TITLE 8 SOCIAL SERVICES
CHAPTER 314 LONG TERM CARE SERVICES - WAIVERS
PART 7 SUPPORTS WAIVER

8.314.7.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.314.7.1 NMAC - N, 4/1/2021; A, 7/1/2024]

8.314.7.2 SCOPE: The rule applies to the general public.
[8.314.7.2 NMAC - N, 4/1/2021]

8.314.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Titles XI, XIX, and XXI of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.314.7.3 NMAC - N, 4/1/2021; A, 7/1/2024]

8.314.7.4 DURATION: Permanent.
[8.314.7.4 NMAC - N, 4/1/2021]

8.314.7.5 EFFECTIVE DATE: April 1, 2021, unless a later date is cited at the end of a section.
[8.314.7.5 NMAC - N, 4/1/2021]

8.314.7.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.314.7.6 NMAC - N, 4/1/2021]

8.314.7.7 DEFINITIONS:

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

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

C. Agency-based: Supports waiver service delivery model offered to an eligible recipient who does not want to 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.

D. Authorized annual budget (AAB): 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).

E. Authorized representative: The individual designated to represent and act on the recipient's behalf. The authorized representative does not have budget or employer authority. The eligible recipient or authorized representative must provide legal documentation authorizing the named individual or individuals for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or other legal designation. The eligible recipient's authorized representative may not be a service provider. The authorized representative may not approve their own timesheets. The authorized representative cannot serve as the eligible recipient's community supports coordinator.

F. Category of eligibility (COE): To qualify for a medical assistance program (MAP), an applicant must meet financial criteria and belong to one of the groups that the New Mexico medical assistance division (MAD) has defined as eligible. An eligible recipient in the supports waiver program must belong to the MAP categories of eligibility (COE) described in 8.314.7.9 NMAC.

G. Centers for medicare and medicaid services (CMS): Federal agency within the United States department of health and human services that works in partnership with New Mexico to administer medicaid and MAP services under HSD.

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

I. Community supports coordinator (CSC): An agency or an individual that provides case management services to the eligible recipient that assist the eligible recipient in arranging for, directing and managing supports waiver program services and supports, as well as developing, implementing and monitoring the individual service plan (ISP) and AAB.

J. Electronic visit verification (EVV): A telephone and computer-based system that electronically verifies the occurrence of HSD selected service visits and documents the precise time the service begins and ends.

K. Eligible recipient: An applicant meeting the financial and medical level of care (LOC) criteria who is approved to receive MAD services through the supports waiver.

L. Employer of record (EOR): The employer of record (EOR) is the individual responsible for directing the work of the support's waiver employees, including recruiting, hiring, managing and terminating 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. EORs authorize the payment of timesheets and vendor payment requests by the financial management agency (FMA). 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. An EOR must be the waiver participant or an EOR must be a legal representative of the recipient.

M. Financial management agency (FMA): HSD contractor that helps implement the AAB by paying the eligible recipient's service providers and tracking expenses.

N. Individual budgetary allotment (IBA): The maximum budget allotment available to an eligible recipient. The maximum IBA under the supports waiver is $10,000 dollars. Based on this maximum amount, the eligible recipient will develop a plan to meet his or her assessed functional, medical, and habilitative needs to enable the recipient to remain in the community.

O. Individual service plan (ISP): The ISP is the name of the person-centered plan for the supports waiver. The ISP includes waiver services that meet the eligible recipient's needs including: the projected amount, the frequency and the duration of the waiver services; the type of provider who will furnish each waiver service; other services the eligible recipient will access; and the eligible recipient's available supports that will complement waiver services in meeting their needs.

P. Intermediate care facilities for individuals with intellectual disabilities (ICF/IID): Facilities that are licensed and certified by the New Mexico department of health to provide room and board, continuous active treatment and other services for eligible MAD recipients with a primary diagnosis of intellectually disabled.

Q. Legal representative: A person that 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.

R. Level of care (LOC): The level of care an eligible recipient must meet to be eligible for the supports waiver program.

S. Participant directed: Supports waiver service delivery model wherein the eligible recipient identifies, accesses and manages the employees and vendors of services (among the state-determined waiver services and goods) that meet their assessed therapeutic, rehabilitative, habilitative, health or safety needs to support the eligible recipient to remain in their community.

T. 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 intellectual/developmental disabilities (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.

U. Reconsideration: A written request by an eligible recipient who disagrees with a clinical/medical utilization review decision or action submitted to the third-party assessor for reconsideration of the decision. The eligible recipient or his or her authorized representative may submit the request for a reconsideration through the community support coordinator or the community support coordinator agency may submit the request directly to MAD.

V. Third-party assessor (TPA): The MAD contractor who determines and re-determines LOC and medical eligibility for the supports waiver program. The TPA also reviews the eligible recipient's ISP and approves the AAB for the eligible recipient. The TPA performs utilization management duties for all supports waiver services.

W. Waiver: A program in which the federal government has waived certain statutory requirements of the Social Security Act to allow states to provide an array of home and community-based service options through MAD as an alternative to providing long-term care services in an institutional setting.
[8.314.7 NMAC - N, 4/1/2021]

8.314.7.8 MISSION STATEMENT: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.
[8.314.7.8 NMAC - N, 4/1/2021]

8.314.7.9 SUPPORTS WAIVER HOME AND COMMUNITY-BASED SERVICES:

A. New Mexico's supports waiver is designed to provide temporary assistance to those on the developmental disabilities (DD) waiver wait list. It is intended to provide support services to eligible recipients to enable work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across the lifespan. The services provided are intended to build on each eligible recipient's current support structures through person-centered planning to work toward individually defined life outcomes, focusing on developing the eligible recipient's abilities for self-determination, community living and participation, and economic self-sufficiency. An eligible recipient has a choice of receiving services through the agency-based service delivery model or the participant directed service delivery model.

B. The program is operated by the New Mexico department of health developmental disabilities supports division (DOH/DDSD), at the direction of the New Mexico human services department medical assistance division (HSD/MAD).
[8.314.7.9 NMAC - N, 4/1/2021]

8.314.7.10 ELIGIBLITY REQUIREMENTS FOR RECIPIENT ENROLLMENT: Enrollment in the supports waiver is contingent upon the applicant meeting the eligibility requirements, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated eligible recipients. When sufficient funding is available, DOH will offer the supports waiver to eligible recipients on the DD wait list. Once an offer has been given to the applicant, they must meet certain medical and financial criteria in order to qualify for enrollment. Eligible recipients must meet the following eligibility criteria: financial eligibility criteria determined in accordance with 8.290.400 NMAC; the eligible recipient must meet the level of care (LOC) required for admittance to an intermediate care facility for individuals with intellectual disabilities (ICF/IID); and additional specific criteria as specified in the categories below.
[8.314.7.10 NMAC - N, 4/1/2021]

8.314.7.11 ELIGIBLE RECIPIENT RESPONSIBILITIES: Supports waiver eligible recipients have responsibilities to participate in the program. Failure to comply with these responsibilities or other program rules and service standards can result in termination from the program. The eligible recipient has the following responsibilities:

A. To maintain eligibility the recipient must complete required documentation demonstrating medical and financial eligibility both upon application and annually at recertification, and seek assistance with the application and the recertification process as needed from a community supports coordinator (CSC).

B. To participate in the supports waiver program, the eligible recipient must:

(1) comply with applicable NMAC rules to include this rule and supports waiver service standards and requirements that govern the program;

(2) collaborate with the CSC to choose between the agency-based or participant directed service delivery models, and determine support needs related to planning and self direction as applicable;

(3) collaborate with the CSC to develop an ISP and budget using the IBA in accordance with applicable NMAC rules to include this rule and supports waiver service standards;

(4) use supports waiver program funds appropriately by only requesting and purchasing goods and services covered by the supports waiver program in accordance with program rules which are identified in the eligible recipient's approved ISP and budget;

(**5)** comply with the approved ISP and not exceed the AAB;

(a) if the eligible recipient, due to mismanangement or failure to properly track expenditures, prematurely depletes the AAB amount during an ISP year, the failure to properly manage the AAB

does not substantiate a claim for a budget increase (e.g. if all of the AAB is expended within the first three months of the ISP year, it is not justification for an increase in the budget for the ISP year);

(b) revisions to the AAB may occur within the ISP year, and the eligible recipient is responsible for ensuring that all expenditures are in compliance with the most current AAB in effect;

(i) the ISP must be amended to reflect a change in the eligible recipient's needs or circumstances before any revisions to the AAB can be requested;

(ii) other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review within the last 60 calendar days of the budget year;

(c) no supports waiver program funds can be used to purchase goods or services prior to TPA approval of the ISP and annual budget request;

(d) any funds not utilized within the ISP and AAB year cannot be carried over into the following year;

(6) access CSC services based upon identified need(s) in order to carry out the approved ISP;

(7) collaborate with the CSC to appropriately document service delivery and maintain documents for evidence of services received;

(8) report concerns or problems with any part of the supports waiver program to the community supports coordinator or if the concern or problem is with the CSC, to DOH;

(9) work with the TPA by providing documentation and information as requested;

(10) respond to requests for additional documentation and information from the CSC provider, FMA, and the TPA within the required deadlines;

(11) report to the local HSD income support division (ISD) office within 10 calendar days any change in circumstances, including a change in address, which might affect eligibility for the program; changes in address or other contact information must also be reported to the CSC provider and the financial management agency (FMA) within 10 calendar days;

(12) report to the TPA and CSC provider if hospitalized for more than three consecutive nights so that an appropriate LOC can be obtained;

(13) have monthly contact and meet face-to-face quarterly with the CSC, as required by the DOH; and

(14) comply with all electronic visit verification (EVV) requirements.

C. Specific responsbilities for eligible recipient in participant directed service delivery model: In addition to the requirements in Subsection A and B of 8.314.7.11 NMAC, the eligible recipient must have an employer of record (EOR) to participate in the participant directed service delivery model. The EOR may be the eligible recipient unless the eligible recipient is a minor or has a plenary or limited guardianship or conservatorship over financial matters in place. An EOR must be the waiver participant or an EOR must be a legal representative of the recipient. The eligible recipient as their own EOR or the designated EOR must:

(1) direct the work of supports waiver employees, including recruiting, hiring, managing and terminating all employees;

(2) direct the work of any vendors contracted to perform services;

(3) track expenditures for employee payroll, goods, and services;

(4) authorize the payment of timesheets and vendor payment requests by the FMA;

(5) keep track of all budget expenditures and ensure that all expenditures are within the AAB;

(6) submit all required documents to the FMA to meet employer-related responsibilities. This includes, but is not limited to, documents for payment to employees and vendors and payment of taxes and other financial obligations within required timelines;

(7) complete all trainings within the required timeframes by the DOH or medical assistance division (MAD);

(8) ensure that all employees have registered and completed required trainings within the timeframes required by the DOH or MAD, identified in the ISP or identified by the EOR;

(9) report any incidents of abuse, neglect or exploitation to the appropriate state agency;

(10) arrange for the delivery of services, supports and goods;

(11) maintain records and documentation for at least six years from first date of service and ongoing; and

(12) comply with all electronic visit verification (EVV) requirements.

D. Voluntary termination: The supports waiver eligibile recipient may voluntarily terminate services through the supports waiver and will not lose their place on DD waiver wait list.

E. Involuntary termination: A supports waiver eligible recipient may be terminated involuntarily by MAD and DOH for the following:

(1) the eligible recipient refuses to comply with 8.314.7 NMAC and the supports waiver service standards, after receiving focused technical assistance from DOH and MAD program staff, CSC, or FMA, which is supported by documentation of the efforts to assist the eligible recipient;

(2) the eligible recipient is an immediate risk to their health or safety, imminent risk of death or serious bodily injury, by continued participant direction of services. Examples include but are not limited to the following:

(a) the eligible recipient refuses to include and maintain services in their ISP and AAB that would address health and safety issues identified in their ISP or challenges the ISP after repeated and focused technical assistance and support from program staff, CSC, or FMA;

(b) the eligible recipient is experiencing significant health or safety needs, and either refuses to incorporate a plan to address health and safety needs or document applicable choices in ISP;

(c) the eligible recipient exhibits behaviors which endanger themselves or others after repeated and focused technical assistance and support from program staff, CSC, or FMA.

(3) the eligible recipient misuses suppports waiver funds following repeated and focused technical assistance and support from the CSC or FMA, which is supported by documentation;

(4) the eligible recipient commits medicaid fraud;

(5) when the DOH is notified that the eligible recipient continues to utilize either an employee or a vendor, or both, who have consistently been substantiated against for abuse, neglect or exploitation while providing supports waiver services after notification of this by DOH;

(6) the eligible recipient 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. [8.314.7.11 NMAC - N, 4/1/2021]

8.314.7.12 SUPPORTS WAIVER CONTRACTED ENTITIES AND PROVIDERS: Services are to be provided in the least restrictive manner. The HSD does not allow for the use of any restraints, restrictive interventions, or seclusions to an eligible supports waiver recipient. The following resources and services have been established to assist eligible recipients to access supports waiver services through the agency-based service delivery model or the participant directed service delivery model. These include the following:

A. Community supports coordinator (CSC) services: CSC services are direct services intended to assist the eligible recipient in attaining and maintaining medical and financial eligibility; educating, guiding and assisting the eligible recipient to make informed planning decisions about service and supports; developing an ISP through a person-centered planning process; implementing and monitoring the ISP and AAB; and under the agency-based service delivery model, arranging for, directing, and managing supports waiver services and supports.

B. Financial management agency (FMA): For eligible recipients selecting the participant directed service delivery model, the FMA acts as the intermediary between the eligible recipient and the MAD payment system and assists the eligible recipient or the EOR with employer-related responsibilities. The FMA pays employees and vendors based upon an approved AAB. The FMA assures there is eligible recipient and program compliance with state and federal employment requirements and monitors and makes available to the eligible recipient the reports related to utilization of services and budget expenditures. Based on the eligible recipient's approved ISP and AAB, the FMA must:

(1) verify that the recipient is eligible for MAD services prior to making payment;

(2) receive and verify all required employee and vendor documentation;

(3) establish an accounting for each eligible recipient's AAB;

(4) process and pay invoices for goods, services and supports approved in the ISP and the AAB and supported by required documentation;

(5) process all payroll functions on behalf of the eligible recipient and EORs including:

(a) collect and process timesheets of employees;

(b) process payroll, withholding, filing, and payment of applicable federal, state and local employment-related taxes and insurance; and

(c) track and report disbursements and balances of the eligible recipient's AAB and provide a monthly report of expenditures and budget status to the eligible recipient and their CSC, and quarterly and annual documentation of expenditures to the MAD;

(6) receive and verify employee and vendor agreements, including collecting required provider qualifications;

(7) monitor hours, the total amounts billed for all goods and services during the month;

(8) process and report on employee background checks;

(9) answer inquiries from the eligible recipient and solve problems related to the FMA responsibilities; and

(10) report to the CSC provider, MAD and DOH any concerns related to the health and safety of an eligible recipient, or if the eligible recipient is not following the approved ISP and AAB.

C. Third-party assessor (TPA): The TPA or MAD's designee is responsible for determining medical eligibility through a LOC assessment, approving the ISP, and authorizing an eligible recipient's annual budget in accordance with 8.314.7 NMAC and the supports waiver service standards. The TPA:

(1) determines medical eligibility using the LOC criteria in 8.314.7.9 NMAC; determinations are completed initially for an eligible recipient who is newly enrolled in the supports waiver and thereafter at least annually for currently enrolled supports waiver eligible recipients. The TPA may re-evaluate LOC more often than annually if there is an indication that the eligible recipient's medical condition or LOC has changed; and

(2) approves the ISP and the annual budget request resulting in an AAB, at least annually or more often if there is a change in the eligible recipient's circumstances, in accordance with this NMAC and supports waiver service standards.

D. Conflict of interest: An eligible recipient's CSC may not serve as the eligible recipient's EOR, authorized representative or personal representative for whom they are the CSC. A CSC may not be paid for any other services utilized by the eligible recipient for whom they are the CSC, whether as an employee of the eligible recipient, a vendor, an employee or subcontractor of an agency. A CSC may not provide any other paid supports waiver services to an eligible recipient unless the recipient is receiving CSC services from another agency. The CSC agency may not provide any other direct services for an eligible recipient that has an approved ISP, an approved budget, and is actively receiving services in the supports waiver program. The CSC agency may not employ as a CSC any immediate family member or guardian for an eligible recipient of the supports waiver program that is served by the CSC agency. A CSC agency may not provide guardianship services to an eligible recipient receiving CSC services from that same agency. The CSC agency may not provide any direct support services through any other type of 1915 (c) developmental disabilities waiver program. A CSC agency shall not engage in any activities in their capacity as a provider of services to an eligible recipient that may be a conflict of interest. As such a CSC agency shall not hold a business or financial interest in an affiliated agency that is paid to provide direct care for any eligible recipients receiving supports waiver services. An affiliated agency is defined as a direct service agency providing supports waiver services that has a marital, domestic partner, blood, business interest or holds financial interest in providing direct care for eligible recipients receiving supports waiver services. Affiliated agencies must not hold a business or financial interest in any entity that is paid to provide direct care for any eligible recipients receiving home and community-based services (HCBS). Any direct service agency or CSC agency that has been referred to the DOH internal review committee (IRC) or is on a moratorium will not be approved to provide supports waiver services.

[8.314.7.12 NMAC - N, 4/1/2021]

8.314.7.13 QUALIFICATIONS FOR ELIGIBLE INDIVIDUAL EMPLOYEES, INDEPENDENT PROVIDERS, PROVIDER AGENCIES, AND VENDORS:

A. Agency-based service delivery model requirements for individual employees, independent providers, provider agencies and vendors: All supports waiver eligible providers under the agency-based model of service delivery must be approved by the DOH or its designee and have an approved MAD and DOH provider agreement. MAD through its designee, DOH/DDSD, must ensure that its subcontractors or employees meet all required qualifications. The provider agency must provide oversight of subcontractors and supervision of employees to ensure that all required MAD and DOH/DDSD qualifications; compliance with EVV requirements; all requirements outlined in the supports waiver services standards, applicable New Mexico administrative code (NMAC) rules, MAD supplements, and as applicable, the provider's New Mexico licensing board's scope of practice and licensure are met.

B. Participant directed service delivery model requirements for individual employees, independent providers, and vendors: In order to be approved to provide services under the participant directed service delivery model, provider agency, employees, vendors, or an independent provider, including non-licensed personal care or direct support worker, must meet the general and service specific qualifications set forth in this rule initially and continually meet licensure requirements as applicable, and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the FMA. In addition, to be an authorized provider for the supports waiver and receive payment for delivered services, the provider must complete a vendor or

employee provider agreement and all required tax documents. The provider must have credentials verified by the eligible recipient or the employee of record (EOR) and the FMA. The provider agency is responsible to ensure that all agency employees meet the required qualifications. Individual employees may not provide more than 40 hours of services in a consecutive seven-day work week.

(1) prior to rendering services to an eligible supports waiver recipient as a personal care or direct support worker, respite worker, customized community supports worker, or employment worker, an individual seeking to provide these services must complete and submit a nature of services questionnaire to the FMA. The FMA will determine, based on the nature of services questionnaire if the relationship is that of an employee or an independent contractor;

(2) an authorized CSC provider must have a MAD approved provider participation agreement (PPA) and the appropriate approved DOH/DDSD agreement.

C. General Qualifications agency-based and participant directed service delivery model providers:

(1) individual employees, independent providers, provider agencies, excluding CSC provider agencies, who are employed by a community supports waiver recipient to provide direct services shall:

(a) be at least 18 years of age;

(b) be qualified to perform the service and demonstrate capacity to perform required tasks;

(c) be able to communicate successfully with the eligible recipient;

(d) pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;

(e) complete all trainings as required by DOH/DDSD and complete training specific to the eligible recipient's needs as identified in the approved ISP;

(f) for participant directed, training needs on items identified in the individual service plan (ISP), and the training plan is determined by the eligible recipient or their legal representative for any training specific to the employee in addition to trainings required by DOH/DDSD; the eligible recipient is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the eligible recipient's AAB; and

(g) meet any other service specific qualifications, as specified in 8.314.7 NMAC and service standards.

(2) vendors, including those providing professional services:

(a) shall be qualified to provide the service;

(b) shall possess a valid business license, if applicable; and

(c) are required to follow the applicable licensing regulations set forth by the profession; refer to the appropriate New Mexico board of licensure for information regarding applicable licenses;

(3) qualified and approved relatives and legal guardians may be hired as employees and paid for the provision, of supports waiver services except for CSC services, customized community supports group services, non-medical transportation services for a minor, environmental modifications services, vehicle modifications services, behavior support consultation services, assistive technology and employment supports. A spouse may not provide transportation for adult participants. A relative or legal guardian may not provide services that the legal responsible individual would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness. A relative or legal guardian may not provide services that the legally responsible individual would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness;

(4) once enrolled, providers, vendors and contractors receive a packet of information from the eligible recipient or FMA including billing instructions, and other pertinent materials. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, an eligible recipient or legal representative, or provider, vendor or contractor receives instruction on how to access these documents. It is the responsibility of the eligible recipient or legal representative, or provider, vendor, or contractor to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The eligible recipient or legal representative, or provider, vendor, or contractor must contact HSD or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials;

(a) no provider of any type may be paid in excess of 40 hours within the established work week for any one eligible recipient or EOR when applicable;

(b) no provider agency is permitted to perform both LOC assessments and provide any services for the eligible recipients;

(c) providers may market their services but are prohibited from soliciting eligible recipients under any circumstances.

(5) Employer of record: The EOR is the individual responsible for directing the work of the eligible recipient's employees under the participant directed service delivery model. The EOR may be the eligible recipient or a legal representative of the recipient. A recipient through the use of the support's waiver EOR questionnaire will determine if an individual meets the requirements to serve as an EOR. The recipient's CSC will provide him or her with the questionnaire. The questionnaire shall be completed by the recipient with assistance from the CSC upon request. The CSC shall maintain a copy of the completed questionnaire in the recipient's file. The EOR does not have budget authority. When utilizing both vendors and employees, an EOR is required for oversight of employees and to sign payment request forms for vendors. The EOR must be documented with the FMA whether the EOR is the eligible recipient or a designated qualified individual.

(a) an eligible recipient that is the subject of a plenary or limited guardianship or conservatorship may not be their own EOR;

(b) a power of attorney or other legal instrument may not be used to assign EOR responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR as designated in 8.316.7 NMAC;

(c) a person under the age of 18 years may not be an EOR;

(d) an EOR who lives outside New Mexico shall reside within 100 miles of the New Mexico state border. If the eligible recipient wants to have an EOR who resides beyond this radius, the eligible recipient must obtain written approval from the DOH prior to the EOR performing any duties. This written approval must be documented in the ISP;

(e) the eligible recipient's provider may not also be their EOR;

(f) an EOR whose performance compromises the health, safety or welfare of the eligible recipient, may have their status as an EOR terminated;

(g) an EOR must be a legal representative if not the recipient; and

(h) an EOR may not be paid for any other services utilized by the eligible recipient for whom they are EOR, whether as an employee of the eligible recipient, a vendor, or an employee or contractor of an agency. An EOR makes important determinations about what is in the best interest of the eligible recipient and should not have any conflict of interest. An EOR assists in the management of the eligible recipient's budget and should have no personal benefit connected to the services requested or approved in the budget.

D. Qualifications of assistive technology providers and vendors: Must hold a current business license issued by the state, county or city government.

E. Qualifications of behavior support consultation providers: Behavior supports consultation provider agencies shall have a current business license issued by the state, county or city government, if required. Behavior supports consultation provider agencies shall comply with all applicable federal, state, and waiver rules and procedures regarding behavior support consultation, and must ensure that provider training is in accordance with the DOH/DDSD training policy. Providers of behavior support consultation must maintain a current New Mexico license with the appropriate professional field licensing body and have a minimum of one year of experience working with individuals with intellectual or developmental disabilities. Providers of behavior support consultation services must possess qualifications in at least one of the following areas:

(1) licensed clinical psychologist, licensed psychologist associate, (masters or Ph.D. level);

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

(3) licensed master social worker (LMSW);

(4) licensed mental health counselor LMHC);

(5) licensed professional clinical counselor (LPCC);

(6) licensed marriage and family therapist (LMFT); or

(7) licensed practicing art therapist (LPAT).

F. Qualifications of the community support coordinator providers: In addition to general requirements, a CSC provider shall ensure that all individuals hired, or contracted for CSC services meet the criteria specified in this section in addition to all applicable rules and service standards. Community supports coordinators shall:

(1) be at least 21 years of age;

(2) possess a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or related field; or have a minimum of six-years direct experience related to the delivery of social services to people with disabilities;

(3) have at least one year of experience working with people with disabilities or I/DD;

(4) complete all trainings as required by DOH/DDSD;

(5) verification of provider qualifications; and

(6) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

G. Qualifications for customized community supports individual providers: For individual community supports providers the worker must meet the following requirements:

(1) be 18 years of age or older;

(2) demonstrate the capacity to perform required tasks;

(3) be able to communicate successfully with the eligible recipient;

(4) complete all training requirements as required by DOH/DDSD; and

(5) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC; and

(6) meet any other service qualifications, as specified in the regulations.

H. Qualifications for customized community supports group providers: Provider agencies must meet requirements including a business license, accreditation with the commission on accreditation of rehabilitation facilities (CARF) international, employment and community services or the council on quality and leadership, quality assurances, financial solvency, training requirements, records management, quality assurance policy and processes. The agency staff must meet the following requirements:

(1) be at least 18 years of age;

(2) have at least one year of experience working with people with disabilities;

(3) be qualified to perform the service and demonstrate capacity to perform required tasks;

(4) be able to communicate successfully with the eligible recipient;

(5) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

(6) complete specific training based on needs identified in the ISP and by the recipient; and

(7) meet any other service qualifications, as specified in the regulations.

I. Qualifications of personal care service providers: In addition to general MAD requirements, the direct support providers must meet additional qualifications specific to the type of services provided. Provider agencies must be homemaker/personal care agencies certified by the MAD or its designee or a homemaker/personal care agency holding a New Mexico homemaker/personal care agency license. A homemaker/personal care agency must hold a current business license when applicable, and meet financial solvency, training, records management, and quality assurance rules and requirements. Personal care direct support workers must:

(1) be at least 18 years of age;

(2) demonstrate capacity to perform required tasks;

(3) be able to communicate successfully with the eligible recipient;

(4) complete all trainings as required by DOH/DDSD; and

(5) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

J. Qualifications of employment supports providers:

(1) A job developer, whether an agency or individual provider, must:

(a) be at least 21 years of age;

(b) complete all training requirements by DOH/DDSD;

(c) have a high school diploma or GED;

(d) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC;

(e) have experience in developing and using job and task analysis;

(f) have knowledge of the Americans with Disabilities Act (ADA);

(g) have knowledge and experience working with the department of vocational rehabilitation (DVR) office; and

(h) have experience with or knowledge of the purposes, functions, and general practices of entities such as department of labor navigators one-stop career centers, business leadership network, chamber of commerce job accommodation network, small business development centers, retired executives, local business community agencies, and DDSD resources.

(2) Job coaches whether agency or individual provider, must:

(a) be at least 18 years of age;

(b) complete all training requirements by DOH/DDSD;

(c) have a high school diploma or GED; and

(d) pass a national care giver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27a-4 et seq. NMSA 1978 and 8.11.6 NMAC.

K. Qualifications of environmental modifications providers: Environmental modification providers must possess an appropriate plumbing, electrician, contractor license; appropriate technical certification to perform the modification; and, hold a current business license issued by the state, county or city government.

L. Qualifications of non-medical transportation providers: Individual transportation providers must possess a valid New Mexico driver's license with the appropriate classification, be free of physical or mental impairment that would adversely affect driving performance, have no driving while intoxicated (DWI) convictions or chargeable (at fault) accidents within the previous two years, have a current insurance policy and vehicle registration. Transportation vendors must hold a current business license and tax identification number. Each agency will ensure drivers meet the following qualifications:

(1) be at least 18 years old;

(2) possess a valid, appropriate New Mexico driver's license;

(3) have a current insurance policy and vehicle registration; and

(4) must complete all training requirements as required by DOH/DDSD.

M. Qualifications of respite providers: Respite services may be provided by eligible individual respite providers. Respite provider agencies must hold a current business license, and meet financial solvency, training, records management and quality assurance rules and requirements. In addition, for participant-directed services, the eligible recipient or their representative evaluates training needs based on the needs identified in the ISP and by the recipient, provides or arranges for training, as needed, and supervises the worker. Respite worker must:

(1) be 18 years of age or older;

(2) demonstrate capacity to perform required tasks;

(3) be able to communicate successfully with the eligible recipient;

(4) pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC; and

(5) complete all training requirements as required by DOH/DDSD.

N. Qualifications of vehicle modification providers: Vehicle modification providers must possess an appropriate mechanic or body work license; appropriate technical certification to perform the modification; and, hold a current business license issued by the state, county or city government.

[8.314.7.13 NMAC - N, 4/1/2021]

8.314.7.14 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA: The services covered by the supports waiver are intended to provide a community-based alternative to institutional care for an eligible recipient that allow greater choice, direction and control over services and supports in an agency-based service delivery model or participant directed service delivery model. These services must specifically address a therapeutic, rehabilitative, habilitative, health or safety need that results from the eligible recipient's qualifying condition. The supports waiver is the payor of last resort. The coverage of the services must be in accordance with the supports waiver rules and service standards. Supports waiver services must be provided in an integrated setting and facilitate full access to the community; ensure the eligible recipient receives services in the community to the same degree of access as those individuals not receiving HCBS services; maximize independence in making life choices; be chosen by the eligible recipient in consultation with the guardian as applicable; ensure the right to privacy, dignity, respect, and freedom from coercion and restraint; optimize recipient employment; and facilitate choice of services and who provides them.

A. General requirements regarding supports waiver covered services: To be considered a covered service under the supports waiver, the following criteria must be met. Services, supports and goods must:

(1) directly address the eligible recipient's qualifying condition or disability;

(2) meet the eligible recipient's clinical, functional, medical or habilitative needs;

(3) be designed and delivered to advance the desired outcomes in the eligible recipient's service and support plan; and

(4) support the eligible recipient to remain in the community and reduce the risk of institutionalization.

B. Assistive technology: Assistive technology (AT) is an item, piece of equipment, or product system used to increase, maintain, or improve functional capabilities. AT services allow for the evaluation and purchase of the AT based on the needs of the eligible recipient and, not covered through the eligible recipient's state plan benefits. Evaluation of the assistive technology needs of the participant include a functional evaluation of the impact of the provision of the appropriate assistive technology to the participant. Services consist of selecting, designing, fitting, customization, adapting, applying, maintaining, and repair or repairing assistive technology devices. AT services also include 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. AT includes remote personal support technology. Remote personal support technology is an electronic device or monitoring system that supports eligible recipients to be independent in their home or community. This service may provide up to 24-hour alert, monitoring or personal emergency response capability, prompting or in-home reminders, or monitoring for environmental controls for independence through the use of technologies. Remote monitoring is prohibited in eligible recipient's bedrooms and bathrooms. This service is not intended to provide for paid, in-person on-site response. On-site response must be planned through back up plans that are developed using natural or other paid supports. Assistive technology services are limited to five thousand dollars ($5,000) every five years.

C. Behavior support consultation: Behavior support consultation services consist of functional support assessments, treatment plan development, and training and support coordination for the eligible recipient related to behaviors that compromise the eligible recipient's quality of life.

D. Community supports coordinator: Community support coordination services are intended to educate, guide and assist the eligible recipient to make informed planning decisions about services and supports, and monitor those services and supports. Specific waiver function(s) that CSC providers have are:

(1) monitor service delivery and conduct face-to-face visits including home visits at least quarterly;

(2) complete process to evaluate/re-evaluate level of care (medical eligibility);

(3) educate, train and assist eligible recipient (and guardian, employer of record) about participant direction or agency-based service delivery models (includes adherence to standards, review of rights, recognizing and reporting critical incidents);

(4) provide support and assistance during the medical and financial eligibility process;

(5) develop the person-centered plan with the eligible recipient; to include revising the plan as needed;

(6) serve as an advocate for the eligible recipient to enhance their opportunity to be successful with participant-direction or agency-based program; and

(7) supports the recipient with identifying resources outside of the supports waiver that may assist with meeting the recipient's needs.

E. 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 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. Customized community support services provide help to the individual to schedule, organize and meet expectations related to chosen community activities. All services are provided in a community setting with the focus on community exploration and true community inclusion.

F. Customized community supports group: Customized community supports 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 may include adult day habilitation, adult day health and other day support models. Customized community supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings.

G. Employment support: Individual community integrated employment offers one-to-one support to an eligible recipient placed in inclusive jobs or self-employment in the community and support is provided at the worksite as needed for the eligible recipient to learn and perform the tasks associated with the job in the workplace. The provider agency is encouraged to develop natural supports in the workplace to decrease the reliance of paid supports.

H. Environmental modifications: Services include the purchase and installation of equipment or making physical adaptations to an eligible recipient's residence that are necessary to ensure the health, welfare and safety of the eligible recipient or enhance the eligible recipient's level of independence.

(1) adaptations include: installation of ramps; widening of doorways and hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; installation of lifts or elevators; modification of bathroom facilities such as roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing; turnaround space adaptations; specialized accessibility and safety adaptations or additions; trapeze and mobility tracks for home ceilings; automatic door openers or doorbells; voice-activated, light-activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating or cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems or signaling devices;

(2) environmental modifications are limited to five thousand dollars ($5000) every five years;

(3) all services shall be provided in accordance with federal, state, and local building codes;

(4) excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the eligible recipient, such as fences, storage sheds, or other outbuildings. Adaptations that add to the square footage of the home are excluded for this benefit except when necessary to complete an adaptation.

I. Personal care services: Personal care services are provided on an intermittent basis to assist an eligible recipient 21 years and older 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 eligible recipient to accomplish tasks he or she would normally do for themselves if they did not have a disability. Personal care direct support services are provided in the eligible recipient's own home and in the community, depending on the eligible recipient's needs. The eligible recipient identifies the personal care direct support worker's training needs through the ISP in addition to required training, and, if the eligible recipient or EOR for the participant directed service delivery model or agency is unable to do the training for themselves, the eligible recipient or EOR for the participant directed service delivery model or agency arranges for the needed training. Supports shall not replace natural supports available such as the eligible recipient's family, friends, and individuals in the community, clubs, and organizations that are able and consistently available to provide support and service to the eligible recipient. Personal care services are covered under the medicaid state plan as enhanced early and periodic screening, diagnostic and treatment (EPSDT) benefits for supports waiver eligible recipients under 21 years of age and are not to be included in an eligible recipient's AAB.

J. Non-medical transportation: Transportation services are offered to enable eligible recipients to gain access to services, activities, and resources, as specified by the ISP. Transportation services under the waiver are offered in accordance with the eligible recipient's ISP. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the medicaid state plan are to transport eligible recipients to medically necessary physical and behavioral health services. Payment for supports waiver transportation services is made to the eligible recipient's individual transportation provider or employee or to a public or private transportation service vendor. Payment cannot be made to the eligible recipient. Non-medical transportation services for minors is not a covered service as these are services that a legally responsible individual (LRI) would ordinarily provide for household members of the same age who do not have a disability or chronic illness. Payment cannot be made to the eligible recipient. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge shall be identified in the ISP and utilized.

K. Vehicle modifications: Vehicle adaptations or alterations to an automobile or van that is the eligible recipient's primary means of transportation in order to accommodate the special needs of the eligible recipient. Vehicle adaptations are specified by the service plan as necessary to enable the eligible recipient to

integrate more fully into the community and to ensure the health, welfare and safety of the eligible recipient. The vehicle that is adapted may be owned by the eligible recipient, a family member with whom the eligible recipient lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the eligible recipient and is not a paid provider of services. Vehicle modifications are limited to five thousand dollars ($5000) every five years. Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services. Vehicle accessibility adaptations consist of installation, repair, maintenance, training on use of the modifications and extended warranties for the modifications. The following are specifically excluded:

(1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the eligible recipient;

(2) purchase or lease of a vehicle; and

(3) regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

L. Respite: Respite is a family support service, the primary purpose of which is to give the primary, unpaid caregiver time away from their duties on a short-term basis. Respite services include assisting the eligible recipient with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities; assisting the eligible recipient to enhance self-help skills, leisure time skills and community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the eligible recipient to make their own choices with regard to daily activities. Respite services are furnished on a short-term basis and can be provided in the eligible recipient's home, the provider's home, or in a community setting of the family's choice (e.g., community center, swimming pool and park).

[8.314.7.14 NMAC - N, 4/1/2021]

8.314.7.15 NON-COVERED SERVICES: The waiver does not pay for the purchase of goods or services that a household without a person with a disability would be expected to pay for as a routine household or personal expense. If the eligible recipient requests a specific good or service, the CSC and the state can work with the eligible recipient to find other, including less costly, alternatives. Non-covered services include, but are not limited to the following:

A. Services covered by the medicaid state plan (including EPSDT), MAD school-based services, medicare and other third parties.

B. Any service or good, the provision of which would violate federal or state statutes, regulations or guidance.

C. 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.

D. Food and shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing, maintenance, utilities and utility deposits, and related administrative expenses; utilities include gas, electricity, propane, firewood, wood pellets, water, sewer, and waste management.

E. Experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC.

F. Any goods or services that are to be used for recreational or diversional purposes.

G. Personal goods or items not related to the disability.

H. Animals and costs of maintaining animals including the purchase of food, veterinary visits, grooming and boarding except for training and certification for service dogs.

I. Gas cards and gift cards.

J. Purchase of insurance, such as car, health, life, burial, renters, homeowners, service warranties or other such policies.

K. Purchase of a vehicle, and long-term lease or rental of a vehicle.

L. Purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items.

M. Firearms, ammunition or other weapons.

N. Vacation expenses, including airline tickets, cruise ship or other means of transport, guided.

O. Meals, hotel, lodging or similar recreational expenses.

P. Purchase of usual and customary furniture and home furnishings, *unless* adapted to the eligible recipient's disability or use, or of specialized benefit to the eligible recipient's condition; requests for adapted or specialized furniture or furnishings must include a recommendation from the eligible recipient's health care provider and, when appropriate, a denial of payment from any other source.

Q. 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 eligible recipient's qualifying condition or disability.

R. 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 eligible recipient's qualifying condition or disability; requests must include documentation that the adapted vehicle is the eligible recipient's primary means of transportation.

S. Clothing and accessories, except specialized clothing based on the eligible recipient's disability or condition.

T. Training expenses for paid employees.

U. Costs associated with such conferences or class cannot be covered, including airfare, lodging or meals; consumer electronics such as computers, printers and fax machines, or other electronic equipment that does not meet the criteria specified in Subsection A of 8.314.6.14 NMAC; no more than one of each type of item may be purchased at one time; and consumer electronics may not be replaced more frequently than once every three years.

V. Cell phone services that include fees for data unless data is for an app specifically approved through supports waiver funds; or more than one cell phone line per eligible recipient.

[8.314.7.15 NMAC - N, 4/1/2021]

8.314.7.16 INDIVIDUAL SERVICE PLAN (ISP) AND AUTHORIZED ANNUAL BUDGET(AAB): An ISP and an AAB request are developed at least annually by the eligible recipient in collaboration with the eligible recipient's CSC and others that the eligible recipient invites to be part of the process. The CSC serves in a supporting role to the eligible recipient, assisting the eligible recipient to understand the supports waiver program, and with developing and implementing the ISP and the AAB. The ISP and annual budget request are developed and implemented as specified in 8.314.7. NMAC and supports waiver service standards and submitted to the TPA or MAD's designee for final approval. Upon final approval the annual budget request becomes an AAB.

A. ISP development process: For development of the person-centered service plan, the planning meetings are scheduled at times and locations convenient to the eligible recipient. This process obtains information about eligible recipient strengths, capacities, preferences, desired outcomes and risk factors through the LOC assessment process and the planning process that is undertaken between the CSC and eligible recipient to develop their ISP.

(1) Assessments:

(a) assessment activities that occur prior to the ISP meeting assist in the development of an accurate and functional plan. The functional assessments conducted during the LOC determination process address the following needs of a person: medical, behavioral health, adaptive behavior skills, nutritional, functional, community/social and employment;

(b) assessments occur on an annual basis or during significant changes in circumstance or at the time of the LOC determination. After the assessments are completed, the results are made available to the eligible recipient and their CSC for use in planning;

(c) the eligible recipient and the CSC will assure that the ISP addresses the information and concerns, if any, identified through the assessment process.

(2) Pre-planning:

(a) the CSC contacts the eligible recipient upon their choosing enrollment in the supports waiver program to provide information regarding this program, including the range and scope of choices and options, as well as the rights, risks, and responsibilities associated with participation in the supports waiver;

(b) the CSC discusses areas of need to address on the eligible recipient's ISP. The CSC provides support during the annual re-determination process to assist with completing medical and financial eligibility in a timely manner;

(3) ISP components: The ISP contains:

(a) the supports waiver services that are furnished to the eligible recipient, the projected amount, frequency and duration, and the type of provider who furnishes each service;

(i) the ISP must describe in detail how the services or goods relate to the eligible recipient's qualifying condition or disability;

(ii) the ISP must describe how the services and goods support the eligible recipient to remain in the community and reduce their risk of institutionalization; and

(iii) the ISP must specify the hours of services to be provided and payment arrangements.

(b) other services needed by the supports waiver eligible recipient regardless of funding source, including state plan services;

(c) informal supports that complement supports waiver services in meeting the needs of the eligible recipient;

(d) methods for coordination with the medicaid state plan services and other public programs;

(e) methods for addressing the eligible recipient's health care needs when relevant;

(f) quality assurance criteria to be used to determine if the services and goods meet the eligible recipient's needs as related to their qualifying condition or disability;

(g) information, resources or training needed by the eligible recipient and service providers;

(h) methods to address the eligible recipient's health and safety, such as emergency and back-up services.

(4) Individual service plan meeting:

(a) the eligible recipient receives a LOC assessment and local resource manual and person-centered planning documents prior to the ISP meeting;

(b) the eligible recipient may begin planning and drafting the ISP utilizing those tools prior to the ISP meeting;

(c) during the ISP meeting, CSC assists the eligible recipient to ensure that the ISP addresses the eligible recipient's goals, health, safety and risks. The eligible recipient and their CSC will assure that the ISP addresses the information, goals and concerns identified in the person-centered planning process. The ISP must address the eligible recipient's health and safety needs before addressing other issues. The CSC ensures that:

(i) the planning process addresses the eligible recipient's needs and goals in the following areas: health and wellness and accommodations or supports needed at home and in the community;

(ii) services selected address the eligible recipient's needs as identified during the assessment process; needs not addressed in the ISP will be addressed outside the supports waiver program;

(iii) the outcome of the assessment process for assuring health and safety is considered in the plan;

(iv) services do not duplicate or replace those available to the eligible recipient through the medicaid state plan or other programs;

(v) services are not duplicated in more than one service code;

(vi) job descriptions are complete for each provider and employee in the plan; a job description will include frequency, intensity and expected outcomes for the service;

(vii) the quality assurance section of the ISP is complete and specifies the roles of the eligible recipient, community supports coordinator and any others listed in this section;

(viii) the responsibilities are assigned for implementing the plan;

(ix) the emergency and back-up plans are complete; and

(x) the ISP is submitted to the TPA after the ISP meeting, in compliance with supports waiver rules and service standards.

B. ISP review criteria: Services and related goods identified in the eligible recipient's requested ISP may be considered for approval if the following requirements are met:

(1) the services or goods must be responsive to the eligible recipient's qualifying condition or disability and must address the eligible recipient's clinical, functional, medical or habilitative needs; and

(2) the services or goods must accommodate the eligible recipient in managing their household; or

(3) the services or goods must facilitate activities of daily living;

(4) the services or goods must promote the eligible recipient's personal health and safety; and

(5) the services or goods must afford the eligible recipient an accommodation for greater independence; and

(6) the services or goods must support the eligible recipient to remain in the community and reduce his/her risk for institutionalization; and

(7) the services or goods must be documented in the ISP and advance the desired outcomes in the eligible recipient's ISP; and

(8) the ISP contains the quality assurance criteria to be used to determine if the service or goods meet the eligible recipient's need as related to the qualifying condition or disability; and

(9) the services or goods must decrease the need for other MAD services; and

(10) the eligible recipient receiving the services or goods does not have the funds to purchase the services or goods; or

(11) the services or goods are not available through another source; the eligible recipient must submit documentation that the services or goods are not available through another source, such as the medicaid state plan or medicare; and

(12) the service or good is not prohibited by federal regulations, NMAC rules, billing instructions, standards, and manuals; and

(13) each service or good must be listed as an individual line item whenever possible; however, when a service or a good are 'bundled' the ISP must document why bundling is necessary and appropriate.

C. Budget review criteria: The eligible recipient'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 supports waiver IBA;

(2) the rate for each service is included;

(3) the proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good;

(4) the estimated cost of the service or good is specifically documented in the eligible recipient's budget worksheets; and

(5) no employee exceeds 40 hours paid work in a consecutive seven-day work week.

D. Modification of the ISP:

(1) The ISP may be modified based upon a change in the eligible recipient's needs or circumstances, such as a change in the eligible recipient's health status or condition or a change in the eligible recipient's support system, such as the death or disabling condition of a family member or other individual who was providing services.

(2) If the modification is to provide new or additional services than originally included in the ISP, these services must not be able to be acquired through other programs or sources. The eligible recipient must document the fact that the services are not available through another source. The new or additional services are subject to utilization review for medical necessity and program requirements as per 8.314.7.17 NMAC.

(3) The CSC initiates the process to modify the ISP by forwarding the request for modification to the TPA for review.

(4) The ISP must be modified before there is any change in the AAB.

(5) The ISP may be modified once the original ISP has been submitted and approved. Only one ISP revision may be submitted at a time, e.g.; an ISP revision may not be submitted if an initial ISP request or prior ISP revision request is under initial review by the TPA. This requirement also applies to any re-consideration of the same revision request. Other than for critical health and safety reasons, neither the ISP nor the AAB may be modified within 60 calendar days of the expiration of the current ISP.

[8.314.7.16 NMAC - N, 4/1/2021]

8.314.7.17 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services, including services covered under the supports waiver program, are subject to utilization review for medical necessity and program requirements. Reviews by MAD or its designees may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made in accordance with 8.310.2 NMAC.

A. Prior authorization: Services, supports, and goods specified in the ISP and AAB require prior authorization from HSD/MAD or its designee. The ISP must specify the type, amount and duration of services. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: To be eligible for supports waiver program services, eligible recipients must require the LOC of services provided in an ICF-IID. Prior authorization of services does not guarantee that applicants or eligible recipients are eligible for medical assistance program (MAP) or supports waiver services.

C. Reconsideration: If there is a disagreement with a prior authorization denial or other review decision, the community supports coordinator provider on behalf of the eligible recipient, can request reconsideration from the TPA that performed the initial review and issued the initial decision. Reconsideration must

be requested within 30-calendar days of the date on the denial notice, must be in writing and provide additional documentation or clarifying information regarding the eligible recipient's request for the denied services or goods.

D. Denial of payment: If a service, support, or good is not covered under the supports waiver program, the claim for payment may be denied by MAD or its designee. If it is determined that a service is not covered before the claim is paid, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

[8.314.7.17 NMAC - N, 4/1/2021]

8.314.7.18 RECORDKEEPING AND DOCUMENTATION RESPONSIBILITIES: Service providers and vendors who furnish goods and services to supports waiver eligible recipients are reimbursed by the financial management agency (FMA) and must comply with all applicable New Mexico administrative code (NMAC), medical assistance division (MAD) rules and service standards. The FMA, community supports coordinators (CSC) and service providers must maintain records, which are sufficient to fully disclose the extent and nature of the goods and services provided to the eligible recipients, as detailed in applicable NMAC, MAD provider rules and comply with random and targeted audits conducted by MAD and department of health (DOH) or their audit agents. MAD or its designee will seek recoupment of funds from service providers when audits show inappropriate billing for services. Supports waiver vendors who furnish goods and services to supports waiver eligible recipients and bill the FMA must comply with all MAD provider participation agreement (PPA) requirements and NMAC, MAD rules and requirements, including but not limited to 8.310.2 NMAC and 8.321.2 NMAC and 8.302.1 NMAC.

[8.314.7.18 NMAC - N, 4/1/2021]

8.314.7.19 REIMBURSEMENT: Health care to MAP eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD.

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

B. Participant directed service delivery model provider and vendor reimbursement: Supports waiver eligible recipients must follow all billing instructions provided by the FMA to ensure payment of service providers, employees, and vendors. Claims must be billed to the FMA per the billing instructions. Reimbursement to a service provider and a vendor in the supports waiver program is made, as follows:

(1) supports waiver service provider and vendor must enroll with the FMA;

(2) the eligible recipient receives instructions and documentation forms necessary for a service provider's and a vendor's claims processing;

(3) an eligible recipient must submit claims for payment of their supports waiver service provider and vendor to the FMA for processing; claims must be filed per the billing instructions provided by the FMA;

(4) the eligible recipient and their supports waiver service provider and vendor must follow all FMA billing instructions; and

(5) reimbursement of a supports waiver service provider and vendor is made at a predetermined reimbursement rate by the eligible recipient with the supports waiver service provider or vendor, approved by the TPA contractor, and documented in the ISP and in the supports waiver provider or vendor agreement; at no time can the total expenditure for services exceed the eligible recipient's AAB;

(6) the FMA must submit claims that have been paid by the FMA on behalf of the eligible recipient to the MAD fiscal contractor for processing; and

(7) reimbursement may not be made directly to the eligible recipient, either to reimburse them for expenses incurred or to enable the eligible recipient to pay a service provider directly.
[8.314.7.19 NMAC - N, 4/1/2021]

8.314.7.20 RIGHT TO AN HSD ADMINISTRATIVE HEARING:

A. The human services department/medical assistance division (HSD/MAD) must grant an opportunity for an administrative hearing as described in this section in the following circumstances and pursuant to 42 CFR Section 431.220(a)(1), Section 27-3-3 NMSA 1978 and 8.352.2 NMAC *Recipient Hearings*:

(1) when a supports waiver applicant has been determined not to meet the LOC requirement for waiver services;

(2) when a supports waiver applicant has not been given the choice of HCBS as alternative to institutional care;

(3) when a supports waiver applicant is denied the services of their choice or the provider of their choice;

(4) when a supports waiver recipient's services are denied, suspended, reduced or terminated;

(5) when a supports waiver recipient has been involuntarily terminated from the program; or

(6) when a supports waiver recipient's request for a budget adjustment has been denied.

B. DOH and its counsel, if necessary, shall participate in any fair hearing involving an eligible recipient. HSD/MAD, and its counsel, if necessary, may participate in fair hearings.
[8.314.7.20 NMAC - N, 4/1/2021]

8.314.7.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to eligible recipients who request an HSD administrative hearing within the timeframe defined in 8.352.2 NMAC. The notice will include information on the right to continued benefits and on the eligible recipient's responsibility for repayment if the hearing decision is not in the eligible recipient's favor. See 8.352.2 New Mexico administrative code (NMAC) for a complete description of the continuation of benefits process of an HSD administrative hearing for an eligible recipient.

B. The continuation of benefit is only available to an eligible recipient that is currently receiving the appealed benefit. The eligible recipient's current AAB and ISP at the time of the request is termed a 'continuation' of benefits. The continuation budget may not be revised until the conclusion of the fair hearing process.
[8.314.7.21 NMAC - N, 4/1/2021]

8.314.7.22 GRIEVANCE/COMPLAINT SYSTEM: An eligible recipient has the opportunity to register grievances or complaints concerning the provision of services under the supports waiver program. Eligible recipients may register complaints with either HSD/MAD or DOH/DDSD via e-mail, mail or phone. Complaints will be referred to the appropriate department for resolution. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing.
[8.314.7.21 NMAC - N, 4/1/2021]

HISTORY OF 8.314.7 NMAC: [RESERVED]