Supports and Assessments for Feeding and Eating (SAFE) Clinic, Transdisciplinary Evaluation and Support Clinic (TEASC) or other experts:
 - (a) The IDT Members shall discuss these recommendations and a determination made if the IDT Members agree with the recommendations.
 - (b) If the IDT Members concur with the recommendation, the ISP is required to be revised and follow-up shall be completed and documented in progress reports and, if applicable, in a revision to relevant therapy plans.
 - (c) If the IDT Members, in their professional judgment, do not agree with the recommendation, the reasons for this shall be clearly documented in the Decision Justification document and filed by the Case Manager with the healthcare provider or consultant report/document in which the recommendation was made.
 - (d) A copy of the Decision Justification document shall also be given to the residential provider (if any) and the guardian.
- (6) The individual's name and the date are required to be included on all pages of documents. All documents shall also include the signature of the author on the last page.

E. Case Manager Qualifications. Case Managers, whether subcontracting or employed by a Provider Agency, shall meet these requirements:

- (1) Case Managers shall possess these qualifications:
 - (a) Licensed social worker, as defined by the NM Board of Social Work Examiners; or
 - (b) Licensed registered nurse as defined by the NM Board of Nursing; or

- (c) Bachelor's or Master's degree in social work, psychology, counseling, nursing, special education, or closely related field; and
 - (d) Have one-year clinical experience, related to the target population, working in any of the following settings:
 - (i) Home health or community health program;
 - (ii) Hospital;
 - (iii) Private practice;
 - (iv) Publicly funded institution or long-term care program;
 - (v) Mental health program;
 - (vi) Community based social service program; or
 - (vii) Other programs addressing the needs of special populations, e.g., school.
 - (e) Have a working knowledge of the health and social resources available within a region.
- (2) Within specified timelines, Case Managers shall meet the requirements for training specified in the DDS policy governing the training requirements for Case Managers serving individuals with developmental disabilities. All Case Management Provider Agencies are required to report required personnel training status to the DDS Statewide Training Database as follows:
- (a) Initial comprehensive personnel status report (name, date of hire, identification number category) on all required personnel to be submitted to DDS Statewide Training Database within the first ninety (90) calendar days of providing services; and
 - (b) Quarterly personnel update reports sent to DDS Statewide Training Database to reflect new hires, terminations, or agency position changes, and name changes.
- (3) Prior written approval from DDS is required for any person providing services as an intern in Case Management. If approval is granted, DDS reserves the right to add conditions (i.e., supervisor review and sign off on quality of work) that shall be adhered to and may rescind the approval at any time for any reason.
- (4) Written approval from DDS is required for any person applying to be a Case Management subcontractor before the person is hired.
- (5) Exception: If a Case Management Provider Agency has made reasonable efforts to recruit Case Management personnel with the required

qualifications without success, that Case Management Provider Agency may request an exception from the Case Manager Qualifications from the DDS Central Office as per the following procedure:

- (a) The requesting Provider Agency will describe and document all efforts made to recruit Case Managers with the required qualifications and the results of those efforts.
- (b) The requesting Provider Agency will describe and document in detail the relevant educational, employment, volunteer, familial, and other experience that will qualify the prospective candidate for successful employment as a Case Manager. Consideration may be given for unique skills needed by the Provider Agency such as fluency in a language other than English.
- (c) If the exception is granted, DDS reserves the right to add conditions (e.g., specific training, supervisory oversight) that shall be adhered to and may rescind the exception at any time for any reason.

F. Conflict of Interest.

- (1) The only circumstances in which a Case Manager may provide any other DD Waiver service is if he or she is providing Family Living Services, Respite, or Personal Care Services either to a member of his or her own family, or to an individual who is receiving Case Management services from another Case Management Provider Agency, with applicable authorization from DDS.
- (2) A Case Manager may not provide any other DD Waiver service to individuals for whom the Provider Agency provides Case Management services.
- (3) The Case Management Provider may not employ, as a Case Manager, any immediate family member or guardian of an individual served by the Provider Agency.
- (4) A Case Management Provider Agency may not be a Provider Agency for any other DD Waiver Service.

G. Case Management Staff Ratio.

- (1) The Case Management Provider Agency shall assure that caseloads are assigned in such a way as not to exceed thirty (30) cases per Case Manager on average. Case Manager services provided to children may be attributed to the caseload proportionally based upon the number of months of service provided per year (e.g., 4 months of Case Management service = $\frac{1}{3}$ case; 6 months of Case Management service = $\frac{1}{2}$ case).
- (2) The Provider Agency shall maintain a current roster per Case Manager. The roster of each Case Manager will be available upon request by DOH or

its designee and will include the names of the individuals and his or her current HAT scores.

- (3) The practice of working for or subcontracting with more than one Case Management Provider Agency simultaneously is prohibited. If a Case Manager provides services to individuals on more than one Medicaid Waiver, or through other funding sources, the Case Manager/Provider Agency will clearly report that information to the DDS Regional Office with the quarterly Case Manager caseload reports.
- (4) The Case Management Provider Agency shall hire and retain sufficient Case Managers to adequately serve the client population.
- (5) Failure of a Provider Agency to adhere to this policy will result in immediate moratorium until caseloads are adjusted to an average of 30 or fewer cases per Case Manager.

H. Case Management Provider Agency Supervision Requirements.

- (1) Provider Agencies shall implement written procedures for training, supervision and corrective action for Case Management staff and/or subcontractors. Documentation of above needs to be maintained in personnel files.
- (2) Individuals providing supervision/oversight must have at least two (2) years as experienced Case Managers for individuals with developmental disabilities and must meet all qualifications for Case Managers under Section IV, E, (1). Case management supervisors who also carry a caseload may not perform quality assurance reviews on their own work.
- (3) Contract performance management procedures equivalent to employee supervision procedures shall be carried out for Case Management subcontractors.
- (4) Provider Agencies shall monitor and oversee the eligibility process for new allocations and for re-determinations.
- (5) On a quarterly basis, Provider Agencies are required to mentor and monitor service planning and ISP development by Case Managers, including a quality assurance review of a sample of ISPs written by each Case Manager. For Jackson Class members, all ISPs are required to be reviewed; for non-Jackson Class members, a ten percent (10%) sample is required. Copies of all critiqued ISPs, both Jackson and non-Jackson samples, shall be submitted to the respective DDS Regional Office.
- (6) Provider Agencies are required to evaluate the quality of monitoring conducted by Case Managers with regard to ISP implementation and health and safety for individuals served, including timely medical intervention to follow-up on recommendations by medical and/or clinical practitioners.

- (7) Provider Agencies shall oversee Quality Assurance and Improvement Requirements for Case Managers.
- (8) Provider Agencies shall assure Case Manager compliance with training requirements.
- (9) Provider Agencies are required to assure all records include current provider quarterly reports and that each record is complete in adherence with DDS policies, procedures and standards.
- (10) Provider Agencies must assure adherence to timelines set forth by DDS.

V. CASE MANAGEMENT SERVICES REIMBURSEMENT.

A. Billable Unit.

- (1) Reimbursement to the Case Management Provider Agency is based upon a monthly rate for a maximum of 12 months per ISP year.
- (2) The Case Management Provider Agency shall provide and document at least one hour of case management services per individual served, and a monthly average of at least three (3) hours of DD Waiver service per individual, including face-to-face contacts, across the caseload of each Case Manager. A Case Management Provider Agency cannot bill for an individual for whom a face-to-face contact did not take place during the month.
- (3) Exceptions to the three-hour average are allowed if the Case Manager is on approved leave, as long as a Provider Agency colleague or supervisor has maintained essential duties during his or her absence, including mandated face-to-face visits.
- (4) Partial units are paid when the individual transitions from one Case Management Provider Agency to another during the month, and a Case Manager provides at least one hour of billable service including face-to-face contact during that calendar month. The monthly rate is pro-rated based on the number of days the individual was with the Case Management Provider Agency.

B. Billable Services. The following activities are deemed to be billable services:

- (1) All services and supports within the Case Management Scope of Services; and
- (2) Case Management may be provided at the same time on the same day as any other service.

C. Non-Billable Services.

- (1) Services furnished to an individual who does not reside in New Mexico;

- (2) Services furnished to an individual who is not eligible for DD Waiver Case Management services;
- (3) Participation by the Case Manager in any educational courses or training unless such training is listed in the ISP as individual specific training that the Case Manager needs to receive;
- (4) Outreach activities, including contacts with persons potentially eligible for the DD Waiver; and
- (5) Case Management services furnished to an individual who is in an institution (e.g., ICF/MR, nursing facility, hospital), except for discharge planning services in accordance with MAD Supplement No. 01-22.

CHAPTER 5 COMMUNITY INCLUSION SERVICES

- I. 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.

When included under the Waiver program, Community Inclusion Services include the following:

- A. Supported Employment.**
- B. Community Access.**
- C. Adult Habilitation.**

- II. SCOPE OF COMMUNITY INCLUSION SERVICES.** 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/her community in the manner desired by the individual.

- A. Community Inclusion Services.** Community Inclusion Services shall be provided in accordance with each individual's ISP, needs and preferences, and shall consist of the following activities, as appropriate to the individual, including, but not limited to:
- (1) Participation in the IDT to assure that ISPs are adequate to define what constitutes a meaningful day for the individual, as well as to guide development of the quantity and quality of the individual's daily activities and experiences;
 - (2) Action by provider staff resulting in community membership, community connections, valued roles, and equitably paid employment;
 - (3) Service delivery that includes, throughout the course of each day, individual choice-based options and age appropriate skill building activities as specified in the individual's ISP Action Plan;
 - (4) Staff training and use of assessment tools to assure knowledge of the individual and that person's ISP;
 - (5) Direct observation, support and mentoring of the quality of daily experiences for individuals receiving Community Inclusion Services;

- (6) Identification of barriers to implementing the ISP Action Plan in the community;
- (7) Implementation of strategies to address these barriers and documentation of what solutions were effective;
- (8) Arranging for and/or provision of transportation needed during the delivery of Community Inclusion Services; and
- (9) Documentation of all activities provided under paragraph (1) - (8) of this subsection. II A.

III. COMMUNITY INCLUSION SERVICES REQUIREMENTS.

A. Implementation of the Employment First Principle for Adult Individuals.

- (1) When considering Community Inclusion Services (Supported Employment, Community Access, and Adult Habilitation), the IDT members are required to offer employment as a priority service over other day service options for all working age adults. In cases when employment is not the immediate goal, the IDT members shall document the reasons for this decision and develop strategies that will be undertaken to explore alternative options that may lead to employment (e.g., volunteer activities, career exploration, situational assessments, etc.). It is the responsibility of the IDT members and Case Manager to ensure that these decisions are based on informed choice.
- (2) Informed Choice of the Individual: In the context of employment, informed choice shall include the following:
 - (a) Assessment of the individual's vocational interests, abilities and needs;
 - (b) Information regarding the range of employment options available to the individual;
 - (c) Information regarding self-employment and customized employment options and resources;
 - (d) The opportunity for job exploration activities including volunteer work and/or trial work opportunities; and
 - (e) Discussion of potential impact on the individual's benefits and services.
- (3) Compensation: When individuals receive compensation in Community Inclusion Services 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.

B. Implementation of a Meaningful Day.

- (1) In the context of DD Waiver services, the term “meaningful day” means that services and supports provide individualized access for individuals with developmental disabilities to participate in activities and functions of community life that are desired and chosen by the general population. The term “day” does not exclusively denote activities that happen between 9:00 a.m. to 5:00 p.m. on weekdays. This includes purposeful and meaningful work, substantial and sustained opportunity for optimal health, self empowerment and personalized relationships, skill development and/or maintenance, and social, educational and community inclusion activities that are directly linked to the vision, goals and desired personal outcomes as stated in the individual’s Individual Service Plan and as documented in daily schedules and progress notes.

C. Performance Expectations for Community Inclusion Services.

- (1) Community Inclusion Services should be integrated into individuals’ daily routines or schedules. All Community Inclusion requirements and other specifications are required to be met by Provider Agencies of Adult Habilitation, Community Access, and/or Supported Employment. Whether through the formal supports and services provided under the Waiver program or through the informal and unpaid networks of support available, it is the direct responsibility of the Community Inclusion provider in collaboration with the individual’s IDT to ensure that each individual, as specified in his or her ISP, develops connections in community life that are typical of the general population. Successful supports, whether paid or unpaid, are measured by whether or not individuals served make progress toward outcomes as identified in ISPs. When Community Inclusion is provided as a Waiver service, the DOH requires that, at a minimum, the individual will be engaged in Community Inclusion Services that support progress toward ISP outcomes and include the types of activities listed in D below not less than 80% of the time in service. These activities are required to be observable in the individual’s daily schedule and require related documentation of progress toward ISP outcomes.

D. Planning for Community Inclusion Services. The following types of activities shall serve as the framework for individual service planning:

- (1) Job placement to secure the best job match consistent with the individual’s Career Development Plan;
- (2) Support for the individual while engaged in work that is compensated under the Fair Labor Standards Act;
- (3) Work exploration in the community in order to learn about jobs that might match the individual’s interests/skills;

- (4) Volunteer time in the community as long as the individual contributes through an identified role and can be observed to have routine and significant personal interactions with non-disabled recipients of the volunteer service and other non-disabled volunteers or staff of the volunteer organization;
- (5) Age-appropriate instruction when it can be demonstrated that learning objectives or skill development activities are directly linked to the individual's desired outcome and action plans specified in the ISP. This may include instruction by direct care staff that is conducted under a structured plan developed by a therapist or time when the therapist, with the active engagement of the individual, is instructing or consulting with direct care staff on therapeutic interventions. The content of instructional or therapeutic activities shall relate to the individual preferences, vision, goals, action plans and support plans, and optimize the individual's physical health and functioning as specified in the ISP. Therapeutic activities should be delivered in a non-stigmatizing, age-appropriate manner and integrated using a functional approach;
- (6) Individual engagement in expanding personal interest and/or establishing or building meaningful social roles;
- (7) Reduced dependence on paid supports, resulting in increased interdependence, community connections, relationship, and networks of natural supports; and
- (8) Adequate planning and support to assure that individuals make measurable, consistent progress toward ISP outcomes.

E. Individual Rights. When planning Community Inclusion Services, the IDT members shall recognize the individual's rights including, but not limited to:

- (1) Individuals retain the right to assume risk. The assumption of risk is required to be inconsideration of, and balanced with, the individual's ability to assume responsibility for that risk and a reasonable assurance of health and safety;
- (2) Individuals make choices during the course of the day about his or her everyday life, including daily routines and schedules, and
- (3) Individuals have the opportunity to develop self-advocacy skills.

F. Community Inclusion Services Performance Contracts. The DDS will develop an annual Performance Contract with each provider of Community Inclusion Services. The Performance Contract will specify the performance outcomes, linked to the individuals served, that the DDS requires the provider to achieve during the term of the contract. Performance Contracts are subject to DDS and DHI management and monitoring. As appropriate to address individual needs or circumstances, individual outcomes contained in contracts may be renegotiated during the term of the contract. Any renegotiation must be done in consultation with the individual and the DDS regional contract

manager. If the change will impact the ISP or the individual's DD Waiver budget, the IDT must be included in the renegotiation process. Failure to demonstrate progress as detailed in the contract will result in interventions up to and including contract enforcement actions and sanctions.

IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS.

- A. General Requirements.** All Community Inclusion Services Provider Agencies are required to have a current business license issued by state, county or city government. Community Inclusion Services Provider Agencies are required to comply with all DD Waiver standards, applicable federal and state regulations, and DOH policies and procedures. The Community Inclusion Services Provider Agencies shall develop, implement and monitor written policies and procedures that maintain and protect the physical and mental health as well as safety of individuals.
- B. IDT Coordination.**
- (1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and
 - (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.
- C. Quality Management.** All Community Inclusion Services Provider Agencies are required to develop and implement a Continuous Quality Management System in accordance with the General Requirements of these standards. This system shall include a Continuous Quality Improvement Plan specific to Community Inclusion Services and shall be used to discover individual and provider level barriers and problems, remediate individual and provider level issues and improve the provider's service provision over time. This Continuous Quality Improvement Plan will include methods to measure the extent to which each individual's definition of a meaningful day is implemented through the use of Community Inclusion Services. For each individual served, the individual data collected is used to measure and improve progress towards desired outcomes and to identify and address barriers to achieving those outcomes in person-centered, timely, age-appropriate ways.
- D. Provider Agency Records.**
- (1) The Provider Agency must maintain a confidential case file for each individual. The individual case file must include the record of:
 - (a) Emergency and personal identification information, including the individual's address, telephone number, name and telephone number of Community Living provider (if any), relatives, and/or guardian or

conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, dentist name address and telephone number, and health plan;

- (b) The individual's current ISP and all supplemental plans specific to the individual;
- (c) Complete and current Health Assessment Tool (HAT);
- (d) Any evaluations of the individual generated by the provider;
- (e) Special incident reports, if any;
- (f) Progress notes signed and dated by the person making the note, contact logs and other service delivery documentation;
- (g) Data collected that measures individual progress in relation to his/her ISP action plans;
- (h) Crisis Prevention and Intervention Plan, if there is one for the individual; and
- (i) If the provider agency delivers medication to the individual in the community inclusion setting, the record shall include the Medication Administration Record (MAR), with complete information as called for in the Medication Assessment and Delivery Policy and Procedures. If no medications are delivered in the community inclusion setting, the record shall instead include a list of current medications, for reference in case of emergency;
- (j) Special health care needs, including medical orders, precautions and nutritional needs;
- (k) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.

E. Provider Agency Reporting Requirements. All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation:

- (1) Identification and implementation of a meaningful day definition for each person served;

- (2) Documentation summarizing the following:
 - (a) Daily choice-based options; and
 - (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP.
- (3) Significant changes in the individual's routine or staffing;
- (4) Unusual or significant life events;
- (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;
- (6) Record of personally meaningful community inclusion;
- (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and
- (8) Any additional reporting required by DDSD.

F. Staff Training Requirements. All Community Inclusion Services Provider Agencies shall provide staff training in accordance with the DDSD Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators. For Community Access Services only, the DDSD may waive these training requirements if requested in writing by the Provider Agency with a justification of why the individual requires the services of a uniquely trained community access staff person (e.g., the community access desired outcome in the ISP relates to participation in the city concert band and the individual wants their music teacher to provide community access services), and with a proposed alternative training plan. All Community Inclusion Services Provider Agencies are required to report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:

- (1) Initial comprehensive personnel status report (name, date of hire, identification number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services; and
- (2) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, or agency position changes, and name changes.

G. Community Inclusion Services Staffing Specifications.

- (1) Community Inclusion Services Provider Agencies may not employ or subcontract with an immediate family member or a spouse of the individual served, to work in the setting in which the individual is served, or to work directly with the individual;

- (2) Whenever possible, direct support staff will share the interests or roles that are being developed;
- (3) Community Inclusion Services staff members who are also employed as Community Living Services staff members may not perform both roles at the same time; and
- (4) The level of supervision for each direct support staff shall be sufficient to appropriately address the needs of the individuals served.

H. Provider Agency Staff Requirements. Staff competencies are specified in each Community Inclusion Services category. Where a current staff member does not demonstrate these qualifications and competencies, a personal professional development plan is required to be developed, implemented and documented.

V. COMMUNITY INCLUSION - SUPPORTED EMPLOYMENT SERVICES. The objective of Supported Employment Service is to provide supports that achieve employment in jobs of the individual's choice in his or her community, and which increase his or her economic independence, self-reliance, social connections, and ability to grow within a career.

A. Employment First Principle. When planning services for adults, work is the priority outcome of supports and services. Individuals with developmental disabilities will be offered employment as a priority service over all other day service options. Individual placements are the preferred service. All Supported Employment services are required to demonstrate appropriately high expectations, enriched opportunities for learning, skill building, and use of least restrictive environments. Supported Employment services shall be provided at the times and places as required by the individual's employment up to 365 days a year.

B. Job Development. The initial consultation and support provided to assist an individual to plan for, explore and secure employment, including:

- (1) Job identification and development activities;
- (2) Employer negotiations;
- (3) Job restructuring;
- (4) Job sampling; and
- (5) Job placement.

C. Supported Employment Models. All of the following models may incorporate the elements of customized employment, which includes job carving, job restructuring and negotiated responsibilities. Reasonable accommodations may be an essential aspect of customized employment.

- (1) Self-Employment: Through a process of discovery, an individual may elect to start his/her own business. The provider agency, along with the IDT,

provides the necessary assistance to develop a simple business plan, conduct a market analysis of the product or service and help establish necessary tax ID, incorporation documents, bookkeeping records and adherence to local and state codes. Self-employment does not preclude employment in the other models;

- (2) Individual Supported Employment: Employment with supports in integrated work settings;
- (3) Group Supported Employment: More than one individual works in an integrated setting with staff supports on site. Regular and daily contact with non-disabled coworkers and/or the public occurs; and
- (4) Intensive Supported Employment: Offers individuals 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.

VI. SCOPE OF SUPPORTED EMPLOYMENT SERVICES.

A. Supported Employment. Supported Employment includes self-employment, individual supported employment, group supported employment and intensive supported employment. The IDT members will consider all Supported Employment options with priority given to the most individualized, normative, and highest paying opportunity for the individual based on his or her informed choice. Vocational assessments and Career Development Plans, as well as the individual's personal definition of a meaningful day, shall be used to help guide the selection of employment outcomes for the individual and shall be integrated into the ISP. The IDT is required to assure that each individual's definition of a meaningful day matches the criteria described in the Definition section of these standards. The Scope of Supported Employment may include, but is not limited to the following service standards (consistent with the ISP):

- (1) Initial development of a Career Development Plan based on the individual's current ISP (containing a vocational assessment/profile);
- (2) Job development activities;
- (3) Employer negotiations, job restructuring and job carving;
- (4) Job sampling;
- (5) Placement in a job related to the individual's desired employment outcomes as stated in the ISP Work/Learn Action Plan;
- (6) Co-worker training;
- (7) Facilitating job accommodations and use of assistive technology, including the use of communication devices;
- (8) Job site analysis (matching workplace needs with those of the person);

- (9) Job coaching;
- (10) Situational and/or vocational assessments and profiles;
- (11) On-the-job training and skill development;
- (12) Integrating therapy plans related to the workplace;
- (13) Educating the individual and others on rights and responsibilities and the role of self-advocacy in the work place;
- (14) Arrange for or provide benefits counseling (e.g. SSI/SSDI);
- (15) For individuals engaged in self-employment, assistance with the development of business plans, marketing, banking, and other services relating to the implementation of their business plan;
- (16) Participation with the IDT to develop a plan to assist a person who desires to move from group employment to individual employment; and
- (17) Facilitate, arrange or provide transportation or public transportation during Supported Employment Services.

B. Service Locations. Development of supports and expectations at the work site are required to be negotiated with employers prior to and during employment. Each ISP shall specify natural supports available to the individual and address related training for the employer's staff that will be providing support. Supported Employment Services occur in integrated settings. An Individual Supported Employment setting is a work environment in which 80% of the employees do not have developmental disabilities and where an individual has consistent (throughout the work day) opportunity to interact with non-disabled people. To be integrated, the work site is required to also provide opportunities for the individual to participate in work-related activities or events (e.g., lunch, breaks, company parties) and develop friendships and relationships with non-disabled co-workers. Persons who select Self Employment or Group Supported Employment may be exempt from this requirement, but interaction with non-disabled individuals other than agency staff is required.

C. Service Limitations for Supported Employment Services.

- (1) Individuals who perform work for the Provider Agency shall adhere to all the requirements of the Supported Employment Services models; and
- (2) Supported Employment Services may not be furnished under the DD Waiver if the service is otherwise available through Rehabilitation Act of 1973 or P.L.94-142; or through the Individuals with Disabilities Education Act (IDEA).

VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS.

A. Service Criteria. Supported Employment Services criteria shall include, but are not limited to the following:

- (1) Supported Employment is intended for individuals who are 18 years of age or older. Any exception to the age requirement shall have the prior written approval of DDS on at least an annual basis;
- (2) Individuals are eligible for DD Waiver Supported Employment Services only when the service is not otherwise available for the individual under a program funded under the Rehabilitation Act of 1973, available through the Division of Vocational Rehabilitation (DVR), or through the New Mexico Department of Education;
- (3) Compensation for individuals working in Supported Employment shall be in compliance with federal and state Wage and Labor laws and standards;
- (4) Employment services are to be available 365 days a year, 24 hours a day. Services are driven by the individual's desired outcome and the job;
- (5) Medicaid funds (i.e., Provider Agency reimbursement) may not be used to pay the individual; and
- (6) Development of specific supports and expectations at the work site shall be appropriate to the setting and negotiated with employer prior to and during employment.

B. Performance Contracts. All Supported Employment Provider Agencies shall adhere to the Performance Contracts standards at Chapter 5, section III, subsection C for applicable requirements.

C. Performance Expectations for Supported Employment Services. The following requirements will be used in the evaluation of and contract management for the Supported Employment Provider:

- (1) Adults of working age are provided the opportunity to become employed in integrated community work environments;
- (2) All individuals requesting benefits counseling will have arrangements made to receive it;
- (3) The ISP, including vocational assessments, has been implemented to guide job development and placement activities;
- (4) Job development activities are focused on the individual's preferred employment outcomes;
- (5) The Supported Employment Provider is engaged in job development activities that lead to successful job matches;

- (6) Individuals are not excluded from Supported Employment services based on level of disability;
- (7) Individual's work at least ten (10) hours or more per week or the hours worked is consistent with the ISP;
- (8) Individuals are typically compensated for work at the prevailing wage;
- (9) Individuals are supported to maintain continuous employment;
- (10) Individuals receive job benefits and services such as paid time off, health insurance, retirement, awards, raises, performance reviews and training consistent with those in a similar job category;
- (11) The Supported Employment Provider Agency helps develop opportunities for career enrichment and supports individual career advancement goals; and
- (12) When an individual is being served to maintain employment, the provider shall also consider career development, skill development for advancement and integration in work-related activities or events.

D. Provider Agency Requirements.

- (1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDS. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.
- (2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:
 - (a) Quarterly progress reports;
 - (b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDS;
 - (c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will

complete specific tasks including the individual, as well and a review and reporting mechanism for mutual accountability; and

- (d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.

(3) Provider Agency Reporting Requirements:

- (a) The Supported Employment Provider Agency shall submit the following to the Case Manager:

- (i) Quarterly Progress Reports based upon the individual's ISP cycle;
- (ii) Vocational Assessment; and
- (iii) Written updates, at least every six (6) months, to the ISP Work/Learn Action Plan. These updates do not require an IDT meeting unless changes requiring team input need to be made (e.g., adding more hours to the supported employment budget).

- (b) The Supported Employment Provider Agency shall submit to DDS:

- (i) Vocational Assessments;
- (ii) Written updates, at least every six (6) months, to the ISP Work/Learn Action Plan;
- (iii) Quarterly Supported Employment Wage and Hour Reports based upon the DDS fiscal year; and
- (iv) A narrative summary report explaining the status of individuals on the performance contract that has not met their outcomes.

- (4) Training Requirements: Each Provider Agency shall retain staff trained to establish Career Development Plans. Staff training shall be provided or arranged in accordance with DD Waiver "Standards for Service Personnel." Training will be provided by the Provider Agency necessary to ensure that individuals are able to demonstrate competency in skills listed under these standards.

(5) Staffing Requirements (Individual to Staff Ratio):

- (a) The provider shall ensure adequate staffing to assure health, safety, and promote positive work behavior and growth. The amount of staff contact time shall be adequate to meet the individual's needs and outcomes as indicated in the ISP and may vary according to purpose (e.g., job development, job training, job stabilization, career enhancement). For Individual Supported Employment, the staff to individual ratio is 1:1 unless otherwise specified in the ISP. For

Individual Supported Employment, a minimum of 1 one-hour face-to-face visit per month is required.

- (b) Staffing Restrictions: Agencies may not employ or sub-contract direct care personnel who are an immediate family member or who are a spouse of the individual served to work in the setting in which the individual is served.
 - (c) Supervision: In a group employment setting, the provider determines the job site and is responsible for the day-to-day supervision of the individuals and for follow-up services. For individual placements, the employer is responsible for the provision of general supervision consistent with his or her role as employer. When necessary and appropriate, the Supported Employment Provider Agency may supplement these services.
- (6) Qualification and Competencies for Supported Employment Staff (includes intensive): Qualifications and competencies for staff providing job coaching/consultation services shall, at a minimum, be able to:
- (a) Provide supports to the individual as contained in the ISP achieve his or her outcomes, action plans;
 - (b) Employ job-coaching techniques and to help the individual learn to accomplish job tasks to the employer's specifications;
 - (c) Increase the individual's capacity to engage in meaningful and productive interpersonal interactions with co-workers, supervisors and customers;
 - (d) Identify and strengthen natural supports that are available to the individual at the job site and fade paid supports in response to increased natural supports;
 - (e) Identify specific information about the individual's interests, preferences and abilities;
 - (f) Effectively communicate with the employer about how to support the individual to success including any special precautions and considerations of the individual's disability, medications, or other special concerns;
 - (g) Monitor and evaluate the effectiveness of the service and provide documentation that this information is effectively communicated to the Case Manager and the IDT members through progress notes, quarterly reports, and participation in IDT meetings;
 - (h) Address behavioral, medical or other significant needs identified in the ISP that require intensive one-on-one staff support;

- (i) Implement therapeutic recommendations including speech, occupational and/or physical therapy, behavioral support, special diets and other therapeutic routines;
 - (j) Communicate effectively with the individual including communication through the use of adaptive equipment as well as the individual's Communication Dictionary, if applicable, at the work site;
 - (k) Administer medications in accordance with DDS's "Medication Assessment and Delivery Policy and Procedures";
 - (l) Monitor health, medication and pharmacy needs;
 - (m) Document information that pertains to ISP, progress notes, outcomes, and health and safety issues/concerns and any and all other required documentation by DDS;
 - (n) Adhere to relevant state policies/standards and Provider Agency policies and procedures that directly impact services to the individual;
 - (o) Model behavior, instruct and monitor any work place requirements to the individual;
 - (p) Adhere to professionally acceptable business attire and appearance, and communicate through interactions a business-like, respectful manner; and
 - (q) Adherence to the rules of the specific work place, including dress, confidentiality, safety rules, and other areas required by the employer.
- (7) Qualifications and Competencies for Job Development: In addition to the competencies listed above, staff providing job development and related services shall, at a minimum, have the following qualifications:
- (a) Utilize community resources to locate potentially appropriate employers;
 - (b) Negotiate job functions, hours, and supervision in the individual's best interests;
 - (c) Conduct satisfaction surveys twice per year with the employer and employee;
 - (d) Broker relationships between the employer and the individual in order to develop and maintain job success;
 - (e) Identify potential employers and jobs in the area that provide work opportunities consistent with the individual's preferences, interests and choice;
 - (f) Conduct job and task analysis to ensure appropriate job match;

- (g) Assess barriers to individual skill development on the job and provide or obtain appropriate accommodations tailored to the individual's ability to master task;
- (h) Interact professionally in individual or group contacts, on the phone, in writing with various levels of a company, including human resources and management;
- (i) Assist employer with ADA issues, WOTC eligibility, and requests for reasonable accommodations, disability awareness training and workplace modifications or make referrals to appropriate agencies;
- (j) Utilize, refer and communicate with DVR concerning job placement and referral activities consistent with standards;
- (k) Utilize, as professionally indicated, Department of Labor Navigators, One-Stop Career Centers, Department of Labor, Business Leadership Network, Chambers of Commerce, Job Accommodation Network, Small Business Development Centers, Retired Executives, Businesses, community agencies, NM Employment Institute, DDS resources, to achieve employment outcomes; and
- (l) Maintain ongoing communication with various levels of the company to assure satisfaction to both the individual and the company.

E. Reimbursement.

(1) Billable Unit:

- (a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job.
- (b) The billable unit for Individual Supported Employment is one hour. A maximum of four units a month is allowed. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. If an individual needs less than one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include:
 - (i) Researching potential employers via telephone, Internet, or visits;
 - (ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents;
 - (iii) Arranging appointments for job tours, interviews, and job trials;
 - (iv) Documenting job search and acquisition progress;

- (v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and
 - (vi) Meetings with individual surrounding job development or retention not at the employer's site.
- (c) Intensive Supported Employment services are intended for individuals who need one-to-one, face-to-face support for 32 or more hours per month. The billable unit is one hour.
 - (d) Group Supported Employment is a fifteen-minute unit.
 - (e) Self-employment is a fifteen minute unit.
- (4) Billable Activities include:
- (a) Activities conducted within the scope of services;
 - (b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and
 - (c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDS Regional Office.

VIII. COMMUNITY INCLUSION: COMMUNITY ACCESS SERVICES.

Community Access Services promote the development of valued social relationships and build connections within local communities. Community Access Services support the development of skills, and behavior that strengthen an individual's connection with his or her community. The objective of the Community Access Services is to create meaningful, sustained relationships with non-disabled community members who share common interests, preferences, and goals. The individual is supported to create such community connections individually in the community, not as part of a group of people with disabilities. Community Access Services support an individual having frequent opportunities to expand meaningful roles in the community with the role of paid staff decreasing as natural supports, networks, friendships and a sense of belonging are built. In order to promote self-determination, increase interdependence and enhance the individual's ability to interact with and contribute to his or her community. This service is provided outside of the individual's residence and segregated facilities.

- A. Community Access Services For Children.** For children and youth, the objective of the Community Access Services is to support the family in understanding and promoting his or her 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. The frequency, duration and scope of this

service are determined by the individual's needs. Consideration in planning is required to be given to family priorities concerns and resources. Community Access Services is funded through the Annual Resource Allotment (ARA). Community Access Services may not supplant the responsibility of the New Mexico Department of Education public school system for children age 3 to age 22, other services through the Medicaid State Plan Program, or the responsibility of the NM Family Infant Toddler Program for early Intervention services under IDEA.

IX. SCOPE OF COMMUNITY ACCESS SERVICES.

A. General. Community Access Services include, but are not limited to, the following requirements:

- (1) Participation in the IDT to provide information and develop strategies for inclusion of Community Access Services within the ISP action plans;
- (2) Identification of individual preferences, interests, vision, goals related to relevant desired outcomes;
- (3) Verification that the ISP contains for each individual a personal definition of a meaningful day; the IDTs shall assure that each person has a definition of a meaningful day that matches the criteria described in the definition of meaningful day at the beginning of these standards;
- (4) Identification of generic community resources and options;
- (5) Facilitation of inclusion of individual within community group or volunteer organizations;
- (6) Development of connections resulting in the individual joining formal or informal associations, community groups, clubs, and associations related to the individual's hobbies, interests, and preference;
- (7) Development of individual access for participation a broad range of community settings and design and implement activities based upon the identified interests and desired outcome;
- (8) Securing supplemental community resources (time, information, materials and other resources) so that the individual may engage in meaningful community activities;
- (9) Training, guidance and support for the development of decision-making skills;
- (10) Training, guidance and support to develop and maintain valued social roles within community groups or organizations;
- (11) Medication administration in accordance with the DDS "Medication Assessment and Delivery Policy";

- (12) Training, guidance and support of volunteer community placements;
- (13) Assistance with the development of natural support networks within integrated settings, including the development and use of strategies, when appropriate, to complement, reduce or replace paid support;
- (14) Community based training and guidance to support successful identification and use of generic community transportation options (includes how to access and utilize transportation services);
- (15) Nursing and medical oversight services as outlined in Chapter 1, III, E;
- (16) Identification of the individual's/family's existing relationships and support network and which could be leveraged as resources for desired relationships and memberships;
- (17) Assure skill acquisition in natural community settings (for example: decision-making, and maintaining valued social roles), and behaviors that strengthen an individual's connection with his or her community, including identifying work options;
- (18) Identify and support development of volunteer peer mentors that emerge from natural community settings related to #1; and
- (19) Identify and support opportunities for mutual mentorship in areas where the person with a disability has talents and gifts to mentor others.

X. SCOPE OF SERVICES SPECIFIC TO CHILDREN.

In addition to the activities above, Community Access Services for children focus on support to the family and the child by providing information and training to the child's natural supports to increase knowledge and capacity to meet the child's needs. Natural Supports include the child's extended family and peers as well as other community members.

A. The scope of Community Access Services. Specific to children shall include, but is not limited to, the following:

- (1) Support and assist the family in identifying priorities and the outcome required of this service;
- (2) Identify or develop and sustain a network within the community to assist in implementing the allowable activities;
- (3) Identify, arrange for and effectively manage access to community resources and use of allowable activities;
- (4) Monitor and evaluate the effectiveness of the service; and
- (5) Report on the effectiveness of the service to the family, the Case Manager and the IDT members through reports (verbal and written) and participation in IDT meetings.

- (6) Community Access Coaching is also child-specific information sharing, consisting of:
- (a) Gathering and sharing with the family and others information about the child's development and medical needs;
 - (b) Assisting families in identifying and accessing natural supports;
 - (c) Coaching the natural supports about needs, interests and goals of the child;
 - (d) Coaching natural supports about special precautions and considerations of the child's disability, medications, or other special concerns; and
 - (e) Developing activities with natural supports that make personal and social outcomes possible.
 - (f) Identifying and establishing peer mentor relationships which develop on-going guidance, functional modeling, and support through peer mentorship to promote interaction and social skills of the eligible child, as well as to create new opportunities to access age-appropriate activities in the community. Peer mentorship may consist of:
 - (i) Assisting the child/family in identifying potential peer mentors who are relevant to the child's interests and needs;
 - (ii) Recruiting peer mentor(s);
 - (iii) Coaching the peer mentor for the purpose of building social relationships, friendships, and participation in community/school extra-curricular activities; and
 - (iv) Organizing or selecting/arranging for co-participation in activities and other opportunities for interaction between the typical peer and the eligible child.
 - (g) Information and training to support the family in achieving goals for the child;
 - (h) Information and training to assist the child to interact in self-directed and growth promoting ways with his or her family, and other caregivers; and
 - (i) Information and training to promote the development of skills that will assist the child with access to and participation in typical activities and functions of community life.

XI. COMMUNITY ACCESS SERVICES REQUIREMENTS.

- A. Community Access Service Criteria.** Individuals of any age are eligible to receive this service. The Community Access Services may be used in conjunction with Community Living, Adult Habilitation, Supported Employment, and Respite Services. Community Access Services may not be provided at the same times as any other service, except Therapies and Case Management. Community Access Services may not be used to provide or replace Supported Employment services, such as job coaching to teach vocational skills or to provide on the job supports. Community Access Services must be provided at times/places appropriate to the activity and desired outcomes as specified in the ISP.
- B. Performance Contracts.** All Community Access Provider Agencies shall adhere to the Performance Contracts standards at Chapter 5, section III, sub-section A for applicable requirements.
- C. Performance Expectations for Community Access Provider Agencies.** The Community Access Services provider shall comply with Community Inclusion Services Performance Expectations, III C and assure and document implementation of the ISP through the following activities:
- (1) Develop with the individual, a schedule of daily activities based on the ISP;
 - (2) The individual is supported to actively participate in integrated activities, in his or her community, to develop friendships and caring relationships with non-disabled peers and with people other than paid staff and family members;
 - (3) The individual makes choices throughout the day about his or her everyday life, including daily routines;
 - (4) The individual is connected with experienced self-advocates through statewide and local advocacy efforts in order to promote self-advocacy;
 - (5) The individual has reduced dependence on paid supports, increased interdependence, and use of natural supports;
 - (6) The individual achieves his/her desired outcomes related to community inclusion;
 - (7) The individual is engaged in building skills in the community that are directly linked to his or her desired outcomes as specified in the IDT;
 - (8) The individual has opportunities to engage in preferred, valued volunteer activities within his/her community;
 - (9) The individual is provided opportunities and supported to participate in age appropriate, generic education classes where non-disabled peers are in the majority within the community;

- (10) The individual is provided opportunities and supported to become an active member of clubs, civic and church groups, hobby clubs, sport groups, political organizations and other interest groups;
- (11) The individual may be engaged in job exploration activities and is referred to the Division of Vocational Rehabilitation and/or Supported Employment providers when the individual indicates a work preference;
- (12) The individual may receive career counseling that is directly linked to his or her desired outcomes; and
- (13) The individual has roles in his or her community that are valued by non-disabled people.

D. IDT Coordination.

- (1) The IDT members shall document Community Access hours in the ISP.
- (2) The IDT members shall determine clear activities, and identify individualized outcome, roles and relationships to be developed.

E. Community Access Services Location.

- (1) Services may be generally provided in any community location that supports achievement of ISP desired outcomes. Services may not be provided within Adult Habilitation Centers. Services may only be provided in the individual's residence in cases where the generic Community Access Services activity involves a periodic meeting with non-disabled peers in the individual's residence (e.g. a cooking club, where members take turns preparing dinner at residence for other club members).
- (2) Community Access Service is not a residential service and shall not supplant or enhance the community integration requirements or other responsibilities of the Community Living Services Providers. Community Access Service does not include activities that would normally be a component of an individual's residential services.
- (3) Community Access Services are not Supported Employment services and may not be used to supplant the requirements or responsibilities of Support Employment Service Providers.

F. Community Access Services Provider Agency Staff Qualifications and Competencies.

- (1) Qualifications and Competencies for Community Access Coaches. The Community Access Coach shall, at a minimum, demonstrate the ability to:
 - (a) Provide non-stigmatizing, age appropriate, respectful personal care and support in typical community settings;

- (b) Support and assist the individual and any natural supports in identifying priorities and the outcomes required of this service;
- (c) Identify or develop, document and sustain a network of natural supports within the community to assist in achieving the individual's desired outcomes;
- (d) Identify, arrange for and effectively manage access to community resources to achieve desired outcomes;
- (e) Document specific information about the individual's interests, choices and abilities;
- (f) Assist the individual to identify natural supports and to understand his or her role;
- (g) Coach the community supports about needs, interests and desired outcomes of the individual as requested and needed to support the individual to success;
- (h) Effectively communicate with natural supports about precautions and considerations of the individual's disability, medications, or other concerns;
- (i) Develop activities with natural supports that make personal and social desired outcomes possible;
- (j) Provide skill training in community settings that supports the attainment of the individual's desired outcomes as specified in the ISP (For example, a direct support staff providing education on the use of public transportation is required to have knowledge of the local transportation system, challenges likely to be encountered by the individual and solutions to those challenges that can be successfully carried out by the individual);
- (k) Work collaboratively with individuals, families, guardians, natural supports, other IDT Members, and the community;
- (l) Monitor and evaluate the effectiveness of the service;
- (m) Report on the effectiveness of the service to the Case Manager and the IDT members through progress notes, quarterly reports, and participation in IDT meetings;
- (n) Demonstrate knowledge and expertise in individual-centered service delivery methods/models, relationship development and peer mentorship models/methods and partnering and networking with community organizations;
- (o) Implement strategies to address behavioral and/or medical needs identified in the ISP and related support plans;

- (p) Implement recommendations from the individual's Therapist(s) and Behavior Consultant. Assist in following special diets and other therapeutic routines in typical community settings;
 - (q) Communicate effectively with the individual including communication through the use of adaptive equipment and use of a communication dictionary when the individual uses these modes of communication;
 - (r) Community Access staff working with a child and his/her family shall have extensive knowledge of the community in which the service is provided and experience related to the following:
 - (i) Working collaboratively with children and families;
 - (ii) Family centered service delivery methods or models;
 - (iii) Youth development and peer mentorship models/methods; and
 - (iv) Partnering with schools and community organizations.
- (2) Individual to Staff Ratio of Care:
- (a) Community Access is intended to be a 1:1 service. However, when appropriate, services may periodically be provided for up to three (3) individuals who wish to pursue a common interest. Provision of this service to more than two individuals at the same time must be approved, in advance, by the DDS Regional Office, which may also time limit this arrangement and may request IDT input.
 - (b) The provider is required to identify and provide adequate staffing patterns to assure health, safety, and promote progress toward ISP outcomes.
- (3) Staff Restrictions: The Community Access staff may not provide any other Waiver service regardless of service location, during the same period of time in which he or she is providing Community Access Services.
- (4) Staff Duties: The Community Access staff provides, arranges for, supports and facilitates community participation by the individual. Required functions are to assist the individual with role development, assist in the development of natural supports, and assist with relationship building. This service promotes access to community activities in which the individual shows an interest or preference. Providers will use these standards to assess their staff members' competence to provide Community Access Services. When individuals employed as Community Access staff do not meet these competencies, a personal professional development plan will be established and implemented.

G. Reimbursement.

- (1) **Billable Unit:** A billable unit is defined as one-quarter hour of service.
- (2) **Billable Activities:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions:
 - (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan;
 - (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and
 - (c) Non face-to-face hours do not exceed 10% of the monthly billable hours.
- (3) **Non-Billable Activities:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:
 - (a) Time and expense for training service personnel;
 - (b) Supervision of agency staff;
 - (c) Service documentation and billing activities; or
 - (d) Time the individual spends in segregated facility-based settings activities.

XII. COMMUNITY INCLUSION: ADULT HABILITATION SERVICES. Adult Habilitation services provide supports to assist the individual in making her/his definition of meaningful day a reality. The service consists of daily functional and purposeful activities, including choice-making and community membership, specified by the IDT members that relate to his or her 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. The IDT are required to assure that each individual has a definition of a meaningful day that adheres to the criteria described in the Definitions section of these standards. Adult Habilitation services are designed to increase or maintain the individual's capacity for independent functioning and decision-making. Services and supports are designed to meet the unique needs of each individual. All services will demonstrate appropriately high expectations, enriched opportunities for learning, skill building, and use of community inclusive environments. All Adult Habilitation Services shall be directed toward implementation of ISP specified outcomes, based upon each individual's choices.

The Adult Habilitation Service Provider Agency is responsible for conducting written assessments of the individual to identify how to provide the services and supports needed to achieve desired outcomes resulting in community membership, community connections, valued roles, as well as moving out of Adult Habilitation into equitably paid employment. This includes identification of barriers to offering individual choice-based, age appropriate, individual ISP specified supports in the community; and a record of solutions, resources and effective practices to address the identified barriers in a time-effective manner.

When planning Adult Habilitation services, the IDT members shall recognize that the individual retains the right to make life choices that include risk. The IDT members shall assess risk on an individual basis and develop or enhance, as needed, risk mitigation strategies. The assumption of risk shall be in consideration of and balanced with the individual's ability to assume responsibility for that risk and a reasonable assurance of health and safety.

When individuals are currently receiving Adult Habilitation Services that are segregated (e.g. center-based or sheltered work), this service would be time-limited by the IDT to support movement to more appropriate, integrated age appropriate options such as employment. Services are required to include some part of each individual's day/week in integrated opportunities for work exploration, skill building, relationship building, and the development of community membership unless based upon clearly documented discussion and informed decision by the IDT.

XIII. SCOPE OF ADULT HABILITATION SERVICE.

A. Scope of Adult Habilitation. Adult Habilitation Service is intended for individuals who are 18 years of age or older. Any age exception shall be pre-approved by DDS on at least an annual basis.

The scope of Adult Habilitation Services includes, but is not limited to, the following as identified in the individual's ISP:

- (1) Skill building to support the individual's desired ISP outcomes;
- (2) Skills application in typical community settings (e.g., banking, shopping);
- (3) Contribution through volunteering in the community;
- (4) Exploration of community inclusive work options, including customized employment;
- (5) Career counseling;
- (6) Vocational assessments provided or obtained through the provider;
- (7) Volunteer placements including offering information and coaching to generic supports to support the individual's success;
- (8) Access to age appropriate adult education (e.g., coursework, conferences, with non-disabled peers);

- (9) Identification of and connection to community resources and options related to the ISP Action Plan;
- (10) Opportunities (time, information, materials and other resources) to pursue age appropriate hobbies, recreation/leisure and other interests with non-disabled peers;
- (11) Active individual choice-making during the course of the day, including daily schedules, activities, skill building, and community participation;
- (12) Information pertaining to individual rights and responsibilities in the community;
- (13) Development of self-advocacy skills;
- (14) Transportation during Adult Habilitation Services;
- (15) Non-stigmatizing, age appropriate, respectful personal care and activities of daily living (such as eating, toileting, and personal hygiene) provided as much as possible with generic methods in natural settings;
- (16) Medication related supports in accordance with DOH “Medication Assessment and Delivery” policy;
- (17) Assistance with the development of natural support networks that complement or replace paid supports, through development of personal relationships/friendships with people who are not disabled with similar interests and preferences;
- (18) Assistance with the acquisition, development, use and functional, age-appropriate application of assistive devices, specific communication dictionary and medical equipment;
- (19) Nursing and medical oversight services as needed, per the ISP and associated healthcare and crisis prevention/intervention plans;
- (20) Integration of therapy plans into daily activities in an age appropriate manner that maximizes engagement of the individual in meaningful interactions and experiences;
- (21) Coordination with the IDT to ensure that each individual with a HAT score of 4, 5, and 6 has a health care plan developed by a licensed nurse;
- (22) Development of social roles related to expressed interests and preferences, that the individual as well as the community values;
- (23) Active engagement in community sponsored activities specifically related to individual, as compared to group, interests;
- (24) Participation in age-appropriate generic retirement activities with non-disabled peers; and

(25) Development of increased independence and interdependence.

XIV. ADULT HABILITATION SERVICE REQUIREMENTS.

A. Service Criteria. Adult Habilitation Service Providers must comply with all Community Inclusion Service requirements, including, but not limited to, the following:

- (1) Providers must comply with the Performance Expectations for Community Inclusion Services in III C;
- (2) Providers must comply with the DDS Employment First Principle for Adult Individuals. When Adult Habilitation is selected as a service for an Adult or Young Adult rather than Supported Employment, the ISP shall include summary documentation of the employment options discussed and the basis for the determination of informed choice regarding the selection of Adult Habilitation Services over Employment; and
- (3) Providers must comply with the Community Inclusion Meaningful Day requirements.

B. Performance Contracts. All Adult Habilitation Provider Agencies shall adhere to the Performance Contracts standards at Chapter 5, section III, subsection C for applicable requirements.

C. Performance Expectations for Adult Habilitation Services.

- (1) Individuals make choices during the course of the day about his or her everyday life, including daily routines, schedules, activities and Community Inclusion Services;
- (2) Individuals receive the supports needed to make measurable progress toward desired outcomes as identified in the ISP;
- (3) Individuals build or maintain skills in age-appropriate activities of daily living (e.g., self-care, community living activities, banking or shopping);
- (4) Individuals have opportunities to choose and engage in age appropriate volunteer activities with non-disabled peers within his or her communities;
- (5) Each individual is supported to explore and experience his/her interests both independently and with other community members with like interests;
- (6) Therapeutic recommendations contained in the ISP, any related support plans, are implemented on a consistent basis in an age appropriate and functional manner, including allowing the designated therapist(s) access to the individual during Adult Habilitation activities and participation of relevant direct care staff in such therapy interventions for the purpose of learning to support the individual's therapy goals on a routine basis;

- (7) Individuals are supported in following special diets and other therapeutic routines in an age appropriate and functional manner;
- (8) Health care plans and medication delivery supports are implemented on a consistent, regular and safe basis consistent with DDS policy;
- (9) Individuals are engaged in exploration of community inclusive work options, including customized self-employment, as identified in ISP interests, gifts and preferences;
- (10) Individuals receive career counseling;
- (11) Appropriate referrals are made to the Division of Vocational Rehabilitation or Supported Employment providers when individuals indicate a work preference; and
- (12) Adult Habilitation Services strategies are included in the ISP, which lead to sufficient quantity and quality of supports to implement each individual's definition of a meaningful day.

D. Adult Habilitation Services Location. Unless specifically approved as an exception by a DDS Regional Office, Adult Habilitation Services take place outside of the individual's residence or any other residential setting.

- (1) Adult Habilitation Services may only be provided in the individual's residence when conditions described below in a, b, and c are all met:
 - (a) The purpose of the time spent in this setting is associated with individual schedules that accommodate personal preferences, preparing for or returning from community activities, or other transitional activities;
 - (b) The individual requires supervision/staff support; and
 - (c) The time at home is intermittent or brief; e.g., a one hour time period for lunch and change of clothes. The Provider Agency may be reimbursed for providing this support under Adult Habilitation Services without the prior approval of the DDS Regional Office.
- (2) In-Home Habilitation Services Request. If the Individual is unable to participate in Habilitation Services outside the residence, the IDT must initiate a written request for In-Home Adult Habilitation to the appropriate DDS Regional Office. The IDT members will address the support and community involvement needs of the individual in the ISP. Justification is required to be based on clinical need, and projected duration of In-Home Adult Habilitation Services, must be obtained from a physician, psychiatrist, or psychologist and submitted with the request. Each approval by DDS shall not exceed 180 calendar days. In-Home Adult Habilitation Services will not be reimbursed unless and until it receives prior approval by DDS. All activities listed under scope of services under Adult Habilitation Services are applicable to In-Home Adult Habilitation Services.

XV. PROVIDER AGENCY STAFF QUALIFICATIONS AND COMPETENCIES.

Staff providing direct services shall, at a minimum, have the ability to demonstrate the following (the provider agency must implement a professional development plan to address any staff member deficiencies in being able to demonstrate the following):

- A.** Know the individuals they support well (likes, dislikes, preferences, choices, interests, gifts, needs);
- B.** Communicate effectively and respectfully with the individual;
- C.** Contribute ideas to support the individual in achieving desired ISP outcomes;
- D.** Assist the individual to identify desired activities throughout the day and actively help the individual accomplish them;
- E.** Provide instruction to facilitate the development of new skills and generally support individual learning and development;
- F.** As part of an IDT, identify and become familiar with any community resources and options needed to fulfill ISP outcomes, Action Plans and personal Meaningful Day definitions;
- H.** Contribute to developing and implementing purposeful activities that meet the individual's definition of a meaningful day;
- I.** Document and effectively communicate daily progress toward achievement of desired outcomes as well as barriers/concerns encountered;
- J.** Communicate effectively with community members, other staff, and IDT members to accomplish the individual's desired outcomes;
- K.** Model appropriate behaviors;
- L.** Implement individual specific strategies to help the individual achieve desired outcomes, as stated in the ISP action plans, strategies and support plans;
- M.** Maintain safety standards and required related documentation at all times to ensure health and wellness;
- N.** Understand and implement crisis or emergency responses needed for individuals served;
- O.** Report incidents;
- P.** Understand when to and ask for help when needed;
- Q.** Maintain confidentiality;
- R.** Implement DDS standards, regulations and performance contract requirements; and

- S. Effectively implement relevant activities from the provider Quality Management System;

XVI. REIMBURSEMENT.

- A. **Billable Unit.** A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care.

- B. **Billable Activities.**

- (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions:

- (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and

- (b) Non face-to-face hours do not exceed 5% of the monthly billable hours.

- (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours.

XVII. Compensation in Adult Habilitation Settings. 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.

CHAPTER 6 COMMUNITY LIVING SERVICES

I. COMMUNITY LIVING SERVICES. Community Living services are individually tailored supports that assist individuals with the acquisition, retention, or improvement of skills related to living independently in the community. The objective of these standards is to establish requirements for DD Medicaid Waiver agencies providing services through Community Living Services Programs. This standard is applicable to individuals, organizations or legal entities that provide Community Living Services. Community Living Services consists of three types of living arrangements:

- A.** Independent Living Services are designed to increase or maintain the individual's skills and independence and promote self-advocacy. Independent Living Services are for people who need less than 24-hour staff support per day. Independent Living supports are only provided in the individual's home or family home in the community. Services include 24-hour on-site response capability to meet an individual's scheduled or unpredictable needs.
- B.** Family Living Services must be available up to 24 hours a day. Family Living Services may be furnished by a companion, surrogate, or natural family member who meets the requirements and is approved to provide Family Living Services in the individual's home or the home of the Family Living Services direct support provider. The individual lives with the paid direct support provider and can receive substitute care as a component of Family Living Services. Substitute care is specifically designed to provide support to the individual and give the Family Living provider relief from their care giving duties. Substitute care services assist the individual in activities of daily living; promote routine health care such as toileting, assist with self-help skills, leisure time skills, community and social awareness, and assist with meal preparation and eating, and community integration; and
- C.** Supported Living Services are typically provided in a home setting of four (4) or fewer individuals and must be available up to 24 hours a day. The reimbursement rates for Supported Living are based on the individual's level of care;

II. SCOPE OF COMMUNITY LIVING SERVICES.

- A.** The scope of Community Living Services includes, but is not limited the following as identified by the IDT:
 - (1) Assist with money management, including financial record keeping;
 - (2) Assistance to attain and maintain safe and sanitary living conditions that may include general housekeeping, shopping, washing and drying laundry;
 - (3) Assistance to maintain activities of daily living such as bathing, eating, meal preparation, dressing, and individual hygiene;
 - (4) Assistance with mobility and orientation in community integration, access and utilization of natural supports

- (5) Assistance in developing and maintaining social, spiritual and individual relationships, to include the development of generic and natural supports of his or her choosing;
- (6) Assistance to access recreational and leisure activities;
- (7) Assistance in access to training and educational opportunities on self-advocacy and sexuality;
- (8) Implementation of the ISP Therapy, Meal-time, Positive Behavioral Supports, Health Care, and Crisis Prevention/Interventions Plans, if applicable;
- (9) Assistance in developing health maintenance supports, as well as monitoring the effectiveness of such supports;
- (10) Provide or arrange for transportation for, but not limited to, Community Inclusion, leisure and recreation activities, medical, dental, and therapy appointments;
- (11) Assistance in medication management and pharmacy needs in accordance with the DDS's Medication Assessment and Delivery Policy;
- (12) Assist the individual as needed, in coordination with the designated healthcare coordinator and others on the IDT, with access to medical, dental, therapy, nutritional, behavioral and nursing practitioners and in the timely implementation of healthcare orders, monitoring and recording of therapeutic plans or activities as prescribed, to include: health care and crisis prevention/intervention plans;
- (13) Support individuals to participate in the development of house rules, schedules and planned activities; and
- (14) For individuals with a HAT score of 5 or 6, the agency nurse shall participate in the annual ISP meeting and any other IDT meetings called to address a change in health condition/new diagnosis. Such participation will preferably occur in person or by phone, but if that is not possible, may occur via provision of information to the team prior to the meeting with follow up contact afterwards.

III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES.

A. Support to Individuals in Family Living. The Family Living Services Provider Agency shall provide and document:

- (1) Assistance to the direct support provider as necessary to implement the ISP;
- (2) Staff support to the direct support provider for emergency situations;
- (3) Up to 1000 hours of substitute care for the individual,

- (4) Internal service coordination.
- (5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include:
 - (a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and
 - (b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members.

B. Home Studies. The Family Living Services Provider Agency shall complete all DDS requirements for approval of each direct support provider, 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 DDS.

C. Service Limitations. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore, a specified deduction to the daily rate for Family Living shall be made for each unit of respite received. Family Living Services can be provided to no more than two individuals with Developmental Disabilities at a time. An exception may be granted by DDS if:

- (1) Three (3) individuals are in the residence. Only two (2) of the three (3) can be on the Waiver; and
- (2) The arrangement is approved by DDS based on the home study documenting the ability of the Family Living Services Provider Agency to serve more than two individuals in the residence; or
- (3) There is documentation that identifies the individuals 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 individuals.

IV. SERVICE LIMITATIONS AND RESTRICTIONS FOR SUPPORTED LIVING SERVICES.

- A.** No more than four individuals may reside in a residence.
- B.** Supported Living Services shall not be provided in conjunction with any other Community Living Services, Respite Care, or Personal Support Service.

V. REQUIREMENTS UNIQUE TO INDEPENDENT LIVING SERVICES.

- A.** This service is intended to provide individual support, but may be provided to and services billed for more than one individual at a time under the following circumstances:
- (1) Roommates (up to 3 individuals with developmental disabilities) who both receive this service and who have compatible outcomes for the service in their ISPs.
 - (2) In small groups (no more than three individuals with developmental disabilities) during activities outside the home, such as social events or grocery shopping.
 - (3) The individual's health and safety needs can be addressed with less than one to one staffing.
- B. Service Limitations.** Independent Living Services shall not be provided in conjunction with any other Community Living Service.

VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING.

- A. IDT Assessment for Community Living Services.** Community Living Services are intended for individuals with an assessed need for residential services which are clinically justified and are the best service alternative at the time. This service is designed to provide the individual with counsel, support, and assistance to live successfully in the community and to maintain a safe and healthy living environment.
- B. Community Living Services Clinical Necessity Criteria.** Substantiated clinical necessity criteria shall be met for each individual to qualify for Community Living Services.
- (1) For Family Living Services and Supported Living Services, substantiated clinical necessity criteria shall include:
 - (a) Documentation of substantiation by the IDT that the severity of the individual's needs warrant the level of support associated with the services requested;
 - (b) Documentation of determination by the IDT that the individual needs paid staff care and support at least 340 hours a month; and
 - (c) Assessment and documentation by the IDT members that the Community Living Supports are being provided due to the unavailability of an alternative and appropriate residential service option because natural supports or less intensive support services (example are respite, personal support services, or Independent Living) are insufficient or ineffective in meeting the individual's residential service needs.
 - (2) For Independent Living Services, substantiated clinical necessity criteria shall include:

- (a) Documentation of determination by the IDT that the individual needs paid staff care and support in their home at least 20 hours per month;
 - (b) Documentation that the individual's needs cannot be met through a combination of natural support and less intensive support services purchased within their ARA.
- C. Individual Age Requirements.** To receive Community Living Services the individual shall be 18 years of age or older. In extraordinary circumstances, case by case exceptions to the age restriction for Community Living may be approved annually by the DDS Director. Under no circumstances will parents or other legally responsible relatives be approved to provide Family Living Services to a child under age 18.
- D. Individual Rights.** When planning Community Living Supports, the IDT members shall recognize the individual's rights including, but not limited to:
- (1) Home ownership
 - (2) Leased/renting a home in their own names
 - (3) Having their utilities/phone etc in their names
 - (4) Lease holder/Renter rights
 - (5) Individual needs and preferences regarding housemates
 - (6) Owning personal property
 - (7) Pursuing adult relationships
 - (8) Privacy
 - (9) General control over when, if, and to where he or she moves, unless precluded by a situation which presents an immediate risk to the individual or others in the home.
 - (10) Assumption of risk. The individual retains the right to assume risk. The assumption of risk is required to be in consideration of and balanced with the individual's ability to assume responsibility for that risk and a reasonable assurance of health and safety.
- E. Implementation of a Meaningful Day.** In the context of DD Waiver services, the term "meaningful day" means that services and supports provide individualized access for persons with developmental disabilities to participate in activities and functions of community life that are desired and chosen by the general population. The term "day" does not exclusively denote activities that happen between 9:00 a.m. to 5:00 p.m. on weekdays, but includes time spent at home and in the community while receiving Community Living Services. This includes: substantial and sustained opportunity for optimal health, self empowerment and personalized relationships; skill development and/or

maintenance; and social, educational and community inclusion activities that are directly linked to the vision, goals and desired personal outcomes as stated in the individual's Individual Service Plan and as documented in daily schedules and progress notes.

F. Financial Responsibilities of the Individual.

- (1) An individual receiving Community Living Service will be presumed able to manage his or her own funds unless the ISP documents and justifies limitations to self-management, and where appropriate, reflects a plan to increase this skill.
- (2) Costs for room and board are the responsibility of the individual receiving the service.
- (3) When room and board costs are paid from the individual's SSI payment to the Community Living Services Provider, the amount charged for room and board, must allow the individual to retain a portion of his/her SSI payment each month for personal use. Therefore, a written agreement shall be in place between the individual and the provider agency that addresses room and board and allows the individual a reasonable amount of discretionary spending money.

G. Health Care Requirements for Community Living Services.

- (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first.
- (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.
- (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:
 - (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.

- (b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.
- (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.
- (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.
- (5) That the physical property and grounds are free of hazards to the individual's health and safety.
- (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:
 - (a) The individual has a primary licensed physician;
 - (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;
 - (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;
 - (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and
 - (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).

VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS

A. Residence Case File. For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:

- (1) Complete and current ISP and all supplemental plans specific to the individual;
- (2) Complete and current Health Assessment Tool (HAT);
- (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name,

address and telephone number and dentist name, address and telephone number, and health plan;

- (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);
- (5) Data collected to document ISP Action Plan implementation;
- (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;
- (7) Physician's or qualified health care providers written orders;
- (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);
- (9) Medication Administration Record (MAR) for the past three (3) months which includes:
 - (a) The name of the individual;
 - (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;
 - (c) Diagnosis for which the medication is prescribed;
 - (d) Dosage, frequency and method/route of delivery;
 - (e) Times and dates of delivery;
 - (f) Initials of person administering or assisting with medication; and
 - (g) An explanation of any medication irregularity, allergic reaction or adverse effect.
 - (h) For PRN medication an explanation for the use of the PRN must include:
 - (i) Observable signs/symptoms or circumstances in which the medication is to be used, and
 - (ii) Documentation of the effectiveness/result of the PRN delivered.
 - (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the

individual's home and an updated copy must be placed in the agency file on a weekly basis.

- (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and
- (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.

B. Quality Assurance.

- (1) Supervisory staff of the Community Living Provider Agency shall:
 - (a) Conduct and document routine monthly visits to the residence. For Supported Living these visits will occur on each shift at least quarterly, and at least one third of these visits throughout the year shall be unannounced; and
 - (b) Meet privately with individuals and contact families/guardians to acquire information about individual and family/guardian satisfaction with his or her Community Living Services;
- (2) The Community Living Services Agency shall document and report on a quarterly basis that the monthly review of each service recipient's home has been conducted to identify any service related deficiencies. The documentation will address at least:
 - (a) For Supported Living: sufficiency of staff present for scheduled shifts;
 - (b) For Independent Living and Family Living: provision of direct support consistent with the ISP;
 - (c) Trends in medication errors;
 - (d) Physical environment health and safety;
 - (e) Action taken regarding any individual grievance; and
 - (f) Presence and completeness of required records.
- (3) The Provider Agency shall document and address all identified deficiencies.

- C. Board of Pharmacy Requirements.** Supported Living and Family Living Provider Agencies shall comply with requirements of Board of Pharmacy for licensure of residences with two (2) or more unrelated individuals.
- D. Community Living Service Provider Agency Reporting Requirements.** All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:
- (1) Timely completion of relevant activities from ISP Action Plans
 - (2) Progress towards desired outcomes in the ISP accomplished during the quarter;
 - (3) Significant changes in routine or staffing;
 - (4) Unusual or significant life events;
 - (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and
 - (6) Data reports as determined by IDT members.
- E. Agency Accounting for Individual Funds.**
- (1) The Community Living Service Provider Agency shall produce an individual accounting of any personal funds managed or used by the Community Living Service Provider Agency on a monthly basis.
 - (2) A copy of this documentation shall be provided to the individual and or his or her guardian upon request.
- F. Agency Staff Training Requirements.** All Community Living Service Agencies shall ensure staff training in accordance with the DDS Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities. Staff or subcontractors delivering substitute care under Family Living Services shall at a minimum comply with the section of this policy that relates to respite. All Community Living Service agencies shall report required personnel training status to the DDS Statewide Training Database as specified in DDS policies as related to training requirements as follows:
- (1) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDS Statewide Training Database within the first ninety (90) calendar days of providing services; and
 - (2) Quarterly personnel update reports sent to DDS Statewide Training Database to reflect new hires, terminations, agency position changes and name changes.

G. IDT Coordination.

- (1) Appropriate staff from the Community Living Provider Agency will participate on each individual's IDT, as specified in the ISP regulations (NMAC 7.26.5)
- (2) Provide copies of the completed HAT to the case manager and other IDT members as specified in Section III, B.1 above.
- (3) For individuals receiving Supported Living and Family Living Services it is the responsibility of the IDT to ensure at least 30 hours per week of planned activities outside the residence. These activities are not limited to paid supports and may include activities appropriate to the individual that are not the responsibility of the Community Living Provider.

H. Community Living Services Provider Agency Staffing Requirements.

- (1) Community Living Service Staff Qualifications and Competencies: Individuals working as direct support staff and supervisors for Community Living Service Provider Agencies shall demonstrate the following:
 - (a) The ability to understand and implement the individual's ISP
 - (b) The ability to assist the individual to meet his or her physical (e.g., health, grooming, toileting, eating) and personal management needs, by teaching skills, providing supports, and building on individual strengths and capabilities;
 - (c) The ability to assist the individual with household management (e.g., meal prep, laundry, cleaning, decorating) and with needs outside the home such as using public transportation or accessing other community services;
 - (d) The ability to assist the individual with identifying, securing and using needed equipment (e.g., adaptive equipment) and therapies (e.g., physical, occupational and speech/language);
 - (e) The ability to support the individual in the development of friendships and other relationships; and
 - (f) The ability to identify crisis situations, defuse the situation, implement immediate intervention crisis response strategies consistent with the Crisis Prevention/Intervention Plan, Positive Behavioral Support Plan or other relevant intervention strategies or actions identified in the ISP;
 - (g) The ability to maintain accurate records;

- (h) The ability to maintain standards of confidentiality and ethical practice;
 - (i) The ability to effectively employ communication skills to build rapport and channels of communication by recognizing and adapting to the range of individual communication styles;
 - (j) The ability to assist and support the individual to develop strategies, make informed choices;
 - (k) The ability to identify the need for community supports and work with the individual's informal support system and other IDT Members to initiate meaningful community connections; and
 - (l) Maintain current First Aid and CPR certification.
- (2) Provision of Services. Community Living Services shall be available up to 24 hours per day, 365 days a year but do not include the time when an individual is employed, at school, or participating in Community Inclusion Services. Examples of when twenty-four (24) hour care shall be provided include:
- (a) Illness, accidents and recovery;
 - (b) Emergencies;
 - (c) Individual works non-traditional hours; and
 - (d) Holidays.
- (3) Supported Living Services Provider Agencies will ensure a staffing ratio that supports the health and safety of the individual. Agency direct support staff shall not simultaneously provide coverage to more than one residence, except as emergency on-call staff.
- (4) For Independent Living Services, staff support is available as needed and is furnished on a planned periodic schedule of less than 10 hours per day as specified in the ISP. Unscheduled direct support personnel are available through an emergency on-call system within sixty (60) minutes.

I. Staffing Restrictions.

- (1) Any individual who operates or is an employee of a boarding home, residential care home, nursing home, group home or other similar facility in which the individual resides shall not serve as guardian for that individual, except when related by affinity or consanguinity § 45-5-31(1) A NMSA (1978). Affinity which stems solely from the caregiver relationship is not sufficient to satisfy this requirement.
- (2) The spouse of the individual may not provide Family Living Services to that individual.

J. Qualification for Agency Supervisors. Personnel who are directly responsible for the supervision of Family Living direct support providers or Supported Living and Independent Living staff are required to meet the following requirements:

- (1) Be twenty-one (21) years of age or older;
- (2) Possess a high school diploma or G.E.D;
- (3) Have a minimum of one-year experience working with individuals with developmental disabilities or related field; OR a degree in a related field may substitute for experience; and
- (4) Complete training and demonstrate the competencies specified in the DDSD Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators.

K. Nursing Requirements and Roles.

- (1) All Community Living Service Provider Agencies are required to have a registered nurse (RN) on staff. The agency nurse may be an employee or a sub-contractor.
- (2) The Community Living Service Provider Agency shall ensure that activities conducted by agency nurses comply with the roles and responsibilities identified in these standards. The Community Living Service Provider Agency reimbursement for nursing services is included in the rate for Community Living Services.
- (3) A Community Living Support Provider Agency shall not use a licensed practical nurse (LPN) without a registered nurse (RN) supervisor.

L. Residence Requirements for Family Living Services and Supported Living Services.

- (1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:
 - (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;
 - (b) General-purpose first aid kit;
 - (c) When applicable due to an individual's health status, a blood borne pathogens kit;
 - (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;

- (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;
 - (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;
 - (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and
 - (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.
- (2) Overall each residence shall maintain basic utilities, i.e., gas, power, water, telephone at the residence and shall maintain the physical environment in a safe and comfortable manner for the individuals.
- (3) Each individual shall have access to all household equipment and cleaning supplies unless precluded by his or her ISP.
- (4) Living and Dining Areas shall:
- (a) Provide individuals free use of all space with due regard for privacy, personal possessions and individual interests;
 - (b) Maintain areas for the usual functions of daily living, social, and leisure activities in a clean and sanitary condition; and
 - (c) Provide environmental accommodations based on the unique needs of the individual.
- (5) Kitchen area shall:
- (a) Possess equipment, utensils, and supplies to properly store, prepare, and serve at least three (3) meals a day;
 - (b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and
 - (c) Water temperature is required to be maintained at a safe level to both prevent injury and ensure comfort.
- (6) Bedroom area shall:

- (a) At a maximum of two (2) individuals share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;
 - (b) All bedrooms shall have doors, which may be closed for privacy
 - (c) Physical arrangement of bedrooms compatible with the physical needs of the individual; and
 - (d) Allow individuals the right to decorate his or her bedroom in a style of his or her choice consistent with a safe and sanitary living conditions.
- (7) Bathroom area shall provide:
- (a) For Supported Living, a minimum of one toilet and lavatory facility for every two (2) individuals with Developmental Disabilities living in the home;
 - (b) Reasonable modifications or accommodations, based on the physical needs of the individual (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.):
 - (i) Toilets, tubs, showers used by the individual(s) provide for privacy; designed or adapted for the safe provision of personal care; and
 - (ii) Water temperature maintained at a safe level to prevent injury and ensure comfort.

IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES.

A. Reimbursement for Supported Living Services.

- (1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year.
- (2) Billable Activities:
 - (a) Direct care provided to an individual in the residence any portion of the day.
 - (b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community.
 - (c) Any activities in which direct support staff provides in accordance with the Scope of Services.
- (3) Non-Billable Activities:

- (a) The Supported Living Services provider shall not bill DD Waiver for Room and Board.
- (b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services.
- (c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.

B. Reimbursement for Family Living Services.

- (1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year.
- (2) Billable Activities shall include:
 - (a) Direct support provided to an individual in the residence any portion of the day;
 - (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and
 - (c) Any other activities provided in accordance with the Scope of Services.
- (3) Non-Billable Activities shall include:
 - (a) The Family Living Services Provider Agency may not bill the for room and board;
 - (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and
 - (c) Family Living services may not be billed for the same time period as Respite.
 - (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight.

C. Requirements Related to Reimbursement of Family Living Direct Support Providers.

- (1) The Family Living-Provider Agency will assure that direct care providers receive payment totaling at least \$2,150 per month less any deductions for respite services used.

(2) Up to 1000 hours of substitute care for direct support providers is included as part of the Family Living Service. Substitute care must be billed under the appropriate Family Living service component code in the Medicaid Management Information System (MMIS) billing system.

D. Reimbursement for Independent Living Services. The billable unit for Independent Living Services is a monthly rate with a maximum of 12 units a year. Independent Living Services is reimbursed at two levels based on the number of hours of service needed by the individual as specified in the ISP. An individual receiving at least 20 hours but less than 100 hours of direct service per month will be reimbursed at Level II rate. An individual receiving 100 or more hours of direct service per month will be reimbursed at the Level I rate.

CHAPTER 7
SERVICE STANDARDS FOR ENVIRONMENTAL MODIFICATIONS

- I. ENVIRONMENTAL MODIFICATION SERVICES.** Environmental modifications are physical adaptations identified in the individual's ISP, which provide direct medical or remedial benefits to the individual's physical environment. All environmental modifications shall address the individual's disability, and enable the individual to function with greater health, safety or independence in the home.

Environmental modification services are not funded through the individual's Annual Resource Allotment (ARA). Funding for adaptations is available in a capped amount of up to seven thousand dollars (\$7,000.00) every five (5) years. Funding not used in any given five year period may not be carried over. For individuals allocated prior to July 1, 2002 the first five (5) year funding period begins with each individual's first ISP date following July 1, 2002. For individuals allocated since July 1, 2002 the five (5) year time period will be tracked individually starting on the date of the first approved ISP.

II. SCOPE OF ENVIRONMENTAL MODIFICATION SERVICE.

- A. Permitted Uses.** The scope of Environmental modifications shall include, but are not limited to the following modification and purchase with installation services:

- (1) Ramps;
- (2) Lifts/elevators;
- (3) Porch or stair lifts;
- (4) Hydraulic, manual or other electronic lifts;
- (5) Modifications/additions to existing bathroom facilities;
- (6) Roll-in showers;
- (7) Sink modifications;
- (8) Bathtub modifications;
- (9) Toilet modification;
- (10) Water faucet controls;
- (11) Floor urinal and bidet adaptations and plumbing modifications;
- (12) Turnaround space adaptations;
- (13) Widening of doorways/hallways;
- (14) Specialized accessibility/safety adaptations/additions;

- (15) Handrails, grab-bars, door handle adaptations, trapeze and mobility track systems for home ceilings;
- (16) Automatic door opener/doorbells;
- (17) Environmental controls incorporated into the house structure;
- (18) Fire safety adaptations;
- (19) Medically necessary air filtering devices;
- (20) Medically necessary heating/cooling adaptations;
- (21) Glass substitutes for windows and doors;
- (22) Modified switches, outlets or environmental controls for home devices; and
- (23) Alarm and alert systems or signaling devices.

B. Exclusions and Restrictions.

- (1) Environmental modification improvements or repairs to the existing home, which do not provide direct medical, safety, or functional benefit to the individual or that should be included as part of routine home maintenance, shall not be approved. Such non-covered adaptations, modifications or improvements include:
 - (a) Carpeting is excluded with the exception of repairs to carpet needed due to permitted modification. For example repair to carpet in the area of a door widening;
 - (b) Roof Repair;
 - (c) Furnace Replacement;
 - (d) Remodeling Bare Rooms;
 - (e) Other General Household Repairs.
- (2) No duplicate environmental modifications shall be approved. For example, if the individual has a safe and usable ramp, a replacement ramp shall not be approved.
- (3) New Construction: Environmental modifications cannot be used to fund new residential construction, even if the new dwelling is designed to accommodate the needs of individuals with disabilities.
- (4) Equipment covered under the State of New Mexico's Medicaid program shall not be purchased under the DD Waiver.

III. ENVIRONMENTAL MODIFICATION REQUIREMENTS. Environmental modifications services shall be coordinated with the individual, guardian, Case Managers, service providers, licensed contractors and DDS. All environmental modification projects may include repairs or modification to existing equipment.

A. Referral and Assessment.

- (1) The individual or any member of the individual's ISP Team may request an assessment for environmental modifications through the Case Manager if they feel that environmental modifications may be needed to enhance the individual's health, safety or function.
- 2) Upon notification by the Case Manager, an Occupational Therapist (OT) shall complete the assessment. The assessment should outline the targeted medical, safety, or functional concerns and include general recommendations that incorporate the individual's specific clinical and functional strengths and needs.
- (3) If an OT is not available, the services of a Physical Therapist (PT) or other qualified individual approved by the DDS Regional Office may be substituted.
- (4) The assessment report is then submitted to the Case Manager. The Case Manager and Therapist should consider less costly alternative methods or Assistive Technologies and other funding sources that may be available to address the individual's needs.
- (5) The Case Manager should then submit the following documentation to the Environmental Modification Service Provider (EMSP) for referral: the individual's contact information sheet and assessment report.
- (6) The EMSP shall coordinate with the Therapist who provided the assessment to assure planned modifications will meet the individual's clinical and functional needs. Coordination may occur during site evaluation (recommended), in person or by phone/e-mail contact.

B. Environmental Modification Budget Request Requirements. The Environmental Modification Service Provider shall submit the request to the Case Manager. The Case Manager submits the request and budget to the Regional Office that includes:

- (1) The name of the individual receiving the service;
- (2) The total estimated and authorized cost of the environmental modification;
- (3) Design criteria, which are in compliance with all Federal, State and local building codes, ordinances and applicable guidelines;
- (4) Written verification that the Environmental Modification Plan has been reviewed by the therapist who wrote the assessment report, the Case Manager and the home owner;

- (5) Written verification that the contractor authorized to complete the project is licensed by the State of New Mexico;
- (6) A copy of the assessment report;
- (7) The physical address of the home receiving the environmental modification;
- (8) The name of owner of the home where the environmental modification is to take place; and
- (9) The individual or guardian or the therapist or the Case Manager must obtain written approval of the project cost and scope from the homeowner. Subsequent materially significant project changes must be approved in writing.

C. Cost of Materials. Materials (including fixtures) utilized in projects shall meet industry construction standards while taking into account the personal preferences of the homeowner; however, Waiver funds may not be used for upgrades in materials that do not offer functional benefits to the individual.

D. Use of Other Private Funding to Augment Environmental Modifications. Other (non-Waiver) funding may be utilized to augment funding available under the Waiver subject to the following restrictions:

- (1) Cost estimates and project plans are required to specifically identify the materials to be purchased and the labor costs associated with the expenditure of Waiver versus non-Waiver funds.
- (2) Waiver funds may not be utilized to upgrade fixtures or other construction materials solely on the basis of aesthetic qualities or personal preferences when compared to lower cost fixtures or materials that provide the same or similar functional benefit to the individual.

IV. ENVIRONMENTAL MODIFICATION SERVICE PROVIDER REQUIREMENTS.

A. General Requirements. Providers of environmental modification services shall perform the following:

- (1) Ensure proper design criteria is addressed in planning and design of the modification;
- (2) Coordinate environmental modification pre-plan reviews with the individual, guardian, or other family members, Case Managers, service providers as applicable and the therapist who conducted the assessment report;
- (3) Interpret codes and clarify building procedures to the individual, guardian, homeowner or other family members, Case Manager, service providers, and DDS prior to construction activities;

- (4) When requested, provide consultation to individual, guardian, homeowner or other family members, Case Managers, service providers, subcontractors and DDS concerning environmental modification projects to the individual's residence prior to or during construction activities;
- (5) Review plans submitted by sub-contractors, if applicable, for environmental modifications to ensure that the plans are architecturally sound and in compliance with state and local building codes and standards and Americans with Disabilities Act (ADA) standards and applicable guidelines;
- (6) Review accuracy of construction costs submitted by sub-contractors, if applicable;
- (7) Ensure inspection of the final environmental modifications to ensure compliance with all local, state and federal codes and requirements.

B. Environmental Modification Service Providers Qualifications. Environmental modification providers shall demonstrate qualifications in the following areas:

- (1) Documented verification that the provider is a licensed contractor authorized to complete the project by the State of New Mexico;
- (2) Demonstrable knowledge and work history with interpreting the principles and practices of architecture, building codes and standards, building materials and construction methods, structural, mechanical and electrical systems;
- (3) Demonstrable knowledge and work history to interpret and prepare architectural working drawings and specifications, mediate contractual problems and ensure compliance with all laws, rules and standards of the State of New Mexico, including the federal, state and local building codes;
- (4) Demonstrable knowledge and work history of contracting practices and procedures, construction cost estimating and knowledge of comparable costs to accomplish the adaptations;
- (5) Demonstrable knowledge and work history of architectural design, standards and technical data relating to building design and construction; and
- (6) Demonstrable knowledge and work history to interpret, implement and ensure that Federal ADA standards and applicable guidelines are followed in all environmental adaptations when applicable to the individual's needs.

V. REIMBURSEMENT.

A. Billable Unit.

- (1) The billable unit for environmental modification is a set dollar amount specified in the current Medicaid Supplement Rate Tables for the Developmental Disabilities Home and Community Based Services Waiver.

Funding for adaptations is available in a capped amount of up to seven thousand dollars (\$7,000.00) every five (5) years. Funding not used in any given five year period may not be carried over.

B. Billable Activities.

- (1) Administrative costs of the provider completing the environmental modification services will not exceed fifteen percent (15%) of the total cost of the environmental modification project for each project managed by the Provider Agency.
- (2) Partial payment may be requested up to 50% of estimated project costs prior to the completion of the project, based upon a report submitted by the provider of environmental modification services.

CHAPTER 8
SERVICE STANDARDS FOR GOODS AND SERVICES

- I. GOODS AND SERVICES STANDARDS.** Goods and Services are services, supports or goods that support opportunities to achieve individual desired work outcomes related to living arrangements, relationships, inclusion in community activities and work, as clearly defined and documented in the Individual Service Plan. Items or services under Goods and Services fall into the following categories:
- A. Membership/Fees.** Fitness memberships, tuition/classes, summer day programs, social membership; and
 - B. Devices/Supplies.** Batteries for hearing aids and Assistive technology devices, nutritional supplements, diapers, therapeutic wedges, positioning supports, instructional supplies, instructional books and computers.
- II. SCOPE OF GOODS AND SERVICES.**
- A. General.** The scope of Goods and Services may include, but is not limited to, the following:
 - (1) Support and assistance to the individual in identifying his or her priorities and the results required from this service;
 - (2) Identification and effective arrangement of access to community resources and use of allowable resources;
 - (3) Monitoring and evaluation of the effectiveness of the service;
 - (4) Assistance to the individual or the individual's family in identifying any natural or generic community resources that might provide the same or similar goods or services;
 - (5) Purchasing goods and services authorized by the individual's IDT members.
 - B. Service Restrictions.** Purchases of goods and services are subject to the following limitations:
 - (1) The purchase of items or services covered by the Medicaid State Plan, DVR, IDEA or other DD Waiver services shall not be purchased using this service;
 - (2) The purchase of items or services that are not designed to meet the individual's non-covered functional, medical or social needs or do not promote the desired outcomes of the individual's Individual Service Plan (ISP);
 - (3) The purchase of items or services that are prohibited by federal, state or local statutes and standards; and
 - (4) The purchase of personal or domestic supplies such as food, clothing, cleaning supplies or utensils are not permitted unless the supplies are used for a specialized purpose consistent with the individual's ISP (e.g., purchase

of a work uniform for an employed individual or specialized equipment/tools).

III. GOODS AND SERVICE REQUIREMENTS.

A. General Requirements.

- (1) Goods and services are available to all qualified individuals receiving Medicaid DD Waiver services.
- (2) Goods and services are required to be delivered as specified in the ISP.

B. Goods and Services Criteria. Items purchased or services delivered shall satisfy at least one of the following criteria:

- (1) The item or service would increase the individual's functioning related to the disability;
- (2) The item or service would increase the individual's safety in the residence environment;
- (3) The item or service would support community inclusion or employment opportunities;
- (4) The item or service would decrease dependence on other Medicaid-funded services; or
- (5) No other public funds are available to cover the item(s)/service(s).

C. Delivery Location. Goods and services may be provided in any location specified in the ISP.

IV. GOODS AND SERVICES PROVIDER AGENCY REQUIREMENTS.

A. Provider Agency Financial Accounting. The Provider Agency is required to maintain a complete accounting of all finances used for each individual served. Complete accounting shall include a primary financial file for each individual, which contains the following:

- (1) Written documentation of the services and goods to include a complete description of any items purchased;
- (2) Receipts for all services and goods purchased; and
- (3) Written documentation of the scope, duration, and frequency of services provided to each individual.

B. Reporting Requirements.

- (1) Quarterly reports of expenditures are required to be submitted to the Case Manager.

(2) The Provider Agency shall provide the individual or his/her legal representative with an annual report of the goods and services purchased with DD Waiver funds. The annual report shall contain all information contained in the individual's primary financial file.

C. IDT Coordination. Purchases of goods and services shall be approved by the IDT members and documented in the ISP.

D. Reimbursement.

(1) **Billable Unit.** The billable unit for Goods and Services is a set dollar amount specified in the current Medicaid Supplement Rate Tables for the Developmental Disabilities Home and Community Based Services Waiver. The total amount allowed per ISP plan year is capped at \$1,000. A plan year ends at the expiration of the individual's ISP.

(2) **Billable Activities.**

(a) Purchases or services consistent with the scope of services subject to service limitations; and

(b) When submitting for reimbursement, provider agencies delivering Goods and Services may include a service fee up to ten percent (10%) of the cost of the good or services purchased to cover administrative costs. Provider service fees must be included as part of the budgeted annual cap of \$1,000 for this service.

CHAPTER 9 OUTLIER SERVICES

- I. OUTLIER SERVICES.** Outlier services are provided to meet the needs of individuals with severe chronic medical support requirements or behavioral issues requiring services of a frequency, duration, and intensity that exceed those typically available in other DD Waiver Services. Individuals with short-term acute support needs are covered within the existing rates or through supports available through the individual's health care insurance. Individuals with long-term extraordinary need may be eligible for Outlier Services in one of two categories: 1) High Medical Necessity and 2) Behavioral Outlier.
- II. SCOPE OF OUTLIER SERVICES.** Outlier for High Medical Necessity and Behavioral Outlier Services consist of the Scope of Services that is specific to either Community Living Supports or Adult Habilitation Service Standards.
- A. Service Requirements Applicable to High Medical Necessity and Behavioral Outlier Services.**
- (1) Outlier services specific to community living supports are available only to individuals in Supported Living Services;
 - (2) Outlier services specific to day services are only available to individuals in Adult Habilitation;
 - (3) Outlier Services are available to qualified individuals only if the frequency, duration and intensity of staff supports greatly surpass those typically available in Supported Living Services or Adult Habilitation.
- B. Service Limitations.**
- (1) Outlier Habilitation includes Nutritional Counseling and Nursing Supports, and therefore Nutritional Counseling and Private Duty Nursing Services shall not be included in the Annual Resource Allotment (ARA) budget as a separate service for an individual receiving Outlier Habilitation.
 - (2) Personal Support Services, Nutritional Counseling and Nursing Supports are included in Outlier Residential services and therefore Personal Support Services, Nutritional Counseling and Private Duty Nursing services shall not be included in the ARA budget for an individual receiving Outlier Residential services. The Outlier Residential service shall not be provided or included in the ISP in combination with Respite, Independent Living or Family Living Services.
 - (3) Approval of High Medical Necessity or Behavioral Outlier services shall be approved for a specified period of time not to exceed 180 days; continuation of Outlier services requires submission of necessary documents to the DDS Regional Office for prior written approval before submission to New Mexico Medicaid Utilization Review (NMMUR) contractor.

III. OUTLIER SERVICE REQUIREMENTS.

- A. **General.** The need for Outlier funding shall be supported by the IDT members, as indicated by the initiation of a request for Outlier services to be included in the ISP. The Provider Agency will gather all pertinent reports and documentation and ensure timely submission for prior approval of Outlier services. The ISP is required to incorporate a detailed health care plan or Positive Behavior Supports Plan as relevant to the purpose of the Outlier service. The plan(s) must specifically address the individual's condition and needs and outline the duties of additional or specialized staff.
- B. **Outlier Service Application Packet Request.** A complete application packet is required to be submitted to NMMUR for prior approval. The packet shall include documentation of the following:
- (1) A signed evaluation from a physician or nurse practitioner that the individual's medical or mental health status requires Outlier services;
 - (2) The staffing pattern necessary to meet the individual's needs (e.g., enhanced staffing hours in relation to total number of hours of staff time available in the setting); this information shall be submitted in a format determined by DDS.
 - (3) The unsuccessful attempts at accessing generic resources to address the extraordinary service need;
 - (4) The current ISP documenting the agreement by the IDT members of the need for outlier, or in lieu of the current ISP, a copy of IDT meeting minutes with participant signature page;
 - (5) For High Medical Necessity Outlier service, a written and signed health care plan developed by the Provider Agency nurse which includes specific staff functions required to meet the health needs of the individual; and
 - (6) For Behavioral Outlier service, a written Positive Behavior Supports Plan, including strategies and timelines to reduce the need for enhanced staffing, developed by the Behavioral Support Consultant.
 - (7) A signed letter from the Provider Agency summarizing alternative interventions implemented, results of those interventions, and justification for why the individual's condition and needs warrant the need for additional or specialized staff. For Behavioral Outlier, this letter must include a summary of successful or unsuccessful attempts to fade out the enhanced staff supports, or a justification as to why a fading trial would put the individual or others at risk.
- C. **High Medical Necessity Outlier Clinical Requirements.** High Medical Necessity is a chronic physical condition, including brain disorders, which results in a prolonged dependency on medical care for which a daily skilled nursing intervention is medically necessary. To be considered for the High Medical

Necessity Outlier services, the individual's condition shall be characterized by one or more of the following:

- (1) A life threatening condition characterized by frequent periods of acute exacerbation that require frequent medical supervision or physical consultation and which, in the absence of such supervision or consultation, would require hospitalization or admission to a nursing home; and/or
- (2) Frequent time-consuming administration of specialized treatments that are medically necessary and/or;
- (3) Dependence on medical technology requiring nursing oversight such that, without the technology, an acceptable level of health could not be maintained and the individual could not participate in DD Waiver services. Examples include, but are not limited to, ventilator dependency, dialysis, enteral or parenteral nutrition support and continuous oxygen and/or;
- (4) Frequent time-consuming administration of specialized treatment(s) that are ordered by a physician or nurse practitioner during a period of recovery from an acute illness or injury that will take place over a period of at least 30 days.

D. High Medical Necessity Outlier Service Requirements. High Medical Necessity Outlier is intended to augment, not replace, generic resources or natural supports including, but not limited to, family, friends, or community services, including generic medical service benefits available through the Medicaid State Plan. Clinical necessity for High Medical Necessity Outlier requires:

- (1) A signed evaluation from a physician or nurse practitioner that the individual's medical status is such that it meets the definition of High Medical Necessity;
- (2) A signed health care plan that outlines the procedures which are necessary and which indicates why the staffing within the setting shall include enhanced staffing hours; and
- (3) The enhanced staffing hours exceeds 84 hours per month in the Adult Habilitation setting or 360 hours per month in the residential setting, depending on the type of service request. Exception: When the hours of enhanced supports are nursing hours, the amount of enhanced support hours may be less than 84 in the Adult Habilitation setting or 360 in the Supported Living Services setting, as specified in the DDS Calculation Worksheets.

E. Behavioral Outlier Clinical Requirements. To be considered for the Behavioral Outlier services, the individual must exhibit frequent or regular episodes of behavior that are historical, chronic and predictable. Examples of Behavioral Outlier episodes 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 self (e.g. rape, manslaughter, battery).

F. Behavioral Outlier Service Requirements. Behavioral Outlier is intended to augment, not replace, generic resources or natural supports including, but not limited to, family, friends, or community services, including generic behavioral health service benefits available through the Medicaid State Plan single entity (Value Options). Behavioral Outlier is intended to provide necessary supports during the interim of time needed to assist the individual to obtain, regain or continue a level of stability needed to participate in daily activities. Clinical necessity for Behavioral Outlier requires:

- (1) Signed documentation in the form of a psychiatric/neurological/psychological evaluation which documents that the individual's mental health status is such that it meets the definition and provides justification for the use of additional or specialized staffing; and
- (2) Written and signed Positive Behavior Supports Plan that outlines the specific duties of additional staff, including strategies and timelines to reduce the need for enhanced staffing; and
- (3) The enhanced staffing hours exceeds 84 hours per month in the Adult Habilitation setting or 360 hours per month in the residential setting, depending on the type of service request.

IV. OUTLIER PROVIDER AGENCY REQUIREMENTS

A. Provider Agency Records. The Provider Agency is responsible for submitting quarterly reports to the Case Manager summarizing progress toward goals and significant incidents that may impact on the individual's progress.

B. Staffing Requirements. The Provider Agency is responsible for providing adequate staffing to promote health, safety, and promote positive development, which may vary according to the needs of each individual.

C. Staffing Restrictions.

- (1) Outlier Provider Agencies shall not employ direct care personnel who are an immediate family member or who are a spouse of the individual served, to work in the setting in which the individual is served;
- (2) Provider Agencies are required to have a Registered Nurse (RN) on staff or contract to perform or supervise nursing duties, if nursing duties are required by the individual while receiving this service.

D. Reimbursement. Outlier services reimbursement is only available after prior authorization has been given by the NMMUR.

(1) Billable Unit:

- (a) The billable unit for Outlier Residential services is a daily unit with a maximum of 340 days per plan year and is based on an individual's level of care (LOC).

(b) The billable unit for Outlier Adult Habilitation is in 15-minute increments and is based on an individual's LOC.

CHAPTER 10
PERSONAL PLAN FACILITATION SERVICES

- I. PERSONAL PLAN FACILITATION SERVICES.** Personal Plan Facilitation provides an opportunity for the individual to explore options and develop a comprehensive personal plan in consultation with persons they choose, rather than solely with the IDT that develops the ISP. DDSD will offer this service to all individuals who are nearing allocation to the DD Waiver free of charge. Case managers will offer the service to all ongoing DD Waiver recipients prior to the individuals annual ISP meeting. Payment will come out of the individual's Annual Resource Allotment (ARA).
- II. SCOPE OF PERSONAL PLANNING FACILITATION SERVICES.** The scope of Personal Planning Facilitation shall include, but is not limited to, the following:
- (1) The facilitator shall meet with the individual and his or her family (or guardian, as appropriate) prior to the personal planning session to discuss the process, to determine who the individual wishes to invite, and determine most convenient date, time and location. This meeting preparation shall include an explanation of the techniques the facilitator is proposing to use or options if the facilitator is trained in multiple techniques. The preparation shall also include a discussion of the role the individual prefers to play at the planning session, which may include co-facilitation of all or part of the session.
 - (2) Arrange for participation of invitees and location; and
 - (3) Conduct the personal planning session; and
 - (4) Document the results of the personal planning session and provide a copy to the individual, the Case Manager (for inclusion in the primary record) and any other parties the individual would like to receive a copy. Elements of this report shall include:
 - (a) Strengths, gifts, talents, interests and preferences of the individual;
 - (b) Long term dream(s)/goal(s) the individual wishes to pursue;
 - (c) Challenges the individual faces (if any) in pursuing his or her dream(s)/goal(s);
 - (d) Potential resources, especially natural supports within the individual's community that can potentially support the individual in pursuing his or her dream(s)/goal(s);
 - (e) A list of any follow up actions participants agreed to take, including time lines.
 - (5) Provide session participants, including the individual receiving services with an opportunity to provide feedback regarding the effectiveness of the session.

III. PERSONAL PLAN FACILITATION REQUIREMENTS.

A. General Requirements. The Personal Planning Facilitation Provider is required to identify the specific people who will be Personal Planning Facilitators who shall demonstrate one or more of the following qualifications:

- (1) Experience and skills with individual-centered planning facilitation techniques as evidenced by certificates of related training;
- (2) Be a mediator (copy of certificate of completion of mediator training will suffice);
- (3) DDS staff have observed and verified sufficient facilitation skills;
- (4) The individual served may waive number 1 through 3 above and request a specific facilitator if the Provider Agency concurs that the selected facilitator has the skills needed to provide this service;
- (5) DD Waiver Case Managers or other providers may become personal planning facilitators but may not provide this service to someone receiving direct services from his or her agency;

B. Personal Plan Facilitation Criteria.

- (1) An initial Personal Plan Facilitation service is an optional service available on a one time only basis to individuals nearing allocation to the DD Waiver. The DDS will not charge a fee for this personal plan facilitation service.
- (2) The Personal Plan Facilitation service is also available to individuals already on the DD Waiver, offered on an annual basis. The individual's ARA budget must be used to pay the Personal Plan Facilitator.

IV. PERSONAL PLAN FACILITATOR PROVIDER AGENCY REQUIREMENTS.

A. Quality Assurance.

- (1) Personal Plan Facilitation Provider Agencies are required to develop and implement quality improvement policies and procedures to assure the effectiveness of facilitation services delivered by the Provider Agency.
- (2) The Personal Plan Facilitation Provider Agencies are required to conduct a process to determine the satisfaction of individuals utilizing his or her services.

B. Reporting Requirements.

- (1) A summary of the results of the consumer satisfaction process shall be reported to the DDS by July 15th following the end of each fiscal year.

C. Reimbursement.

- (1) Billable Activities: The billable unit for Personal Plan Facilitator is set dollar amount specified in the current Medicaid Supplement Rate Tables for the Developmental Disabilities Home and Community Based Services Waiver. The maximum billable amount is \$850.00 per plan year.

CHAPTER 11
PERSONAL SUPPORT SERVICES

I. PERSONAL SUPPORT SERVICES. Personal Support Services assist the individual with activities of daily living while providing companionship to acquire, maintain or improve social interaction skills. Services range from furnishing total personal care to assisting and enhancing the individual's skills and abilities in these areas. Personal Support Services are required to be provided in ways that promote self-advocacy.

II. SCOPE OF PERSONAL SUPPORT SERVICES.

A. General. The scope of Personal Support duties shall include, but is not limited to, assistance with the following:

- (1) Household services (e.g., mopping, dusting, changing linen, laundry, cleaning bathroom, cleaning the kitchen area, etc.);
- (2) Meal preparation (e.g., eating or feeding supports to maintain good nutrition and hydration);
- (3) Accompaniment or assistance with transportation or with shopping, and/or errands, assistance with therapeutic activities or an individualized exercise program;
- (4) Personal care services (e.g., hygiene/grooming, bathing, showering, dressing, shaving, oral care, nail care, perinea care, toileting);
- (5) Minor maintenance of assistive devices (e.g., changing batteries of communication board, routine cleaning of equipment);
- (6) Skin care to maintain good skin integrity and prevent skin infection, irritation, ulceration or pressure sores;
- (7) Mobility assistance (e.g., ambulation, transfer) and minor wheelchair maintenance;
- (8) Mobility training including the use of public transportation services;
- (9) An individualized bladder program prescribed by a physician, nurse practitioner or physician assistant and developed by a registered nurse;
- (10) An individualized bowel program prescribed by a physician, nurse practitioner or physician assistant and developed by a registered nurse;
- (11) Support for the self-administration of medication;
- (12) Personal care activities and daily living to support the individual in the work place or at the site of Community Access activities;
- (13) Visual monitoring of the individual at the worksite or Community Inclusion site due to behavioral or medical issues and/or health and safety concerns that interfere with the maintenance of a job or with social integration; and

- (14) Implementation of appropriate elements of therapy plans to support daily routines at the work site and in Community Access settings.

III. PERSONAL SUPPORT SERVICES REQUIREMENTS.

A. Service Criteria.

- (1) Personal Support Services may be provided to an individual, of any age, based on necessity of care established by the IDT members, except that medically necessary personal support services to children under age 21 are required to be covered by the Medicaid state plan as required by Early Periodic Screening Diagnosis and Treatment (EPSDT) rather than being paid for through the DD Waiver ARA budget.
- (2) Personal Support Services are determined within the context of the IDT and are recorded in the individual's ISP.
- (3) Individuals requiring assistance for his or her individualized bowel and bladder program shall be determined to be medically stable by his or her primary care practitioner who shall prescribe a bowel and bladder program for an individual. A registered nurse is required to train the personal support staff assigned to implement the bowel and bladder program. The staff shall demonstrate competency to the nurse that he or she is able to properly implement the bowel or bladder program.
- (4) Individuals requiring tube feeding as a Personal Support Service shall have a primary care practitioner prescribe the feeding tube. A registered nurse is required to train the personal support staff assigned to implement the feeding program. The staff shall demonstrate competency to the nurse that he or she is able to properly implement the feeding program.

B. Service Limitations.

- (1) Personal Support Services cannot be included in the ISP to complement or supplant any Community Living Support service (i.e., Family Living Services, Supported Living Services or Independent Living). Personal Support may be used to provide support to individuals engaged in competitive employment or Community Access Services as long as no other service is billed for the same time period.
- (2) The service shall not be provided while the individual is in Adult Habilitation Services.
- (3) Personal Support Services may not be provided under the DD Waiver to children and youth under the age of 21 when the primary function of the support is physical assistance with activities of daily living or other medically necessary functions; however, the IDT members are required to coordinate with the appropriate Medicaid state plan provider to ensure provision of this service when needed.

- (4) Personal Support Services may not be provided to the individual by his or her spouse or to a minor child by a parent.

IV. PERSONAL SUPPORT PROVIDER AGENCY REQUIREMENTS.

A. Specific Privacy Requirements. For activities requiring privacy (e.g., bathing, toileting, dressing, etc.), the provider shall ensure that the place (room) in which the personal care service is delivered is suitable to the activity, that he/she is able to physically accommodate the individual in a safe, comfortable manner and that the individual's privacy and preferences are known to direct care staff and are respected. Preferences of the individual served with regard to the gender of the direct care staff shall be accommodated whenever possible.

B. Staffing Requirements. The staff to individual ratio shall be 1:1 for the period of time that the individual is receiving Personal Support Services.

(1) The designated Personal Support supervisor is responsible for the following:

- (a) Documentation of on-site visits for each personal support staff at least monthly with the individual served, at least one-third of such visits shall be unannounced;
- (b) Documentation in the individual's record, of the safety of the service and the quality of care provided to the individual;
- (c) Conduct quarterly staff meetings to review caseloads, service requirements and other service issues and activities;
- (d) Ensuring that the personal support staff is completely trained in the manner and method of caring for the individual before that staff works independently with the individual;
- (e) Ensuring that the personal support staff is made aware of any and all information from the individual's record that is essential for that staff to work effectively and safely with the individual; and
- (f) Ensuring that each individual is matched with a personal support staff who has received training in the services to be provided to the individual and is knowledgeable about the needs and preferences of the individual.

(2) Personal Support Staff Training Requirements: The Provider Agency shall ensure that the personal support staff have completed:

- (a) Current CPR and First Aid certification;
- (b) A minimum of 40 hours of initial personal support training;
- (c) Ten (10) hours of training prior to placing the personal support staff with an individual (this can be counted towards the 40-hour requirement); and

- (d) A minimum, of ten (10) hours annually of continuing education or in- service training;
- (e) Other family members may be direct support providers only if the following requirements are met:
 - (i) The individual meets the qualifications for personal support staff;
 - (ii) There is adequate written justification as to why the individual is an appropriate choice based on the individual's need and preferences; and
 - (iii) Justification is provided in writing by the Provider Agency and approved by DDS.

C. Reporting Requirements. The provider is required to submit quarterly progress reports to the Case Manager. These reports shall summarize progress towards desired outcomes and action plans and any significant events that may impact on the individual's progress.

D. Reimbursement.

- (1) Billable Unit: The reimbursement unit for the Personal Support Service is a one-quarter hour (15 minutes) interval of face-to-face contact between the direct support provider and the individual.
- (2) Billable Activities: Include those activities detailed under Scope of Service.
- (3) Non-Billable Activities:
 - (a) Attendance at in-service training, if the individual is not present;
 - (b) Visits during which specific personal support services are not provided;
 - (c) Preparation and submission of progress reports;
 - (d) Preparation of billing statements;
 - (e) Supervision activities;
 - (f) Travel to and from the individual's residence; and
 - (g) Services otherwise covered by EPSDT for children under age 21.

CHAPTER 12 RESPITE SERVICES

I. RESPITE SERVICES. The primary object of respite is to provide support to the individual while giving the primary caregiver time away from his or her duties. The primary caregiver, in collaboration with the Interdisciplinary Team (IDT), is responsible for establishing the amount of respite needed and scheduling the service with the Respite provider.

II. SCOPE OF RESPITE SERVICES.

A. The scope of respite services. Include, but are not limited to, the following:

- (1) Assistance with money management;
- (2) Assistance to attain and maintain safe and sanitary living conditions when using the individual's home for respite service that may include general housekeeping, shopping, washing and drying laundry;
- (3) Assistance to maintain activities of daily living such as bathing, eating, meal preparation, dressing, and individual hygiene;
- (4) Assistance with mobility and orientation in community integration and access to include natural and other supports for medical, dental, therapy, nutritional, behavioral and nursing supports;
- (5) Assistance in developing, maintaining social, spiritual and individual relationships, to include the development of generic and natural supports of his or her choosing;
- (6) Assistance in developing and participating in recreational and leisure activities;
- (7) Assistance in implementing the Therapy, Mealtime, Positive Behavior Supports, Healthcare and Crisis Prevention/Intervention Plans (if any);
- (8) Assistance in implementing health maintenance supports; and
- (9) Assistance with medication management needs to include only reminding, observing and monitoring self-administration of medication. Medication administration is not a respite service and must be arranged separately by the primary caregiver.

III. RESPITE SERVICES REQUIREMENTS.

A. General Requirements.

- (1) Respite services are available to any individual of any age.

- (2) The use of respite services is determined by the primary care giver in consultation with the IDT and recorded on the individual's Individual Service Plan (ISP).
- (3) If respite services are the only services included in the ISP other than Case Management for an adult age twenty-one or older, the following requirements must be met:
 - (a) At least one desired outcome and associated action plan(s) must be developed by the IDT that includes the action steps the respite provider will take to support the individual to achieve their vision.
 - (b) The IDT shall complete a Decision Justification Document to explain why respite alone is the appropriate service delivery approach for the individual. This document must be attached to the ISP.
 - (c) The respite Provider Agency must submit quarterly progress reports to the Case Manager that describe progress on the action plan(s) and desired outcome(s).

B. Respite Services Restriction. Individuals receiving Supported Living services or Independent Living services may not access respite. Respite services may be delivered to individuals receiving Family Living services as long as it is not for the same time period in which Family Living services are billed.

C. Respite Services Delivery Location. Respite may be provided in:

- (1) The individual's home or provider's home;
- (2) A community setting of the family's choice (e.g., community center, swimming pool, park); or
- (3) A location in which other individuals are provided care (e.g., a respite home).

IV. RESPITE SERVICES PROVIDER AGENCY STAFFING REQUIREMENTS.

A. Provider Agency Financial Accounting. The Respite Provider Agency must provide an individual accounting of any personal funds used on a monthly basis.

B. Staffing Requirements.

- (1) Staff Qualifications:
 - (a) Direct Support Staff are required to complete a minimum of forty (40) hour initial training program. The required training is outlined in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities.
 - (b) Direct Support Staff are required to also participate in ongoing training at a minimum of ten (10) hours per year after the first year.

- (c) Direct Support Staff are required to have current CPR and First Aid agreement.
- (d) Complete individual-specific training as outlined in the ISP for individuals they serve.

(3) Staffing Restrictions:

- (a) Respite services shall not be provided by a primary caregiver or any other individual who resides in the same dwelling as the individual served.
- (b) When respite services are provided overnight, direct service personnel may sleep when the individual is asleep, but only when the IDT members agree to this and the environment is safe and secure.

C. Respite Services Reimbursement.

(1) Billable Unit: A billable unit of service is fifteen (15) minutes of face-to-face contact between the individual and the Respite Provider that may include participation in individual-specific training required in the individual's ISP.

(2) Billable Activities:

- (a) Include those activities detailed in the Scope of Respite Service;
- (b) Participation in individual-specific training required of the Respite Provider in the ISP.

(3) Non-Billable Activities:

- (a) Travel to and from the individual's residence, except when the individual is being transported;
- (b) Attendance at training and other personnel development activities that are not face-to-face with the individual.

CHAPTER 13 THERAPY WAIVER SERVICES

- I. THERAPY WAIVER SERVICES.** Physical Therapy (PT), Occupational Therapy and Speech/Language Therapy (SLP) are skilled therapies that are recommended by an individual's Interdisciplinary (IDT) members and a clinical evaluation that demonstrates need for the therapy. A licensed practitioner, as specified by applicable state laws and standards, provides the skilled therapy services.
- II. SCOPE OF THERAPY SERVICES.** Strategies and support plans reflecting the objectives of therapy shall be developed by the therapist and training on the support plans shall be provided to caregivers for routine implementation whenever appropriate. The objectives of therapy services include the following:
- A.** Identify, implement and train therapeutic strategies to support the individual and his or her family and support staff in efforts to meet the individual's ISP visions, desired outcomes and action plans;
 - B.** Increase, maintain or reduce loss of functional skills;
 - C.** Treat a specific condition clinically related to an individual's developmental disability; and
 - D.** Support the individual's health and safety needs.
- III. THERAPY SERVICE REQUIREMENTS.**
- A. Therapy Service Models.**
 - (1) The Integrated Therapy Model includes interventions that are provided in the natural contexts of an individual's life (such as residence, day habilitation site, vocational site and community locations or at IDT/ISP planning meetings). While it is understood that a portion of therapeutic intervention may be direct skilled treatment, it is required that, whenever appropriate, therapists will provide services in an integrated model of therapy. The integrated model means involving caregiver(s) to the maximum extent possible in the implementation of therapeutic goals. If an individual has caregivers, meaningful involvement of the caregivers shall occur during at least part of a minimum of 50% of therapy sessions for that therapy to qualify as integrated therapy. In the Integrated Therapy Model, therapy is applied to a functional activity during each session. When appropriate, the therapist will design and train the therapy strategies and/or support plans in all relevant settings.
 - (2) The Clinical Model includes interventions that are provided in a clinic setting (such as a therapy clinic or a therapist's office) OR in an isolated, non-integrated manner, even within natural environments, such as a residence or Adult Habilitation site. The Clinical Model includes pull-out therapy services. A clinical context would include any location that an individual would not otherwise visit, if he or she did not have a therapy appointment.

B. Eligibility for Medicaid DD Waiver Therapy Services.

- (1) All adults allocated to the DD Waiver are eligible for an evaluation to determine the need for therapy services. It is the responsibility of the IDT members to recognize the potential need for therapy services according to the specific needs of the individual and the potential benefit of each service. Children under age twenty-one must obtain an evaluation to determine the need for therapy services through the Medicaid State Plan rather than through the DD Waiver.
- (2) For children under the age of 21, medically necessary therapy services must be obtained through the Medicaid state plan as part of federal Early Periodic Screening Diagnosis and Treatment (EPSDT) requirements. Educationally related therapies must be obtained through the public schools as required by the Individuals with Disabilities Education Act (IDEA). Only therapy services not covered by the State Plan under EPSDT requirements nor through the public schools may be delivered through the DD Waiver. See Section VII.A “Scope of Therapy Services for Children Under Age 21” for specific therapy services covered by the DD Waiver for this age group.

C. Referral for Medicaid DD Waiver Therapy Services.

- (1) The IDT members may refer the individual to the appropriate discipline(s) for assessment, evaluation and recommendation(s) for clinical or functional need for service.
- (2) The IDT members may identify areas of concern to be included in the assessment.
- (3) The therapist will complete a written initial evaluation report and submit the report to the Case Manager.
- (4) All referrals to therapy for evaluation or treatment shall be documented in the individual’s ISP.

D. Referral for Medicaid State Plan Therapy Services.

- (1) When medically necessary therapy services are indicated and covered by the Medicaid state plan, clients shall get a referral from his or her PCP or physician. For clients enrolled in Medicaid Fee-For Service (FFS), the therapist shall request prior authorization through NM utilization review. For clients enrolled in Salud!, the therapist requests prior authorization through the client’s Salud! organization, according to the protocols of each Salud! organization. Therapy services are required to be provided by a FFS enrolled provider for FFS clients. For clients enrolled in Salud! therapy services shall be provided by a provider enrolled in the client’s Salud! Organization.
- (2) Covered state plan therapy benefits are different for children versus adults. Therefore it is important to review current service definitions, Medicaid

definitions, Medicaid standards and guidelines to determine appropriate referrals.

- (3) All referrals for Medicaid state plan therapy for evaluation and/or treatment shall be documented in the individual's ISP.

IV. PROVIDER AGENCY REQUIREMENTS.

A. Administrative. Therapy Provider Agency Administrative Requirements are as follows:

- (1) The therapy Provider Agency shall maintain a confidential case file for each individual. The individual case file is required to include the most current copies of:
 - (a) The individual's ISP including mandated individual specific training;
 - (b) Any reports regarding the individual and generated by a therapist working for the therapy Provider Agency; and
 - (c) Contact notes, training rosters and other service delivery documentation.
- (2) The Therapy Provider Agency is required to maintain the following information/data and is responsible for timely submission to DDS/D upon request:
 - (a) The number of Waiver participants served;
 - (b) A listing of all individuals by name and social security number who have received therapy services;
 - (c) Initial or revised Provider Agency policies related to therapy services; and
 - (d) Service documents and records that will be used by DDS/D or DHI for quality assurance review. The documentation shall include:
 - (i) Assessments or evaluations; and
 - (ii) Therapy intervention plans and revisions, individual therapy service contact notes and discontinuation of services report if applicable.
- (3) The Therapy Provider Agency is required to maintain the following financial information:
 - (a) Therapy Provider Agencies shall establish and maintain separate financial reporting and accounting activities that are in accordance with state requirements.

- (b) Therapy Provider Agencies shall have an established automated data system for financial and program reporting purposes Note: Direct linkage/modem to the DOH and the HSD may be required.
 - (c) For billing purposes, the Therapy Provider Agency is required to maintain records of the following information for each billable contact, such as therapy service type, start time, and end time, session progress notes, notation indicating under which Rate Model of Therapy Service therapy was provided, signature of therapist delivering service.
- (4) Therapy Provider Agencies shall establish and maintain policies and procedures including, but not limited to HIPAA, Incident Reporting, Criminal Background Checks and Quality Improvement in accordance with the DOH provider contract.
- (5) The Therapy Provider Agencies shall convey all information received from DDS that is relevant to service delivery to his or her employees, contractors, etc. in a timely manner.
- (6) Therapist's Administrative Requirements are as follows:
- (a) All OTs, PTs and SLPs serving individuals on the DD Waiver are required to attend training regarding the Therapy Standards/Participatory Approach and the ISP process during the first twelve months they provide therapy under the DD Waiver. All Therapy Provider Agencies are required to report required personnel training status to the DDS Statewide Training Database as follows:
 - (i) Initial comprehensive personnel status report (name, date of hire, identification number category) on all required personnel to be submitted to DDS Statewide Training Database within the first ninety (90) calendar days of providing services; and
 - (ii) Quarterly personnel update reports sent to DDS Statewide Training Database to reflect new hires, terminations, or agency position changes, and name changes.
 - (b) All OTs, PTs and SLPs serving individuals on the DD Waiver are required to attend any newly developed DDS mandated trainings.
 - (c) Therapists providing therapy under the DD Waiver through a Therapy Provider Agency are responsible for providing all required documentation to that Provider Agency.

V. THERAPY SERVICE REQUIREMENTS.

A. Interdisciplinary Team (IDT) Determination.

- (1) Therapy services are required to be determined within the context of the IDT.

- (2) Therapists shall participate in all IDT meetings by physical presence or conference call. If real-time participation is not possible, the therapist is expected to interact with the Case Manager before and after the IDT meeting.
- (3) Therapists will contribute to development and support of the individual's vision, desired outcomes and action plans as identified in the ISP.
- (4) Therapists are required, according to his or her specialized expertise, to develop written strategies that guide caregivers as he or she implement the action plans stated in the ISP.
- (5) Therapy services are to be provided in a manner that promotes self-advocacy.

B. Participatory Approach. The "Participatory Approach" asserts that no one is too severely disabled to benefit from Assistive Technology and other supports that promote participation in life activities. The "Participatory Approach" rejects the premise that an individual shall be "ready" or demonstrate certain skills before Assistive Technology can be provided to support functional interaction.

- (1) All therapists are required to consider the Participatory Approach during evaluation, treatment planning and treatment implementation.
- (2) Services will be offered in a fashion that takes into account whatever cognitive or physical challenges are present currently in the individual's life.
- (3) Use of a "readiness" or "candidacy" model is rejected in this approach.
- (4) Goals are not of a prerequisite nature, but instead are required to lead to immediate functional participation.

C. Individual Centered.

- (1) Therapy services shall be based upon each individual's needs, preferences and abilities as identified in his or her ISP.
- (2) The individual's life context may include his or her residence, work or volunteer experiences and his or her roles with family, friends and members of common interest groups.
- (3) Services shall be designed to support functional participation and self-advocacy in each of these settings and in fulfilling each of these roles.
- (4) Interventions will be determined by the individual, whether his or her preferences are expressed independently or interpreted by others and according to culturally appropriate, age-appropriate and gender-appropriate values.
- (5) An individual's tolerance and preference for activity shall also be considered.

D. Integrating Therapy Strategies in Daily Life. Therapy services to individuals receiving more than one therapy shall be delivered in an integrative and collaborative manner.

- (1) The therapist shall develop written support plans and therapy strategies to support the individual's action plans identified in the ISP and to support the individual's health and safety needs as applicable.
- (2) Related activities developed or identified by the licensed therapist that incorporate therapeutic methods and strategies are to be adopted by the IDT members for implementation throughout all appropriate life activities by service providers supporting the individual.
- (3) Therapeutic intervention may be direct skilled treatment or when appropriate integrated services.

E. Service Delivery in Natural Contexts. Failure to generalize performance to natural contexts is a commonly cited drawback to traditional pullout models for therapy service delivery to individuals with developmental disabilities. Service delivery in natural contexts is more compatible with goal-related functional participation where generalization is an integral aspect of the treatment rather than being a separate treatment goal.

- (1) Services delivered in natural contexts allow for the specific challenges of that context to be identified and addressed during intervention. Strategies to address these challenges can be developed for immediate implementation.
- (2) It is required that training for functional participation will occur in natural contexts.

VI. STANDARDS, LICENSING AND ACCREDITATION FOR THERAPIST. Therapy services shall be provided in compliance with the applicable NM Licensing Board/Practice Act standards and in accordance with all other applicable State and Federal standards, guidelines, regulations, rules and statutes.

A. Staff Qualifications. All therapists who are working as contractors of a therapy provider or as employees of the therapy provider shall meet all the requirements of the DD Waiver Service Standards.

B. Therapist Qualifications. All Therapists are required to possess at a minimum at least one of the following qualifications:

- (1) Physical Therapy Services:
 - (a) A physical therapist, licensed by the New Mexico Regulation and Licensing Department, may provide billable physical therapy services in accordance with the American Physical Therapy Association (APTA)'s scope of practice. A physical therapist providing services under the DD Waiver shall follow supervision provisions of New Mexico's Physical Therapy licensure standards.

- (b) A physical therapist assistant, licensed by the New Mexico Standards and Licensing Department, may provide billable physical therapy services in accordance with the APTA's scope of practice. A physical therapist assistant shall follow supervision provisions of New Mexico's Physical Therapy licensure standards.
- (c) A student physical therapist or a student physical therapist assistant may provide billable physical therapy services only under supervision as required by an APTA approved training program and in accordance with the respective stipulations of the New Mexico Standards and Licensing Department.

(2) Occupational Therapy (OT) Services:

- (a) An OT with a current and active license issued by the New Mexico Regulation and Licensing Department (NMRLD) may provide billable occupational therapy services in accordance with the American Occupational Therapy Association (AOTA) scope of practice.
- (b) An Occupational Therapy Assistant (OTA) with a current and active license issued by the NMRLD may provide billable occupational therapy services in accordance with the AOTA scope of practice. An OTA shall be supervised by a licensed OT and follow all supervision provisions of New Mexico's current OT licensure Act.
- (c) An OT or OTA with a provisional permit issued by the NMRLD may provide billable occupational therapy services in accordance with the AOTA scope of practice. OT's or OTA's with a provisional permit shall be supervised by a licensed OT and follow all standards as set forth in the current New Mexico OT Licensure Act.
- (d) A Level II Student Intern from an AOTA accredited university may provide billable services on behalf of an occupational therapy Provider Agency, if a formal academic intern agreement is signed by the therapy Provider Agency and the student's university and 100% face-to-face on-site supervision is provided during client evaluation and treatment by a DD Waiver OT (for OT students) or a DD Waiver OT and OTA as applicable (for OTA students). The supervising OT shall review and approve support services such as non-direct Assistive Technology services. The supervising OT shall review and sign all therapy related reports/documentation completed by the Level II Student Intern.
- (e) Academic intern agreements shall be submitted to the DDS Central Office and are required to be approved by the DDS annually. Approval to work as an intern may be granted twice (for two one year terms) for any individual.

- (f) An Occupational Therapy Aide/Technician is not permitted to provide billable occupational therapy services to DD Waiver participant.
- (g) A Level I Student Intern is not permitted to provide billable occupational therapy services to DD Waiver participants.

(3) Speech Therapy Services:

- (a) A Speech Language Pathologist (SLP), licensed by the New Mexico Regulation and Licensing Department, may provide billable speech therapy services in accordance with the ASHA scope of practice.
- (b) A clinical fellow with clinical fellow licensure issued by the New Mexico Regulation and Licensing Department, may provide billable speech therapy services with supervisory experiences as detailed in his or her Clinical Fellowship Plan accepted by American Speech and Hearing Association (ASHA). The clinical fellowship supervisor shall be knowledgeable about current clinical best practices with the MR/DD (Mental Retardation/Developmental Disabilities) population and these DD Waiver Therapy Standards. All services provided are required to be within the ASHA scope of practice. A copy of the clinical fellow temporary license shall be submitted to DDS/D with required provider application materials. The approval to provide services shall be obtained prior to the initiation of therapy services by the clinical fellow. Proof of permanent New Mexico Speech Language Pathology licensure shall be submitted to DDS/D within 18 months or at the successful completion of the Clinical Fellowship Plan, whichever occurs first.
- (c) A graduate student intern from an ASHA accredited university may provide billable services in cooperation with a speech therapy Provider Agency, if a formal academic intern agreement is signed by the therapy Provider Agency and the university and 100% on-site face-to-face supervision is provided for evaluation and treatment services by a licensed speech language pathologist who is an approved DD Waiver therapist. All required documentation should be signed by the student intern and the supervising DD Waiver therapist. Academic intern agreements shall be approved annually. This approval is for a term of one year. Approval to work as an intern may be granted twice (for two one year terms) for any individual.
- (d) A speech language assistant (SLA) is not permitted to provide billable speech therapy services to DD Waiver participants.

VII. SPECIFIC SERVICE REQUIREMENTS FOR THERAPIES.

- A. Scope of Therapy Service for Children Under Age 21.** The following therapy services for children are funded through the DD Waiver:

- (1) Limited, short-term training of a third party regarding devices or techniques to be used to enable or support the child's participation in a community integration activity;
- (2) Developing and implementing interventions for the purpose of adaptation exercise equipment and associated training for family members or other support individuals to promote ongoing fitness of the child;
- (3) Assessing for appropriate environmental modifications in the residence as described in DD Waiver Service Standards;
- (4) Recommending equipment, techniques, or therapy interventions to increase family/caregiver ability to provide for the child's comfort and convenience (e.g., developing a switch system so the child can operate household appliances such as the stereo or a blender to make a snack);
- (5) Developing and implementing interventions for children with swallowing disorders to reduce aspiration risk in accordance with the interdisciplinary team approach described in the DDS Policy and Procedure entitled "Supporting People on the DD Waiver with Dysphagia/Risk for Aspiration," as appropriate to the therapist's scope of practice;
- (6) Providing associated evaluation, assessment, and training of child, family and/or other caregivers only related to above activities;
- (7) Coordinating with other therapists serving the child through EPSDT and/or the public schools and/or with other disciplines on the child's DD Waiver when the therapist is also providing services through the DD Waiver.

B. Physical Therapy (PT).

- (1) Physical therapy is a skilled 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.
- (2) 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.

C. Physical Therapy Scope of Services for Adults.

- (1) Providing assessments, evaluations, interventions and monitoring of the individual for therapeutic purposes within the professional scope of practice of the physical therapist;
- (2) Developing, implementing, modifying and monitoring physical therapy treatments and interventions for the individual;

- (3) Designing, building or preparing, implementing, modifying and monitoring the use of specialized or adaptive equipment, prosthetics and assistive technologies for the individual;
- (4) Designing, modifying or monitoring the use of related environmental modifications for the individual;
- (5) Designing, modifying and monitoring the use of related activities (e.g., therapeutic strategies and/or support plans, for the individual that are supportive of ISP desired outcomes);
- (6) Providing assessments for Environmental Accessibility Adaptations;
- (7) Training IDT Members and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, treatments, use of equipment and technologies or any other aspect of the individual's physical therapy services including any data collection methodologies or procedures;
- (8) Attending and participating at annual or any other IDT meetings convened for service planning, either in person or by conference call;
- (9) Consulting with IDT member(s), guardians, family, or support staff;
- (10) Consulting or collaborating with the individual's primary care practitioner and/or other licensed therapists and/or medical personnel for the purposes of evaluation of the individual or developing, modifying and monitoring physical therapy services for the individual;
- (11) Observing the individual in all relevant settings in order to monitor the individual's status as it relates to therapeutic goals or implementation of physical therapy services or professional recommendations;
- (12) Conducting other non-administrative activities that are delivered as professional services within the scope of the practice of physical therapy and as described in a written therapy intervention plan specific to the individual;
- (13) Providing other skilled physical therapy treatments, interventions or technologies deemed appropriate by the licensed physical therapist; and
- (14) Conducting assessments for Durable Medical Equipment.

D. Occupational Therapy (OT).

- (1) Occupational Therapy is a health and rehabilitation profession that assists people of all ages who, because of illness, injury, or impairment, need skilled therapy services to help them regain, maintain, develop, and/or build skills that enable them to lead more independent, healthy, productive and/or satisfying lives. 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 skills assessments and treatment, assistive technology recommendations and usage training and guidance to family members and caregivers.

- (2) Certified Occupational Therapy Assistants may perform occupational therapy procedures and related tasks pursuant to a plan of care/therapy plan written by the supervising OT.

E. Occupational Therapy Scope of Services for Adults.

- (1) Providing assessments, evaluations, interventions and monitoring of the individual for therapeutic purposes within the professional scope of practice of the occupational therapist;
- (2) Developing, implementing, modifying and monitoring the use of professional occupational therapy treatments and interventions for the individual;
- (3) Designing, building or preparing, implementing, modifying and monitoring the use of specialized or adaptive equipment, orthotic devices, and assistive technologies for the individual;
- (4) Designing, modifying or monitoring the use of related environmental modifications for the individual;
- (5) Designing, modifying and monitoring the use of related activities for the individual that is supportive of ISP desired outcomes;
- (6) Training IDT Members, and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, treatments, use of equipment and technologies or other aspects of occupational therapy services;
- (7) Providing assessments for Environmental Accessibility Adaptations and Assistive Technology needs within the professional scope of practice of Occupational Therapy;
- (8) Attending and participating in IDT meetings convened for service planning; either in person or by conference call;
- (9) Consulting with IDT member(s), guardians, family, or support staff;
- (10) Consulting and collaborating with the individual's primary care practitioner and/or other therapists and/or medical personnel for the purposes of evaluation of the individual or developing, modifying or monitoring occupational therapy services for the individual;
- (11) Observing the individual in all relevant settings in order to monitor the individual's status as it relates to therapeutic goals or implementation of occupational therapy services and professional recommendations;

- (12) Providing other non-administrative activities that are delivered as professional services within the scope of the practice of occupational therapy and described in a written therapy intervention plan specific to the individual; and
- (13) Providing other skilled occupational therapy treatments, interventions or assistive technologies deemed appropriate by the licensed Occupational Therapist.

F. Speech and Language Pathology (SLP).

- (1) Speech and Language Pathology, 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 and disorders of communication including speech fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal, sensorimotor competencies. Speech therapy is also used when an individual requires the use of an augmentative communication device. For example, Speech Therapy services are intended to:
 - (a) Improve or maintain the individual's capacity for successful communication or to lessen the effects of individual's loss of communication skills; and
 - (b) Improve or maintain the individual's ability to eat foods, drink liquids and manage oral secretions with minimal risk of aspiration or other potential injuries or illness related to swallowing disorders.

G. Speech-Language Pathology Scope of Services for Adults.

- (1) Providing assessment(s), evaluation(s) and monitoring of the individual for therapeutic purposes within the professional scope of practice of the SLP;
- (2) Participating in audiological or medical assessment(s) (e.g., swallowing studies), evaluation(s) and monitoring of the individual for conditions related to the scope of Speech Therapy services;
- (3) Developing, implementing, modifying and evaluating the effectiveness of the use of speech, hearing or language therapy treatments to the individual;
- (4) Developing, implementing, modifying and monitoring the use of related specialized or adaptive equipment and assistive technologies/augmentative communication devices for the individual;
- (5) Developing, modifying or monitoring the use of related environmental modifications for the individual;

- (6) Developing, modifying and monitoring the use of related activities for the individual that is supportive of ISP desired outcomes and utilizes therapeutic strategies;
- (7) Training IDT Members, and all relevant individuals in all relevant settings, including support staff, as needed for successful implementation of therapeutic activities, treatments, use of equipment and technologies or other aspect of speech or language therapy services including any data collection procedures;
- (8) Attending and participating at annual, or any other IDT meetings convened for service planning; either in person or by conference call;
- (9) Consulting with IDT member(s), guardians, family, or support personnel;
- (10) Consultation and collaboration with the individual's primary care physician and/or with other therapists and/or medical personnel for the purposes of evaluating the individual or developing, modifying or monitoring speech therapy services for the individual;
- (11) Observing the individual in all relevant settings in order to monitor the individual's status or implementation of speech therapy services and professional recommendations;
- (12) Performing other non-administrative activities that are delivered as professional services within the scope of the practice of speech therapy and described in a written plan specific to the individual;
- (13) Providing other skilled speech and language therapy treatments, interventions or technologies deemed appropriate by the licensed Speech Language Pathologist; and
- (14) Conducting assessment for communication devices.

VIII. THERAPY SERVICES STAFFING RATIO REQUIREMENTS.

A. Individual Therapy.

- (1) Therapy services are an individualized service unless group therapy and the rationale for the use of group therapy are stated in the individual's Therapy Intervention Plan.
- (2) The therapist-to-client ratio for individual therapy is at least one therapist to one DD Waiver participant (1:1 ratio) for the period of the therapy service.

B. Collaborative Therapy.

- (1) In collaborative therapy service events, more than one therapy discipline may participate in the therapy services for one Waiver participant at the same time.

- (2) Collaborative therapy services are provided when there is a professional, functional and/or clinical need for more than one therapy discipline to address the needs of one individual within each therapist's area of expertise to meet a desired outcomes.

C. Group Therapy.

- (1) In Group Therapy service events, one therapist may participate in the therapy services for 2 or more Waiver participants.
- (2) The therapist who wishes to employ group therapy as a therapeutic intervention for an individual served shall include group therapy and the rationale for the use of group therapy in the individual's Therapy Intervention Plan.
- (3) SLPs, OTs or PTs. may provide Group Therapy services.
- (4) The therapist may utilize both individual therapy and group therapy at different times within the ISP year depending on the individual's needs.
- (5) A therapist can bill for no more than three (3) individuals for each group therapy session, regardless of the number of participants in the group.

D. Consultation with other Therapists. The objectives of consultation are to assure consistent approaches, coordinate therapy interventions and share information as it pertains to the individual receiving services. Examples of consultations would include consultation between a school and a DD Waiver therapist, two therapists of the same discipline or an OT and OTA or a PT and PTA during specialized evaluations or crossover training. This does not include supervisory activities. Up to six hours (24 units) of DD Waiver therapy may be billed per year to consult with the other provider(s) for these stated purposes.

E. Mandatory DDSD Trainings. The time a therapist spends in mandatory DDSD training sessions may be billed utilizing the individual clinical rate. The total amount of training units may be divided among the therapist's caseload, with no single individual's budget billed for more than one hour per ISP year. If the ISP requires participation of the therapist in individual-specific training (e.g., seizure response training delivered by the nurse), such time is also billable at the individual clinical rate.

IX. SERVICE PROVISIONS.

A. Interdisciplinary Team (IDT) Meetings.

- (1) Therapists are core IDT members and are required to attend and participate fully in IDT meetings. This includes annual ISP meetings and any other IDT meetings convened for service planning.
- (2) If a therapist must miss a meeting due to illness or unavoidable schedule conflict, it is the therapist's responsibility to:

- (a) Contact the Case Manager before the meeting to let them know the therapist will be absent and to provide input relevant to the topic of the meeting;
- (b) Submit applicable Therapy Reports and other required documentation in a timely manner;
- (c) Contact the Case Manager for a meeting summary and to determine assignments the IDT members may have requested of the therapist; and
- (d) Collaborate with the Service Coordinator(s) to develop strategies related to any new ISP desired outcomes and or action plans that were added at the meeting, in the Therapy Intervention plan.

B. Specialized Appointments.

- (1) Therapists are encouraged to attend specialized appointments when the individual's IDT members make a request to have the therapist present.
- (2) Specialized appointments include, but are not limited to, appointments with doctors, dentists, orthotists, clinics and employers.

C. Direct Service Provision.

- (1) Therapists provide direct therapy services designed to assist the individual to realize the visions and desired outcomes outlined in that individual's ISP.
- (2) Direct Services shall be activities that are identified as appropriate by that therapist's professional national association.

D. Assistive Technology Services. Refer to the "Guidelines for the Provision of Assistive Technology Services to Individuals with Developmental Disabilities According to the Participatory Approach"

- (1) Therapists providing services under the DD Waiver are required to be familiar with the "Participatory Approach to Assistive Technology" and to use this philosophy whenever appropriate.
- (2) The Participatory Approach affirms that access to assistive technology shall not be denied to an individual because of the severity of that individual's disability.
- (3) Therapists are responsible for being familiar with the assistive technology related to that therapist's practice area and used by individuals on that therapist's caseload.

E. Report Writing and Other Paperwork. Therapists are responsible for preparing an array of reports related to the provision of therapy (see section X of this chapter entitled "Documentation Requirements").

F. Training Family/Support Staff.

- (1) Whenever possible family members and/or support staff are to be involved in therapeutic activities designed by the therapist and directed toward assisting the individual to achieve the visions and desired outcomes of that individual's ISP.
- (2) Family/support staff are required to be trained at least annually on all written support plans and specific therapy strategies.
- (3) Family/support staff may require a more frequent schedule of training according to DOH Policy & Procedure, e.g., "Supporting Individuals Served by the DD Waiver with Dysphagia/Risk of Aspiration."
- (4) Training/retraining may be provided more frequently, on an "as needed" basis, according to therapist's judgment or as requested from other family/support staff.
- (5) Training shall include family/support staff from all relevant settings.
- (6) Day Program directors, Home supervisors and Supported Employment supervisors are required to notify therapists if new staff members need to be trained.
- (7) Therapists are to use training techniques that are appropriate for family/support staff being trained.
- (8) The individual should be present during training sessions whenever appropriate. The presence of the individual is necessary for effective training on such programs as mealtime support plans and physical care techniques.

G. Monitoring.

- (1) Therapists are responsible for monitoring the progress of an individual toward the achievement of therapeutic goals and objectives, as well as progress toward desired outcomes in the ISP.
- (2) Therapists are responsible for monitoring the performance of activities outlined in strategies and/or support plans written by that therapist.
- (3) Individuals may require a specific schedule of monitoring according to DOH Policies & Procedures, e.g., "Supporting Individuals Served by the DD Waiver with Dysphagia/Risk of Aspiration."
- (4) Therapists shall monitor to ensure that needed assistive technology devices are functioning properly and available in the settings where the device(s) are to be used.

H. Consultation.

- (1) Therapists should be available for consultation with other IDT members to allow for appropriate evaluation of the individual, development of action plans, provision of therapy and delivering training.
- (2) There may be occasions when a therapist is required to consult with individuals outside the IDT. These individuals may include, but are not limited to, doctors, dentists, orthotists, clinic professionals and employers. Recommendations in an area related to a particular therapy may be made to the therapist or the IDT members by various healthcare staff, consultants, auditors and clinics such as Supports and Assessment for Feeding and Eating (SAFE), Trans-disciplinary Evaluation and Support Clinic (TEASC) and others. These recommendations shall be discussed by the IDT members and a determination made if the IDT members agree or disagree with the recommendations. If the IDT members concur with the recommendations, follow-up is required to be completed and documented in the therapist's next progress report. If the IDT members do not agree with the recommendation of the outside consultant, auditor or clinic, the reason shall be clearly documented in the Rational Justification Document. The therapist may need to assist the Case Manager in wording the reason for disagreement in accordance with professional justification. The therapist shall also note the decision in the therapy progress report for the individual served. This documentation shall be filed by the Case Manager with the healthcare provider or consultant's report/document in which the recommendation was made.

X. DOCUMENTATION REQUIREMENTS.

A. General Documentation Requirements.

- (1) Documentation is required to be completed in accordance with applicable DDS standards and guidelines established by the Therapist's National Professional Association.
- (2) Evaluations shall contain: the individual's name; the individual's date of birth; the individual's Social Security number; the date of the report; the name of the therapy Provider Agency; the therapist's name, credentials and contact information; and the individual's Case Manager's name and agency.
- (3) All written documentation shall be signed and dated by the therapist.
- (4) Each successive page of documentation are required to include the name of the individual, date and the document title as identifying information.

B. Initial Therapy Evaluation Report.

- (1) Suggested general content for an Initial Evaluation Report includes:
 - (a) Individual information and referral information; and

- (b) Relevant background information, diagnosis, assessments used and results, summary of assessment data and interpretations and recommendations.
- (2) The initial evaluation recommendations shall include:
 - (a) Recommendations for referral for other services as appropriate; and
 - (b) Areas of further evaluation needed and suggestions for initial therapy objectives.
- (3) The initial evaluation is required to state the therapist's recommendation regarding the need for therapy services. If therapy services are recommended, the therapist shall state the number of units requested in each rate model category (Integrated, Clinical, Group Integrated, Group Clinical).
- (4) A new initial evaluation may be required when a new therapist is beginning to work with an individual, unless the previous evaluation is reviewed and accepted.

C. Annual Re-Evaluation Report. An annual re-evaluation report is required to continue therapy services.

- (1) The annual re-evaluation report shall be included as a part of the documentation provided to all IDT members fourteen (14) calendar days prior to the annual ISP.
- (2) The annual re-evaluation report may be submitted as a separate report or as part of the annual therapy progress report. If the annual re-evaluation Report is part of the annual therapy progress report, the annual re-evaluation shall have its own identifying title.
- (3) An additional re-evaluation report is required to be completed if there is a significant change in the individual's status at a point in the year before the annual re-evaluation report is required.
- (4) Suggested general content for the annual re-evaluation includes a summary of any new medical information, information regarding new living, day activity or working circumstances, a summary of and the IDT member's response to any outside clinics, audits, or evaluations as applicable, assessment tools used for the re-evaluation, summary of assessment data and interpretations and recommendations.

D. Annual Therapy Progress Report. An annual therapy progress report is required to continue therapy services.

- (1) The annual therapy progress report shall be included as a part of the documentation provided to all IDT members fourteen (14) calendar days prior to the annual ISP.

- (2) Suggested general content for the annual therapy report includes:
 - (a) How therapy goals/objectives are related to and support the individual's ISP visions/desired desired outcomes and action plans;
 - (b) Current therapy goals and objectives, the status of current therapy goals and objectives, summary of data/desired outcomes measures collected to individual's progress/status; and
 - (c) Documentation of written support plans, documentation of training that has occurred since the last report, summary of the individual's assistive technology monitored by the therapist and recommendations for therapy.
- (3) Therapy recommendations shall include:
 - (a) Recommendations for new and/or modified and/or discontinued therapy goals/objectives;
 - (b) Recommendations for development or modification of written support plans;
 - (c) Recommendations for other services or referrals;
 - (d) Recommendations related to needed assistive technology and/or environmental modifications;
 - (e) Recommendations regarding the need for continued therapy services; and
 - (f) If continued therapy services are recommended, the therapist shall state the number of units requested in each service category.

E. Bi-Annual Therapy Progress Report. The bi-annual therapy progress report is required to continue therapy services, and is required to be submitted to the IDT members six (6) months following the annual therapy progress report.

- (1) Suggested general content for the bi-annual therapy progress report includes:
 - (a) Current therapy status summary of measures collected to document the individual's progress or status related to therapy related desired outcomes and action plans;
 - (b) Any changes in assistive technology or environmental adaptations since the last report, status of written support plans and training; and
 - (c) Recommendations regarding therapy.

F. Therapy Intervention Plan. The therapy intervention plan must contain the therapy objectives, intervention approaches and strategies that will be used to assist the individual in meeting identified therapy goals, objectives and desired outcomes

listed in the ISP. The therapy intervention plan is based on the evaluation process and results in the establishment of the agreed upon ISP desired outcomes and action plans.

The therapy intervention plan shall be updated annually and is required for continuation of therapy services. The therapy intervention plan shall be included as a part of the documentation provided to all IDT members within fourteen (14) calendar days following the ISP meeting. The therapy intervention plan may not be submitted as part of the annual therapy report. The therapy intervention plan may need to be revised during the year if there is a change in the individual's status or a change in the therapist providing services to the individual. Suggested general content for the therapy intervention plan includes:

- (1) Therapy goals/objectives as based on the results of the evaluation processes and on the individual's visions, desired outcomes and action plans;
- (2) Intervention approaches and types of interventions to be used and specific written support plans to be developed and/or modified;
- (3) Family/support staff training and education needs, plans for specific assistive technology and environmental adaptation supports; and
- (4) Plans for desired outcomes measures as applicable.

G. Written Support Plans.

- (1) Written support plans shall be developed by the therapist in all areas that the individual/family/support staff need guidance to incorporate therapeutic methods and strategies in the individual's daily life routines.
- (2) Examples of common written support plans include alternative positioning, wheelchair positioning and care, functional ambulation, home exercise plan, mealtime support plan, communication dictionary, 24-hour communication support plan, interactive routines, Activities of Daily Living (ADL) and daily activity support plans, environmental access/switch use plan, sensory support plan, active and passive movement of limbs plan and splint use plan.
- (3) Written support plans shall be developed with user-friendly language that is easily understood by those implementing the plan. The use of bullet-lists, diagrams and photos can be good strategies for effective written support plans.
- (4) Written support plans become the basis for training sessions with family/support staff.
- (5) The therapist shall provide copies of all written support plans for each location in which they are to be used (e.g., home, work site).

H. ISP Action Plans and Therapy Strategies.

- (1) The therapist will actively contribute therapy strategies that provide detailed instructions to family/support staff from a therapeutic perspective designed to guide those who will implement ISP action plans.
- (2) Therapy strategies can be developed during an IDT meeting or within fourteen (14) calendar days after the ISP meeting.
- (3) At the request of the agency, therapy strategies shall be provided in a timely manner to any agency supporting the individual.

I. Training Rosters.

- (1) When a therapist conducts a training session, all persons attending the training session shall be asked to sign a training roster to record his or her attendance.
- (2) The training roster shall include the name of the individual receiving DD Waiver services, the date of the training, the signatures of the attendees, the role of the attendees (home staff, supported employment staff, family, etc.), the topic for the training (support plans covered, ISP strategies trained), the beginning and ending time of the training and the name of the trainer.
- (3) The training roster shall be submitted to the Case Manager as part of the documentation for the annual ISP meeting or the bi-annual therapy progress report depending on which report is due next.

J. Monitoring Forms. Monitoring forms may be required documentation as indicated by DDS Policies and Procedures, (e.g., “Supporting Individuals Served by the DD Waiver with Dysphagia/Risk for Aspiration”).

K. Therapy Service Contact Notes. A therapy contact note is required for each client contact or allowable billed support service (meetings, consultation, specialized appointments, assistive technology support, etc.)

- (1) Each page of therapy contact notes shall include the name of the therapy provider agency, name of the individual served, date and social security number of the individual served.
- (2) Each therapy service contact note shall include the date of service, beginning and ending time of the service, a summary of the individual’s response to the intervention, relevant therapy objective data, family/support staff training or involvement, description of other applicable service provided, the therapist’s signature and his or her professional credentials.

L. Discontinuation of Services Report.

- (1) When the individual reaches his or her therapy goals or no longer demonstrates a need for a particular therapy service as determined by the IDT members and the therapist, one of the following shall happen:
 - (a) New goals consistent with the individual's ISP are required to be developed;
 - (b) The IDT members are required to consider a reduction in hours of the therapy involved when training and monitoring are required to be maintained; or
 - (c) The IDT members are required to consider discontinuation of the therapy service. When an ongoing therapy service is discontinued, a discontinuation of services report shall be written. The discontinuation of services report shall include:
 - (i) The reason for discontinuation of services;
 - (ii) The status of goals at the time of discontinuation; and
 - (iii) The balance of budget units remaining at the end of the therapy service; and
 - (iv) If individual's status changes after the discontinuation of services and the IDT members agree therapy may again be needed, the IDT members may recommend that a new evaluation be completed to determine the clinical need for services.
- (2) If the individual or their legal guardian disagrees with the discontinuation of therapy services, they shall be informed of their right to a Fair Hearing.

XI. THERAPY REIMBURSEMENT.

A. Billable Unit. The billable unit is 15 minutes. Therapists are responsible for appropriate documentation to substantiate the request for reimbursement for services provided.

- (1) Collaborative and consultative therapy services are billed by each therapist involved. The service delivery rates (see section XI.D) apply to collaborative therapy sessions.

B. Non-Billable Services.

- (1) Non-treatment visits;
- (2) Services exceeding the annual budget limit;

- (3) Time spent on preparation of billing activities;
- (4) Travel to and from any site of therapy services;
- (5) General (non-client specific) training seminars; and
- (6) Therapy services which are the responsibility of the Local Educational Agency under IDEA Part B or which are medically necessary and required by EPSDT requirements in the Medicaid State Plan.

C. Therapy Services Determination.

- (1) Therapists are required to use professional judgment as documented in the Therapy Intervention Plan to justify the number of units of service needed to support the individual.
- (2) Service/Funding Model:
 - (a) Therapy services are funded under the DD Waiver to assist an individual to meet the visions, desired outcomes and action plans identified in the individual's ISP and to support health and safety.
 - (b) Appropriate levels of therapy services are determined by clinical and functional assessment with participation from the individual and the IDT members regarding the desired outcomes from a given therapy.
 - (c) All requests for therapy may be subject to clinical review by the DDSD.

D. Service Delivery Rates. For funding purposes, there are four (4) therapy service rates as follows: individual integrated therapy model, individual clinical model, group integrated therapy model and group clinical model.

- (1) Individual integrated therapy rate:
 - (a) The individual integrated therapy rate may be billed for interventions within the licensed therapist's scope of service when those services are provided in the natural contexts of an individual's life (such as residence, day habilitation site, vocational site, community locations or at IDT/ISP planning meetings), the services apply to a functional activity and when collaboration with a caregiver occurs in at least 50% of all therapy sessions (e.g., during 25 or more of 50 therapy sessions).
 - (b) When a direct skilled therapy is provided within a natural context, the individual integrated therapy unit may be billed if the intervention is applied to a functional activity/routine and collaboration with a caregiver occurs in at least 50% of all therapy sessions (e.g., during 25 or more of 50 therapy sessions).

- (c) Caregiver training and consultation in a natural context may be billed at the individual integrated therapy rate.
 - (d) Attendance at specialized appointments (doctors, dentists, orthotists, clinics and employers, etc.) even in clinical settings can be billed under the integrated therapy rate.
 - (e) IDT meetings may be billed at the integrated therapy rate.
 - (f) The integrated therapy rate may be billed for any therapy service delivered at a thirty (30) mile or greater radius from the individual therapist's office.
 - (g) Functional evaluations that are conducted in natural contexts may be billed under the integrated therapy rate.
- (2) Individual clinical rate:
- (a) The individual clinical rate may be billed for interventions within the licensed therapist's scope of service when those interventions are provided in a clinic setting (e.g., therapy clinic or a therapist's office) or when services are delivered in an isolated, non-integrated manner, even within natural contexts of an individual's life (e.g., residence, day habilitation site, vocational site or community locations).
 - (b) The individual clinical rate shall be billed when the therapy session does not address a functional activity or when collaboration with caregivers does not occur during 50% or more of therapy sessions (e.g., during 25 or fewer of 50 sessions).
 - (c) The individual clinical rate includes individual specific development of the therapy intervention plan, written support plans and ISP strategies, annual and bi-annual reports, reports requesting or justifying assistive technology, non-integrated assistive technology fabrication and phone consultation.
 - (d) The individual clinical rate may be billed for therapist participation in mandated DDSD trainings (see section VIII. Therapy Services Staffing Ratio Requirements for specific billing instructions).
- (3) Group integrated therapy rate:
- (a) Group integrated therapy rate includes services that are delivered in a group context with two (2) or more individuals to one therapist.
 - (b) Interventions delivered as group integrated therapy are those that benefit the individuals involved due to a group context.
 - (c) The purposes may include, but is not limited to, teaching caregivers strategies and techniques for supporting several individuals to participate in an activity/routine that naturally occurs with small

groups (in the residence, day habilitation site, vocational site or community location) or to teach and practice opportunities for physical and communication interaction in a small group context.

- (d) The context of the group shall reflect the context of a naturally occurring activity/routine (e.g., yoga group instruction, social interaction, leisure activity, etc.).
 - (e) The determination for group integrated billing shall match the criteria stated previously in the section describing the integrated therapy rate (e.g., location, functional activity, caregiver participation).
 - (f) One therapist can bill for no more than three individuals regardless of the number of participants in a group.
- (4) Group clinical rate:
- (a) The group clinical rate reflects non-integrated services that are delivered in a group context with two (2) or more individuals to one therapist.
 - (b) Interventions delivered under the group clinical rate are provided in a clinical setting or in a pullout session in a natural context. Group clinical services are services that benefit the individuals involved due to a group context.
 - (c) The purpose of services provided under the group clinical rate may include, but is not limited to, teaching individuals strategies and techniques to participate in an activity/routine that naturally occurs with small groups or to teach and practice opportunities for physical and communication interaction in a small group context and does not include direct care staff.
 - (d) The determination for group clinical billing shall match the criteria stated previously in the section describing the clinical therapy rate (e.g., location, functional activity and caregiver participation).
 - (e) One therapist can bill for no more than three individuals regardless of the number of participants in a group.

E. Budget Approval Process.

- (1) To request a budget exception to the Annual Resource Allotment (ARA) cap for adults age 21 and older for the purpose of obtaining additional therapy services, an individual is required to have a combined ARA budget for all therapies of at least \$6,000.00.
- (2) A Case Manager may authorize an IDT member's request for therapy services that exceed 72 hours, but are within the ARA. However DDS reserves the right to conduct a clinical review.

- (3) In the first year of service or with a new therapist, the Case Manager may approve an ARA budget exception for up to 72 hours of each therapy service.
- (4) In subsequent years of service with the same therapist, the Case Manager may approve an ARA exception up to 58 hours for each therapy service.
- (5) Requests for clinical therapy exceptions in subsequent years for more than 58 hours (59-72 hours) require prior approval from the Clinical Services Bureau (CSB). Such requests shall be submitted by the therapist and shall contain supporting documentation. The application form for a clinical therapy exception may be obtained from the CSB/Therapy Services Coordinator.
- (6) DDS reserves the right to require specific documentation for the purpose of clinical review.
- (7) A clinical therapy exception may be requested at any time during the ISP year.
- (8) When a clinical therapy exception is granted, total therapy hours may not exceed the following yearly ISP budget caps:
 - (a) Physical Therapy-72 hours
 - (b) Occupational Therapy-72 hours
 - (c) Speech Language Pathology-72 hours
- (9) A quality assurance review may occur on any request for therapy.
- (10) The IDT members can appeal a denial or reduction to a requested exception for therapy services to the DDS Division Director by memorandum with attached justification. In addition, the individual will be given notice of their right to file a request for a Medicaid Fair Hearing.

CHAPTER 14
TIER III CRISIS SERVICES

I. TIER III SERVICES. Tier III services provide intensive supports by trained staff to an individual experiencing a behavioral or medical crisis via one of the following models:

A. Crisis Supports in the Individual's Residence. Crisis supports in the Individual's residence provide crisis response staff to assist in supporting and stabilizing the individual while also training and mentoring staff and/or family members, who normally support the individual, in order to remediate the crisis and minimize or prevent recurrence.

B. Crisis Supports in an Alternate Residential Setting. Crisis supports in an alternate residential setting 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 to their residence 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.

In both of the above models, crisis support staff will deliver such support in a way that maintains the individual's normal routine to the maximum extent possible. This includes support during attendance at employment or Adult Habilitation services.

II. SCOPE OF TIER III SERVICE. Tier III Crisis services include, but are not limited to, the following service standards:

A. The provision of trained crisis response staff to assist in supporting and stabilizing the individual's medical or behavioral condition.

B. Train and mentor staff and/or family members, who normally support the individual, in order to remediate the crisis and minimize or prevent recurrence.

C. If required, arrange for an alternative residential setting and provide crisis response staff to support the individual in that setting,

D. Stabilize and prepare the individual to return to their residence 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.

E. In both of the above models, crisis support staff will deliver such support in a way that maintains the individual's normal routine to the maximum extent possible. This includes support during attendance at employment or Adult Habilitation services, which may be billed on the same dates and times of service as Crisis Supports.

F. Consultation with IDT members, direct care personnel and other relevant personnel needed on the implementation of the individual's Positive Behavior Supports Plan.

- G. Attend IDT meetings.
- H. The Tier III Crisis Service Provider Agency will establish an “on call” system and ensure that sufficient staff is available to respond to Tier III events on a twenty-four hour, seven days a week basis. The Provider Agency is required to designate sufficient staff to be available in the event of a Tier III crisis.
- I. The Tier III Crisis Service Provider Agency’s plan for an alternate residential setting will be submitted to DDS within thirty (30) calendar days of the approval of the Provider Agency’s application to provide this service. The plan will include a primary and secondary means for providing alternate residential setting.

III. TIER III SERVICE REQUIREMENTS. Tier III Crisis services are provided when an individual requires Tier III Crisis Intervention services as determined through the DDS’s Office of Behavioral Services, in accordance with the DDS’s “Establishment of Administrative Procedures for Crisis Services.”

A. Service Criteria Location.

- (1) Tier III Crisis support in the individual’s residence. The Tier III Crisis Provider Agency will provide crisis response staff to support the individual, in the individual’s residence when feasible and recommended by the Office of Behavioral Services. The Provider Agency will provide or coordinate support services with the individual’s approved residential and day services Provider Agencies. Such services will conform to the supports needed by the individual as per his or her ISP, with accommodations consistent with the IDT Member’s consideration of the crisis event and the individual’s status. The crisis response staff will train, model and mentor the approved residential/day staff to remediate the current crisis and minimize or prevent the crisis from reoccurring.
- (2) Tier III Crisis Support in an Alternate Residential Setting. The Tier III Crisis Provider Agency will provide or coordinate an alternate residential setting. In the event an individual needs to receive Tier III crisis services in a setting away from his or her primary residence, the Provider Agency will arrange to have such a setting available. This may be an apartment, a motel or a bedroom at a different residence. The crisis response staff will train, model and mentor the approved residential/day staff to remediate the current crisis and minimize or prevent the crisis from reoccurring.

B. Service Limitations. Service requires prior written approval and referral from the Office of Behavioral Services (OBS). Tier III Crisis services are designed to be a short-term response (two to ninety calendar days). The timeline may exceed ninety (90) calendar days under extraordinary circumstances. The duration and intensity of the Tier III intervention will be assessed weekly. The IDT members, the OBS, the DDS Regional Office and the contractor shall agree to any extension of the time.

IV. TIER III PROVIDER AGENCY REQUIREMENTS.

- A. Reporting Requirements.** The Tier III Crisis Service Provider Agency's plan for an alternate residential setting will be submitted to DDS within thirty (30) calendar days of the approval of the Provider Agency's Agreement to provide this service. The plan will include a primary and secondary means for providing alternate residential setting.
- B. IDT Coordination.** The Tier III Crisis Provider Agency shall work with the individual's IDT members, respective DDS Regional Office and Regional OBS staff to affect a timely transition of services to the contracted Crisis Provider Agency. Any permanent change in location as the result of a Tier III crisis will occur either as a result of an ISP modification that is reviewed and approved by the IDT members and the guardian, and is based upon the long term interests of the individual, in accordance with DOH policies and regulations.
- C. Required Orientation.** The Agency Contractor's upper and middle management, to include the Chief Executive Officer's, agency directors, service coordinators and direct support staff supervisors, will attend orientation to the crisis response system. Orientation will be conducted by DDS/OBS staff and will address the following:
- (1) Elements of Tier III crisis response;
 - (2) DDS policy regarding Behavior Support Service Provisions; and
 - (3) Review and monitoring process for Tier III crisis services.
- D. Staffing Requirements.**
- (1) Staff-to-client ratio for this service is, at a minimum, one-to-one.
 - (2) The Tier III Crisis Provider Agency is responsible for the management and staffing of the crisis, unless an alternative agreement has been reached between the contractor and the OBS Director or designee. The OBS Clinical Director, OBS Consultant and/or designated OBS staff will be available for consultation and technical assistance on a case-by-case basis.
 - (3) Designated crisis support staff shall have completed the following training no later than ninety (90) calendar days after this agreement has been entered. Newly designated staff will receive the training within ninety (90) calendar days of designation to their position:
 - (a) Crisis Response Training (8 hours);
 - (b) Clinical Training (4 hours);
 - (c) Settings/Consideration Grid (4 hours);
 - (d) Positive Behavioral Supports (4 hours); and

- (e) Required DDSD training (See section IV. General Requirements for Provider Agency Service Personnel).

E. Reimbursement.

- (1) Billable Unit. The billable unit for Tier III Crisis Support in an Alternative Residential Setting is a daily unit. The billable unit for Tier III Crisis Support in an Individual's Residence is a 15- minute unit.
- (2) Non-Billable Activities include:
 - (a) Time spent on writing reports;
 - (b) Time spent on billing; and
 - (c) Travel to and from the site of service.

CHAPTER 15
PRIVATE DUTY NURSING SERVICES

- I. PRIVATE DUTY NURSING SERVICES.** Private Duty Nursing services are provided by registered nurses or licensed practical nurses under direction of a registered nurse as required by the Nurse Practice Act. Nursing interventions are activities, procedures and treatments provided to provide relief from or to cure a physical condition, physical illness or chronic physical disability. Nursing services include assessment, planning, implementation and evaluation. For children under the age of 21, medically necessary private duty nursing services must be obtained through the Medicaid state plan as part of federal Early Periodic Screening Diagnosis and Treatment (EPSDT) requirements.
- II. SCOPE OF PRIVATE DUTY NURSING SERVICES FOR ADULTS.** Private Duty Nursing services include but are not limited to the following:
- A. Promoting self-advocacy;
 - B. Aspiration precautions;
 - C. Bowel and bladder care;
 - D. Feeding tube management (Gastrostomy and Jejunostomy);
 - E. Health education;
 - F. Physical assessment and completion of a Health Assessment Tool (HAT) on at least an annual basis;
 - G. Health Risk Assessment, health maintenance and monitoring;
 - H. Infection control;
 - I. Medication management and medication administration;
 - J. Providing training of medication administration for appropriate personnel as well as providing “assisting with medication” training;
 - K. Environmental management for safety;
 - L. Nutrition management;
 - M. Oxygen management;
 - N. Tracheostomy care;
 - O. Seizure management and precautions;
 - P. Anxiety reduction;
 - Q. Behavior and self-care assistance;

- R. Skin care;
- S. Weight management;
- T. Wound care;
- U. Urinary catheter management and urostomy care; and
- V. Staff/family supervision and training regarding treatments procedures and activities as appropriate for each care giver according to their level of competence.

III. SERVICE REQUIREMENTS FOR PRIVATE DUTY NURSES. Service requirements of the Private Duty Nurse include, but are not limited to, the following service standards:

- A. Implement and direct nurses and direct service staff to implement only activities, procedures and treatments that have been prescribed by a primary care physician, a physician specialist, dentist or mid-level practitioner;
- B. The nurse assessment will be the basis on which the IDT determines whether or not an individual requires nursing services;
- C. Develop and implement Health Care Plans as indicated by the each individual's primary and secondary medical diagnoses and conditions;
- D. Submit documentation to each individual's Case Manager regarding changes in physician's orders;
- E. Review and revise Health Care Plans on an annual basis at a minimum and when each individual's health status changes;
- F. Collaborate with IDT members and participate in IDT meetings as needed. Attendance at IDT meetings may be in person or via telephone. If the nurse attends the IDT meeting via telephone the IDT signature page shall reflect that the nurse attended by telephone; and
- G. Provide training to other caregivers regarding health care precautions and practices specific to each individual's care.

IV. PROVIDER AGENCY REQUIREMENTS.

- A. **Supervision.** A registered nurse will supervise activities, treatments and procedures provided by licensed practical nurses as required by the Nurse Practice Act.
- B. **Financial Reporting.** Establish and maintain financial reporting and accountability for each individual served.

- C. Reporting Requirements.** The direct service Provider Agency is to submit quarterly progress reports to the Case Manager that complies with DDSD documentation requirements.
- D. Private Duty Nursing Qualifications.** All nurses providing private duty nursing services shall:
- (1) Be a registered nurse or licensed practical nurse licensed with the New Mexico State Board of Nursing; and
 - (2) Have a minimum of one-year experience as a licensed nurse.
- E. Reimbursement.**
- (1) Private Duty Nursing services unit: Reimbursement for Private Duty Nursing services is on a fifteen (15) unit basis.
 - (2) Billable Activities: Billable activities include direct nursing services as well as non face-to-face activities that include:
 - (a) Consultation with and training of IDT members, family members and direct care staff (e.g., respite provider);
 - (b) Time spent developing Health Care Plans, not to exceed four (4) hours annually; and
 - (c) Participation in individual specific training required of the nurse in the ISP.
 - (3) Non-Billable Activities: Non-billable activities include, non-treatment visits or travel to and from individual's homes.

CHAPTER 16
NUTRITIONAL COUNSELING SERVICES

- I. NUTRITIONAL COUNSELING SERVICES.** Nutritional counseling services are designed to meet the unique food and nutritional needs presented by individuals with developmental disabilities. This does not include oral-motor skill development services, such as those services provided by a speech pathologist. Nutritional counseling may be provided in the same setting and at the same time as another service; for example, in the individual's home when Personal Support services are being provided.
- II. SCOPE OF NUTRITIONAL COUNSELING SERVICES.** Nutritional Counseling services include but are not limited to the following:
- A. Promoting self-advocacy;
 - B. Perform assessment of the individual's nutritional needs;
 - C. Develop and revise, as needed, the nutritional plan;
 - D. Provide counseling and other nutritional interventions;
 - E. Revise nutritional plan at least annually;
 - F. Attend IDT meetings;
 - G. Consult with IDT members, direct care personnel, and other relevant personnel needed on the implementation of the individual's nutritional plan;
 - H. Observation and technical assistance for the implementation of the nutritional plans in various settings; and
 - I. Monitoring the effectiveness of nutritional interventions, and adjusting nutritional plan as needed.
- III. SERVICE REQUIREMENTS.**
- A. **Staff to Individual Ratio.** The staff to individual ratio is typically 1:1 for the period of time in which a specific individual is receiving nutritional counseling.
 - B. **Service Location.** Nutritional counseling may be provided in any setting.
- IV. PROVIDER AGENCY REQUIREMENTS.**
- A. **Reporting Requirements.** The Provider Agency is required to submit quarterly reports to the Case Manager that summarize progress towards goals and significant events that may impact the individual's progress. These quarterly reports shall address the extent to which nutritional interventions are successful in supporting the individual's health (e.g., has increased dietary fiber been successful in treating chronic constipation, has caloric intake been successful in reaching/maintaining target weight, has specialty diet contributed toward

improved management of chronic disease). These reports are due within fourteen (14) calendar days following the end of each quarter.

- B. Provider Agency Records.** Nutritional Counseling Providers are required to establish and maintain financial reporting and accounting for each individual and have a copy of the individuals current ISP on file. Nutritional counseling records shall contain the service start time, end time for each actual provision of service. Date and consumer identification, must be included on each page of all documents, and all documents must be signed by the author(s).

- C. Staffing Requirements.** The service provider shall be registered as a Dietitian by the Commission on Dietetic Registration of the American Dietetic Association.

- D. Reimbursement.**
 - (1) **Billable Unit:** The billable unit for nutritional counseling is fifteen (15) minutes of face-to-face contact with an individual with developmental disabilities or others who implement nutritional plans.

 - (2) **Billable Activities:** All activities detailed in the scope of service are billable activities.

 - (3) **Non-Billable Activities:** Non-Billable activities include:
 - (a) Non-treatment visits;

 - (b) Time spent on writing reports;

 - (c) Time spent billing; and

 - (d) Travel to and from the site of service.

- E. Service Limitations.** For individuals receiving Community Living services or Adult Habilitation services, Nutritional Counseling services are provided as part of the rate for the service and may not be billed separately. Nutritional Counseling services may be provided in the same setting and at the same time as another service (e.g., in the individual's home when Personal Support services are being provided).

CHAPTER 17
NON-MEDICAL TRANSPORTATION SERVICE

I. NON-MEDICAL TRANSPORTATION SERVICES. Non-Medical Transportation Services assist the individual in accessing other waiver supports and non-waiver activities identified in the Individual Service Plan (ISP). The primary goals of this service are to facilitate greater inclusion in community life and to promote self-determination. Non-Medical Transportation services enable individuals to gain physical access to non-medical community services and resources promoting individual opportunity and responsibility in carrying out ISP activities. Non-Medical Transportation services are accessed through a DDS approved Non-Medical Transportation Provider. This service is to be considered only when transportation is not available through the Medicaid State Plan or when other arrangements cannot be made.

II. SCOPE OF SERVICE.

A. Non-Medical Transportation services shall include, but not be limited to, the following service standards. Transportation services between the individual's home and non-medical services, resources or activities such as:

- (1) Community events or activities;
- (2) Work or volunteer site;
- (3) Homes of family or friends;
- (4) Civic organizations or social clubs;
- (5) Public meetings or other civic activities; or
- (6) Spiritual activities or events.

III. SERVICE REQUIREMENTS.

A. Service Criteria. Written justification shall address the need for Non-Medical Transportation services to fulfill identified activities and supports in the ISP and identify the associated ISP goals or outcomes. When possible, private payment for public transportation, independent arrangements, or transportation services without charge will be used prior to accessing this service.

The Non-Medical Transportation Provider may use funding under this service to purchase a pass for public transportation for the individual, when determined appropriate by the IDT to support or fulfill identified activities associated with ISP goals or outcomes.

For individuals who receive Supported Living or Family Living, non-medical transportation services may only be provided under the following conditions:

- (1) Situations where extensive travel (more than 100 miles round trip) is required to meet outcomes in the ISP.

(2) Non-Medical Transportation may be used to travel to and from the individual's place of employment, even if the individual is traveling from the site of another DD Waiver Service (e.g., Community Living or Adult Habilitation).

(3) Non-Medical Transportation may not be used during the hours an individual is receiving Adult Habilitation services.

B. Location. Non-Medical transportation services may be provided to/from any location, with the exception that they may not be used for transportation to a location that is covered by Medicaid Medical Transportation.

IV. PROVIDER AGENCY REQUIREMENTS.

A. Provider Agency Records.

(1) A signed consent form shall be obtained prior to transporting a child (ages birth through 17). The appropriate parent, guardian, or legal representative shall complete the consent form. The signed form shall be maintained at the Provider Agency and a copy provided to the Case Manager for inclusion in the individual's primary record at the Case Management Agency.

(2) The Non-Medical Transportation Providers will maintain documentation in the form of a transportation log to include:

(a) Proper consumer identification shall be included on all pages of documents;

(b) Date(s) of service, including dates and signatures of authors on all documents;

(c) Time in and time out;

(d) Location(s) where the individual begins travel and the destination point (point to point, not round trip); and

(e) Total miles traveled.

(3) For those using public transportation passes, documentation supporting the implementation of activities in the ISP including desired outcomes may be substituted in lieu of the time in/time out and beginning destination/location for audit and billing purposes. The Non-Medical Transportation Provider is responsible for compiling and maintaining this documentation.

B. Reporting Requirements. Upon request the Non-Medical Transportation Provider will submit a copy of the transportation log to the Case Manager on a quarterly basis through out the individual's ISP year.

C. IDT Coordination. A Non-Medical Transportation Provider is not required to attend IDT meetings. However, the Non-Medical Transportation Providers, if requested, will provide documentation or information to the IDT in order to

support the planning process. This information/documentation may be provided in person or through the Case Manager.

D. Non-Medical Transportation. Provider shall develop and implement policies and procedures that comply with Chapter 1, Section II.G. of these standards.

E. Driver Qualifications/Vehicle Requirements.

(1) Driver Qualifications:

- (a) All drivers shall possess a valid New Mexico driver's license, and be free of physical or mental impairment that would adversely affect driving performance. Eligible drivers will not have any DWI convictions, or chargeable (at fault) accidents within the previous two years;
- (b) All drivers shall have current CPR/First Aid certification; and
- (c) All drivers, staff, and volunteers will be trained to implement specific techniques to ensure the safe transportation of individuals who have unique medical or physical considerations.

(2) Vehicle Requirements:

- (a) All vehicles used to provide Non-Medical Transportation are required to be in compliance with state automobile insurance requirements.
- (b) Vehicles used to transport individuals with physical disabilities shall be accessible. Special lifts and other equipment shall be in safe working order.
- (c) The provider will ensure the following when transporting individuals:
 - (i) Written procedures for reporting incidents will be kept in all vehicles used to provide non-medical transportation services;
 - (ii) No individual will remain unattended in the vehicle;
 - (iii) Keys will be removed from the vehicle at all times when the driver is not in the driver's seat; and
 - (iv) Doors will be locked at all times while the vehicle is moving.
- (d) All persons will use appropriate safety restraints as required for the individual (seat belts; car seats or other age appropriate child restraint systems). Vehicles serving individuals who use wheelchairs shall have and will use locking mechanisms to immobilize wheelchairs during travel; and
- (e) A basic First Aid kit will be kept in all vehicles.

F. Exceptions for use of Public Transportation. The purchase of a pass for travel on public transportation does not require the Public Transportation System to be a Non-Medical Transportation Provider. Only Public Transportation Systems operated in accordance with State of New Mexico Regulations and Licensing Requirements may be used for the provision of Non-Medical Transportation services.

G. Reimbursement.

(1) **Billable Unit:** The billable unit for non-medical transportation (per mile) is a mile. The billable unit for non-medical transportation (Pass/Ticket) is a set dollar amount specified in the current Medicaid Supplement Rate Tables for the Developmental Disabilities Home and Community Based Services Waiver. Separate trips may be combined within one unit of service.

(2) **Billable Activities:**

(a) Transportation services between locations (e.g., individual's home and non-medical services or resources) that support activities or achievements of ISP outcomes;

(b) Purchase of a pass for use of public transportation plus up to 10% of the purchase price for each pass purchased to support administrative activities (e.g., documentation or IDT coordination); and

(c) Transportation to locations/events stated in the scope of services.

(3) **Non-Billable Activities:**

(a) Transportation to medical care appointments;

(b) No payment shall be made for charges when the individual is not actually in the vehicle; and

(c) Time spent documenting mileage or maintaining the transportation log required for use of the three-mile unit. Note: This service cannot be used to supplant the transportation responsibility of the Supported Living or Family Living provider. In addition, Supported Living or Family Living providers are required to provide transportation to and from the adult habilitation setting if applicable. This service cannot be used to supplant the transportation responsibility of the Adult Habilitation Provider for transportation to activities that are part of the habilitation service.

(d) Transportation available through Medicaid State Plan benefits.

CHAPTER 18
SUPPLEMENTAL DENTAL CARE

I. SUPPLEMENTAL DENTAL CARE. Supplemental Dental Care provides one routine oral examination and cleaning to individuals on the Waiver for the purpose of maintaining and/or preserving oral health. Supplemental Dental Care provided through the Waiver is for individuals who require more than the number of cleanings in a year than is available through the Medicaid State Plan.

II. SCOPE OF SERVICE.

A. Supplemental Dental Care shall include:

- (1) Oral examination; and
- (2) Routine dental cleaning.

III. SERVICE REQUIREMENTS.

A. Service Criteria. The need for an additional routine oral examination and cleaning in addition to what is allowable under the Medicaid State Plan to preserve and/or maintain oral health.

IV. PROVIDER AGENCY REQUIREMENTS.

A. Provider Agency.

- (1) The Supplemental Dental Care Provider will ensure that a licensed dentist per New Mexico Regulation and Licensing Department provides the oral examination.
- (2) The Supplemental Dental Care Provider will ensure that a dental hygienist certified by the New Mexico Board of Dental Health Care provides the routine dental cleaning services.
- (3) The Supplemental Dental Care Provider will demonstrate fiscal solvency.
- (4) The Supplemental Dental Care Provider will function as a payee for the service.

B. Reporting Requirements. Upon request the Supplemental Dental Care provider shall submit a copy of the documentation of service delivery for individuals accessing the service to the Case Manager.

C. IDT Coordination. A Supplemental Dental Care provider is not required to attend IDT meetings.

D. Reimbursement.

- (1) Billable Unit: The billable unit for this service is one visit up to set dollar amount specified in the current Medicaid Supplement Rate Tables for the

Developmental Disabilities Home and Community Based Services Waiver.
Only one visit per ISP year is allowed.

- (2) Billable Activities: Skilled dental services provided by a licensed dentist or a certified dental hygienist.
- (3) Non-Billable Activities: Any activity that does not meet the service description of the scope of work is considered to be a non-billable activity.