

# Supports Waiver Service Standards

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## **CHAPTER 1. INTRODUCTION TO THE SUPPORTS WAIVER**

### **1.1 General Authority**

The Centers for Medicare and Medicaid Services (CMS) approved the Supports Waiver effective July 1, 2020.

The Supports Waiver program is administered through a partnership between the Department of Health (DOH) and Human Services Department (HSD). The Supports Waiver application approved by Centers for Medicare and Medicaid, state regulations (8.314.7.9 NMAC) and these Service Standards detail the processes necessary to implement and administer the Supports Waiver.

In extraordinary circumstances, an exception to these standards may be needed. Any exception to the standards needs prior approval from DDS Support Waiver unit using required forms.

### **1.2 Purpose**

New Mexico's Supports Waiver is a Home and Community Based Services (HCBS) waiver that is designed to provide an option for support to individuals who are on the Developmental Disabilities (DD) Waiver Wait List.

Supports Waiver services are intended to complement unpaid supports that are provided to individuals by family and others. Supports Waiver services are not intended to nor do they provide twenty-four (24) hour paid supports.

Individuals who are on the DD Waiver Wait List will receive an Offer Letter from DDS for the Supports Waiver. The number of offers to the Supports Waiver are based on legislative funding. Individuals keep their place on the DD Waiver Wait List, for the DD Waiver or the Mi Via Waiver, while they access the Supports Waiver.

### **1.3 Guiding Principles**

All participants:

1. Have value and potential.
2. Will be viewed in terms of their abilities.
3. Have the right to participate and be fully included in their communities.
4. Have the right to live, work, learn, and receive services and supports to meet their individual needs, in the most integrated settings possible in their community.

### **1.4 Person with Intellectual/Developmental Disabilities (IDD) at the Center**

The Supports Waiver participant is encouraged and supported to direct their planning and services as much as possible whether through agency-based service delivery or participant directed service delivery. No matter what the nature or severity of a person's disability, there are many ways to identify a person's strengths, abilities, preferences, needs, and goals with the person's participation. Being person-centered includes person centered thinking, planning and practices.

1. **Person-Centered Thinking:** Values and supports individuals with intellectual and developmental disabilities to make informed choices and exercise the same basic, civil and human rights as other citizens, including dignity of risk.



2. **Person-Centered Planning:** Person centered planning discovers and acts on what is important to a person. Participants decide who they want to assist them with planning and managing their services and supports. The individual is at the center of the process and is encouraged to direct the process as much as possible.
3. **Person-Centered Practice:** Person centered practice aligns service resources that give people access to the full benefits of community living and ensure they receive services in a way that helps them achieve their individual goals.

### **1.5 Participant Rights**

Supports Waiver participants have the same basic legal, civil and human rights and responsibilities as everyone else. In the case of child (legal minors) Supports Waiver participant, the parents or legal guardian exercise decision making on behalf of the child.

In case of adults, even if the adult has a legal guardian, Supports Waiver participant rights shall never be limited or restricted. All rights should be honored through any assistance, support and services that are received. A Supports Waiver participant has the right to:

1. Decide where and with whom to live.
2. Choose their own work or productive activity.
3. Choose how to establish community and personal relationships.
4. Be respected and supported during the decision-making process and in the decisions made.

5. Access natural and generic supports as needed.
6. Hire, train schedule, supervise and dismiss service providers.
7. Receive training, resources, and information related to the Supports Waiver in a format that meets the American with Disabilities Act (ADA) requirements.
8. Appeal denials or decisions through the reconsideration and fair hearing processes.
9. Transfer to a service delivery model on the Supports Waiver that meets the participants' needs.
10. Receive culturally competent services.
11. Be free from restraint, restrictive interventions, seclusion and coercion.

## **1.6 Prohibition of Restraints, Restrictions, and Seclusion**

On the Supports Waiver the use of any restraints, restrictive interventions, and/or seclusion is not allowed during the provision of Supports Waiver services. Examples of these could include the use of forced physical guidance, coercion, over correction, isolation, physical restraint, mechanical restraint and/or chemical restraint designed as aversive methods to address and/or preclude challenging behaviors. No individual provider, employee, EOR or agency provider can employ restraints, restrictive interventions or seclusion. CSCs monitor for this regularly and any noted use should be reported using abuse neglect and exploitation reporting guidelines.

## CHAPTER 2. SERVICE DELIVERY MODELS

When an individual chooses the Supports Waiver, they also choose the service delivery model. The Community Support Coordinator (CSC) assists the participant in understanding and choosing the service delivery model.

### 2.1 Circle of Support

The Circle of Support should be considered as an ongoing and ever developing aspect of person-centered planning. The CSC will be prepared to assist the Supports Waiver participant on an ongoing basis to identify strategies to engage and invite individuals to be a part of their Circle of Supports. The CSC will assist the participant to determine what role each member of their identified Circle of Support will play in their lives and in their Supports Waiver services. At a minimum initially and annually the CSC will work with the participant prior to the development of the ISP to identify and document the participant's Circle of Support.

### 2.2 Agency-Based Service Delivery Model

In the agency-based service delivery model, the participant works with their selected Circle of Support to identify services through the person-centered planning process. Agency-based services are provided by a qualified provider agency with an approved agreement with Department of Health (DOH) to provide supports waiver services. Qualified provider agencies in the participant's county are listed on a Secondary Freedom of Choice (SFOC) form. The SFOC is available on the SFOC website: <http://sfoc.health.state.nm.us/>.

1. The CSC assists the participant with completing the form and provides it to the selected provider agency.

2. The CSC submits the Individual Service Plan and budget through the TPA.
3. The CSC distributes the approved ISP containing all the necessary information to provide services to the provider agency.
4. Provider agencies are paid through Medicaid online claims entry.
5. The Provider Agency follows the AAB and is accountable for the use of Supports Waiver funds.
6. Participants cannot be reimbursed directly for any services and goods or supports.

### **2.2.1 Getting Services**

Once a Provider Agency has received the signed SFOC form and an approved budget, the agency has up to 60 calendar days in which to begin providing services to the person. Provider Agencies cannot require participants and/or guardians to complete an admission packet or screen individuals. Provider Agencies cannot maintain a “waiting list”.

#### **2.2.1.1 Provider Agency Exceptions**

Provider Agencies cannot deny services to any individual once a SFOC form has been signed, unless DDSD has granted an exception to the Provider Agency. To obtain an exception, the Provider Agency must:

1. Complete and submit the SFOC Exception Request Form to the applicable DDSD Regional Office;
2. Include information that demonstrates the agency does not have the capability to ensure the health and safety of that individual or others prior to their moratorium expiration date;
3. Communicate with the appropriate DDSD Regional Office to identify what is

essential to support the type of individual the Provider Agency was unable to support; and

4. Develop the capacity to support the individual(s) for which they originally received the exception and all Supports Waiver individuals by the moratorium expiration date.

#### 2.2.1.2 Moratorium

If for any reason a Provider Agency determines it is unable to accept new individuals into service, the agency is required to request a self-imposed moratorium from the DDSD Provider Enrollment Unit (PEU) and must continue to accept individuals until they have received notice from the PEU that their self-imposed moratorium request has been approved.

### **2.3 Participant Directed Service Delivery Model**

In the participant directed service delivery model, the participant is or designates an Employer of Record (EOR) and works with their selected circle of support to identify services through the person-centered planning process. In this model. Under the participant-directed service delivery model, the Employer of Record (EOR) is the director of goods and service vendors and the employer of directly hired employees. The Fiscal Management Agent (FMA) serves as the participant's agent in conducting payroll and other employer-related responsibilities that are required by Federal and State law.

1. The CSC assists the participant/EOR to identify and hire employees or to select a vendor or goods.
2. The CSC submits the ISP and Budget through FMA Online portal.
3. EOR arranges for employees or vendors to provide services within an

approved budget.

4. Payment to employees and vendors are made through the FMA.
5. The participant/EOR follow the AAB and are accountable for the use of Supports Waiver funds throughout the budget year.
6. Participants cannot be reimbursed directly for any services and goods or supports.

### **2.3.1 Financial Management Agent**

The Financial Management Agent (FMA) is under contract with the HSD/MAD to provide the following for the participant directed service delivery model:

1. Assure program compliance with State and Federal employment and Internal Revenue Service (IRS) requirements.
2. Assist each participant or legal representative acting as Employer of Record to set up a unique Employer Identification Number (EIN).
3. Answer participant inquiries, solve related problems, and offer periodic trainings for participants and their representatives on how to handle the Supports Waiver billing and invoicing processes. The FMA will provide all participants with necessary documents, instructions and guidelines.
4. Collect all documentation necessary to verify that providers and vendors have the qualifications and credentials required by Supports Waiver regulations.
5. Collect all documentation necessary to support the participant's specific arrangements with each employee and vendor, including employment agreement forms and vendor agreement forms.
6. Complete criminal history and/or background investigations for service

providers, pursuant to 7.1.9 NMAC and in accordance with 1978 Section 29-17-1 NMAC of the Caregivers Criminal History Screening Act.

7. Check the Department of Health Employee Abuse Registry, pursuant to 7.1.12 NMAC Consolidated Online Registry (COR), to determine whether service providers or employees of participants are included in the registry. If a provider or employee is listed in the Abuse Registry, that person may not be employed by a Supports Waiver participant.
8. Process and pay invoices for services and goods that are approved in the participant's ISP and AAB, when supported by required documentation.
9. Handle all payroll functions on behalf of the participants who hire direct service employees and other support personnel, including collecting and processing timesheets of support workers, processing payroll and withholding, filing and payment of applicable Federal, State and local employment-related taxes and insurances.
10. Track and report on employee payment disbursements and balances of participant funds, including providing the participant and his/her community supports coordinator with a monthly report of expenditures and budget status.
11. Report any concerns related to the health and safety of a participant or that the participant is not following the approved ISP and AAB to the Community Supports Coordinator provider, HSD/MAD and DOH/DDSD, as appropriate.
12. Operates an online system through which the Supports Waiver program is operated for participants accessing services through the participant-directed service delivery model. The web-based system is used for traditional FMA

functions like tracking the credentialing status of employees and vendors, timesheet submission, payment processing for employees and vendors, and tracking ISP/budget expenditures.

13. Provide participants and community supports coordinators with training and access for the online system as well as on-going technical assistance and help with problem solving.

### **2.3.2 Employer of Record Responsibilities**

An eligible recipient may be their own EOR unless the eligible recipient is a minor or has a plenary or limited guardianship or conservatorship over financial matters in place. If the participant is not their own EOR, the EOR must be a legal representative of the recipient. The EOR must:

1. Submit all required documents to the FMA. Documents must be completed and provided to the FMA according to the timelines and rules established by the Human Services Department through their contractor. Documents include but are not limited to vendor and employee enrollment agreements, vendor information forms, criminal background check forms, timesheets, payment request forms (PRFs), invoices, and other documentation needed by the FMA to enroll and/or process payment to employees and vendors.
2. Arrange for the delivery of services, supports and goods.
3. Ensure that all employees, vendors and providers complete DOH/DDSD/HSD required training for the Supports Waiver and any additional training needs identified in the participants ISP and by the participant.
4. Recruit, hire, train, schedule, supervise or dismiss service providers (vendors and/or employees).



5. Maintain employee and service records and documentation (for at least six (6) years from date of service and ongoing) in accordance with Supports Waiver regulations and Federal and State employment rules.
6. When necessary, request assistance from the CSC with any of the above responsibilities.

### CHAPTER 3. PARTICIPANT RESPONSIBILITIES

Supports Waiver participants have certain responsibilities in order to participate in the program. Participant responsibilities include:

1. Comply with NMAC 8.314.7.11, the rules and regulations.
2. Work with the CSC to determine needs for support related to the activities of chosen service delivery model.
3. Work with the CSC to develop an appropriate Individual Support Plan (ISP)/budget request, receive necessary assistance with carrying out the approved ISP/budget and with documenting service delivery.
4. Establish annual medical and financial eligibility with the support of CSC.
5. Communicate with the CSC at least once a month, either in person or by phone.
6. Meet with the CSC in-person at least once a quarter and with at least two meetings per year at home.
7. Report concerns or problems to the CSC.
8. Use program funds appropriately by only requesting services and goods covered by the Supports Waiver program.
9. Comply with the approved ISP and not spend more than the authorized annual budget (AAB).
10. Work with CSC to respond to requests for additional documentation (RFI/RFA) and information from the CSC, FMA, or the TPA within the required deadlines outlined in the request.
11. Report any change in circumstances, including a change in address, which

might affect eligibility for the program to the local Income Support Division (ISD), CSC provider and the FMA (for participant directed model) within 10 days.

12. Report to the CSC if hospitalized for more than three (3) nights so that a new appropriate LOC can be obtained.
13. Communicate with Supports Waiver service providers, State contractors and State personnel in a non-abusive and non-threatening manner.
14. Report any incidents of abuse, neglect or exploitation to the appropriate State authority, as defined by NMAC 7.1.14
15. Maintain a current emergency back-up plan for waiver services and confirm this with your CSC at least monthly.
16. Complete all DOH/DDSD/HSD required training for Supports Waiver.

## CHAPTER 4. MEDICAL AND FINANCIAL ELIGIBILITY

The most basic responsibility of a Supports Waiver participant is to obtain initial financial and medical eligibility and recertify annually. The Community Supports Coordinator (CSC) is available to assist with the Medicaid application and recertification process and monitor to completion as needed.

### 4.1 Initial and Annual Medical Eligibility Process

Medical eligibility begins with the CSC scoring the Level of Care (MAD378) and coordinating physician review. The participant also needs to get a complete History and Physical (H&P) from their health care practitioner. The H & P is a comprehensive review of health systems. Forms and instructions are enclosed in the allocation packet sent to the participant by the Department of Health and available on the NM Medicaid Portal:

<https://nmmedicaid.portal.conduent.com/static/index.htm>

1. The CSC ensures that the LOC documents are submitted to the TPA.
2. The TPA reviews the Mad 378, the current H & P; and other relevant medical information submitted. The TPA reviewer applies the ICF/IDD LOC criteria to determine the participant's medical eligibility.
3. Recertification of medical eligibility is required every twelve (12) months.
4. The CSC tracks the LOC expiration date and works with the participant to identify and discuss the LOC expiration date and to obtain the necessary forms to complete the LOC prior to the expiration of their LOC.
5. Every year, the TPA sends a reminder letter to the participant ninety (90) calendar days prior to the expiration of their LOC.
6. The participant and CSC are responsible for the timely submission of the

required forms and medical documents to the TPA to ensure eligibility re-evaluation.

#### **4.1.1 Expedited Medical Eligibility Process**

When necessary for the health and safety of the participant, the TPA will conduct an expedited LOC determination to establish Supports Waiver medical eligibility as requested by the CSC and authorized by HSD.

#### **4.2 Initial and Annual Financial Eligibility Process**

The participant must meet initial and annual financial eligibility. The steps are:

1. The participant/guardian completes the required ISD forms for initial eligibility and recertification, electronically or takes the completed forms to the County Income Support Division (ISD).
2. If the participant/guardian is not contacted to schedule a meeting with ISD within 10 days from the date of ISD recertification submission, it is their responsibility to call ISD to get an appointment scheduled.
3. Forms are available on the website:

<https://www.hsd.state.nm.us/LookingForAssistance/apply-for-benefits.aspx>

## CHAPTER 5. COORDINATION WITH MCO SERVICES

“Centennial Care” is New Mexico’s comprehensive Medicaid managed care delivery system that offers the full array of current Medicaid services such as doctor visits, behavioral health, vision, dental, medical transportation and medications. There are three (3) MCOs to choose from. Participants can visit the Yes NM Portal

<https://www.yes.state.nm.us/yesnm/home/index> and for information on MCO enrollment provisions for Native Americans visit:

[https://www.hsd.state.nm.us/LookingForAssistance/Native\\_Americans.aspx](https://www.hsd.state.nm.us/LookingForAssistance/Native_Americans.aspx)

The MCO initiates completion of a Comprehensive Care Plan (CCP) and assigns a Care Coordinator to the Supports Waiver participant upon enrollment. The Care Coordinator works with the participant to coordinate the delivery of services in the MCO CCP.

1. The MCOs and respective Care Coordinators assigned cannot make recommendations or changes to the Supports Waiver participant’s Individual Support Plan (ISP) and budget.
2. A Comprehensive Needs Assessment (CNA) is completed by the MCO but is not required for eligibility for the 1915 (c) HCBS Waiver Programs.
3. The MCO and CSC are encouraged to coordinate the CNA visit and the annual CSC visit at the direction of the participant to reduce any burden.
4. The TPA is authorized to provide to the MCO a copy of the Level of Care (LOC) abstract (MAD 378 form) to provide information about the participant and their needs.

## **CHAPTER 6. MAKING CHANGES TO MEET NEEDS AND PREFERENCES**

The Supports Waiver offers opportunities to make changes along the way.

### **6.1 Changing the Service Delivery Model**

Supports Waiver participants may choose to switch between the agency-based service delivery model and the participant-directed service delivery model after meeting medical and financial eligibility and after the original ISP and budget has been submitted and approved.

1. Participants must contact their CSC to request the change and an ISP and budget must be submitted through the new service delivery model.
2. The spending through the date of the transfer must accompany a close out budget.
3. Opening a new budget is the Individual Budget Allotment (IBA) minus expenditures through the date of transfer.
4. Services under the new model always start on the first of the month,
5. There must be no break in waiver services.

### **6.2 Changing Community Supports Coordinator Agency**

Supports Waiver participants may choose to switch to CSC Agency. If the individual has already started the eligibility process, they must wait until they meet medical and & financial eligibility before they request a transfer. Participants must contact DOH-DDSD Regional Office to request the CSC Agency change form.

1. When the Community Supports Coordinator Agency change form is completed, DDSD provides the form to the current and new CSC Agency.
2. The two (2) agencies will have a transition meeting with the participant to

decide upon a transition date and to exchange documents following the Letter of Transfer and Receipt instructions. The receiving CSC Agency will forward the completed Letter of Transfer and Receipt to the DDS Regional Office prior to the transfer.

3. The new CSC Agency will always start on the first of the month.
4. There must be no break in waiver services.

### **6.3 Changing Agency Providers**

A participant may choose to change Provider Agencies under the agency-based service delivery model. The CSC should inquire about the reason for the request and attempt to resolve any issues or concerns with the person and/or guardian and the Provider Agency prior if possible. If there is no resolution of the issues/concerns and the participant simply wishes to change agencies:

1. The CSC provides the participant or guardian, when applicable, with SFOC forms and information about different provider agencies. (The SFOC is also available on-line at <http://sfoc.health.state.nm.us/> )
2. Once the SFOC form(s) are signed by the person or guardian and returned to the CSC, the CSC is responsible for:
  - a. Notifying affected agencies, (by providing the current and new agency selected a copy of the signed SFOC);
  - b. Scheduling a transition meeting with the person and guardian (when applicable), the current Provider Agency and the new Provider Agency within two weeks of the completion of the SFOC form(s);
  - c. Completing and submitting a budget revision; and



- d. Facilitating the transition meeting, which should occur in person, but if necessary, can occur via teleconference.
3. The current Provider Agency is responsible for continuing the person's services and supports until the transition to the new Provider Agency is complete.
4. Services cannot start with the new Provider Agency until budget revision has been approved.
5. There must be no break in waiver services.

#### **6.4 Changing Employer of Record**

A participant may choose to change the EOR under the participant directed model. The CSC should inquire about the reason for the request and attempt to resolve any issues or concerns with the person and/or guardian and the Employer of Record if possible. If there is no resolution of the participant wishes to change EORs. The CSC:

1. Provides the participant or legal representative, when applicable, with the appropriate forms to enroll as employer of record and forward the necessary enrollment forms to the FMA and to DDSD.
2. Ensures that the new EOR has received education and program information as described in 16.3.1 [Annual Waiver Eligibility Recertification and Program Paperwork](#).
3. Works with the participant to determine if there is a need to expedite the EOR process and make that request to DDSD.
4. Ensures that all the necessary forms including new EOR, vendor and

employee packets have been submitted to establish new employees and vendors with a new EOR.

## CHAPTER 7. PLANNING FOR AVAILABLE SERVICES

### 7.1 Non-Covered Services

The Supports Waiver Program is the payor of last resort. Services and goods that are not covered by the Supports Waiver program include, but are not limited to the following:

1. Services covered by the Medicaid Centennial Care [including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Medicaid school-based services, Medicare and other third parties].
2. Any service or good that would violate Federal or State statutes, regulations or guidance.
3. Any goods or services that are considered primarily recreational or diversional in nature.
4. Formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the Public Education Department (PED), Division of Vocational Rehabilitation (DVR);
5. Special education and related services (as defined in sections 602 (16) and (17) of the Education of the Handicapped Act) (20 U.S.C. 1401 (16) and (17)) that are otherwise available to the individual through a local educational agency.
6. Room and board, meaning food and shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing(s), home and property maintenance, utilities and utility deposits, and related administrative expenses. Utilities include gas, electricity, propane, firewood wood pellets, water, sewer, and waste management.

7. Experimental or investigational services, procedures or goods.
8. Any goods or services that a household that does not include a person with a disability would be expected to pay for such as a routine household or personal expense.
9. Personal goods or items not related to the participant's disability.
10. Purchase of animals and the costs of maintaining animals, including the purchase of food, veterinary visits, grooming and boarding
11. Gas cards and gift cards. Items that are purchased with Supports Waiver program funds may not be returned for gift cards.
12. Purchase of insurance, such as, car, health, life, burial, renter's, homeowner's service warranties or other such policies. This includes purchase of cell phone insurance.
13. Purchase of a vehicle, and long-term lease or rental of a vehicle.
14. Purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items.
15. Firearms, ammunition or other weapons.
16. Gambling, games of chance (such as bingo or lottery), alcohol, tobacco, or similar items.
17. Vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses. This also includes mileage or driver time reimbursement for vacation travel by automobile.
18. Purchase of usual and customary furniture and home furnishings, *unless* adapted to the participant's disability or use, or of specialized benefit to the

participant's condition.

19. Regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, *except* upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the participant's qualifying condition or disability.
20. Regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, *except* upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the participant's qualifying condition or disability. Requests must include documentation that the adapted vehicle is the participant's primary means of transportation.
21. Clothing and accessories, *except* specialized clothing based on the participant's disability or condition.
22. Training time for paid employees and expenses for required OSHA related or other required training.
23. Consumer electronics such as computers (including laptops or any electronic tablets), printers and fax machines, or other electronic equipment that does not meet the criteria specified in Supports Waiver NMAC 8.314.7.
24. Cell phone services that include more than one (1) cell phone line per participant. Cell phone service, including cell phone service that includes data, is limited to the cost of one hundred dollars per month.

## **7.2 Available Services**

The available Supports Waiver services to mix and match based on need within the

annual \$10,000 budget per participant:

- Assistive Technology
- Behavior Support Consultation
- Customized Community Supports-Group
- Customized Community Supports-Individual
- Supported Employment
- Environmental Modifications
- Personal Care
- Non-Medical Transportation
- Respite
- Vehicle Modifications

### **7.3 Improper Solicitation**

No one providing Supports Waiver services should engage in improper solicitation. Provider Agencies or vendors may develop and distribute information or educational materials about their agency and services. However, Federal Medicaid regulations prohibit the use of marketing materials and practices that are inaccurate or misleading, that confuse, or that defraud an individual. Improper solicitation includes, but is not limited to the following actions:

1. Asserting or implying a person will lose benefits if the person fails to select a certain provider.
2. Making inaccurate, misleading, or exaggerated statements designed to influence the person's choice of a provider.
3. Asserting or implying that the Provider Agency offers unique services while other Provider Agencies also offer the same or similar services.

4. Asserting that a specific provider will gain benefits for the individual, e.g., to obtain a service approval when it was previously denied.
5. Use gifts, the promise of gifts, or other improper incentives to influence or entice an individual to select a provider.
6. Using improper incentives to support or identify an EOR to influence participant directed selection or to provide continued services by an agency, employee, or vendor that are EOR responsibilities.

#### **7.4 Conflicts of Interest**

Conflict of interest issues should be avoided by at least the following:

1. Any individual who is paid for providing Supports Waiver services to an individual must not serve as guardian or Power of Attorney for that individual, except when related by blood, adoption or marriage.
2. A relative or legal guardian may not be paid for Behavior Support Consultation, Customized Community Supports Group, Supported Employment, Assistive Technology, Environmental Modification, Vehicle Modification, or CSC.
3. A CSC agency may not:
  - a. Provide any other direct services for Supports Waiver participants.
  - b. Provide any direct support services through the DD Waiver or Mi Via Waivers or through any affiliated agency.
  - c. Employ a CSC who is an immediate family member of a participant served by the agency.
  - d. Provide guardianship services to any participant receiving CSC from the agency.

- e. Employ a CSC who also is the EOR or legal representative for an eligible participant served by agency.
4. A new legal relationship which diminishes or influences a person's independence in other areas of life may not be established for the sole purpose of becoming an EOR.



## **CHAPTER 8. INDIVIDUAL SUPPORT PLAN AND BUDGET DEVELOPMENT**

The Individual Service Plan (ISP) is the person-centered plan for the Supports Waiver. The development of the ISP starts with person-centered planning. This process obtains information about the participant's strengths, capacities, preferences, desired outcomes and risk factors. The ISP must revolve around the individual participant and reflect their chosen lifestyle, cultural, functional, and social needs for successful community living. The goal of the planning process is for the participant to achieve a meaningful life in the community, as defined by the participant.

The participant leads or is encouraged and supported to lead the development of the ISP through pre-planning and planning meetings with their CSC. The participant may involve, if they so desire, family members or other individuals, including employees or providers, in the planning process.

### **8.1 Sections of the Individual Service Plan (ISP)**

The Supports Waiver ISP template is available on the Supports Waiver website and will be provided to Supports Waiver participants as a pre-planning document. It is organized by several sections including four (4) categories of services and emergency back-up plan. In each section, questions help identify the participant's strengths, goals, natural and informal supports, concerns and challenges, and how the participant will know whether the plan they have developed is working well.

Because the ISP is a comprehensive planning tool, all areas need to be considered carefully. Each section of the ISP must be completed, even if the participant does not plan to request services or goods from that section. The ISP can be written out by hand or in the Word version of the form.

### **Personal Care Services**

The first section of the ISP covers supports that help the participant stay in his/her own home and community. These supports can provide needed assistance with activities of daily living, home management, supports for health and safety. Supports are provided through Personal Care Services.

### **Community Membership Supports**

Community Membership Supports help with participation in community life in order to enhance relationships with others, work or participate in meaningful activities. These supports include: Supported Employment and Customized Community Supports Group and Individual.

### **Health and Wellness Supports**

The third section of the ISP covers Health and Wellness Supports. This area identifies the participants needs and identifies where the participant will access waiver and non-waiver services to address those needs. The service provided by the Supports Waiver in this category is Behavior Support Consultation. Some Assistive Technology devices and equipment available through the Supports Waiver may be linked to health-related issues and may be ordered or recommended by a licensed

primary care practitioner or therapist. The participant and CSC may need to research and/or interview Support Consultants to address whether or not the particular behavioral health need can be fulfilled via the BSC of the Supports Waiver, or should be directly asked for of the behavioral health system (via EPSTDT, Medicaid State plan or Medicare).

### **Other Supports**

The fourth section of the ISP addresses other supports that are available to enhance or enable the participant to receive other services on his/her plan, thereby increasing his/her independence and potentially decreasing the need for more specialized or *direct* services. In the Supports Waiver these supports include: Vehicle Modification, Non-medical Transportation, Respite, and Assistive Technology.

### **Other Sections of the ISP**

The ISP also includes a section for Environmental Modification services which are physical adaptations that provide medical or remedial benefits to the individual's physical environment that address the qualifying diagnosis.

### **Quality Assurance Criteria**

The ISP contains the quality assurance criteria to be used to determine if the service or goods meet the participant's need as related to the qualifying diagnosis.

### **24-Hour Emergency Back-Up Plan**

This section lists who the participant will contact in an emergency or if regularly scheduled employees or service providers are unable to report to work. The Emergency Back-Up Plan is mandatory and must be completed in the ISP. The individuals or agencies who provide back-up services if regularly scheduled employees who are not available are responsible for ensuring continuity of services and providing care while new employees are being on-boarded. An agency who is providing services is required to be listed on the emergency back-up plan and to provide back-up employees.

### **Community Supports Coordinator**

The last section of the ISP addresses how much help the participant may need from the CSC to be successful. For example, a participant needs two calls a month from CSC when beginning with a new provider or a participant needs additional support during medical and financial eligibility process.

### **8.2 Budget Development Process**

Once the ISP has been completed and the participant has identified the supports, they would like to obtain through the Supports Waiver, the CSC and participant work together to develop the budget request.

1. The participant and CSC may need to research the estimated cost of services such as Assistive Technology, Environmental Modification, Non-Medical Transportation and Vehicle Modification.
2. The budget is developed one (1) goal at a time. Each goal includes a clear and

complete explanation of the requested service(s) or good(s), how they are related to the participant's qualifying condition or disability and why they are appropriate for the participant.

3. Each goal includes full details about each of the requested service(s) or good(s), including amount, frequency and duration, type of provider, cost or estimated cost, rate of pay, etc.

### **8.3 Completing and Submitting the ISP/Budget Request**

Initial ISP/budget requests should be completed and submitted so that it will be in effect within ninety (90) calendar days of eligibility determination.

Annual ISP/budget requests shall be submitted to the TPA no later than thirty (30) days prior to the end of the current ISP/budget year.

The CSC submits the participant approved ISP directly to the TPA for agency-based services and through the FMA on-line portal for participant-directed services. The CSC will be responsible for submitting the ISP with a budget for approval in the format requested by DOH/DDSD.

### **8.4 Modification of the ISP and Budget**

The ISP and budget should be modified when there is a new service, change in service, transfer of services or based upon a change in the participant's needs or circumstances. The ISP and budget may be modified once the original ISP/budget has been submitted and approved. When revisions to the AAB may occur within the

ISP and budget year, the participant, EOR, CSC and Provider Agencies as applicable are responsible for assuring that all expenditures follow the most current AAB in effect. To modify the ISP and AAB:

1. The CSC assists the participant with exploring other available resources.
2. The participant must provide written documentation of the change in needs or circumstances as specified in the Supports Waiver Service Standards and submit the documentation to the CSC.
3. The CSC initiates the process to modify the ISP and budget by forwarding the request for modification to the TPA for review.
4. Only one (1) ISP/budget revision may be submitted at a time, for example, an ISP/budget revision may not be submitted if an initial ISP/budget request or prior ISP/budget revision request is under initial review by the TPA. This requirement also applies to any reconsideration of the same revision request.
5. Other than for critical health and safety reasons, ISP/budget revision requests may not be submitted to the TPA within the last sixty (60) calendar days prior to the expiration date of the current ISP/budget. Submissions within the last sixty (60) calendar days must be approved prior to submission by the DOH Supports Waiver Program Manager or their designate for approval.
6. Expedited review requests must be submitted to the DOH Supports Waiver Program Manager or their designate for approval.
7. Criteria that constitute health and safety considerations for these types of request may include but not be limited to:
  - a. The participant has experienced a significant change in their health status, including physical, behavioral and cognitive health status; or

- b. The participant has experienced a significant loss of his/her natural support(s), such as family members, friends or other community resources that were providing direct care or services, whether paid or unpaid.

## **CHAPTER 9. ISP/BUDGET REVIEW AND APPROVAL PROCESSES**

The CSC, in cooperation with and after approval from the participant, shall submit the ISP/budget request to the TPA for review and approval. The participant's ISP/budget request must be approved by the TPA before any services under Supports Waiver may begin. The Supports Waiver will not pay for any services, supports and goods provided or purchased prior to the approval of the ISP/budget.

### **9.1 Request for Additional Information (RFI) Request for Administrative Action (RFA)**

The TPA may request additional information, through the RFI process, from the participant and/or the CSC during the process of reviewing the ISP/budget request. If the TPA has questions about the reasonable cost of requested goods, they may request additional information and/or documentation through the RFI process; and The CSC will assist the participant in obtaining requested documents and will respond to the RFI. If information is not received within 21 calendar days from the date of the initial RFI request, the service or good will be technically denied.

The TPA may issue an RFA to the CSC agency if there are administrative corrections required for the Participant Directed Service Model. The CSC agency must submit the corrections within 5 business days.

### **9.2 ISP Review Criteria**

Services and related goods identified in the participant's requested ISP may be considered for approval if the following requirements are met:

1. The services or goods must be responsive and directly related to the



- participant's qualifying condition or disability; and
2. The services or goods must address the participant's clinical, functional, medical, or habilitative needs; and
  3. The services or goods must accommodate the participant in managing their household; or
  4. The services or goods must facilitate activities of daily living; or
  5. The services or goods must promote the participant's personal health and safety; and
  6. The services or goods must afford the participant an accommodation for greater independence; and
  7. The services or goods must support the participant to remain in the community and reduce his/her risk for institutionalization; and
  8. The services or goods must be documented in the ISP and facilitate the desired outcomes in the participant's ISP; and
  9. The ISP contains the quality assurance criteria to be used to determine if the service or goods meet the participant's need as related to the qualifying condition or disability; and
  10. The services or goods must decrease the need for other Medicaid services; and
  11. The services or goods are not available through another source. (The participant must submit documentation that the services or goods are not available through another source, such as the Medicaid State Plan (Centennial Care) or Medicare); and
  12. The service or good is not prohibited by Federal and State statutes,

regulations and any other guidance; and

13. Each service or good must be listed as an individual line item.

### **9.3 Budget Review Criteria**

The participant's proposed annual budget request may be considered for approval, if all the following requirements are met:

1. The proposed annual budget request is within the participant's IBA (\$10,000); and
2. The rate for each service is an approved Supports Waiver rate for that chosen service; and
3. The proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and
4. The estimated cost of the service or good is specifically documented with supporting documentation in the participant's ISP/budget; and
5. No employee of any type is being paid in excess of 40 hours in a consecutive seven-day work week for any one participant or EOR.

### **9.4 ISP/Budget Approval, Partial Approval or Denial**

The TPA will notify the participant and CSC when a determination has been made on the ISP/budget request. The participant will receive a letter and the CSC will receive an electronic notification. The determination may be a full approval, a partial approval, or a denial. The TPA shall indicate which goal(s) of the ISP/budget have been approved or denied.

The TPA shall send final decisions to the participant in writing with Fair Hearing

Rights, including steps to follow if they disagree with the decision and want to pursue reconsideration and/or a Fair Hearing. Written denial notices from the TPA includes the reasons for the proposed action, the specific regulations that support the proposed action, or the change in the Federal or State law that requires the action.

### **9.5 Reconsideration**

If the ISP/budget, or a part of the ISP/budget is not approved the CSC assists the participant to explore their options, including the right to request a reconsideration of the decision. Reconsideration must be requested and submitted to the TPA within thirty (30) calendar days of the date on the denial notice. Reconsideration requests are submitted by the CSC in writing and provide additional documentation or clarifying information regarding the participant's request for the denied services or goods.

## **CHAPTER 10. RIGHT TO FAIR HEARING**

### **10.1 Circumstances for Appeal**

Participants always have the right to appeal a TPA decision through a Fair Hearing. A Fair Hearing must be requested within ninety (90) calendar days of the date of the denial.

A Fair Hearing may be requested when:

1. A Supports Waiver applicant's LOC has been denied;
2. A Supports Waiver applicant has not been given the choice of HCBS as an alternative to institutional care;
3. A Supports Waiver applicant is denied the services of his/her choice or the provider of their choice;
4. A Supports Waiver participants services are denied, suspended, reduced or terminated;
5. A Supports Waiver participant has been involuntarily terminated from the program; or
6. A Supports Waiver participant request for a budget adjustment has been denied; and
7. When any other adverse action is taken by MAD against the participant.

### **10.2 Agency Conference**

An Agency Conference is an opportunity to go over concerns with a representative from DDSD prior to a Fair Hearing. This is an informal way that may resolve concerns. However, regardless of what happens during this conference, the participant may continue with the Fair Hearing.

An Agency Review Conference does not replace a Fair Hearing. A Fair Hearing, including any related events such as a Pre-Hearing Conference which is scheduled by the Administrative Hearing Officer pursuant to 8.352.2.13.C. of the New Mexico Administrative Code, will proceed unless the participant or their guardian withdraws the request for a hearing by contacting the Fair Hearings Bureau directly at telephone number: (505) 476-6213 or (800) 432-6217, option 6.

### **10.3 Continuation of Benefits**

Continuation of benefits may be provided to participants who request a hearing within the timeframe defined in 8.352.2 NMAC of the date on the denial notice. The notice will include information on their right to continued benefits and on the participant's responsibility for repayment if the hearing decision is not in the participant's favor.

The continuation of a benefit is only available to a participant that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the participant's current allocation, budget or LOC. The continuation budget may not be revised until the conclusion of the fair hearing process, unless one of the criteria to modify the budget is met.

## **CHAPTER 11. IMPLEMENTATION OF THE INDIVIDUAL SERVICE PLAN AND BUDGET**

Supports Waiver services should not start until an approved ISP and AAB have been received from the TPA. Services that are provided without an approved ISP and AAB will not be paid.

### **11.1 Completion and Distribution of the Approved ISP**

For Agency Based services the CSC is required to assure all elements of the approved ISP, budget and companion documents are complete and distributed to service providers. The CSC also distributes the ISP and budget to the DDS Regional Office. The CSC will work to identify any resolve and barriers to the participant accessing the services approved in the ISP.

For Participant Directed services the CSC is required to distribute the approved ISP, budget and companion document to the participant and EOR within 5 business days of approval. If the budget start date is within the 5 business days or the participant will not receive the documents within enough time to make informed decisions regarding directing employees and vendors, then the CSC agency is required to distribute immediately upon approval. The participant and employer of record will distribute the necessary information to service providers. The CSC will work to identify and resolve any barriers to the participant accessing the services approved in the ISP. The DDS Regional Office will access the documents through the on-line FMA portal.

## **11.2 ISP Implementation**

All Supports Waiver services must be provided as detailed in the ISP. CSC's facilitate and maintain communication with the participant, their representative, Provider Agencies, and anyone requested by the participant to ensure the person receives the maximum benefit of his/her services and revisions to the ISP are made as needed.

## **11.3 Regional Office Request for Assistance (RORA)**

DDSD has statewide Regional Offices to provide information and technical assistance to anyone at any time. DDSD's RORA system is the mechanism to track any formal Requests for Regional Office Assistance (RORA). The system operates as follows:

1. Provider Agencies or Participants can make requests for assistance for various reasons.
2. Typical requests are listed in specific categories on the RORA template available on the DOH website <https://nmhealth.org/about/ddsd/>.
3. The RORA form should be completed in its entirety by the requestor and submitted to the appropriate Regional Office via Therap S-Comm or via fax to Regional Office in the participant's region
4. CSC's should complete a RORA when there are no available Provider Agencies of a specific service type in a county or region to assist DDSD in tracking service.

## **11.4 Use of the Client Information Update Form (CIU/MAD 054)**

The CIU is a tool for internal communication among the following entities: HSD-ISD,



HSD-Medical Assistance Division (HSD/MAD, Managed Care Organizations (MCO), TPA, DD Waiver Case Management Agencies, Mi Via Consultant Agencies, Support Brokers, Community Supports Coordinators, and other partnering state agencies. The CIU/MAD 054 is available with instructions for completion on the NM Medicaid Portal (<https://nmmedicaid.acs-inc.com/webportal/home>). The CIU shall be completed by the CSC, Supports Waiver participant, legal guardian, authorized representative, or other partnering state agencies to request an update in the following circumstances:

1. Change in address;
2. Change in state of residence;
3. Change of CSC Agency;
4. Level of Care'
5. Status of allocation or transition;
6. Reason for denial or closure;
7. Plan of Care/ISP/SSP dates;
8. Death of the person in services;
9. Nursing facility admission;
10. Hospital facility admission;
11. Incarceration;
12. Request for a Setting of Care change;
13. Request for a COE Extension; and
14. Waiver services not accessed.

### **11.5 Monitoring**

Provider Agencies or anyone providing goods and services through the Supports

Waiver are required to respond to issues at the individual and agency level. Records must be made available upon request. Implementation of the ISP and approved budget can be monitored in the following ways:

1. CSC monthly monitoring by phone or in person at least quarterly;
2. Surveys conducted by Division of Health Improvement (DHI) – Quality Management Bureau (QMB);
3. Regional Office monitoring activities which may include quality assurance activities, site and home visits, and responses to RORAs;
4. Bureau of Behavioral Support monitoring activities; and
5. Regional Office contract management activities.

### **11.6 General Events Reporting**

#### **General Events Reporting (GER)**

The purpose of General Events Reporting (GER) is to report, track and analyze events that concern Supports Waiver Participants. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows:

1. Community Support Coordinator Providers will utilize GER as directed by DDSD.

## **CHAPTER 12. PROVIDER ENROLLMENT, BILLING AND RECORD KEEPING**

### **12.1 Provider Enrollment Unit**

The Provider Enrollment Unit (PEU) enrolls agencies and sole proprietors to provide services through the SW Waiver Agency Based Service Model and manages numerous processes related to enrollment and Provider Agreements. The PEU processes both new and renewal provider applications, waivers of provider accreditation, amendments to Provider Agreements, expiration and termination of Provider Agreements, Provider Agency withdrawal from the SW Waiver, as well as moratoria on new clients to Provider Agencies. The PEU maintains the most current information on Provider Agencies and the SFOC forms which list all available Provider Agencies for each SW Waiver service in all thirty-three counties of the State. The PEU also tracks licensure and insurance policies of SW Waiver Provider Agencies.

### **12.2 Application Process**

Enrollment is ongoing, and there is no cost associated with an application. The PEU provides requested information via phone, face to face meetings, email, fax, or the United States Postal Service.

PEU processes provider applications according to the following steps:

1. Applicants must submit the application to the PEU to review for completeness.
2. If the application is missing three items or less, the PEU contacts the applicant to request the missing items. If the application is missing more than three items, the application is denied.

3. The PEU submits a completed application to the appropriate DDS Regional Office(s) for review.
4. The Regional Office(s) responds with an approval, a request for additional information, or a denial.
  - a. If the application is approved, the PEU will produce a new Provider Agreement for the provider to sign and begin working with the HSD/MAD and the Medicaid Fiscal Agent to obtain a Medicaid number for a new provider. Provider Agencies shall not make a direct request to HSD/MAD or the Medicaid Fiscal Agent to obtain a Medicaid number.
  - b. If the DDS Regional Office requests additional information, the PEU contacts the Provider Agency with the request.
  - c. If the application is denied, the PEU sends a letter to the applicant, advising them of the Regional Office's decision and the reason(s) for the denial.

#### New Applicants

1. New applicants must fully meet the CMS Final Rule Settings Requirements to be approved as a SW Waiver provider.
2. Provider Agencies cannot begin providing SW Waiver services until the HSD/MAD has approved their application and the PEU has placed their agency on the SFOC form.
3. The entire application process takes approximately three months to complete.

#### Renewing Provider Agencies

1. Current Provider Agencies who are 120 days away from the expiration of their existing Provider Agreement, will receive a renewal notice from the PEU via email.
2. Provider Agencies have 30 days from the date of the renewal notice to turn in a completed renewal application.

3. During the renewal process, Provider Agencies may update demographic information, phone and fax numbers, counties, and add or delete services.
4. If a Provider Agency needs to delete services upon renewal of their Provider Agreement, the Provider Agency must provide written confirmation stating that the current SW Waiver recipients have been transitioned and billing for the deleted service(s)/county(s) is complete.
5. The entire renewal process takes approximately 60 days to complete.

### **12.3 Amendments**

DDSD may approve an amendment to a Provider Agreement when a provider wants to add or delete services, counties, or regions or when the term of a Provider Agreement needs to be extended for any reason. Amendments are processed according to the following steps:

1. Provider Agencies must mail the Amendment Form to the PEU and must include an original signature. Faxed or emailed amendment requests are not accepted.
2. If the term of a Provider Agreement needs to be extended, the PEU sends a pre-filled Amendment Form to the provider for signature.
3. To add a county, region, or service to a Provider Agreement, the Provider Agency must submit an Amendment Form, the appropriate Additional Program Description(s) and licensure (if applicable) to the PEU. A Provider Agency may not amend their Provider Agreement to add services or a county to a region where the provider already has a moratorium.
4. To delete a county, region, or service from a Provider Agreement, the Provider Agency must submit an Amendment Form and written confirmation stating that any

current SW Waiver recipients have been transitioned and billing for the deleted service(s)/county(s) has been completed.

5. If any of the necessary items are missing from an amendment request, the PEU contacts the Provider Agency for the missing items.

6. The PEU submits a complete amendment request to the appropriate DDSD Regional Office(s) for review.

7. The Regional Office(s) responds with an approval, a request for additional information, or a denial. a. If the amendment request is approved, the PEU processes the amendment request and sends a confirmation letter to the Provider Agency.

b. If the DDSD Regional Office requests additional information, the PEU contacts the Provider Agency with the request.

c. If the amendment request is denied, the PEU sends a denial letter to the Provider Agency.

## **12.4 Moratoria**

### **Self-Imposed Moratorium**

A self-imposed moratorium is the removal of a Provider Agency from the SFOC form in specific counties for a limited amount of time, per the provider's request. This allows the Provider Agency to refrain from accepting new clients during the term of the moratorium. Provider requests for a self-imposed moratorium must be related to extenuating circumstances and conditions, for example: (a) many individuals have been accepted into service within a short time frame, (b) loss of key staff, (c) temporary economic issues that impact the agency's ability to accept additional individuals and (d) staff illness or physical disability affects the ability of the agency

staff to travel long distances. A self-imposed moratorium must be approved by the DDSD and may be approved in part or in whole.

Provider Agencies requesting a self-imposed moratorium must:

1. fill out a Self-Imposed Moratorium Form and submit the form to the PEU for processing; and
2. provide services to all of individual(s) who selected their agency via a signed SFOC form prior to the approval date of the self-imposed moratorium.

#### State-Imposed Moratorium

A state-imposed moratorium is issued by the DDSD or the Internal Review Committee (IRC). A state-imposed moratorium removes the provider from the SFOC for an unspecified amount of time. Provider Agencies placed on a state-imposed moratorium receive a letter explaining the reason(s) for the action and what must occur in order for the moratorium to be lifted.

#### **12.5 Provider Withdrawal from the SW Waiver**

Provider Agencies may choose to withdraw from the SW Waiver at any time but retain responsibility for providing services until all SW Waiver participants have been transitioned to new Provider Agencies or no longer need the services. When verification that all transitions have occurred, and the agency's billing is complete, the PEU works with HSD/MAD to close the provider's SW Waiver Medicaid number or to remove the SW Waiver from the provider's Medicaid number.

To withdraw from the SW Waiver program, Provider Agencies are required to:

1. Submit the following to the PEU at least 30 days prior to the estimated closure date:
  - a. written notice of intent to withdraw;
  - b. a copy of the notice that will be provided to the person and/or guardians and their CMs; and
  - c. a current list of individuals who will need to be transitioned including each person's legal name, address, phone number, social security number, and CM.
2. Continue providing services to individuals on the agency's existing caseload until those individuals have been transitioned to another agency or no longer require services.
3. Follow all transition requirements provided by DDS.
4. Notify the DDS Regional Office(s) and/or the PEU when all individuals have been transitioned and billing is complete.

### **12.6 Expiration or Termination of Provider Agreement**

A Provider Agreement may expire or be terminated by the DOH. The Provider Agency remains responsible for providing services to ensure health and safety until all SW Waiver participants have been transitioned to new Provider Agencies or no longer need the services. If necessary, the PEU will extend the Provider Agreement until the transition of services and provider billing is complete.

Upon verification that all transitions have occurred and the agency's billing is complete, the PEU works with HSD/MAD to close the provider's SW Waiver



Medicaid number or to remove the SW Waiver from the provider's Medicaid number.

Immediately upon receipt of the written notice from DDS of the expiration or termination from SW Waiver program, the Provider Agency must:

1. provide written notice to all staff and individuals/guardians within five calendar days of receipt;
2. continue to provide essential services and supports during the period of expiration or termination management until the transition of all individuals is complete;
3. work with the DDS Regional Office to ensure adequate transition planning takes place;
4. follow all transition requirements; and
5. notify the DDS Regional Office(s) and/or the PEU when all individuals have been transitioned and billing is complete.
6. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing.

### **12.7 General Billing Requirements**

To bill for agency-based services provided, a SW Waiver provider must have:

1. a fully executed Provider Agreement with the DOH;
2. an approved Provider Participant Agreement (MAD 335);

3. an active Medicaid number; and
4. prior authorization.

### **12.8 Prior Authorization Requirements**

Prior Authorization numbers for SW Waiver participants are issued by the New Mexico TPA contracted by HSD. The TPA completes system entry into the Medicaid Management Information System (MMIS) of approved SW Waiver services by type, amount, and effective dates. Prior authorization cannot be issued until all requirements related to service approval are met and an active COE 096 is in place for the SW Waiver participant.

SW Waiver Provider Agencies are responsible for verifying a person's Medicaid COE 096 for the dates of service. Provider Agencies complete the following steps in order to bill for services:

1. Verify the COE on the NM Medicaid web portal to ensure an active COE.
2. Notify the CSC immediately if no active COE is shown in the web portal or the COE is expired.
3. Work with the CSC to meet all submission requirements to obtain timely approval of the SW Waiver participant's ISP and budget.
4. Complete the following activities to ensure accurate and complete submissions:
  - a. provide documents demonstrating clinical justification for service requests as required;

- b. Review the ISP and budget required to be sent by CSCs via secure communications; and
  - c. Verify the ISP and budget accurately reflect the planning conducted at least 48 hours or two business days prior to the CSC submission of a packet to the TPA and/or OR.
5. Bill only within specified effective dates and for service types and amounts approved on the person's budget.
6. In extenuating circumstances, work with the DDSD Regional Office through the CSC to submit ISPs and budgets outside of the normal submission deadlines. (Special conditions must be met which include a demonstration of the need for an exception to process.)

### **12.9 Timely Filing**

There is a ninety (90) calendar daytime limit for filing all Medicaid claims and since the Supports Waiver is a Medicaid program, the same requirements apply. Required paperwork to bill for any approved services must be submitted no more than 90 days after the service has been provided.

### **12.10 Recording Keeping and Documentation Requirements**

All medical and business records must be maintained for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the Attorney General is completed regarding settlement of any claim, whichever is longer. Comprehensive documentation of direct service delivery

must include, at a minimum:

1. Individual provider or agency name;
2. Name of the recipient of the service;
3. Location of the service;
4. Date of the service;
5. Type of service;
6. Start and end times of the service;
7. Signature and title of each staff member who documents their time; and
8. The Nature of services.

### **12.11 Rates and Rate Table**

Rate determination and oversight are joint responsibilities between the DDS and HSD. Rates and rate methodology are approved by CMS. Most Supports Waiver services are reimbursed on a prospective, fee-for-service basis, except for select items that are reimbursed based on the purchase price (plus administrative fees for agency-based purchasing agent).

The Supports Waiver Rate Table is maintained by the HSD and is updated periodically based on legislative appropriations, rate studies, or other program decisions that affect reimbursement rates. The Supports Waiver Rate Table provides the service type, billing code and billing unit and can be found in on the HSD Website.

## **CHAPTER 13. TERMINATION FROM THE SUPPORTS WAIVER PROGRAM**

### **13.1 Voluntary Termination**

Supports Waiver participants may voluntarily terminate services through the Supports Waiver and not lose their place on the DD Waiver Wait List.

### **13.2 Involuntary Termination**

A Supports Waiver participant may be terminated involuntarily by MAD and/or DOH. A participant may be transferred to the participant-directed or agency-based track before being terminated. A participant who is involuntarily terminated from the Supports Waiver will remain on the DD Waiver Wait List and will continue to have access to other Medicaid benefits based on eligibility. Any participant who is involuntarily terminated has the right to contest that termination by requesting a Fair Hearing. Notification from the HSD or DOH that the participant has been involuntarily terminated will be made in writing and will include instructions for how to appeal the decision.

Cause for involuntary termination may include, but is not limited to:

1. The participant refuses to follow Supports Waiver rules and regulations after receiving focused technical assistance on multiple occasions, support from the program staff, community supports coordinator, or FMA, which is supported by documentation of the efforts to assist the participant.
2. The participant is at immediate risk to their health or safety by continued agency-based services or participant-direction of services, e.g., the

participant is in imminent risk of death or serious bodily injury related to participation in the waiver. Examples include but are not limited to the following:

- a. The participant refuses to include and maintain services in their ISP and AAB that would address health and safety issues identified or challenges the issues identified after repeated and focused technical assistance and support from program staff, community supports coordinator, or FMA.
- b. The participant is experiencing significant health or safety needs, and, after having been referred to DDSD assistance, refuses to incorporate recommendations or alternatives into his/her ISP and AAB.
- c. The participant exhibits behaviors which endanger him/her or others.
- d. The participant misuses Supports Waiver funds following repeated and focused technical assistance and support from program staff, the community supports coordinator or FMA, which is supported by documentation of efforts to assist the participant. Focused technical assistance is defined as a minimum of three (3) separate occasions where a participant, participant's authorized representative, and/or the Employer of Record (EOR) have received training, education or technical assistance, or a combination of both.
- e. The participant commits Medicaid fraud.
- f. DOH notification that the participant continues to utilize an employee and/or vendor who have consistently been substantiated against for abuse, neglect, exploitation while providing Mi Via or traditional waiver services after notification of this on multiple occasions by DOH.

## **CHAPTER 14. RISK MANAGEMENT AND ANE REPORTING REQUIREMENTS**

ANE refers to abuse, neglect, exploitation, suspicious injury, death or environmental hazard (collectively, ANE). Agency Providers, EORs and CSCs shall provide information to participants related to reporting ANE and reporting guidelines.

### **14.1 Reporting Requirements**

For individuals in the Supports Waiver program, reports of abuse neglect and exploitation should be immediately reported to:

1. The Department of Health/Division of Health Improvement (DOH/DHI) for persons 18 years or older. The DHI hotline is (800) 445-6242.
2. The Department of Health/Division of Health Improvement (DOH/DHI) and/or Children, Youth and Families Department/Child Protective Services for persons under 18 years of age. The CYFD Hotline is (800) 797-3260.
3. Report to CSC Agency within 24 hours.

### **14.2 Training Requirements**

All employees, contractors, and volunteers shall be trained on ANE training curriculum approved by DOH. ANE training requirements for Supports Waiver by role and responsibility are listed in **15.2. [Training Requirements](#)**. Employees or volunteers can work with a Supports Waiver participant prior to receiving the training only if directly supervised, at all times, by a trained staff. Provider Agencies, CSCs and EORs are responsible for ensuring the ANE training requirements are met.

### **14.3 Immediate Action and Safety Planning**

Upon discovery of any alleged incident of abuse, neglect, or exploitation, the

responsible provider agency or the CSC for participant directed service delivery model shall:

1. Develop and implement an immediate action and safety plan (IASP) for any potentially endangered participants, if applicable;
2. Be immediately prepared to verbally report the IASP, and revise the plan according to the DHI's direction, if necessary;
3. Provide the accepted IASP in writing on the IASP form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at <https://nmhealth.org/about/dhi/ane/racp/> otherwise it may be submitted by faxing it to the division at 1-800-584-6057.

#### **14.4 Corrective and Preventive Action Plans for Substantiated Findings.**

Provider Agencies will be held accountable for the actions of employees, volunteer, or contractors when incidents are substantiated by the DHI investigation.

The Supports Waiver Provider Agency shall:

1. Establish and maintain a quality improvement program for reviewing alleged complaints and incidents of ANE made against them as a provider;
2. Provide to the DHI written documentation of corrective actions taken;
3. Take all reasonable steps necessary to prevent further incidents; and
4. Share the approved Corrective and Preventive Action (CPA) plan with the person's CSC.

#### **14.5 Reports of Death**

Any death should be reported using the DHI toll-free hotline at 1-800-445-6242.



Further instructions can be found at:

<https://nmhealth.org/about/dhi/ane/racp/>.

In the event of a death of a person receiving services through the Supports Waiver, the following must occur:

1. The Provider Agency or EOR must immediately notify the CSC and the DHI of the person's death.
2. Regardless of circumstances, the CSC must ensure any death is immediately reported to DHI after knowledge of the death.
3. The CSC must submit the CIU form to provide notification of the person's death.
4. The person's primary file must be made available to DOH-DHI upon request.
5. If systemic issues are identified in the SW mortality review process, the DDS will address concerns in a quality improvement process.

#### **14.6 Notifications**

After an allegation of ANE has been reported to DHI, Supports Waiver Provider Agencies have requirements related to notifying participants, guardians, EORs and CSCs regarding allegations of ANE. Notification responsibilities are outlined in training.

#### **14.7 CSC, EOR and Provider Agency Responsibilities for Risk Management**

CSCs, EORs and Provider Agencies have a continuous responsibility to monitor for risk of harm especially during and after an investigation. If the IASP is not being followed, the information must be reported to the DHI hotline at 1-800-445-6242. In situations where DHI substantiates the ANE report, the CSC must:

1. Review the DHI findings detailed in the DHI issued *Decision Letter: Substantiated*;
2. Work with the participant to modify the ISP and back-up plan if necessary, to address any concerns identified in the investigation; and
3. In situations where a person is at significant risk of harm, work with the participant to modify the ISP and back-up plan within one working day, in person or by teleconference, and in writing within 72-hours.

## **CHAPTER 15. GENERAL QUALIFICATIONS AND TRAINING REQUIREMENTS**

### **15.1 Agency-Based Provider Requirements**

Supports Waiver Provider Agencies must have a current Provider Agreement and continually meet required screening, licensure, accreditation, and Supports Waiver training requirements as well as continually adhere to the Supports Waiver Service Standards. All Provider Agencies must comply with contract management activities to include any type of quality assurance review, announced and unannounced site reviews, and/or compliance review completed by DDS, the Division of Health Improvement (DHI) or other state agencies. All Provider Agencies must comply with CMS Final Rule Settings Requirements.

#### **15.1.1 General Agency-Based Requirements**

Supports Waiver Agencies are required to:

1. Possess a current business license;
2. Provide a tax identification number;
3. Meet financial solvency;
4. Adhere to Supports Waiver training requirements;
5. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each participant that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan.

6. Communicate the agency grievance policy to the Supports Waiver participant;
7. Be listed on the Supports Waiver Emergency Back-up Plan to provide services in the event that a scheduled agency employee is not available to provide services.

### **15.1.2 Quality Assurance Requirements**

To achieve a higher level of performance and improve quality, an organization is required to have an efficient and effective Quality Improvement System (QIS). As part of a QIS, Provider Agencies are required to evaluate their performance and to identify areas of non-compliance with the Supports Waiver Service Standards, areas of improvement, and issues that impact quality of services. The findings should help inform the agency's QIS plan.

#### **15.1.2.1 Data Sources**

Provider agencies should use the following data sources for discovery and analysis:

1. Satisfaction surveys;
2. QMB survey findings;
3. DDS training database;
4. New Mexico Regulation and Licensing Boards;
5. CCHSP; and
6. EAR.

#### **15.1.2.2 Implementing a QI Committee**

A QI committee must convene on at least a quarterly basis and more frequently if needed. The QI Committee convenes to review data; to identify any deficiencies, trends, patterns, or concerns; to remedy deficiencies; and to identify opportunities

for QI. QI Committee meetings must be documented and include a review of at least the following:

1. Activities or processes related to discovery, i.e., monitoring and recording the findings;
2. The entities or individuals responsible for conducting the discovery/monitoring process;
3. The types of information used to measure performance;
4. The frequency with which performance is measured; and
5. The activities implemented to improve performance.

#### 15.1.2.3 Annual Reporting

The Provider Agency must complete an annual report based on the quality assurance (QA activities and the QI Plan that the agency has implemented during the year). The annual report shall:

1. Be submitted to the DDS PEU by February 15th of each calendar year.
2. Be kept on file at the agency, and made available to DOH, including DHI upon request.
3. Address the Provider Agency's QA or compliance with at least the following:
  - a. Compliance with DDS Training Requirements;
  - b. Compliance with reporting requirements, including reporting of ANE;
  - c. Timely submission of documentation for budget development and approval;
  - d. Presence and completeness of required documentation;
  - e. Compliance with CCHS, EAR, and Licensing requirements as applicable;and

- f. A summary of all corrective plans implemented over the last 24 months, demonstrating closure with any deficiencies or findings as well as ongoing compliance and sustainability. Corrective plans may relate to a CMB survey, substantiated ANE reports or Regional Office contract management.

### **15.1.3 Accreditation**

Unless a waiver is granted by DOH-DDSD, Provider Agencies of CSC, CIE, CCS, and Respite are required to become accredited by CARF International or The Council on Quality and Leadership. Accreditation requirements include:

1. Obtaining accreditation for each required service;
2. Meeting initial accreditation requirements within 18 months of becoming a provider; and
3. Keeping accreditation current unless a waiver of accreditation is granted by meeting any of the following criteria:
  - a. The Provider Agency has not provided services to any individuals within nine months of being placed on the SFOC form.
  - b. The Provider Agency has three or fewer individuals, and/or received an annual sum of less than \$100,000 of Medicaid funding from the prior year, specifically for the Supports Waiver.
  - c. The Provider Agency has a waiver or is not obligated to be accredited under parallel services provided in other waivers operated by DDSD.
  - d. Quality review and quality assurance activities conducted by state agencies do not result in DDSD revocation of the exemption.

**15.1.4 Direct Support Personnel Educational and Experience Requirements**

DSP refers to the staff and subcontractors employed by EORs or Supports Waiver Provider Agencies that provide direct, daily, hourly and routine supports. DSP are primary implementers of the ISP and carry out individualized strategies developed and trained to promote health, safety, and the achievement of ISP visions.

The Caregivers Criminal History Screening Program (CCHSP) is essential to the enforcement of the DOH policy of “Zero Tolerance” of Abuse, Neglect & Exploitation (ANE) and to the DHI mission of enhancing the quality of health systems for all New Mexicans. CCHSP includes Provider Agency requirements to complete a caregiver criminal history screening background check and to check the Employee Abuse Registry (EAR). Requirements are as follows:

1. For the purposes of the Supports Waiver, the CCHSP applies to any non-licensed person whose employment, contractual or volunteer service with a Supports Waiver Provider Agency includes direct care or routine and unsupervised physical or financial access to any care recipient serviced by that Provider Agency.
2. All personnel must obtain a caregiver criminal history screening background check within 20 calendar days of hire (NMAC 7.1.9). Provider Agencies must also check the EAR prior to hiring or contracting with an employee (NMAC 7.1.12).
3. Individuals with a disqualifying criminal conviction or who have been placed on the EAR for a substantiation of ANE are not eligible to work as a caregiver or have access to patient/client/resident information or records

*15.1.4.1 Minimum education requirements for DSP are:*

1. DSP must be 18 years or older.
2. Be qualified to perform the service and demonstrate capacity to perform required tasks as identified in the ISP.
3. Be able to communicate successfully with the participant;
4. Complete required DOH-Supports Waiver Training and any specific trainings determined by the participant and outlined in the ISP.

15.1.4.2 Professional Licensure

Professionals licensed by their respective boards must practice under the confines of their license and keep their license current. Licenses must be provided to DDSD Provider Enrollment Unit (PEU) upon request. All relevant professional licensure for all hired and subcontracted personnel must be active in New Mexico for:

1. Behavioral Support Consultation;
2. Environmental Modification; and
3. Vehicle Modification.

**15.2 Training Requirements**

**15.2.1 Educational Information and Acknowledgments**

Some service providers are required to acknowledgement receipt of important information about ANE reporting.

These are:

1. Environmental modification, AT and VOMD providers who enter the home.

**15.3 Core Training Requirement**

Each required element will be delivered through in-person training or online



training and will be accompanied by certificate of course completion. CSCs, BSCs and DSP providing employment have additional requirements described in the service requirements section of these standards. Participants always have the option of training and will have access to training materials through their choice of training modules, education through CSC and/or other accessible materials provided by DDSD.

Individuals who are participating in the Participant Directed Service Model will have training that is required and administered through the FMA for the designated EOR for the purpose of directing their plan. CSCs will have training that is required through the FMA and the TPA.

Any additional trainings identified in the SW participant's ISP through the person-centered planning process will be the responsibility of the agency or the participant directed Employer of Record.

Personal Care Service and any service that allows PCS as an element and has approved Personal Care Services approved in the ISP will require the following Personal Care Discipline Specific Training. This Personal Care discipline specific training is the discipline specific training that is referenced in the CORE training grid. If DDSD sponsored training is unavailable then the agency or EOR is responsible for referring or coordinating training that covers the required PCS discipline specific topics. The required PCS discipline specific areas are HIPPA, ADL, iADL, nutrition, housekeeping skills, lifting and transferring, emergency response, CPR and First Aid, universal precautions, infectious diseases and basic infection control, home safety including oxygen and fire safety and wheelchair tie down. A competency test is

required to be taken through the DDS training database to satisfy and record these requirements. CPR and First Aid requires independent certification.

Core Training Requirements for the Supports Waiver are listed below.

	Prior to working with the Supports Waiver Participant					
	Introduction to Waiver System	Discipline Specific Training	EOR Guidebook	Indications of Illness & Injury	ANE*- and annually	Introduction to PCP
CSC	√	√	√	√	√	√
BSC		√		√	√	
Personal Care		√		√	√	√
Employment		√		√	√	√
CCS-I and CCS-G				√	√	√
EOR	√		√	√	√	√
Respite		√		√	√	√
Non-Mileage Transportation					√	

## **CHAPTER 16. COMMUNITY SUPPORTS COORDINATOR**

### **16.1 Community Support Coordinator Services**

Community Support Coordinator (CSC) Services are intended to educate, guide, assist and monitor the participant to make informed planning decisions about services and supports through a person-centered planning process. This leads to the development of an individual service plan (ISP) based on the participants needs within the budget limit of \$10,000.

CSCs serve as advocates for the participant and help the participant identify supports, services and goods that meet their need for covered waiver services and are specific to the participant's disability or qualifying condition and help prevent institutionalization. CSC services help the participant identify non-waiver specific supports, services and goods.

Community Support Coordinators assist the participant during two distinct phases: initial waiver eligibility and waiver enrollment activities and ongoing services.

### **16.2 Initial Waiver Eligibility and Waiver Enrollment Activities**

Initial Waiver Eligibility and Waiver Enrollment Services are intended to provide information, support, guidance, assistance and monitoring to individuals during the Supports Waiver initial enrollment and Medicaid eligibility process. This includes

both financial and medical components. The level of support provided is based upon the unique needs of the individual for the sole purpose of helping them navigate the Medicaid eligibility and enrollment processes and to ensure that the participant is successful in both. The Initial Waiver Eligibility phase is 90 days. Any CSC who is assisting a participant who has not established Medicaid eligibility in 90 days will need to receive an extension from DDS prior to the expiration of the 90 days. Once Medicaid eligibility has been established and the initial ISP and budget are approved, ongoing CSC services begin, and the CSC must schedule an ISP meeting within 10 days. In the Initial Waiver Eligibility and Waiver Enrollment phase the CSC:

1. Contacts the individual within five (5) working days after receiving the PFOC to schedule an initial orientation and enrollment meeting:
2. Conducts a waiver enrollment meeting within 30 days of receiving the PFOC. (Requirements for the waiver enrollment process are described in 16.3.1 Waiver Eligibility Recertification and Program Paperwork ) Informs, supports, and assists new Supports Waiver participants with the requirements for establishing Level of Care (LOC) within ninety (90) calendar days of receiving the PFOC following processes described in 16.3.3 Medical Eligibility.
3. Educates the participant regarding the required documentation and submission process to establish Financial Eligibility and monitors the status of the submission of the required documentation to ISD.
4. Routinely reports the status of initial participant eligibility to the DOH – DDS in frequency and format requested by DOH – DDS.

5. Assist the participant to identify any barriers that may occur during this process.
6. Contacts the participant at least monthly for follow up on initial waiver eligibility and waiver enrollment activities. This contact can be either be face-to face or by telephone but at least one (1) face to face visit is required.
7. Provide as much support as needed during this phase to ensure that the medical and financial eligibility is obtained.
8. As much as possible, conducts service pre-planning during this time to ensure the completion and submission of the initial ISP so that it will be in effect within ninety (90) calendar days off eligibility determination.
9. Shall not to exceed three (3) months of monthly billing. If an extension is granted during this phase by DDSD then the monitoring requirements are subject to DDSD approval.
10. Prior to ISP development or during the development process, obtain a copy of the Approval Letter or verify that the Income Support Division (ISD) office of the Human Services Department (HSD) has completed a determination that the individual meets financial and medical eligibility to participate in the Supports Waiver program.
11. Schedule an ISP meeting within ten (10) business days of the approval verification from ISD. For those participants transferring from another waiver or benefit program like State General Fund or Centennial Care Community Benefit, the transfer meeting and transfer of program

information as referenced in the Supports Waiver transition grid and the waiver change form must occur prior to the ISP meeting and according to HSD- DOH transition guidelines.

12. Submit all Initial Waiver Eligibility/ Waiver Enrollment service billing following the Human Services Department (HSD) instructions available through the Medicaid Provider Portal <https://nmmedicaid.portal.conduent.com/static/index.htm>.

### **16.3 Ongoing CSC Services**

The CSC assists the participants with implementation and quality assurance related to the ISP and Authorized Annual Budget (AAB). CSC services provide support to participants to maximize their ability to access and direct their Supports Waiver participation through an agency-based service delivery model or participant-directed service delivery model.

#### **16.3.1 Annual Waiver Eligibility Recertification and Program Paperwork**

The CSC conducts a program meeting annually. This meeting consists of providing program information and completing annual paperwork prior to the expiration of the budget term. Paperwork and forms related to Supports Waiver issued by the State must remain in their original format. The meeting may have to be conducted in two or more parts to assure meaningful review of all the necessary information.

The CSC role is to:

1. Educate the participant and legal representatives regarding Supports Waiver Program Guiding Principles and Requirements; including the person-centered planning process, determining circle of support and participant rights;
2. Discuss medical and financial eligibility requirements and discuss the process

- for establishing both;
3. Educate and assist the participant in selecting agency-based or participant-directed services and document the participants selection;
  4. Provide information regarding Support Waiver roles and responsibilities, including key agencies and supports and contact information;
  5. Complete the Participant Responsibilities Form and the HCBS Consumer Rights and Freedoms Form;
  6. Review the Support Waiver Service Standards with the participant. Based on the preference of the participant provide a written copy of the Standards, assist the participant to access the Standards on-line or provide both.
  7. Review the CSC agency grievance process;
  8. Clearly educate the participant that any use of restraint, restriction and seclusion is not allowed on the Supports Waiver;
  9. Provide information to participants related to recognizing and reporting abuse, neglect, exploitation, suspicious injury or any participant death and environmentally hazardous conditions which create an immediate threat to life’;
  10. Provide and review all enrollment information identified by DOH/DDSD.
  11. For participants who have chosen the agency-directed services, discuss the Secondary Freedom of Choice Process;
  12. For participants who have chosen participant-directed services:
    - a. Discuss the Employer of Record (EOR), complete the EOR Questionnaire, and complete the EOR Information Form (for annual meeting only if there is a change);

- b. Review the process for hiring employees and contractors and required paperwork;
- c. Discuss the background check and other credentialing requirements for employees and contractors;
- d. Provide initial and ongoing education and guidance to support participants and EORs with understanding their role as detailed in EOR Guide;
- e. Provide assistance participants with problems solving employee and vendor payment issues with the FMA and other relevant parties;
- f. Provide initial education and ongoing assist the participant to identify and access other resources for training employees(s)/service provider (s), if applicable; and
- g. Provide initial education and ongoing assistance to the participant in managing their budget, reviewing budget expenditures; and preparing and submitting revisions.

### **16.3.2 Financial Eligibility**

The CSC educates the participant regarding the required documentation and submission process to establish Medical Eligibility and monitors the status of the submission of the required documentation to ISD.

### **16.3.3 Medical Eligibility**

The CSC ensures the initial and annual evaluation of the LOC is complete. The CSC role includes:

1. Assistance and completion with required LOC documentation and paperwork:
2. Scoring the MAD 378 and coordinate physician review.



3. Assisting and supporting the participant with completion of the H&P.
4. Submit a completed MAD 378 and H&P to the TPA within the timeframes established by DOH/HSD.

#### **16.3.4 Program Training**

CSCs provide information necessary for all to enroll in and take the required DOH/DDSD/HSD trainings and identify any additional training needs through the person-centered planning process. Educate participants and EORs about and monitoring training requirements. Activities are to:

1. For Participant Directed participants, CSCs enter the participant, employee, EOR and any plan participant necessary into the training system within the timeframes established by DOH/DDSD so that they may have access to on-line trainings.
2. CSCs provide communication and support to the participant, EOR and the individual entered into the training system to ensure that the trainings are completed within the timeframes established by the DOH/DDSD.
3. Follow DOH/DDSD training instructions and guidance regarding DDSD database, participant notification and compliance.

#### **16.3.5 Service Pre-Planning**

The CSC Initiates pre-planning meetings and assists the participant to identify or develop a circle of support. The CSC:

1. Provides information on the Individual Service Plan (ISP) including covered and non-covered goods and services, pre-planning and planning tools and

community resources available to assist with the development of the ISP.

2. Ensures the completion and submission of the initial ISP so that it can be in effect within 90 calendar days of eligibility determination.
3. Ensures annual ISP for continuing Supports Waiver participants are submitted 30 calendar days prior to the expiration of the current ISP.
4. Assists the participant to identify resources outside the Supports Waiver that may assist in meeting their needs and link the person and guardian to publicly funded programs, community resources and non-disability specific resources available to all citizens and natural supports within the person's community.

### **16.3.6 ISP Development and Submission**

The CSC will work with the participant through pre-planning meetings and an ISP meeting during the participants budget year, to create an ISP and budget. The CSC will:

1. Prior to ISP development or during the development process, obtain a copy of the Approval Letter or verify that the Income Support Division (ISD) office of the Human Services Department (HSD) has completed a determination that the individual meets financial and medical eligibility to participate in the Supports Waiver program;
2. Ensure that the ISP for each participant is complete according to [8.1 Sections of the Individual Service Plan \(ISP\)](#);
3. Ensure that the ISP and budget documents are completed in the appropriate format;
4. Submit the ISP and budget the TPA at least thirty (30) calendar days prior to

- the expiration of the plan and through the procedure established according to the service delivery model (i.e. participant directed, or agency based).
5. Provide a copy of the final approved ISP and budget documents to participants.
  6. Provide a copy of TPA documents to the participant upon their request.
  7. Assist the participant and EOR when applicable to complete service-related forms and documents necessary to submit to the TPA for their review.
  8. Assist the participant to identify issues related to the implementation of the ISP.
  9. Assist the participant with reconsiderations of goods or services denied by the TPA, submit documentation as required, and participate in Fair Hearings as requested by the participant.
  10. Assist participants to identify measures to help them assess the quality of their services/supports/goods and, as needed to, self-direct their quality improvement process.
  11. Assist the participant to monitor their chosen service providers are adhering to the Support Waiver Service Standards as applicable.

### **16.3.7 Monitoring during Ongoing Community Support Coordinator Services**

The CSC is required to complete a formal, ongoing monitoring process to evaluate the quality, effectiveness, and appropriateness of services and supports provided to the person as specified in the ISP. This monitoring will also capture any issue the participant is experiencing that is unique to either agency-based or participant-based services. The CSC is also responsible for monitoring the health and safety of the person. This includes providing, reviewing and completing annual, quarterly

and monthly documents identified by DOH/DDSD.

Community Support Coordinator providers contact the participant at least monthly to discuss items identified on the Supports Waiver contact form. This contact can either be face to face or by telephone. Contact may be more frequent as identified in the ISP or as requested by the participant. CSC providers shall meet in person with the participant at a minimum quarterly based on the participants budget dates. At least two visits per year must be in the participant's residence. Monitoring activities include:

1. Review and document progress on implementation of the ISP, including training;
2. Review the participant's access to services and whether they were furnished per the ISP;
3. Document the participant's access to related goods identified in the ISP;
4. Review the participant's exercise of informed choice including choice of CSC, of agency-based provider or participant directed employees and of service delivery model;
5. Review whether services are meeting the participant's needs;
6. Review whether the participant is receiving access to non-waiver services as outlined in the ISP;
7. Follow up on complaints against service providers;
8. Document change in status;
9. Monitor the use and effectiveness of the emergency back-up plan and update within 48 business hours in the Participant Directed System and sending to

- the DDS Regional Offices systems if any changes have been identified. The CSC Agency must have immediate access and be prepared to provide as needed prior to the 48 hours;
10. Document and provide follow up (if needed) if challenging events occurred;
  11. Assess for suspected abuse, neglect or exploitation and report accordingly, if not reported, take remedial action to ensure correct reporting;
  12. Review any incidents or events that have impacted the participant's health and welfare or ability to fully access and utilize support as identified in the ISP;
  13. Use General Events Reporting according to SW GER Guide to report and monitor identified event types (e.g. COVID events);
  14. Assess for restraint, restriction and seclusion;
  15. Document progress on any time sensitive activities outlined in the ISP;
  16. Determines if health and safety issues are being addressed appropriately;
  17. Review ISP/budget spending patterns (over and underutilization);
  18. Assess quality of services, supports and functionality of goods in accordance with the quality assurance section of the ISP if applicable and any applicable Support Waiver service standards;
  19. Discuss or follow-up on any requests to revise the ISP and budget within five business days of the request of the participant; and
  20. Identify other concerns or challenges, including but not limited to complaints, eligibility issues, health and safety issues as noted by the participant and/or representative.
  21. Use the DDS issued monthly site visit form to document monthly

monitoring through Therapy Case Notes.

#### **16.4 Administrative Requirements**

The CSC agency shall ensure that participants have access to the CSC. This requirement includes, but is not limited to the following:

1. Presence in each region for which they are providing services.
2. Maintain a consistent way (for example, landline, cell, email, and fax) for the participant to contact the CSC during typical business hours which are 8:00 a.m. to 5:00 p.m. Monday through Friday.
3. Assure that CSCs and other staff will respond to participant and/or participant representative within three (3) working days except in emergency situations where a response is needed within twenty-four (24) hours during the work week.
4. Provide a location to conduct confidential meetings with participants when it is not possible to do so in the participant's home. This location must be convenient for the participant and compliant with the Americans with Disabilities Act (ADA).
5. Maintain an operational email address, internet access, and the necessary technology to access Supports Waiver related systems.
6. Maintain a current local/state community resource manual that is accessible to a participant.
7. Ensure the development and implementation of a written grievance procedure in compliance with 7.26.4 NMAC.
8. Maintain HIPAA compliant primary records for each participant including, but not limited to:

1. All program enrollment documents, /annual documents including notes on person-centered planning meeting and identification of the participant's Circle of Support;
  - a. All enrollment, submission and completion of required timeframes established by the Supports Waiver Program and DOH/DDSD/HSD;
  - b. Current and historical ISPs and budgets;
  - c. Contact log(s) that documents all communication with the participant;
  - d. Completed monthly and quarterly visit form(s);
  - e. TPA documentation of approvals/denials, including budgets and requests for additional funding;
  - f. TPA correspondence; (requests for additional information; requests for additional funding, etc.);
  - g. Notifications of medical and financial eligibility;
  - h. Approved Long Term Care Assessment Abstract with level of care determination and Individual Budgetary Allotment from the TPA;
  - i. Budget utilization reports from the FMA;
  - j. Documentation that the Community Support Coordinator has provided information on reporting abuse, neglect and exploitation, suspicious injuries, environmental hazards and death and how to report;
  - k. Copy of legal guardianship or representative papers and other pertinent legal designations and proof that they have been submitted to the FMA if applicable;
  - l. Copy of any authorized agent or records release forms;
  - m. Secondary Freedom of Choice Forms; and

- n. Primary Freedom of Choice form (PFOC) and/or CSC Agency Change Form (CAC) and/or Waiver Change Form as applicable;
- o. Supports Waiver service delivery model change form;
- p. Supports Waiver approval of relative or legal representative;
- q. Employer of Record Questionnaire;
- r. EMOD, VMOD and AT Fund Verification.

### **16.5 Qualifications**

Agencies shall ensure that all employees or subcontractors providing CSC services meet the criteria specified in this section. CSCs shall:

1. Be at least 21 years of age;
2. Possess a minimum of a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field or have a minimum of six (6) years of direct experience related to work with Individuals with IDD;
3. Have one (1) year of supervised experience working with people living with disabilities;
4. Complete all required Supports Waiver orientation and training courses; and
5. Have agreed to and signed the Community Support Coordinator Code of Conduct.

### **16.6 Caseload Ratio Requirements**

The CSC provider must assure that the number of participants assigned to CSCs do not exceed an average (mean) of fifty (50) participants across all DDSD operated waiver programs. The actual number of participants on each case load shall be



determined based upon the individual needs to be determined by the agency.

The CSC agency must ensure that all required CSC functions are met and that there is adequate time to provide the necessary supports unique to each participant.

### **16.7 CSC Reimbursement**

CSC services shall be reimbursed based upon a per-member/per-month unit. A maximum of one (1) unit per month can be billed per each participant. Provider records are subject to post payment reviews and must be sufficiently detailed to substantiate the nature, quality, and amount of CSC services provided. Post payment reviews may result non-payment or recoupment.

1. There is a maximum of twelve (12) billing units per participant per ISP year.
  2. A maximum of one unit per month can be billed per each participant receiving CSC services.
  3. The CSC provider/agency shall provide the level of support required by the participant.
  4. A minimum of four (4) face to face quarterly visits are required per ISP year, with two face to face visits being in the home.
1. One of the quarterly faces to face meetings must include the development of the annual ISP and assistance with the LOC assessment.

## **CHAPTER 17. SUPPORTS WAIVER SERVICES**

The \$10,000 budget for the Supports Waiver allows choice among multiple services. CSC is not included in the \$10,000 budget.

### **17.1 Assistive Technology**

Assistive Technology (AT) is intended to increase the individual's physical and communicative participation in functional activities at home and in the community. Items purchased through the AT service assist the individual to meet outcomes outlines in the ISP, increase functional participation in employment, community activities, activities of daily living, personal interactions, and/or leisure activities, or to increase the individual's safety during participation of the functional activity.

Assistive Technology (AT) services allow individuals to purchase and maintain needed items to develop low-tech augmentive communication, environmental access, mobility systems and other functional AT not covered through the individual's State Plan benefits.

AT includes Remote Personal Support Technology. Remote Personal Support Technology is an electronic device or system with a remote monitoring component that supports individuals to be independent in their home or community. This service may provide up to twenty-four (24) hour alert, monitoring or personal emergency response capability, prompting or in-home reminders, or monitoring for environmental controls for independence using 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. This service is not intended to provide for paid, in-person on-site response. On-site response must be planned through use of natural supports or other paid supports when the support is within the service scope of available supports.

The person's Primary Care Provider, therapist through Centennial Care or other home health or medical/dental provider may recommend AT. The State Plan therapist may perform evaluations and share ideas regarding Assistive Technology devices that are not covered by the State Plan (Centennial Care) and may be purchased under this service.

#### **17.1.1 Scope of Services**

Examples of AT include but are not limited to:

1. Specialized equipment for bathing or ADLs;
2. Switch access devices for environmental control;
3. Specialized adaptive clothing designed to help with dressing;
4. Specialized positioning or mobility devices;
5. Remote cueing and alert systems (e.g., medication box with audible notifications/alarms);
6. Home sensors with alert capability that detect movement, door/window status, or appliance use/status;
7. Software programs and applications that allow remote task/event cueing or location assistance/monitoring;

8. Personal emergency response systems; and
9. Remote Personal Support Technology. Remote video, audio or other monitoring systems; and environmental control device/systems that are associated with a monitoring device/system.

Assistive Technology services allow for:

1. The purchase and acquisition and maintenance of AT items as identified.

Training or technical assistance for the participant, or where appropriate, the family members, guardians, advocates or authorized representatives of the participant, or professionals or direct service providers involved in the major life functions of the participant.

2. Installation of remote electronic devices;
3. Education in the use of the devices;
4. Rental of electronic devices;
5. Maintenance costs for the electronic device;
6. Purchase of batteries to power AT devices up to \$60.00 per year.
  - a. Cell phone data must be for an application approved through the Supports Waiver;
7. Subscription costs which may include a customized response plan, maintenance costs, remote call center staff response, monitoring fees;
8. Training or technical assistance for the participant, or where appropriate, the family members, guardians, advocates or authorized representatives of the participant, or professionals or direct service providers involved in the major life functions of the participant;

9. Daily remote monitoring;
10. Remote Personal Support Technology;
11. Purchase of items meeting AT scope through a purchasing agent.

### **17.1.2 Service Requirements and Limitations**

**Agency-Based:** Participants arrange for AT through selection of an AT provider agency that acts as a purchasing agent for the technology or acts as the direct vendor of any AT identified in the ISP. When the provider acts as a purchasing agent the approved budget must be inclusive of 15% administrative fee and the agency purchases the items directly. The purchasing agency does not reimburse for prior purchases.

**Participant-Directed:** Participants will purchase technology through a vendor selected by the participant and approved through the FMA.

For all purchased items, the agency-based purchasing agent or the EOR must:

- a. Ensure the purchase is received by/delivered to the participant;
- b. Maintains receipts of purchase that can only represent items as detailed in the approved ISP and Budget;
- c. Ensure through direct contact with the CSC and participant that the item arrived and is functioning, and if not exchanges the item.

When the provider agency or vendor is the direct provider of the technology, the agency/vendor must:

- a. Deliver and install as needed;

- b. Only provide items as detailed in the approved ISP and Budget;
- c. Provide consultation regarding use;
- d. Assure functioning and warranties as applicable;
- e. Provide training to the participant and other identified supports regarding use of the technology;
- f. Follow back up plans as developed in the ISP.

#### 17.1.2.2 General Limitations

- 2. AT cannot duplicate or replace AT that is covered by the person's state plan benefit, Division of Vocational Rehabilitation (DVR), the public schools, or other funding sources shall not be covered by the Supports Waiver.
- 3. Items used primarily for sensory stimulation shall not be approved.
- 4. Devices, materials, or supplies used primarily during the delivery of direct therapy services or directed primarily toward a therapeutic outcome such as increasing range of motion shall not be approved.
- 5. Use of remote monitoring devices in bathrooms and bedrooms is strictly prohibited.
- 6. Educational software shall not be approved, except for applications for iPads, smartphones, and other similar devices used to increase the person's level of independent functioning.
- 7. Items intended to prepare a person for a functional activity rather than perform the functional activity shall not be approved.
- 8. No more than one (1) of each type of item may be purchased at one (1) time, and consumer electronics may not be replaced more frequently than once every three (3) years, including those consumer electronics previously

purchased through any other MAD program.

9. AT is limited to five thousand dollars (\$5,000) every five (5) years including those previously accessed through any other Medical Assistance Division (MAD) program.

## **17.2 Behavior Support Consultation Services**

Behavior support consultation (BSC) services consist of functional support assessments, positive behavior support plan/treatment plan development, training and support coordination for a participant related to the acquisition of positive skills and intervention in behaviors that compromise a participant's quality of life. Services are provided in an integrated, natural setting, or in a clinical setting.

The purpose of BSC services should be to improve the ability of unpaid caregivers and paid direct support staff to carry out positive behavior support interventions. BSC identifies skills and capacities that contribute to a person's ability to experience success and satisfaction in a range of settings. Support includes all efforts to teach, strengthen, and expand positive behaviors. The focus of support is primarily on assisting and guiding the participant toward opportunities to pursue the goals that genuinely represent what is most important to them. An important, but secondary consideration is to understand, anticipate, and prevent problem behaviors. Effective support considers changes to the environments, relationships, and activities available to a participant rather than exclusively targeting problem behavior.

BSC has several components:

- assessment of the person and their environment, including barriers to independent functioning via Positive Supports Assessment (PSA);
- determination of behavioral needs, review of potential sources of behavioral health treatment and referral to those sources if warranted;
- designing, writing, and testing of strategies to address behavioral concerns



and build on strengths and skills for independence via Positive Supports Plan (PSP) if warranted; and

- training plans in a way that the participant, natural and paid supports can understand and implement them.

### **17.2.1 Scope of Services**

The Supports Waiver BSC will:

1. Inform and guide the participant, family, employees, and/or vendors toward understanding the contributing factors to the participant's behavior.
2. Identify support strategies to improve the participant's functional capacities including development and enhancement of social and other skills adding to the provider's competency to predict, prevent and respond and potentially reduce interfering behaviors.
3. Support effective implementation based on a functional assessment and subsequent service and support plans.
4. Collaborate with medical and ancillary therapies to promote coherent use of psychotherapeutic medications and to limit the need for psychotherapeutic medications; and
5. Monitor and adapt support strategies based on the response of the participant and family, employees and/or vendors and others in the participant's support network for services to be provided in the least restrictive manner.

### **17.2.2 Licensure**

A mental health professional that wants to provide BSC services must have a minimum of one year of clinical experience or history of working with individuals

with I/DD and possess one of the following licenses approved by the New Mexico Regulation and Licensing Department and/or applicable New Mexico

Licensing/Practice Board:

1. An independent practice license as a:
  - a. Psychologist,
  - b. Licensed Clinical Social Worker (LCSW),
  - c. Licensed Independent Social Worker (LISW)
  - d. Licensed Professional Clinical Mental Health Counselor (LPCC)
  - e. Licensed Professional Art Therapist (LPAT)
  - f. Licensed Marriage and Family Therapist (LMFT)
2. A supervisory-level practice license: Professionals licensed at this level are require direct clinical supervision by an independently licensed mental health professional. These licenses include:
  - a. Mental Health Counselor (LMHC)
  - b. Clinical Mental Health Counselor (LPCC)
  - c. Master Social Worker (LMSW)
  - d. Psychologist Associate (PA)

### **17.2.3 Service Requirements and Limitations**

1. BSC reporting includes
  - a. Positive Supports Assessment (PSA): Assessments are conducted on an annual basis, or when a new BSC deems it necessary to ensure the assessment accurately reflects current situation.
  - a. Positive Supports Plan (PSP): When BSC services are desired based upon PSA results, the PSP must be developed and/or revised as

needed; when there has been a change in the status of the participant; and is updated at least annually.

2. BSC services are only available to individual under age 21 to the extent that they are different from and do not duplicate services offered under the Medicaid EPSDT benefit, Medicaid School Based Services, services offered by the New Mexico State Department of Education or services offered through the DOH Family Infant Toddler Program.
3. BSC services do not include individual or group therapy, or any other mental health or behavioral health treatment that may be received from other sources listed above.
4. Supports Waiver services may not replace services available through Medicaid or Medicare behavioral health services but may be provided concurrently.
5. Children and young adults who receive counseling or behavioral health services through their local school may also receive BSC services through the Supports Waiver; the focus is limited to home and community, rather than the school setting. No more than five hours of BSC services per year may occur in the school setting for school age children and young adults to attend IEP meetings and conduct cross-over training in the school setting.

### **17.3 Customized Community Supports Individual**

Customized Community Supports consist of individualized services and support that enable an individual to acquire, maintain, and improve opportunities for independence, community membership, and inclusion. The support provider may be a skilled independent contractor or a hired employee depending on the level of support needed by the eligible recipient to access the community. Customized Community Supports services are designed around the preferences and choices of each individual and offers 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 inclusion, arrangement of transportation, and relationship building. Provide help to the individual to schedule, organize and meet expectations related to chosen community activities. All services are provided exclusively, in a community setting with the focus on community exploration and true community inclusion.

#### **17.3.1 Scope of Services**

Customized Community Supports Individual Services include, but are not limited to the following:

1. Instruct and model social behavior necessary to interact with community members or in groups.
2. Promote social relationships and build connections within local communities.
3. Promote self-determination, enhance the participant's ability to interact with and contribute to his/her community.
4. Help with ancillary tasks related to community membership.
5. Provide support for ADLs/IADLs when incidental to the service in the

community and as identified in the ISP.

6. Assist the participant to schedule, organize and meet expectations related to chosen community activities.
7. Create individualized schedules that can be modified easily based on individual needs, preferences, and circumstances and that outline planned activities per day, week and month including date, time, location, and cost of the activity.
8. Assist in the development of skills and behaviors that strengthen a participant's connection with his or her community, individually, not as a part of a group of people with disabilities.

### **17.3.2 Service Requirements and Limitations**

1. The skills to assist someone in a community setting may be different than those for assisting a person at home. The provider will:
  - a. Demonstrate knowledge of the local community and resources within that community that are in the ISP.
  - b. Be aware of the participant's level of independence in the community and assess potential barriers to communicating and maintaining health and safety while in the community setting.
2. CCS- I cannot replace special education and related services (as defined in sections 602 (16) and (17) of the Education of the Handicapped Act) (20 U.S.C. 1401 (16) and (17)) that are otherwise available to the individual through a local educational agency.

## **17.4 Customized Community Supports – Group**

Customized Community Supports Group (CCS-G) can include participation in congregate community day programs and centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills for an eligible recipient. Customized Community Supports Group may include adult day habilitation. Customized Community Supports Groups are provided in community, to the fullest extent possible and may also be provided in day program facilities and centers, as necessary.

### **17.4.1 Scope of Services**

Customized Community Supports Group services include, but are not limited to the following:

1. Provide supports in integrated and congregate settings within the community which can include day programs and community centers that assist with the acquisition, retention or improvement in self-help, socialization and adaptive skills.
2. Supports and provides opportunities for participants to access and engage with community resources and activities with others in their community.
3. Creating individualized schedules that can be modified easily based on individual needs, preferences, and circumstances and that outline planned activities per day, week and month including date, time, location, and cost of the activity.
4. Providing opportunities for active individual choice-making during the day, including daily schedules, activities, skill building, and community participation.

5. Providing support to the person in becoming actively engaged in community sponsored activities specifically related to the person's (as compared to the group and/or agency) interests.

**17.4.2 Service Requirements and Limitations**

1. CCS-Group are not segregated vocational or prevocational activities, e.g., center-based or sheltered work.
2. CCS- Group is only available to participants 18 and older when no longer enrolled in special education and related services (as defined in sections 602 (16) and (17) of the Education of the Handicapped Act) (20 U.S.C. 1401 (16) and (17)) that are otherwise available to the individual through a local educational agency.
3. Staff ratios at a day facility or in the community may not exceed 1:6

## **17.5 Environmental Modification Services**

Environmental Modification Services: Environmental modification services include the purchase and/or installation of equipment and/or making physical adaptations to a participant's residence that are necessary to ensure the health, welfare, and safety of the participant or enhance the participant's level of independence and must be identified in the participant's ISP. All services shall be provided in accordance with applicable federal, state, and local building codes. 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 participant, such as fences, storage sheds or other outbuildings. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

The environmental modification provider must ensure proper design criteria is addressed in the planning and design of the adaptation, be a licensed and insured contractor(s) or approved vendor(s) to provide construction/re-modeling services, provide administrative and technical oversight of construction projects, provide consultation to family members, Supports Waiver providers and contractors concerning environmental modification projects to the participant's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

### **17.5.1 Scope of Services**

Environmental Modifications include the following:

1. Installation of ramps and grab-bars;



2. Widening of doorways/hallways;
3. Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;
4. Installation of lifts/elevators;
5. Modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing);
6. Turnaround space adaptations;
7. Installation of specialized accessibility/safety adaptations/additions;
8. Installation of trapeze and mobility tracks for home ceilings;
9. Installation of automatic door openers/doorbells;
10. Installation of voice-activated, light-activated, motion-activated and electronic devices;
11. Installation of fire safety adaptations;
12. Installation of air filtering devices;
13. Installation of heating/cooling adaptations;
14. Installation of glass substitute for windows and doors;
15. Installation of modified switches, outlets or environmental controls for home devices; and
16. Installation of alarm and alert systems and/or signaling devices.

#### **17.5.2 Service Requirements and Limitations**

1. Each participant's CSC shall verify and establish the amount of Environmental Modification Funds through the DDSD Regional Office. No duplicative adaptations, modifications, or improvements shall be approved regardless of

the payment source. For example, if the participant has a safe and usable ramp, a replacement ramp shall not be approved.

2. This service cannot be used to fund new construction including apartment buildings and Assisted Living Facilities.
3. An Environmental Modification Service Quote Packet shall be submitted to the TPA and includes:
  - a. Assessment of Need: description of function/medical need for EM in order to ensure health and safety to enhance Participant's level of independence; The therapist under the State Plan (Centennial Care) benefit may provide guidance on specific equipment, devices and specifications.
  - b. Brief description of work to be done (e.g. build ramp to front entrance, modify shower);
  - c. Itemized cost for equipment and materials;
  - d. Description and cost of labor;
  - e. Total Environmental Modification Service Cost Quote, including all applicable taxes, approved and signed by the Participant and Property Owner (if not the same) and the Contractor;
  - f. Permission of the Property Owner;
  - g. Building Permit if required;
  - h. Assurance that project will comply with Americans with Disabilities Act (ADA) guidelines, as relevant;
  - i. Assurance that project will comply will all relevant building codes;
  - j. Warranty period on parts and labor (minimum of 1 year);

- k. Projected Start Date and Projected Completion Date;
  - l. Two (2) Copies of Contractor's License, or appropriate certification to perform the work described; and
  - m. Two (2) Copies of Contractor's liability/insurance.
4. Provider must submit to the CSC (Agency-Based) or EOR (Participant Directed), after the completion of work and prior to the final payment:
    - a. Letter of approval of work completed signed by the member; and
    - b. Photographs of the completed modifications.
  5. Environmental modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects.
  6. Environmental Modification Providers must have applicable New Mexico license(s) (e.g., plumbing, electrician, contractor license; and/or applicable technical certification or other New Mexico licensure/certification to perform the modification.
  7. Environmental modification services are limited to five thousand dollars (\$5,000.00) every five (5) years including those previously accessed through any other Medical Assistance Division (MAD) program.

## **17.6 Personal Care**

Personal Care Services are provided on an intermittent basis to assist the Supports Waiver participant with a range of activities of daily living, performance of incidental homemaker and chore service tasks if they do not comprise of the entirety of the service, and enable the Supports Waiver participant to accomplish tasks as indicated in the ISP he or she would normally do for himself or herself if they did not have a disability. Personal Care Service are not intended to be a 24-hour service. Personal Care Services are provided in the eligible participants home and are not intended to replace medical services that have been identified to need a medical professional or are required to be directed by a medical professional. This service is not to be provided in homes or apartments owned/leased by provider agencies. Services are not intended to replace supports available from a primary caregiver.

### **17.6.1 Scope of Services**

Personal Care Services include:

1. Assistance with activities of daily living (ADLS) such as grooming, bathing, dressing, oral care, eating, transferring, mobility, mobility assistance to ensure appropriate bathing, dressing, grooming, oral care, skin care and toileting.
2. Assistance in performing IADLs (more complex life activities, e.g. personal hygiene, light housework, laundry, meal preparation, grocery shopping, using the telephone, medication and money management.
3. ADL and IADL activities specific to the upkeep of the member's personal living

areas are limited to maintain a safe and clean environment for the participant, particularly a person who may not have adequate support in his or her residence.

4. Assistance with mobility and prompting and cueing a participant to ensure appropriate household support services.
5. May include performing incidental homemaker and chore services tasks; however, such activities may not comprise the entirety of the service.
6. May include errands in the community as they relate to IADLs.

#### **17.6.2 Service Requirements and Limitations**

1. Service plan development is individualized. The TPA will assess the service plans of participants living in the same residence to determine whether or not there are services that are common to more than one participant living in the same household in order to determine whether one or more employees may be needed to ensure that individual personal care needs are met.
2. A family member will not be reimbursed for a service he or she would have otherwise provided as a natural support. A Personal Care employee regardless of family relationship, who resides with the member will not be paid to deliver household services, or supports such as shopping, errands, or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the participant.
3. This service is not available for participants under age 21, because personal care services are covered under the Medicaid state plan as expanded EPSDT benefits for waiver participants under age 21.
4. Personal Care Services do not include skilled or nursing care, medication

administration, assisting with or giving medications or providing tube feedings, treatments, suctioning or ventilator care.

5. An individual providing Personal Care Services who resides in the same household as the participant may not be paid for household support services routinely provided as part of the household division of chores, unless those services are specific to the participant such as, changing the person's linens, and cleaning the person's personal living areas.
6. Providers bill for services in shared households within state guidelines.  
Waiver participants in all living arrangements are assessed individually and service plan development is individualized. Two or more eligible recipients living in the same residence, who are receiving services and supports from the Supports Waiver will be assessed both independently and jointly to determine coverage of services and supports that are shared. Services and supports will be approved based on common needs and not individual needs unless the TPA has assessed that the eligible recipient has an individual need for the services.

## **17.7 Non-Medical Transportation Services**

Non-Medical Transportation services are offered in order to enable participants to gain access to waiver and other community services, activities and resources, as specified by the ISP. Transportation services under Supports Waiver are non-medical in nature, whereas transportation services provided under the Medicaid state plan are to transport participants to medically necessary physical and behavioral health services.

### **17.7.1 Scope of Services**

Non-Medical Transportation provided and reimbursed as follows:

1. **Agency-Based** -Participants purchase public or private transportation or reimbursement for mileage through a provider agency that acts as a purchasing agent. When the provider acts as a purchasing agent the approved budget must be inclusive of 10 %. The agency purchases the items directly. The purchasing agency does not reimburse for prior purchases or prior mileage accrued.
2. **Participant-Directed** -Participants purchase public or private transportation or reimbursement for mileage through a provider selected by the participant or through an individual transportation vendor.
3. Public and private transportation includes private and public tickets or passes to local transportation systems and ride share systems.

### **17.7.2 Service Requirements and Limitations**

1. Non-Medical Transportation services cannot be used instead of or to replace transportation services available under the Medicaid state plan.
2. Whenever possible, family, neighbors, friends, or community agencies that

can provide this service without charge will be identified in the ISP and utilized.

3. Non-Medical Transportation for minors is not a covered service as these are services that a Legally Responsible Individual would ordinarily provide for household members of the same age who do not have a disability or chronic illness.
4. Transportation for the purpose of vacation is not covered through the Supports Waiver.
5. Mileage reimbursement or hourly driver reimbursement is not available while CCS-Group is provided because it is incidental to the scope of the service.
6. Mileage reimbursement can be an add on to Personal Care, Respite, Supported Employment and CCSI if the applicable service provider meets all driver requirements and if it is approved in the ISP:
7. For mileage reimbursement and driver payment, the agency-based purchasing agent or EOR must ensure drivers receiving the mileage reimbursement:
  - a. Are at least 18 years of age;
  - b. Have a background check in accordance with these Supports Waiver Service Standards;
  - c. Possess a valid New Mexico driver's license with the appropriate classification;
  - d. Do not have any Driving Under the Influence convictions, or chargeable (at fault) accidents within the previous two years; and
  - e. Receive ANE Training;



- f. Possess and maintain current insurance policy and registration; and
  - g. Have a basic first aid kit in the vehicle.
8. For purchase of passes, the agency-based purchasing agent or the EOR:
- a. Maintains receipts of purchase that can only represent transportation as detailed in the approved ISP and Budget; and
  - b. Ensures the purchase is received and used by the participant.

## **17.8 Supported Employment**

Supported Employment offers one-to-one support to individuals placed in inclusive jobs or self-employment in the community and support is provided at the worksite as needed for the individual to learn and perform the tasks associated with the job in the workplace with the goal of obtaining and maintaining competitive employment at or above minimum wage. The service encourages development of natural supports in the workplace to decrease the reliance of paid supports.

Supported Employment includes job development and job coaching and is available for participants age 16 and older. Supports are provided at the work site for the individual to learn and perform the job specific to the Supports Waiver participants disability and not part of the job-training for the general public.

All Supported Employment services are available only when service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

**Job Development:** Job development services are provided to individuals when the services are not otherwise available for the individual under a program funded under the Rehabilitation Act of 1973, the Division of Vocational Rehabilitation or through the New Mexico Department of Education. Job development is a service provided to participants by skilled staff. The service can include but is not be limited to; job identification and development activities; employer negotiations; job restructuring; job sampling; and job placement.

**Job Coaching:** Job coaching is a service provided to individuals when the services are not otherwise available for the individual under a program funded under the Rehabilitation Act of 1973, the Division of Vocational Rehabilitation or through the New Mexico Department of Education. Job coaching services are available 365 days a year, twenty-four (24) hours a day. Services are driven by the participant's Service plan and job. Medicaid funds are not used to pay the participant. Job coaches will adhere to the specific supports and expectations negotiated with the participant and employer prior to service delivery.

### **17.8.1 Scope of Job Development Services**

Job development is a service provided to participants by a skilled individual. The service has several components:

1. Conducting Situational and or Vocational Assessments.
2. Developing and/or identifying community-based job opportunities that are in line with the individual's skills and interests.
3. Supporting the individual in gaining the skills or knowledge to advocate for themselves in the workplace.
4. Promoting career exploration based on interests within various careers through job sampling, job trials or other assessments as needed.
5. Arranging for or providing benefits counseling.
6. Facilitating job accommodations and use of assistive technology such as communication devices.
7. Providing job site analysis (matching workplace needs with those of the individual).
8. Assisting the individual in gaining and/or increasing job seeking skills

(interview skills, resume writing, work ethics, etc.).

9. Assisting with arranging for or training on transportation supports, including public transportation.
10. Utilizing other employment resources such as Division of Vocational Rehabilitation, One Stop Career Centers, Department of Workforce Solutions, Job Accommodation Network, Small Business Development Centers, businesses, community agencies, Partners for Employment, to achieve employment outcomes.
11. Assisting employers with the American's with Disabilities Act (ADA) issues, Work Opportunity Tax Cred (WOTC) eligibility, and requests for reasonable accommodations.
12. Integration of behavior consultation strategies

*17.8.1.1 Specialized Job Developer Qualifications – Individual*

1. Be at least 21 years of age.
2. Experience developing and using job task analyses.
3. Knowledge of and/or experience working with the Division of Vocational Rehabilitation, a waiver employment provider, an independent living center or organization that provides employment supports or services for people with disabilities.
4. Knowledge of and/or experience with the purposes, functions and general practices of entities such as:
  - f. Department of Workforce Solutions Navigators;
  - g. One-Stop Career Centers;
  - h. Job Accommodation Network;

- i. Small Business Development Centers or Service Corps of Retired Executives (SCORE);
- j. Partners for Employment
- k. Local Businesses;
- l. Community Agencies; and
- m. DDSD Resources.

### **17.8.2 Scope of Job Coach Services**

The job coach provides the following services:

1. Task analysis and training to perform specific work tasks on the job;
2. Vocational skill development;
3. Employer consultation specific to the participant;
4. Co-worker training;
5. Job site analysis;
6. Education of the participant and co-workers on rights and responsibilities;
7. Assistance with use of community resources to develop a business plan if the participant elects to start their own business;
8. Market analysis and help with needs to support a business for self-employment;
9. Increasing the participants' capacity to engage in meaningful and productive interpersonal interactions co-workers, supervisors and customers.
10. Increasing a participant's independence on the job to support fading of supports.
11. Integration of behavior consultation strategies.

### **17.8.3 Service Requirements and Limitations**

1. Services must occur in an integrated setting in accordance with the Workforce Innovation and Opportunity Act (WIOA), the Fair Labor Standards Act (FLSA) and NM Labor Law.
2. Waiver funding is not available for the provision of vocational services (e.g. sheltered work performed in a facility) where individuals are supervised in producing goods or performing services under contract to third parties (Centers for Medicare and Medicaid Service Technical Guidance January 2015).
3. Supported Employment will be provided by staff at current or potential work sites. Employment services are provided at a work site where persons without disabilities are employed.
4. Payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.
5. Waiver funds cannot be used to defray expenses associated with starting up or operating a business.
6. Waiver funds cannot be used for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
  - c. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
  - d. Payments that are passed through to users of supported employment programs; or

- e. Payments for training that is not directly related to an individual's supported employment program.
  - f. 7. Employment will only be supported in work environments that pay at or above minimum wage.
  - g. 8. Personal Care Services cannot be billed as a concurrent service to Supported Employment.
  - h. 9. Supported Employment service documentation for each Supports Waiver individual should include documentation that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq).
7. Transportation between residence and worksite is not included in the Supported Employment rate.

## **17.9 Respite**

Respite is a flexible family support service that provides support to the participant and gives the primary, unpaid caregiver time away from his/her duties. Respite services are furnished on a short-term basis and can be provided in the participant's home, the provider's home, in community setting of the family's choice (e.g., community center, swimming pool and park).

Respite Services are not intended to replace medical services that have been identified to need a medical professional or are required to be directed by a medical professional.

### **17.9.1 Scope of Services**

Respite services include, but are not limited to the following and must be provided in accordance to what is identified in the approved ISP:

1. Assist with routine activities of daily living (e.g. bathing, toileting, preparing or assisting with meal preparation and eating);
2. Enhance self-help skills, leisure time skills and community and social awareness;
3. Provide opportunities for leisure, play and other recreational activities;
4. Provide opportunities for community and neighborhood integration and involvement;
5. Provide opportunities for the participant to make his/her own choices with regards to daily activities;
6. Respite services do not include the cost of room and board;
7. Cannot be used for purposes of day-care; and



8. Cannot be provided to school age children during school (including home school) hours.

### **17.9.2 Service Requirements and Limitations**

Service plan development is individualized. Respite cannot be billed at the same time as any other Supports Waiver services. The TPA will assess the service plans of participants living in the same residence to determine whether or not there are services that are common to more than one participant living in the same household in order to determine whether one or more employees may be needed to ensure that individual cognitive, health related, and habilitative needs are met. Providers bill for services in shared households within state guidelines. Waiver participants in all living arrangements are assessed individually and service plan development is individualized. Two or more eligible recipients living in the same residence, who are receiving services and supports from the Supports Waiver will be assessed both independently and jointly to determine coverage of services and supports that are shared. Services and supports will be approved based on common needs and not individual needs unless the TPA has assessed that the eligible recipient has an individual need for the services.

## **17.10 Vehicle Modification Services**

Vehicle Modification Services are vehicle adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant and must be identified in the participant's ISP. Vehicle adaptations enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of services. Payment may not be made to adapt the vehicles that are owned or leased by paid providers for services.

### **17.10.1 Scope of Services**

Vehicle modification services include the purchase and/or installation of equipment, repair, maintenance, training on use of the modifications and extended warranties for the modifications that are necessary to ensure the health, welfare and safety of the participant or enhance the participant's level of independence and must be identified in the participant's ISP. All services shall be provided in accordance with applicable federal, state and local laws.

The vehicle modification provider must:

1. Ensure that proper consideration is made for the specific vehicle or van;
2. Be a licensed and insured contractor(s) or approved vendor(s)
3. Provide administrative and technical oversight of modification;
4. Provide consultation to family members, waiver providers and contractors

concerning vehicle modification projects to the participant's vehicle or van;  
and

5. Inspect the final vehicle modification to ensure that the adaptations meet the approved plan submitted for vehicle adaptation.

#### **17.10.2 Service Requirements and Limitations**

1. The following are specifically excluded:
  - a. Those adaptations or improvements to the vehicle or van that are of general utility and are not of direct medical or remedial benefit to the participant.
  - b. Any purchase of a vehicle, and long-term lease or rental of a vehicle, purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items.
  - c. Regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement,
  - d. Upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the eligible recipient's qualifying condition or disability;
  - e. Duplicative adaptations, modifications, or improvements shall not be approved regardless of the payment source. For example, if the participant has a safe and usable vehicle lift, a replacement shall not be approved.
2. Vehicle modifications are managed by professional staff available to provide technical assistance and oversight to vehicle modification projects.

3. Each participant's CSC shall verify and establish the amount of Vehicle Modification Funds through the DDS Regional Office.
4. A Vehicle Modification Service Quote Packet shall be submitted to the TPA and will include:
  - a. Assessment of Need: Description of function/medical need written by the participant and the CSC for VM in order to ensure health and safety and to enhance Participant's level of independence;
  - b. Documentation that the adapted vehicle is the eligible recipient's primary means of transportation;
  - c. Brief description of work to be done (e.g., install steering wheel modification);
  - d. Itemized cost for equipment and materials;
  - e. Description and cost of labor;
  - f. Total Vehicle Modification Service Cost Quote, including all applicable taxes, approved and signed by the Participant and Vehicle Owner (if not the same) and the Contractor;
  - g. Permission of the Vehicle Owner and verification that the vehicle is the participant's primary means of transportation;
  - h. Assurance that project will comply with Americans with Disabilities Act (ADA) guidelines, as relevant;
  - i. Assurance that project will comply will all relevant state, city and county laws;
  - j. Warranty period on parts and labor (minimum of 1 year);

- k. Projected Start Date and Projected Completion Date;
  - l. Two Copies of Provider's License, or appropriate certification to perform the work described; and
  - m. Two copies of Provider's liability/insurance.
5. Provider must submit to the CSC (agency-based) or Employer of Record (Participant Directed Track), after the completion of work and prior to the final payment:
- a. Letter of approval of work completed signed by the member; and
  - b. Photographs of the completed modifications.
6. Vehicle modification services are limited to five thousand dollars (\$5,000) every five (5) years including those previously accessed through any other Medical Assistance Division (MAD) program.

## CHAPTER 18. SUPPORTS WAIVER DEFINITIONS AND ACRONYMS

**ANE**-abuse, neglect, exploitation, suspicious injury, death or environmental hazard (collectively, ANE).

**Activities of Daily Living (ADL)** – Basic personal everyday activities that include bathing, dressing, transferring (e.g. from bed to chair), toileting, mobility and eating.

**Agency Based Service Delivery Model**- Supports Waiver service delivery model offered to an eligible recipient who does not want to participant direct their supports waiver services. Agency based services are provided by an agency with an approved agreement with Department of Health (DOH) to provide supports waiver services.

**Assistive Technology (AT)** — Assistive Technology (AT) is intended to increase the individual’s physical and communicative participation in functional activities at home and in the community. Items purchased through the AT service assist the individual to meet outcomes outlines in the ISP, increase functional participation in employment, community activities, activities of daily living, personal interactions, and/or leisure activities, or to increase the individual’s safety during participation of the functional activity.

Any item, piece of equipment, product, or system, acquired commercially (off the shelf), modified, customized, or fabricated that is used to maintain, increase, or improve functional capabilities of individuals with disabilities. This term generally includes items that are considered adaptive equipment and augmentive communication devices as well.

**Authorized Annual Budget (AAB)** - The Authorized Annual Budget (AAB) is the total approved annual amount of the community support services and goods which includes the frequency, the amount, and the duration of the waiver services and the cost of waiver goods approved by the Third-Party Assessor (TPA). Participants work with their Community Support Coordinator to develop an annual budget request, which is submitted to the TPA for review and approval. The total amount approved by the TPA is the AAB.

**Care Coordinator-** A care coordinator is the person assigned to the Medicaid recipient by the MCO to coordinate the care and services under Centennial Care such as medical, behavioral health, long term care, prescriptions, medical equipment, and others. The MCO Care Coordinator is different from the Supports Waiver Community Support Coordinator, but both should work together to coordinate services.

**Category of Eligibility (COE)-**To qualify for a medical assistance program, an applicant must meet financial criteria and belong to one of the groups that the state has defined as eligible. An eligible recipient in the Supports Waiver Program must belong to the COE 096 as described in 8.314.7.9 NMAC.

**Centers for Medicare and Medicaid Services (CMS)** – Federal agency within the United States Department of Health and Human Services that works in partnership with the New Mexico to administer Medicaid. CMS must approve all HCBS waiver programs.

**Community Support Coordinator (CSC)-** The Community Support Coordinator is the primary contact for the participant to develop and monitor implementation of an Individual Service Plan, obtain an approved budget, assist with annual medical and financial recertification. The Supports Waiver Community Support Coordinator is different from the and the MCO Care Coordinator, but both should work together to coordinate services.

**Comprehensive Needs Assessment (CNA):** The CNA is an assessment of the Member’s physical, behavioral health, and long-term care needs; it will identify potential risks and provide social and cultural information. The results of the CNA will be used to create the care plan which is based on the Member’s assessed needs. The CNA may also include a functional assessment, if applicable.

**Comprehensive Care Plan (CCP) means** a comprehensive plan of services that meets the Member’s physical, behavioral and long-term care needs.

**Corrective and Preventive Action Plan-** An Agency Provider’s written documentation of corrective actions taken, including all reasonable steps to prevent further incidents after a substantiated report of abuse, neglect or exploitation.

**Department of Health (DOH)** – State Agency responsible for operating the Supports Waiver for populations (intellectual/developmentally disabled) that meet the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) LOC.

Within the DOH the Developmental Disabilities Supports Division and the Department of Health Improvement operate the Supports Waiver.

**Developmental Disabilities (DD) Waiver Wait List**– The DD Waiver Waitlist is made up of individuals Medicaid HCBS waiver program for individuals who have met the definition of intellectual/developmental disability (I/DD) or a specific related condition as determined by Department of Health (DOH) in accordance with approved criteria. Individuals on the DD Waiver Wait list are waiting for waiver services and when a spot opens can choose either the Mi Via Waiver or the DD Waiver. criteria and the LOC provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities.

**Employee**- person who is employed by and provides services to a Supports Waiver participant through a provider agency or a participant directed Employer of Record. In order to provide services to a Supports Waiver participant and receive payment for delivered services, the employee must meet qualifications set forth in the waiver, regulations and standards; and complete all required documentation.

**Employer of Record (EOR)** – The individual responsible for directing the work of Supports Waiver employees, including recruiting, hiring, managing and terminating all employees. The EOR is responsible for directing the work of any vendors contracted to perform services. The EOR tracks expenditures for employee payroll, goods and services. EOR's authorize the payment of timesheets and vendor payment requests by the financial management agency (FMA). An eligible recipient may be his/her own EOR unless the eligible recipient is a minor or has plenary or limited guardianship or conservatorship over financial matters in place. An Employer of Record who is not the participant must be a legal representative of the recipient.

**Financial Management Agency (FMA)** – State Contractor that helps implement the approved budget by paying the participant's employees and vendors and tracking expenditures on the participant directed track.

**Fiscal Management Agent (FMA) online portal** – For participant directed services the on-line application and system used by the Supports Waiver FMA for receiving and processing payments. The FMA online portal is also used by participants and Community Support Coordinators to develop and submit ISP/budget requests for TPA review and to monitor spending throughout the ISP/budget year for participant directed services.



**Home and Community Based Services (HCBS) Waiver** – Medicaid program that provides alternatives to long-term care services in institutional settings. The federal government waives certain statutory requirements of the Social Security Act to allow states to provide an array of community-based options through HCBS waiver programs.

**Human Services Department (HSD)** – The Medicaid administering agency in New Mexico.

**Individual Action and Safety Plan-** Form completed and submitted with the abuse, neglect or exploitation report that identifies the immediate steps implemented to ensure the health and safety of an individual when there has been a report of abuse, neglect, exploitation, suspicious injury, death or environmental hazard (collectively, ANE).

**Individual Budgetary Allotment (IBA)** – The maximum amount of funding for each participant. This amount of funding will allow the participant to develop a plan to meet functional, medical and habilitative assessed need(s) in order to enable the participant to remain in their community. The IBA for the Supports Waiver is ten thousand dollars (\$10,000) per budget year.

**Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (IID)** – Facilities that are licensed and certified by DOH Health Facilities and Licensing to provide room and board, continuous active treatment and other services for eligible Medicaid recipients as an alternative to home and community-based services for individuals at the ICF/IDD level of care.

**Individual Service Plan (ISP)** – Participant plan that includes, but is not limited to: waiver services of the participant’s choice; the projected amount, frequency and duration of services and goods; the type of provider who will furnish each service or good; other services and goods to be used by the participant (regardless of funding source, including State Plan services); and the participant’s available natural and informal supports that will complement waiver services in meeting the needs of the participant.

**Legal Representative** - A person who is a legal guardian, conservator, power of attorney or otherwise has a court established legal relationship with the eligible recipient. The eligible recipient must provide certified documentation to the community support coordinator provider and FMA of the legal status of the

representative and such documentation will become part of the eligible recipient's file. The legal representative will have access to the eligible recipient's medical and financial information to the extent authorized in the official court documents.

**Level of Care** - The level of care an eligible recipient must meet to be eligible for the Supports Waiver program. Participants must meet the Level of care annually.

**Managed Care Organization (MCO)**-A managed care organization (MCO) is an insurance company that contracts with providers and medical facilities to provide healthcare services to its members. Centennial Care, the New Mexico Medicaid program is provided by three managed care organizations (MCOs). These services include physical health, behavioral health, long-term care and community benefits.

**Mechanical Restraint**-The use of a physical device to restrict a participant's capacity for desired or intended movement including movement or normal function of a portion of a participant's body for the exclusive purpose of precluding a challenging behavior.

**New Mexico Consolidated On-Line Registry (NMCOR)**-The New Mexico Consolidated On-line Registry (NMCOR) application provides a one-stop repository for NM healthcare employers to quickly ascertain employment suitability for new healthcare employees through data from information sources such as: Nurse Aide Registry (NAR), New Mexico Employee Abuse Registry (EAR) and New Mexico Sex Offender information. All employees, independent providers, provider agencies and vendors must pass the NMCOR screening prior to initial hire. Individual employees must pass the NMCOR screening every three years after initial hire.

**NMAC**- NMAC is the New Mexico Administrative Code which is the official compilation of current rules filed by State agencies. 8.314.7.9 NMAC is the reference to code for the Supports Waiver rules and regulations.

**NMSA**-New Mexico Statutes Annotated 1978 compilation

**Participant** – An individual who meets medical and financial eligibility and is approved to receive services through the Supports Waiver program.

**Participant Directed Service Delivery Model** – The Service Delivery model where participants have choices (among approved waiver services and goods) in identifying, accessing and managing the services they obtain to meet their personal assistance and other health-related needs.

**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 Supports Waiver and provider's work with individuals with I/DD. The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the eligible recipient. The process may include other persons, freely chosen by the eligible recipient who are able to serve as important contributors to the process. It involves person centered thinking, person centered service planning and person-centered practice. The PCP enables and assists the recipients' strengths, capacities, preferences, needs, and desired outcomes of the eligible recipient.

**Physical Restraint**-The use of physical interventions to restrict a participant's capacity for desired or intended movement including movement or normal function of a portion of a participant's body for the exclusive purpose of precluding a challenging behavior.

**Positive Supports Assessment (PSA)**- means a written report detailing the participant's current situation, their functional capacities (including social and other skills) and factors that may contribute to challenging behaviors that compromise a participant's quality of life. The PSA also includes consideration of all other behavioral health treatments that may be beneficial to the participant.

**Positive Supports Plan (PSP)** means a document that includes the strategies and interventions to be used in interacting with the participant daily in all relevant life settings. The PSP contains details of prevention and intervention strategies, skill development, teaching strategies, and desired long-term changes affecting quality of life.

**Psychoactive or psychotherapeutic medications**- means a chemical substance that acts on the central nervous system that is prescribed to improve the principal symptoms of behavioral health disorders (for example, anxiety, depression, or psychosis).

**Provider Agency**-An Agency with a MAD approved provider participation agreement and the appropriate approved DOH-DDSD agreement.

**Quality Assurance and Quality Improvement (QA/QI)** – Processes utilized by State and Federal governments, programs and providers whereby appropriate oversight and monitoring of HCBS waiver programs of waiver assurances and other measures provide information about the health and welfare of participants and the delivery

of appropriate services. This information is collected, analyzed and used to improve services and outcomes and to meet requirements by State and Federal agencies. Quality plans, systems and processes are designed and implemented to maintain continuous quality improvement.

**Reconsideration** - An eligible recipient who disagrees with a clinical/medical utilization review decision or action may submit a written request to the Third-Party Assessor (TPA) for reconsideration of the decision.

**Restrictive Interventions**-The use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods to preclude a challenging behavior.

**Request for Information/ Request for Additional Information (RFI/RFA)**-The Third-Party Assessor or Fiscal Management Agency may issue request for additional documentation or request for additional Information. These processes provide an opportunity to submit further information. Depending on the circumstances timelines to respond are provided with the request.

**Seclusion/Isolation**-The use of coercion or physical force to confine a participant alone in a room or limited space that prevents interaction with others. This applies to whether the setting is mechanically locked or forcibly contained by other means. This does not include limiting access to specifically identified areas such as the bedrooms of others or any areas deemed unsafe such as closets with cleaning solvents. This definition does not include or eliminate a participant's preference to spend time alone.

**Shared Household** - Two (2) or more Supports Waiver participants who live in the same private residence (not a group home or other facility) are defined as living in a shared household. Waiver participants in all living arrangements are assessed individually and service plan development is individualized. The TPA will assess the service plans of participants living in the same residence to determine whether there are services that are common to more than one participant living in the same household. This is done in order to determine whether one or more employees may be needed to ensure that individual, different cognitive, clinical and habilitative needs are met.

**Technical Denial**- Any denial that is a result of not responding within required timeframes to a request for information/additional document (RFI/RFA).

**Third Party Assessor (TPA)** – The Third-Party Assessor (TPA) is under contract with the HSD/MAD to determine initial and annual medical eligibility for individuals who choose the Supports Waiver and performs utilization management duties and review and approval or denial of individual ISP/budget.

**Vendor-** Vendor who is employed by and provides services to a Supports Waiver participant on the participant-directed track. In order to provide services to a Supports Waiver participant and receive payment for delivered services, the vendor must meet qualifications set forth in the waiver, regulations and standards; complete and sign a vendor agreement and all required tax documents.