

Highlights of Final Revisions to DD Waiver Standards
Effective Date: April 1, 2007

Location	Change
Definitions	Added definition of Preliminary Risk Screen.
Chapter 1	Effective date changed from January 1, 2007 to April 1, 2007.
Chapter 1, II.G.	Added expectation for provider policy and procedures related to transportation of individuals served.
Chapter 1, III.E(1)(b)	Added option for Family Living caregivers to complete the Health Assessment Tool (HAT) instead of the agency nurse or primary care physician.
Chapter 4, III.A(2)	Case management agency to BOTH assign case manager and complete first contact with individual within five working days of notification of Primary Freedom of Choice for new allocations.
Chapter 4, III.A(3)	Added requirement to keep Central Registry Unit informed of progress with new allocations.
Chapter 4, III.B(3)	Added requirement to provide copy of MAW letter to service providers on the MAD 046.
Chapter 4	Allowed answering machine instead of staff phone coverage during office hours with expectation that calls will be returned by end of following business day.
Chapter 4, IV.D(2) & (3)	Provided consistency in expectation that ISP is distributed within 14 days of approval.
Chapter 5, III.C	Removed requirement that all individuals receiving Community Living Services receive at least one Community Inclusion service. Language now acknowledges that Community Living recipients may in some cases achieve their 30 hours per week outside the home exclusively through natural supports or services other than those included under Community Inclusion.
Chapter 5, IV.D (c)(i)(j)&(k)	Clarified health related records required for Community Inclusion individual case files.
Chapter 5, XIV.C(6)	Required that Community Inclusion Provider allow therapy providers access to work with individuals during Community Inclusion services and that staff are expected to participate in such therapy intervention to a sufficient degree to learn how to reinforce therapeutic goals/supports on a routine basis.
Chapter 6, III.A(3)	Increased maximum hours of substitute care per year to 1000 (from previous level of 649).
Chapter 6, III.C	Clarified services bundled into Family Living and therefore not allowed within ARA. Also clarifies that use of respite in ARA will result in a deduction to Family Living reimbursement.

Location	Change
Chapter 6, VI.B	Clarified current criteria for each type of Community Living services; less stringent for Independent Living criteria.
Chapter 6, VI.C	Clarified that DDS Director must approve requests to allow Community Living for any individual under age 18, & under no circumstances will the parent or other legally responsible adult be approved to deliver Family Living to individuals under age 18.
Chapter 6, VI.G(2)	Required the Community Living provider to assign a healthcare coordinator on their staff if no one on the team volunteers for this role for individuals who have a HAT score of 4, 5 or 6.
Chapter 6, VIII.A(4)(6) & (9)	Reduced requirement for in-home records to include only the past one month of progress notes – but requires past 3 months for MARs.
Chapter 6, VIII.B(1)(a)	Clarified frequency of supervisory visits required for Community Living.
Chapter 6, VIII.F	Clarified that staff providing substitute care under Family Living must meet training requirements equivalent to respite providers.
Chapter 6, VIII.G(3)	Clarified that responsibility of IDT to plan and assure 30 hours outside the home applies to Support Living and Family Living – optional for Independent Living since those in Independent Living may not need or desire this level of support from the team.
Chapter 6, IX.C	Clarified minimum amount of Family Living payment that must be provided to the caregiver and also increased maximum amount of substitute care from 649 to 1000 hours per year.
Chapter 7, II.A	Clarified that payment for environmental modifications can include purchase and installation of items (such as a hoist lift or shower insert), not just remodeling work.
Chapter 7, VI.B(1)	Corrected percentage allowable for administrative costs under Environmental modifications.
Chapter 7, III.B	Added clarification that Regional Office must approve Environmental Modifications prior to work beginning.
Chapter 9, II.B(3)	For renewal of outlier after the first 6 months, required prior written approval by Regional Office prior to submission to NMMUR.
Chapter 9, III.B	Clarified justification requirements for Outlier packets.
Chapter 9, III.F	Clarified intent of Behavioral Outlier Services.
Chapter 12	Removed reference to preferred staff ratio.
Chapter 13, III.B(2) & VII.A	Moved limits on services to children under age 21 from “Eligibility” section to VII “Specific Service Requirement”. Also in section VII clarified that the other service definitions for therapy apply only to adults.

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 NMDOH-Developmental Disabilities Supports Division

Location	Change
Chapter 13, X.L(2) & XI.E(10)	Added requirement to notify individual/legal guardian of right to fair hearing if therapy services are discontinued or if exceptions are denied. Clinical Services Bureau will develop forms and a process to comply.
Chapter 14, III.B	Clarified that OBS prior approval required must be written.
Chapter 15, I & II	Clarified that Private Duty Nursing is only available through DD Waiver for adults and that children under age 21 must obtain this service through EPSDT state plan.
Chapter 17, IV.D	Clarified that non-medical transportation providers must comply with policy procedure requirements in Chapter 1.
Chapter 17, IV.G(2)(d)	Clarified that Non-Medical Transportation may not be used if the trip would be covered by the Medicaid state plan (e.g., to medical or therapy appointments).
Throughout	All references to specific rates have been removed and replaced with a reference to the Medicaid rate tables.