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

8.314.5.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.314.5.1 NMAC - Rp, 8.314.5.1 NMAC, 12/1/2018; A, 7/1/2024]

8.314.5.2 SCOPE: The rule applies to the general public.
[8.314.5.2 NMAC - Rp, 8.314.5.2 NMAC, 12/1/2018]

8.314.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.314.5.3 NMAC - Rp, 8.314.5.3 NMAC, 12/1/2018; A, 7/1/2024]

8.314.5.4 DURATION: Permanent.
[8.314.5.4 NMAC - Rp, 8.314.5.4 NMAC, 12/1/2018]

8.314.5.5 EFFECTIVE DATE: December 1, 2018, unless a later date is cited at the end of a section.
[8.314.5.5 NMAC - Rp, 8.314.5.5 NMAC, 12/1/2018]

8.314.5.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs (MAP).
[8.314.5.6 NMAC - Rp, 8.314.5.6 NMAC, 12/1/2018]

8.314.5.7 DEFINITIONS:

A. Activities of daily living (ADLs): Basic personal everyday activities that include bathing, dressing, transferring (e.g., from bed to chair), toileting, oral care, mobility and eating.

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

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

D. Child: An individual under the age of 18. For purpose of early periodic screening, diagnosis and treatment (EPSDT) services eligibility, "child" is defined as an individual under the age of 21.

E. Clinical Documentation: Sufficient information and documentation that demonstrates the request for initial and ongoing developmental disabilities waiver (DDW) services is necessary and appropriate based on the service specific DDW clinical criteria established by the department of health (DOH) developmental disabilities support division (DDSD) for adult recipients excluding class members of Walter Stephen Jackson, et al vs. Fort Stanton Hospital and Training School et. al, (757 F. Supp. 1243 DNM 1990). Examples of clinical documentation include but are not limited to: the DDW therapy documentation form (TDF), intensive medical living supports (IMLS) and adult nursing services parameter tools, electronic comprehensive health assessment tool (e-Chat), all other assessments, clinical notes, progress notes, interdisciplinary team (IDT) meeting minutes, letters or reports from physicians or ancillary service providers that provide sufficient clinical information that demonstrates the need for requested services, etc. Any relevant supporting information and documentation is acceptable and will be considered by the outside reviewer.

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

(1) meet the eligible recipient's clinical, functional, physical, behavioral or habilitative needs;

(2) promote and afford support to the eligible recipient for their greater independence and to maintain current level of function or minimize risk of further decline; or

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

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

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

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

H. Electronic visit verification (EVV): A telephone and computer-based system that electronically verifies the occurrence of selected services, as required by the 21st Century CURES Act. The EVV system verifies the occurrence of authorized service visits electronically by documenting the precise time and location where service delivery visit begins and ends. EVV is implemented according to federal requirements and timelines. The 21st Century CURES Act requires EVV for personal care services (PCS), defined as services that provide assistance with activities of daily living (ADLs) or instrumental activities for daily living (IADLs) effective January 1, 2020 and for home health services effective January 1, 2023.

I. Individual service plan (ISP): A person-centered plan for an eligible recipient that includes their needs, functional levels, intermediate and long-range outcomes for achieving their goals and specifies responsibilities for the eligible recipient's support needs. The ISP enables and assists the recipient to identify and access a personalized mix of paid waiver and non-paid services and supports that assists them to achieve personally defined outcomes in the community.

J. Outside reviewer: An independent third-party assessor who has a contract with the DOH to conduct clinical reviews of all requested DDW services. The outside reviewer will make a written determination on whether the requested supports are clinically justified and will recommend whether the eligible recipient's requested ISP and budget should be approved or denied. The decision of the outside reviewer to approve any requested service is binding on the state. However, the state may agree to overturn a decision to deny requested services.

K. Person centered planning (PCP): Person centered planning is a process that places a person at the center of planning their life and supports. It is an ongoing process that is the foundation for all aspects of the DDW program and DDW service provider's work with individuals with I/DD. The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the recipient. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. It involves person centered thinking, person centered service planning and person- centered practice.

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

M. Young Adult: An individual between the ages of 18 through 20 years of age who is allocated to the DDW and is receiving specific services as identified in the DOH/DDSD standards. An individual under age 21 is eligible for medical services funded by their medicaid providers under EPSDT. Upon the individual's 21st birthday, they are considered to be an adult recipient of DDW services.

[8.314.5.7 NMAC - Rp. 8.314.5.7 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.8 SAFEGUARDS CONCERNING RESTRAINTS, RESTRICTIONS AND SECLUSION:

A. Seclusion and isolation is prohibited during waiver services.

B. Use of restraints or restrictions is only permitted during the course of delivery of waiver services under strict limitations and oversight.

(1) Certain specific interventions are considered ethically unacceptable for application and, as such, are unequivocally prohibited. Interventions that are prohibited include but are not limited to:

(a) contingent electrical aversion procedures;

(b) seclusion and isolation;

(c) use of time out (for an adult);

(d) use of mechanical or chemical restraints;

(e) use of manual application of any physical restraint, except in emergent situations involving imminent risk of harm to self or others (personal restraints);

(f) overcorrection;

(g) forced physical guidance;
(h) forced exercise;
(i) withholding food, water, or sleep;
(j) public or private humiliation;
(k) privacy violations;
(l) restricting exit from home with locks on windows or doors;
(m) application of water mist; and
(n) application of noxious taste, smell, or skin agents; etc.

(2) Use of restrictive interventions must be documented in the individual's positive behavior support plan or behavioral crisis intervention plan or risk management plan and must be reviewed by the human rights committee prior to implementation.

(3) Chemical restraint is defined as the administration of medication at a dose or frequency to intentionally and exclusively preclude behavior without identifying an underlying anxiety, fear or severe emotional distress or other symptoms of psychiatric/emotional disturbance to be eased, managed or treated. The administration may be regularly scheduled or on a pro re nata (PRN), or "as needed" basis. The use of chemical restraints is prohibited.

(4) The administration of PRN psychotropic medication is allowed when prescribed in advance by the prescribing professional. A PRN psychotropic medication plan is a collaborative document that outlines the behavioral indications for using the medication. A human rights committee must approve use of PRN psychotropic medication prior to its implementation and the procedures that DSP must use to gain approval for its implementation.

(5) Mechanical restraints are defined as the use of a physical device to restrict the individual's capacity for desired or intended movement including movement or normal function of a portion of their body. The use of mechanical restraints is prohibited.

(6) Use of any emergency physical restraints must be written into a behavioral crisis intervention plan only and approved by a human rights committee prior to its use. Personal restraints (i.e. emergency physical restraints) are used as a last resort, only when other less intrusive alternatives have failed and under limited circumstances that include protecting an individual or others from imminent, serious physical harm, or to prevent or minimize any physical or emotional harm to the individual. Staff must be trained in both nonphysical and physical interventions.

(7) Any individual for whom the use of emergency physical restraints or PRN psychotropic medications is allowed is required to have a positive behavioral supports assessment, positive behavior support plan, and a behavioral crisis intervention plan or PRN psychotropic medication plan completed by a behavior support consultant in conjunction with the individual's agency nurse and interdisciplinary team.

(8) Ethical, medical or behavioral concerns, use of live or recorded video monitoring/observational systems, and resolution of plans contested on the individual team or provider agency level in local human rights committees are heard and resolved in a statewide and state coordinated super human rights committee.

[8.314.5.8 NMAC - N, 4/1/2022]

8.314.5.9 DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER: The New Mexico medical assistance division (MAD) has obtained a waiver from certain medicaid payment and benefit statutes (42 CFR 441.300) to provide home and community-based services (HCBS) to eligible recipients as an alternative to institutionalization. DDW services are intended to enhance, not replace, existing natural supports and other available community resources. Services will emphasize and promote the use of natural and generic supports to address the eligible recipient's assessed needs in addition to paid supports. Provider agencies are required to ensure the settings in which they provide services meet the below requirements. All providers have a responsibility to monitor settings for compliance; monitor that waiver recipients are given choices; and, ensure rights are respected. DDW services must be provided in a setting that:

A. is integrated in and facilitates full access to the greater community;

B. ensures the individual receives services in the community to the same degree of access as individuals not receiving medicaid HCBS;

C. maximizes independence in making life choices;

D. is chosen by the individual (in consultation with the guardian if applicable) from among residential and day options, including non-disability specific settings;

E. ensures the right to privacy, dignity, respect and freedom from coercion and restraint;

F. supports health and safety based upon the individual's needs, decisions or desires;
G. optimizes individual initiative, autonomy and independence in making life choices;
H. provides an opportunity to seek competitive employment;
I. provides individuals an option to choose a private unit in a residential setting; and
J. facilitates choice of services and who provides them.

[8.314.5.9 NMAC - Rp, 8.314.5.9 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.10 ELIGIBLE PROVIDERS:

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

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

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

D. Qualifications of case management provider agency: A case management provider agency, its case managers, whether subcontractors or employees must comply with 8.314.5.10 NMAC. In addition, case management provider agency must ensure that a case manager meets the following qualifications:

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

(2) one or more of the following:

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

(b) hold a current registered nurse (RN) license as defined by the New Mexico board of nursing; or

(c) hold a bachelor's or master's degree in social work, psychology, sociology, counseling, nursing, special education, or a closely related field or have a minimum of six years of direct experience related to the delivery of social services to people with disabilities; and

(3) comply with all training requirements as specified by DOH/DDSD; and

(4) have received written notification from DOH that they do not have a disqualifying conviction after submitting to the caregiver criminal history screening (CCHS);

(5) does not provide any direct waiver services through the same 1915 (c) HCBS waiver program; and

(6) any exception to the above must be approved by DOH/DDSD.

E. Qualifications of respite provider agency: A respite provider agency must comply and ensure that all direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. In addition, respite provider agencies and direct support personnel must:

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

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

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS; and

(4) comply with all EVV requirements as defined by the 21st Century CURES Act and implemented by MAD including but not limited to documenting service provision using the approved EVV system.

F. Qualifications of adult nursing provider agencies: Adult nursing provider agencies must ensure all subcontractors or employees, including nurses, comply with DOH DDW service definitions, DDW service standards, applicable NMAC rules, MAD billing instructions, utilization review instructions, and supplements, and applicable federal and state laws, rules and statutes. Direct nursing services shall be provided by a New Mexico licensed RN or licensed practical nurse (LPN), have a minimum of one year experience as a licensed nurse, and must comply with all aspects of the New Mexico Nursing Practice Act, including supervision and delegation requirements of specific nursing function and 8.314.5.10 NMAC.

G. Qualifications of therapy provider agency: A therapy provider agency must comply and ensure that each of its therapists including physical therapists (PT), occupational therapists (OT), and speech therapists (SLP), physical therapy assistants (PTA), and certified occupational therapy assistants (COTA), whether a subcontractor or employee complies with 8.314.5.10 NMAC.

H. Qualifications for living supports provider agency: Living supports consist of family living, supported living, and intensive medical living supports. A living supports provider agency must comply with the accreditation policy and all requirements set forth by the DOH, DDW service definitions, all requirements outlined in the DDW service standards and the applicable NMAC rules. A living supports provider agency must ensure that all direct support personnel meet all qualifications set forth by DOH, DDW service standards, and applicable NMAC rules.

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

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

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

(c) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

(2) A family living provider agency must ensure that all direct support personnel, whether a subcontractor or employee, meet all qualifications set forth by DOH and the DDW service standards and the applicable NMAC rules. Legal guardians who are also natural or adoptive family members who meet the DOH/DDSD requirements and are approved to provide family living services may be paid for providing services. A family living provider agency must employ or subcontract with at least one registered or licensed dietician or licensed nutritionist. A family living provider agency must also be an adult nursing services provider and must employ or subcontract with at least one licensed RN; employ or subcontract with at least one additional nurse for on call services and comply with the New Mexico Nurse Practice Act, including supervision and delegation requirements of specific nursing functions. The number of nurses (RNs and LPNs) must be sufficient to meet the routine and on call health care needs of the individuals. Both the direct support personnel employed by or subcontracting with the provider agency and the physical home setting must be approved through a home study completed prior to the initiation of services, revised with any change in family composition, move to a new home, or other significant event and periodically thereafter as required of the provider agency.

(3) A supported living provider agency must ensure that all direct support personnel meet all qualifications set forth by DOH and the applicable NMAC rules and the DDW service standards. A supported living provider agency must employ or subcontract with at least one registered or licensed dietician or licensed nutritionist. The number of RD/LDs employed or under contract must be sufficient to meet the routine nutritional needs of the individuals. They must employ or subcontract with at least one licensed RN, employ or subcontract with at least one additional nurse for on call and services, and comply with the New Mexico Nurse Practice Act, including supervision and delegation requirements of specific nursing functions. The number of nurses (RNs and LPNs) must be sufficient to meet the routine and on call health care needs of the individuals.

(4) An intensive medical living supports provider agency must employ or subcontract with at least one registered or licensed dietician or licensed nutritionist. The number of RD/LDs employed or under contract must be sufficient to meet the routine nutritional needs of the individuals. They must employ or subcontract with at least one New Mexico licensed RN who must have a minimum of one year of nursing experience employ or subcontract with at least one additional nurse for on call services and comply with the New Mexico Nursing Practice

Act including supervision and delegation requirements of specific nursing functions. The number of nurses (RNs and LPNs) must be sufficient to meet the routine and on call health care needs of the individuals.

I. Qualifications of a customized community supports provider agency: A customized community supports provider agency must comply with and ensure that all direct support personnel comply with 8.314.5.10 NMAC. A customized community supports provider agency and direct support personnel must:

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

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

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

J. Qualifications of a community integrated employment provider agency: A community integrated employment provider agency must comply with and ensure that all direct support personnel comply with 8.314.5.10 NMAC. A community integrated employment provider agency and direct support personnel must:

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

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

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

K. Qualifications of a behavioral support consultation provider agency: A behavioral support consultation provider agency must comply with and ensure that all behavioral support consultants, whether subcontractors or employees, comply with 8.314.5.10 NMAC.

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

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

(b) a licensed psychologist; or

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

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

(e) a licensed master social worker (LMSW); or

(f) a licensed professional clinical mental health counselor (LPCC); or

(g) a licensed marriage and family therapist (LMFT); or

(h) a licensed professional art therapist (LPAT); or

(i) Other related licenses and qualifications may be considered with DOH's prior written approval.

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

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

L. Qualifications of a nutritional counseling provider agency: A nutritional counseling provider agency must comply with and ensure that all nutritional counseling providers, whether subcontractors or employees comply with 8.314.5.10 NMAC. In addition, a nutritional counseling provider must be registered as a dietitian or a licensed nutritionist by the commission on dietetic registration of the American dietetic association and be licensed by RLD as a nutrition counselor.

M. Qualifications of an environmental modification provider agency: An environmental modification contractor and their subcontractors and employees must be bonded, licensed by RLD, and authorized by DOH to complete the specified project. An environmental modification provider agency must comply with 8.314.5.10 NMAC. All services shall be provided in accordance with applicable federal, state and local building codes.

N. Qualifications of a crisis supports provider agency: A crisis supports provider agency must comply with and must ensure that direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. In addition, a crisis supports provider agency and direct support personnel must:

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

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

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

O. Qualifications for a non-medical transportation provider agency: A non-medical transportation provider agency must comply with 8.314.5.10 NMAC. In addition, a non-medical transportation provider must have a business license and drivers must have a valid driver's license and not have a disqualifying

conviction after submitting to the CCHS. Must have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

P. Qualifications of an assistive technology provider agency: An assistive technology purchasing agent provider and agency must comply with 8.314.5.10 NMAC, demonstrate fiscal solvency when functioning as a payee for this service. Assistive technology providers may also be the direct vendors of approved technology.

Q. Qualifications of an independent living transition service provider agency: An independent living transition service provider agency must comply with 8.314.5.10 NMAC, demonstrate fiscal solvency and function as a payee for this service.

R. Qualifications of a remote personal support technology provider agency: Remote personal support technology provider agencies must comply with 8.314.5.10 NMAC. This includes having a current business license and must demonstrate fiscal solvency and function as a payee of services. In addition, remote personal support technology provider agencies must comply with all laws, rules, and regulations of the federal communications commission (FCC) for telecommunications.

S. Qualifications of a preliminary risk screening and consultation (PRSC) related to inappropriate sexual behavior provider agency: A PRSC provider agency must comply with 8.314.5.10 NMAC and all training requirements as specified by DOH. Additionally, the PRSC provider agency must subcontract with or employ the evaluator, who at a minimum must be:

(1) an RLD independently licensed behavioral health practitioner, such as an LPCC, LCSW, LMFT, LISW, or a psychologist; or

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

T. Qualifications of a socialization and sexuality education provider agency: A socialization and sexuality education provider agency must comply with 8.314.5.10 NMAC. A provider agency must be approved by the DOH, bureau of behavioral support (BBS) as a socialization and sexuality education provider and must meet training requirements as specified by DOH. In addition, a socialization and sexuality education provider agency must employ or contract with a provider who has one of the following qualifications for rendering the service:

(1) a master's degree or higher in psychology;

(2) a master's degree or higher in counseling;

(3) a master's degree or higher in special education;

(4) a master's degree or higher in social work;

(5) a master's degree or higher in a related field;

(6) a RN or LPN;

(7) a bachelor's degree in special education or a related field such as psychology or social work;

(8) a certification in special education;

(9) a New Mexico level three recreational therapy instructional support provider license; or

(10) a certified therapeutic recreation therapist (CTRS) obtained through the national council for therapeutic recreation.

U. Qualifications of a customized in-home supports provider agency: A customized in-home supports provider agency must comply with and ensure that direct support personnel, whether subcontractors or employees, comply with 8.314.5.10 NMAC. Legal guardians who are also natural or adoptive family members, relatives, or natural family members that meet the DOH/DDSD requirements and are approved to provide customized in-home supports may be paid for providing services. A customized in-home supports provider agency and direct support personnel must:

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

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

(3) have written notification from DOH that they do not have a disqualifying conviction after submitting to the CCHS.

(4) comply with all EVV requirements as defined by the 21st Century CURES Act and implemented by MAD including but not limited to documenting service provision using the approved EVV system.

V. Qualifications of a supplemental dental care provider agency: A supplemental dental care provider agency must comply with 8.314.5.10 NMAC. A supplemental dental care provider must contract with a New Mexico licensed dentist and dental hygienist who are licensed by RLD. The supplemental dental care provider will ensure that a RLD licensed dentist provides the oral examination; ensure that a RLD licensed dental hygienist provides all routine dental cleaning services; demonstrate fiscal solvency; and function as a payee for the service.

[8.314.5.10 NMAC - Rp, 8.314.5.10 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.11 PROVIDER RESPONSIBILITIES:

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

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

C. Provider agencies must mitigate any conflict of interest issues by adhering to at least the following:

(1) Any individual who operates or is an employee of a DDW provider shall not serve as guardian for a person served by that agency, except when related by affinity or consanguinity Paragraph (1) of Subsection A of Section 45-5-31 NMSA 1978. Affinity which stems solely from the caregiver relationship is not sufficient to satisfy this requirement.

(2) DDW provider agencies may not employ or sub-contract with a direct support person who is an immediate family member to support the person in services, except when the person is in family living, respite, or customized in home supports (CIHS).

(3) DDW provider agencies may not employ or subcontract with the spouse of the participant to support the person in any DDW funded services.

D. Case management agencies are required to mitigate real or perceived conflict of interest issues by adhering to, at minimum the following requirements. Case managers who are contracted under the DDW are identified as agents who are responsible for the development of the ISP.

(1) Case management agency owners and individually employed or contracted case managers may not:

(a) be related by blood or affinity to the person supported, or to any paid caregiver of the individual supported. Following formal authorization from DDSD, a case manager may provide family living services or respite to their own family member;

(b) have material financial interest in any entity that is paid to provide DDW or mi via services. A material financial interest is defined as anyone who has, directly or indirectly, any actual or potential ownership, investment, or compensation arrangement;

(c) be empowered to make financial or health related decisions for individuals on their caseload;

(d) be related by blood or affinity to any DDW service provider for individuals on their caseload. Providers are identified as providers of living care arrangements, community inclusion services, mi via consultants, mi via vendors, BSC's and therapist**.**

(2) A case management provider agency may not:

(a) be a provider agency for any other DDW service;

(b) provide guardianship services to an individual receiving case management services from that same agency;

(3) A case manager or director of a case management provider agency may not:

(a) serve on the board of directors of any DDW provider agency;

(b) provide training to staff of DDW provider agencies unless meeting criteria as outlined in the DDW service standards.

(4) Case management provider agencies must disclose to both DDSD and the people supported by their agency any familial relationships between employees or subcontract case managers and providers of other DDW services.

(5) Case management provider agency staff and subcontractors must maintain independence and avoid all activity which could be perceived as a potential conflict of interest.

[8.314.5.11 NMAC - Rp, 8.314.5.11 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.12 ELIGIBLE RECIPIENTS: The MAP category of eligibility criteria for DDW services is found in 8.290.400 NMAC.
[8.314.5.12 NMAC - Rp, 8.314.5.12 NMAC, 12/1/2018]

8.314.5.13 [RESERVED]
[8.314.5.13 NMAC - Rp, 8.314.5.13 NMAC, 12/1/2018]

8.314.5.14 DDW COVERED WAIVER SERVICES FOR IDENTIFIED POPULATION UNDER 18 YEARS OF AGE: The DDW program is limited to the number of federally authorized unduplicated eligible recipient (UDR) positions and program funding. All DDW covered services in an ISP must be authorized. DDW services must be provided in accordance with all requirements set forth by DDW service definitions, all requirements outlined in the DDW service standards, and the applicable NMAC rules, supplements and guidance. The DDW covers the following services for a specified and limited number of waiver eligible recipients as a cost effective alternative to institutionalization in an intermediate care facilities for individuals with intellectual disabilities (ICF-IID).

A. Eligible recipients age birth to 18: Services funded within this age category must be coordinated with and shall not duplicate other services such as the medicaid school-based services program, the MAD early periodic screening diagnosis and treatment (EPSDT) program, services offered through the New Mexico public education department (PED), or the early childhood education and care department (ECECD) family infant toddler (FIT) program.

B. Service options available include:

(1) environmental modifications;
(2) assistive technology;
(3) remote personal support technology;
(4) preliminary risk screening and consultation;
(5) socialization and sexuality education;
(6) behavioral support consultation;
(7) customized community support;
(8) respite;
(9) non-medical transportation;
(10) case management; and
(11) nutritional counseling.

[8.314.5.14 NMAC - Rp, 8.314.5.14 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.15 DDW COVERED WAIVER SERVICES: The DDW program is limited to the number of federally authorized unduplicated eligible recipient (UDR) positions and program funding. All DDW covered services in an ISP must be authorized by DOH. DDW services must be provided in accordance with all requirements set forth by DOH DDW service definition, all requirements outlined in the DDW service standards, and the applicable NMAC rules, supplements and guidance. Services for individuals under the age of 21 must be coordinated with and shall not duplicate other services such as the medicaid school-based services program, the MAD early periodic screening diagnosis and treatment (EPSDT) program, or the early childhood education and care department (ECECD) family infant toddler (FIT) program. Services offered through the New Mexico public education department (PED), the Individuals with Disabilities Education Act (IDEA), the New Mexico division of vocational rehabilitation (DVR), the Rehabilitation Act, the Workforce Innovation and Opportunities Act (WIOA), the New Mexico department of workforce solutions (DWS) must be utilized prior to accessing funding from the DDW. DDW covers the following services for a specified and limited number of waiver eligible recipients as a cost effective alternative to institutionalization in an ICF-IID.

A. There are seven proposed budget levels (PBL) which the IDT use for person centered planning. They encompass descriptions and characteristics of seven levels of typical support needs designed to meet the needs of most individuals. Each PBL has a corresponding suggested budget dollar amount based on the type of living care arrangement, typical service options, intensity of staffing needs, and support needs in each level. The case manager guides the IDT in the person-centered planning process. The IDT makes a determination of which proposed budget level the person falls based on history, current assessments, and support needs, using both the PBL and suggested dollar amount as a tool or guide in the person-centered planning process and in budget development. The OR approves services based on clinical justification. Approvals may be over or under the suggested amount. The OR

does not verify or approve the IDT's determination of a PBL, nor does a PBL limit the request for services or require that the budget be developed within a set amount.

B. Exception authorization process, formerly known as the H authorization process is the process that allows individuals on the DDW, who have extenuating circumstances, including extremely complex clinical needs to receive services beyond what is authorized in their current ISP/budget level or to allow individual exceptions to DDW service standards. Exception authorization process includes:

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

(2) Exception authorization packet includes: the completed individual supports needs review form with all attachments indicated on the form as relevant to the nature/type of exception authorization process request submitted.

C. When determining what services the eligible recipient needs, the IDT should consider the individual's proposed budget level and service options with the understanding that the focus must always be on the individual's DDW support needs that can be clinically justified. Services available:

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

(a) assessing needs;

(b) assisting in the submission process of the application for assistance and yearly recertification to the local income support division (ISD) office;

(c) directing the person-centered planning process;

(d) advocating on behalf of the eligible recipient;

(e) coordinating waiver and state plan service delivery and collaborating with managed care organization care coordinators;

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

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

(h) health care coordination;

(i) assuring cost containment by preventing the expense of DDW services from exceeding a maximum cost established by DOH and by exploring other options to address expressed needs.

(j) Case managers must:

(i) evaluate and monitor direct service through face-to-face visits with the eligible recipient to ensure the health and welfare of the eligible recipient, and to monitor the implementation of the ISP;

(ii) support informed choice;

(iii) support participant self-advocacy;

(iv) allow participants to lead their own meetings, program and plan development;

(v) increase an individual's experiences with other paid, unpaid, publicly-funded and community support options;

(vi) increase self-determination;

(vii) demonstrate that the approved budget is not replacing other natural or non- disability specific resources available; and

(viii) document efforts demonstrating choice of non-waiver and non-disability specific options in the ISP, IDT meeting minutes or companion documents when an individual has only DDW funded supports.

(2) Respite services: Respite services are a flexible family support service for an eligible recipient. The primary purpose of respite services is to provide support to the eligible recipient and give the primary, unpaid caregiver relief and time away from their duties. Respite services include assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills and providing opportunities for play and other recreational activities; community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the eligible recipient to make their own choices with regard to daily activities. Respite services will be scheduled as determined by the primary caregiver. An eligible recipient receiving living supports or customized in-home supports (when an eligible recipient is not living with a family member), may not access respite services. Respite services may be provided in the eligible recipient's own home, in a provider's home, or in a community setting of the eligible recipient family's choice. Respite services must be provided in accordance with 8.314.5.10 NMAC.

(3) Adult nursing services: Adult nursing services (ANS) are provided by a licensed RN or LPN under the direct supervision of the RN to an eligible adult recipient. Adult nursing services are intended to support the highest practicable level of health, functioning and independence for an eligible recipient. This includes the direct nursing services and activities related to the assessment, planning, training and nursing oversight of unrelated direct support staff when assisting with a variety of health related needs in specific settings. Nursing services may be delivered in person and via remote or telehealth services. Nursing services include an array of supports including efforts to support aspiration risk management (ARM). Nursing services may be delivered in person and via remote or telehealth services. Individuals and their health care decision makers will be informed of telehealth service and technology as part of the ISP process.

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

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

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

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

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

(4) Therapy services: Therapy services are to be delivered consistent with the participatory approach philosophy and two models of therapy services (collaborative-consultative and direct treatment). These models support and emphasize increased participation, independence and community inclusion in combination with health and safety. DDW therapy services are intended to improve, maintain or minimize the decline in functional ability and skills. Therapy services are designed to support achievement of ISP outcomes and prioritized areas of need identified through therapeutic assessment. PT, OT and SLP are skilled therapies that are recommended by an eligible recipient's IDT members and a clinical assessment that demonstrates the need for therapy services. Therapy services may be delivered in an integrated setting, clinical setting, or through telehealth as appropriate and will support the use of assistive or remote personal support technology as needed. Upon recommendation for therapy assessment by the IDT members all three therapy disciplines: PT, OT, and SLP will be available to all DDW recipients if the therapy assessment indicates that services are needed. Individuals and their health care decision makers will be informed of telehealth service and technology as part of the ISP process. Therapy services for an eligible adult recipient require a prior authorization except for their initial assessment. A RLD licensed practitioner, as specified by applicable state laws and standards, provides the skilled therapy services. Therapy services for eligible adult recipients must comply with 8.314.5.10 NMAC. All medically necessary therapy services for children

under 21 years of age, are covered under the state plan through the early periodic screening, diagnostic and treatment (EPSDT) and must comply with 8.320.2 NMAC. To the extent that any listed services are covered under the state plan, the services under the waiver are additional services not otherwise covered under the state plan, and consistent with DDW objectives to support the recipient to remain in the community and prevent institutionalization. The exception is aspiration risk management supports for persons between age 18 and 21.

(a) Physical therapy (PT): PT is a skilled, RLD licensed therapy service involving the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance, and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy prevents the onset, symptoms and progression of impairments, functional limitations, and disability that may result from diseases, disorders, conditions or injuries. PT supports access, mobility and independence in all environments. A RLD licensed physical therapy assistant (PTA) may perform physical therapy procedures and related tasks pursuant to a plan of care/therapy intervention plan written by the supervising physical therapist. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC.

(b) Occupational therapy (OT): OT is a skilled, RLD licensed therapy service involving the use of everyday life activities (occupations) for the purpose of evaluation, treatment, and management of functional limitations. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC. Occupational therapy addresses physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement, performance and access to work and life activities that affect health, well-being and quality of life. A RLD certified occupational therapy assistant (COTA) may perform occupational therapy procedures and related tasks pursuant to a therapy intervention plan written by the supervising OT as allowed by RLD licensure.

(c) Speech-language pathology (SLP): SLP service, also known as speech therapy, is a skilled therapy service, provided by a speech-language pathologist that involves the non-medical application of principles, methods and procedures for the diagnosis, counseling, and instruction related to the development of and disorders of communication including speech, fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction and sensory-motor competencies. Therapy services for eligible recipients must comply with 8.314.5.10 NMAC. Speech-language pathology services are also used when an eligible recipient requires the use of assistive technology or an augmentative communication device. For example, SLP services are intended to improve, maintain or minimize the loss of communication skills; treat a specific condition clinically related to an intellectual developmental disability of the eligible recipient; or improve or maintain the eligible recipient's ability to safely eat food, drink liquids or manage oral secretions while minimizing the risk of aspiration or other potential injuries or illness related to swallowing disorders.

(5) Living supports: Living supports are residential habilitation services, available up to 24 hours a day, that are individually tailored to assist an eligible recipient 18 year and older who is assessed to need daily support or supervision with the acquisition, retention, or improvement of skills related to living in the community to prevent institutionalization. Living supports include residential-type instruction intended to increase and promote independence and to support an eligible recipient to live as independently as possible in the community in a setting of their own choice. Living support services assist and encourage an eligible recipient to grow and develop, to gain autonomy, self-direct and pursue their own interests and goals. Living supports includes support to individuals to access: healthcare, dietary, nursing, therapy and behavior supports through telehealth and in person appointments; generic and natural supports, standard utilities including internet services, assistive and remote technology, transportation, employment, and opportunities to establish or maintain meaningful relationships throughout the community. Living supports providers are also required to coordinate and collaborate with nursing, behavior support consultants, dieticians, therapists and therapy assistants to implement plans including aspiration risk management plans. Living supports providers are also required to coordinate and collaborate with behavior support consultants to implement positive behavior support plans. Living support providers take positive steps to protect and promote the dignity, privacy, legal rights, autonomy and individuality of each eligible recipient who receives services. Services promote inclusion in the community and an eligible recipient is afforded the opportunity to be involved in the community and actively participate using the same resources and doing the same activities as other community members. Living supports providers are responsible for providing an appropriate level of services and supports up to 24 hours per day, seven days per week. Room and board costs are reimbursed through the eligible recipient's social security insurance (SSI) or other personal accounts and cannot be paid through the DDW. Living support services for eligible recipients must comply with 8.314.5.10 NMAC. Living supports consists of family living, supported living, and intensive medical living as follows.

(a) Family living (FL): Family living is intended for an eligible recipient who is assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family living is a residential habilitation service that is intended to increase and promote independence and to provide the skills necessary to prepare an eligible recipient to live on their own in a non-residential setting. Family living services are designed to address assessed needs and identified individual eligible recipient outcomes. Family living is direct support and assistance that is provided to no more than two eligible recipients with intellectual or developmental disabilities at a time furnished by a natural or host family member, or companion who meets the requirements and is approved to provide family living services in the eligible recipient's home or the home of the family living direct support personnel. The eligible recipient lives with the paid direct support personnel. The FL provider agency is responsible for providing nutritional services from a registered dietician or licensed nutritionist. All FL providers must be adult nursing services (ANS) providers and deliver budgeted nursing services including nursing assessment and on call. The provider agency is responsible for up to 750 hours of substitute coverage for the primary direct support personnel to receive sick leave and time off as needed. An exception may be granted by DOH if three eligible recipients are in the residence, but only two of the three are on the DDW and the arrangement is approved by DOH based on the home study documenting the ability of the family living provider to serve more than two eligible recipients in the residence; or there is documentation that identifies the eligible recipients as siblings or there is documentation of the longevity of a relationship (e.g., copies of birth certificates or social history summary). Documentation shall include a statement of justification from a social worker, psychologist, and any other pertinent professionals working with the eligible recipients. Family living services cannot be provided in conjunction with any other living supports service, respite, or additional nutritional counseling accessed through the person's budget. Family living provider must arrange transportation for all medical appointments, household functions and activities, and to-and-from day services and other meaningful community options. The family living services provider agency shall complete all DOH requirements for approval of each direct support personnel, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home or other significant event. The content and procedures used by the provider agency to conduct home studies shall be approved by DOH and must include assessment of environmental safety.

(b) Supported living (SL): Supported living is intended for an eligible recipient who is assessed to need residential-type habilitation support to ensure health and safety. Supported living is a living habilitation support service that is intended to increase and promote independence and to provide the skills necessary to prepare an eligible recipient to live on their own in a non-residential setting. Supported living services are designed to address assessed needs and identified individual eligible recipient outcomes. The service is provided to two to four eligible recipients in a community residence. Prior authorization is required from DOH for an eligible recipient to receive this service when living alone. The SL provider agency is responsible for providing nutritional services from a registered dietician or licensed nutritionist based on the person's needs. All SL providers must provide needed nursing services including on call based on the person's needs. The SL provider must arrange transportation to all medical appointments, household functions and activities, and to-and-from day services and other meaningful community options. Supported living services cannot be provided in conjunction with any other living supports service, respite, or additional nutritional counseling assessed through the person's budget.

(c) Intensive medical living supports: An intensive medical living supports agency provides residential-type supports for an eligible recipient in a supported living environment who requires daily direct skilled nursing, in conjunction with community living supports that promote health and assist the eligible recipient to acquire, retain or improve skills necessary to live in the community and prevent institutionalization, consistent with their ISP. An eligible recipient must meet criteria for intensive medical living supports according to DDW service definitions and DDW standards for this service and they require nursing care, ongoing assessment, clinical oversight and health management that must be provided directly by a MAD recognized RN or LPN, see 8.314.5.10 NMAC.

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

(ii) In addition to providing support to an eligible recipient with chronic health conditions, intensive medical living supports are available to an eligible recipient who meets a high level of medical acuity and require short-term transitional support due to recent illness or hospitalization. This service will afford the core living support provider the time to update health status information and health care plans, train staff on new or exacerbated conditions and assure that the home environment is appropriate to meet the needs of the

eligible recipient. Short-term stay in this model may also be utilized by an eligible recipient who meets the criteria that is living in a family setting when the family needs a substantial break from providing direct service. Both types of short-term placements require prior approval from DOH. In order to accommodate referrals for short-term stays, each approved intensive medical living supports provider must maintain at least one bed available for such short-term placements. If the short-term stay bed is occupied, additional requests for short-term stay will be referred to other providers of this service.

(iii) The intensive medical living supports provider will be responsible for providing the appropriate level of supports, 24 hours per day seven days a week, including necessary levels of skilled nursing based on assessed need of the eligible recipient. Daily nursing visits are required; however, a RN or a LPN under a RN's supervision is not required to be present in the home during periods of time when skilled nursing services are not required or when an eligible recipient is out in the community. An on-call RN or LPN, under the supervision of a RN must be available to staff during periods when a RN or a LPN under a RN's supervision is not present. Intensive medical living supports require supervision by a RN, and must comply with 8.314.5.10 NMAC.

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

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

(vi) Intensive medical living supports providers must comply with 8.314.5.10 NMAC.

(6) Customized community supports (CCS): CCS consists of individualized services and supports that enable an eligible recipient to acquire, maintain, and improve opportunities for independence, community integration and employment. Customized community supports services are designed around the preferences and choices of each eligible recipient and offer skill training and supports to include: adaptive skill development; adult educational supports; citizenship skills; communication; social skills, socially appropriate behaviors; self-advocacy, informed choice; community integration and relationship building. This service provides the necessary support to develop social networks with community organizations to increase the eligible recipient's opportunity to expand valued social relationships and build connections within communities. This service helps to promote self-determination, increases independence and enhances the eligible recipient's ability to interact with and contribute to their community. Customized community supports are intended to be provided in the community to the fullest extent possible. Customized community supports must not duplicate services available through the New Mexico public education department or the Individuals with Disabilities Education Act (IDEA).

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

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

(c) Customized community supports services may be provided regularly or intermittently based on the needs of the eligible recipient and are provided during the day, evenings and weekends. Customized community supports are not limited to specific hours or days of the week and should be provided in alignment with the persons desired outcomes.

(d) Customized community supports may be provided in a variety of settings to include the community, classroom, remotely and at site-based locations, depending on the ISP and the particular type of service chosen within CCS. Services provided in any location are required to provide opportunities that lead to participation and inclusion in the community or support the eligible recipient to increase their growth and development.

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

(f) Customized community supports services must be provided in accordance with 8.314.5.10 NMAC.

(7) Community integrated employment (CIE): Community integrated employment is intended to provide supports that result in jobs in the community which increase economic independence, self-reliance, social connections, and the ability to grow within a career. CIE consists of intensive, ongoing services that support individuals to achieve competitive integrated employment or business ownership who, because of their disabilities, might otherwise not be able to succeed without supports to perform in a competitive work setting or own a business. Community integrated employment results in employment alongside non-disabled coworkers within the general workforce or in business ownership. This service may also include small group employment including mobile work crews or enclaves. An eligible recipient is supported to explore and seek opportunity for career advancement through growth in wages, hours, experience or movement from group to individual employment. Each of these activities is reflected in individual career plans. Community integrated employment services must not duplicate services offered through the New Mexico public education department (PED), the Individuals with Disabilities Education Act (IDEA), the New Mexico division of vocational rehabilitation (DVR), the Rehabilitation Act, New Mexico department of workforce solutions (DWS), or the Workforce Innovation and Opportunities Act (WIOA). Compensation shall comply with state and federal laws including the Fair Labor Standards Act. DDW funds (e.g., the provider agency's reimbursement) may not be used to pay the eligible recipient for work. CIE services shall be provided based on the interests of the person and desired outcomes listed in the ISP. Employment services are to be available 365 days a year, 24 hours a day. Community integrated employment services must comply with 8.314.5.10 NMAC. Community integrated employment consists of job development, self-employment, short term job coaching, job maintenance, job aid, intensive community integrated employment and group community integrated employment models.

(a) Job development services through the DDW can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in the Individuals with Disabilities Education Act (IDEA) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). Job development may include but is not limited to, activities to assist an individual to plan for, accommodate, explore and obtain CIE.

(b) Short term job coaching services through the DDW can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in the Individuals with Disabilities Education Act (IDEA) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). Short term job coaching services may include but are not limited to, activities to assist an individual to learn, accommodate and perform work duties, and maintain employment.

(c) Job maintenance is intended to be used as the long-term supports once all available funding and services through vocational rehabilitation or the educational systems has been utilized. Job maintenance is provided on a one-to-one ratio. Job maintenance services may include, but are not limited to, activities to assist the individual to accommodate, maintain employment and career advancement.

(d) Self-employment: Services through the DDW can only be accessed when services are not otherwise available to the beneficiary under either special education and related services as defined in the Individuals with Disabilities Education Act (IDEA) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730). Self-employment services are intended to be used as the long-term supports once all available funding and services through vocational rehabilitation or the educational systems have been utilized. Self-employment does not preclude employment in the other models. Self-employment may include but is not limited to development of a business plan, conducting market analysis, and establishing and supporting the infrastructure for a successful business.

(e) Job aid: One to one personal care services in an individual, community integrated employment setting for people who require assistance with activities of daily living (ADLs) during work hours to maintain successful employment as job supports are reduced.

(f) Intensive community integrated employment (ICIE): Services for people who are working in an individual, community integrated employment setting and require more than 40 hours of staff supports per month to maintain their employment. ICIE is the same scope of services as outlined in 8.314.5.10 NMAC.

(g) Group community integrated employment: Group community integrated employment is when more than one eligible recipient works in an integrated setting with staff supports on site. Regular and daily contact with non-disabled coworkers or the public occurs. Group community integrated employment services may include but are not limited to activities to assist the individual to accommodate, maintain and advance from group to individual employment.

(8) Behavioral support consultation services: The behavior support consultation supports the person's successful achievement of vision-driven desired outcomes. Behavior support consultation services identify behaviors that impact quality of life and provide specific prevention and intervention strategies to manage and lessen the risks these behaviors present. This service is provided by an authorized behavior support consultant and includes a positive behavior supports assessment and positive behavior support plan development; interdisciplinary team (IDT) training and technical assistance; and monitoring of an individual's behavioral support services. Services may be provided in person for training, evaluation or monitoring and remotely via telehealth as needed. Annual assessments require an in person interview or observation except when conducted during declared state or national emergencies or pandemics. Behavioral support services include:

(a) Assessment of the person and their environment, including barriers to independent functioning;

(b) Design and testing of strategies to address concerns and build on strengths and skills for independence;

(c) Writing and training in the implementation of plans in a way that the person and direct support personnel (DSP) can understand and implement them.

(d) Behavioral support consultation services must comply with 8.314.5.10 NMAC.

(9) Nutritional counseling services: Nutritional counseling services include the assessment, evaluation, collaboration, planning, teaching, consultation and implementation and monitoring of a nutritional plan and menu services that supports the eligible recipient to attain or maintain the highest practicable level of health. It may be provided by a registered/licensed dietician (RD/LD) or licensed nutritionist (LN). This service may be delivered in person or via telehealth. The RD/LD/LN is an active member of the IDT and addresses overall nutritional needs, diet, tube feeding, weight loss or gain, wounds and a variety complex medical or behavioral conditions that have or may impact the persons overall health. These nutritional counseling services are in addition to those nutritional or dietary services allowed in the eligible recipient's medicaid state plan benefit, or other funding source. This service does not include oral-motor skill development services, such as those services provided by a speech pathologist. Nutritional counseling cannot be billed as a separate service during the hours of living supports. Nutritional counseling services must comply with 8.314.5.10 NMAC.

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

(a) Adaptations, installations and modifications include:

(i) heating and cooling adaptations;

(ii) fire safety adaptations;

(iii) turnaround space adaptations;

(iv) specialized accessibility, safety adaptations or additions;

(v) installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;

(vi) installation of trapeze and mobility tracks for home ceilings;

(vii) installation of ramps;

(viii) widening of doorways or hallways;

(ix) modification of bathroom facilities (roll-in showers, sink, bathtub and toilet modification, water faucet controls, floor urinals and bidet adaptations and plumbing);

(x) purchase or installation of air filtering devices;

(xi) purchase or installation of lifts or elevators;

(xii) purchase and installation of glass substitute for windows and doors;

(xiii) purchase and installation of modified switches, outlets or environmental controls for home devices; and

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

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

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

(d) Environmental modification services must comply with 8.314.5.10 NMAC.

(11) Crisis supports: Crisis supports are services that provide intensive supports by appropriately trained staff to an eligible recipient experiencing a behavioral or medical crisis either within the eligible recipient's present residence or in an alternate residential setting. Crisis support must comply with 8.314.5.10 NMAC.

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

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

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

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

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

(12) Non-medical transportation: Non-medical transportation services assists the eligible recipient in accessing other waiver supports and non-waiver activities identified in their ISP. Non-medical transportation enables the eligible recipient to gain physical access to non-medical community services and resources promoting the eligible recipient opportunity and responsibility in carrying out their ISP activities. This service is to be considered only when transportation is not available through the medicaid state plan or when other arrangements cannot be made. Non-medical transportation includes mileage reimbursement and funding to purchase a pass for public transportation for the eligible recipient. Non-medical transportation provider services must comply with 8.314.5.10 NMAC.

(13) Supplemental dental care: Supplemental DDW dental care services are provided for an eligible recipient that requires routine oral health care more frequently than the coverage provided under other MAP benefit plans. Supplemental dental care provides one oral examination and one cleaning once every ISP year to an eligible recipient for the purpose of preserving or maintaining oral health. The supplemental dental care service must comply with 8.314.5.10 NMAC.

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

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

(b) Assistive technology may be accessed through an approved waiver provider acting as a purchasing agent for technology vendors whose products meet definition and needs or directly through an approved technology provider who is the direct vendor of the service and approved DDW Provider.

(c) Assistive technology must comply with 8.314.5.10 NMAC.

(15) Independent living transition services: Independent living transition services are one-time set-up expenses for an eligible recipient who transitions from a 24 hour living supports setting into a home or apartment of their own with intermittent support that allows them to live more independently in the community. The service covers expenses associated with security deposits that are required to obtain a lease on an apartment or home, set-up fees or deposits for utilities (telephone, internet, electricity, heating, etc.), and furnishings to establish

safe and healthy living arrangements, such as a bed, chair, dining table and chairs, eating utensils and food preparation items, and a cell phone. The service also covers services necessary for the eligible recipient's health and safety such as initial or one-time fees associated with the cost of paying for pest control, allergen control or cleaning services prior to occupancy. Independent living transition services must comply with 8.314.5.10 NMAC.

(16) Remote personal support technology: Remote personal support technology is an electronic device or monitoring system that supports individuals to be independent in the community or in their place of residence with limited assistance or supervision of paid staff. This service provides up to 24-hour alert, monitoring or remote personal emergency response capability, remote prompting or in-home reminders, or environmental controls for independence through the use of technologies. The service is intended to promote independence and quality of life, to offer opportunity to live safely and as independently as possible in one's home, and to ensure the health and safety of the individual in services. Remote personal support technology is available to individuals who may want to live independently in their own homes, may have a demonstrated need for timely response due to health or safety concerns, or may be afforded increased independence from staff supervision in residential services. The use of technology should ease life activities for individuals and their families. Remote personal support technology includes development of individualized response plans with the installation of the electronic device or sensors, monthly maintenance, rental or subscription fees. This service is not intended to provide for paid, in-person on-site response. On-site response must be planned through response plans that are developed using natural or other paid supports for on-site response. Remote personal support technology may be accessed through an approved waiver provider acting as a purchasing agent for technology vendors whose products meet definition and needs or directly through an approved technology provider who is the direct vendor of the service and approved DDW provider.

(17) Preliminary risk screening and consultation related to inappropriate sexual behavior (PRSC): PRSC is designed to assess continued risk of sexually inappropriate or offending behavior in persons who exhibit or have a history of exhibiting risk factors for these types of behaviors. This service is part of a variety of behavior support services (including BSC and socialization & sexuality education) that promotes community safety and reduces the impact of interfering behaviors that compromise the person's quality of life. PRSC is provided by a licensed mental health professional who has been trained and approved as a risk evaluator by the BBS.

(a) The key functions of PRSC are to:

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

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

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

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

(b) Preliminary risk screening and consultation related to inappropriate sexual behavioral services must comply with 8.314.5.10 NMAC.

(18) Socialization and sexuality education service: Socialization and sexuality education in the form of the friends & relationships course (FRC) is a comprehensive lifelong adult education program that teaches students knowledge and skills to increase social networks with healthy, meaningful relationships and to increase personal safety including decreasing interpersonal and intimate violence in relationships, sexual victimization, exploitation and abuse. This enhances their ability to develop close friendships and romantic relationships. The FRC involves the person's network of support (natural supports, paid supports, teachers, nurses, family members, guardians, friends, advocates, or other professionals) teaching them to support the social and sexual lives of persons with I/DD, through participation in classes, and by using trained and paid self-advocates as role models and peer mentors in classes. Socialization and sexuality education services must comply with 8.314.5.10 NMAC.

(19) Customized in-home supports: Customized in-home support services is not a residential habilitation service and is intended for an eligible recipient that does not require the level of support provided under living supports services. Customized in-home supports provide an eligible recipient the opportunity to design and manage the supports needed to live in their own home or family home. Customized in-home supports include a combination of instruction and personal support activities provided intermittently to assist the eligible recipient with ADLs, meal preparation, household services, and money management. The services and supports are

individually designed to instruct or enhance home living skills, community skills and to address health and safety of the eligible recipient, as needed. This service provides assistance with the acquisition, improvement or retention of skills that provides the necessary support to achieve personal outcomes that enhance the eligible recipient's ability to live independently in the community. Services are delivered by a direct support professional in the individuals own home or family home in the community. Services may be provided as part of on-site response plan with use of remote personal support technology. This service is intended to provide intermittent support and cannot be provided 24 hours a day/seven days a week. Customized in-home support services must comply with 8.314.5.10 NMAC.
[8.314.5.15 NMAC - Rp, 8.314.5.15 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.16 NON-COVERED SERVICES: Only those services listed in the DDW benefit package may be reimbursed through the DDW. Room, board and ancillary services are not covered under DDW services. An eligible recipient may access, as medically necessary, all medicaid state plan benefits in addition to their DDW services. If the eligible recipient is an enrolled member of a HSD managed care organization (MCO), they may access, as medically necessary, the benefits listed in 8.308.9 NMAC.
[8.314.5.16 NMAC - Rp, 8.314.5.16 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.17 INDIVIDUALIZED SERVICE PLAN (ISP):

A. CMS requires a person-centered service plan for every individual receiving HCBS. The ISP must be developed annually through an ongoing person-centered planning process. The ISP development must:

(1) Involve those whom the participant wishes to attend and participate in developing the service plan and are provided adequate notice;

(2) Use assessed needs to identify services and supports;

(3) Include individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others;

(4) Identify roles and responsibilities of IDT members responsible for implementing the plan;

(5) Include the timing of the plan and how and when it is updated, including response to changing circumstances and needs; and

(6) Outline how the individual is informed of available services funded by the DDW as well as other natural and community resources.

B. The IDT must review the eligible recipient’s person-centered plan every 12 months or more often if indicated.

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

D. The person-centered service plan must consist of the following:

(1) identifies risks and includes a plan to reduce any risks;

(2) incorporates other health concerns (e.g. mental health, chemical health, chronic medical conditions, etc.);

(3) is written in plain language;

(4) records the alternative HCBS that were considered by the person;

(5) includes natural supports and services;

(6) includes strategies for solving conflict or disagreement within the process, including any conflict of interest guidelines for planning participants;

(7) identifies who is responsible for monitoring implementation of the plan;

(8) includes the person’s strengths;

(9) describes goals or skills that are related to the person’s preferences;

(10) includes a global statement about the person’s self-determined goals and aspirations;

(11) details what is important to the person; and

(12) includes a method for the individual to request updates to the plan, as needed.

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

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

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

H. The case manager must conduct a pre ISP meeting annually with the recipient to evaluate and plan for upcoming ISP term. The CM is required to meet with the DD Waiver participant and guardian prior to the ISP meeting. The CM reviews current assessment information, prepares for the meeting, creates a plan with the person to facilitate or co-facilitate the meeting if desired, discusses the budget, reviews the current secondary freedom of choice forms, and facilitates greater informed participation in ISP development by the person.
[8.314.5.17 NMAC - Rp, 8.314.5.17 NMAC, 12/1/2018; A, 4/1/2022]

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

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

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

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

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

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

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

E. Reconsideration: Providers who disagree with the denial of a prior authorization request or other review decisions may request a reconsideration. See 8.350.2 NMAC, Reconsideration of Utilization Review Decisions.
[8.314.5.18 NMAC - Rp, 8.314.5.18 NMAC, 12/1/2018; A, 4/1/2022]

8.314.5.19 REIMBURSEMENT: DDW service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. A DDW provider must follow 8.302.2 NMAC, MAD billing instructions, utilization review instructions, and supplements. Reimbursement to providers of waiver services is made at a predetermined reimbursement rate.
[8.314.5.19 NMAC - Rp, 8.314.5.19 NMAC, 12/1/2018]

8.314.5.20 RIGHT TO A HSD ADMINISTRATIVE HEARING: An eligible recipient may request a HSD administrative hearing to appeal a decision of MAD or its third party assessor contractor, or the OR, that is an adverse action against the recipient. Prior to the fair hearing an eligible recipient may be offered an agency review conference. An agency review conference (AC) means an optional conference offered by the DOH to provide an

opportunity to informally resolve a dispute over the denial, suspension, reduction, termination or modification of DDW benefits or services. An AC will be attended by the recipient and their authorized representative if applicable, representatives of the outside review, DOH and any other necessary parties. The recipient may also bring whomever they wish to assist during the AC. The AC is optional and shall in no way delay or replace the fair hearing process or affect the deadline for a fair hearing request.

A. An authorized representative means any individual designated by the eligible recipient or their guardian, if applicable, to represent the recipient and act on their behalf. The authorized representative must provide formal documentation authorizing them to access the identified case information for this specific purpose. An authorized representative may be, but need not be, the recipient's guardian or attorney.

B. The DOH will issue written notification describing the outcome of the AC and any agreements within seven business days of the AC to the recipient, recipient's guardian if applicable, and case manager.

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

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

E. Denials of services through the exception authorization process or other actions during this process adverse to the participant can also be appealed through a fair hearing.

F. All HSD administrative hearings are conducted in accordance with state and federal law.

G. No ex parte communications with an HSD administrative law judge are permitted by any DDW participant or counsel regarding any pending case. The MAD director shall not have ex parte communications regarding any pending cases with any DDW participant or counsel involved in that case. The MAD director's decision shall be limited to an on the record review.

[8.314.5.20 NMAC - Rp, 8.314.5.20 NMAC, 12/1/2018; A, 4/1/2022]

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

[8.314.5.21 NMAC - Rp, 8.314.5.21 NMAC, 12/1/2018]

HISTORY OF 8.314.5 NMAC:

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

ISD-Rule 310.2000, Coordinated Community In-Home Care Services, 3/19/1984.

History of Repealed Material:

ISD-Rule 310.2000, Coordinated Community In-Home Care Services, Repealed 1/18/1995.

8 NMAC 4.MAD.736.12 - Repealed 9/1/1998; and

8 NMAC 4.MAD.736.412 - Repealed 9/1/1998.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, Repealed 3/1/2007.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, filed 2/15/2007 - Repealed effective 11/1/2012.

8.314.5 NMAC, Developmental Disabilities Home and Community-Based Services Waiver, filed 10/2/2012 - Repealed effective 3/1/2016.