



CLINICAL REVIEW AND CLINICAL/SERVICE CRITERIA V6

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INTRODUCTION TO VERSION 6

The Clinical Criteria was first implemented in October 2015. This version contains updates that:

- Align the Clinical Criteria to DD Waiver Standards effective 11/01/2021;
 - Removal of Individual Intensive Behavioral Supports (IIBS));
 - Increased limit on Assistive Technology from \$250 to \$500;
 - Increased limit on Non-Medical Transportation from \$750 to \$810;
- Include review of child budgets;
- Detail the clinical review versus validation;
- Incorporation of the frequency of clinical reviews into V6

ABOUT THE DEVELOPMENTAL DISABILITIES WAIVER

The primary purpose of the DD Waiver is to support persons to live the life they prefer in the community of their choice, and to gain increased community involvement and independence in accordance with their personal and cultural preferences. It comes from the knowledge that people with Intellectual/Developmental Disabilities (I/DD) learn, grow, and contribute to their community throughout their life.

DD Waiver services are intended to enhance, not replace, already existing supports the person has in their life. Natural supports and services normally utilized by the community at large shall be preferred over specialized services in assisting individuals to reach desired outcomes; when specialized services are necessary, they shall take place in natural settings whenever possible.

Medicaid State Plan benefits should always be considered before DD Waiver paid services and supports.

PERSON CENTERED PLANNING (PCP)

Person-centered planning involves identifying what is *important to and for the person*, and is an on-going and evolving process. The person with intellectual and developmental disabilities has choices in and ownership of the planning process and this should be reflected in the ISP. If the person is unable to independently communicate, the team shall use observed preferences and consultation with close friends, family members, guardians, direct support personnel and advocates to guide decisions.

Additionally, the waiver recipient, and his or her chosen supports, direct the development of the ISP and Budget Worksheet. All IDT members play an important role in this process. Successful individualized planning starts from and builds upon individual and family strengths, interests, preferences, and assessed support needs, not deficits or perceived barriers of what a person cannot do or accomplish.

All persons have strengths and interests and are capable of growth and development at their own individual pace. Individuals with I/DD live in and are contributing members of their community in the same manner as any other person of like age and interest. Furthermore, all working age adults with developmental disabilities are capable and should be afforded the opportunity and right to work with the appropriate supports as needed. Individualized planning must be flexible and responsive to changing circumstances and environments. All team discussions and planning must occur with the understanding that people with I/DD have the same basic legal, civil and human rights as other citizens and a person's choice of dignity of risk should be incorporated into all plans.

INDIVIDUAL SERVICE PLAN (ISP) AND PLANNING PROCESS

The team identifies what the person wants for their life. This information is distilled into Vision Statements, sorted by life areas. The individual's long-term Vision Statements guide professional assessments, specialized planning, plan implementation, and service evaluation. In addition, the person's Vision Statements, and other types of information, (e.g. professional assessments, diagnostic information, risk assessments, and psychosocial stressors) help inform the team about what type of support (paid and non-paid) the person will need to achieve his or her Visions. All the above information should support the request for paid services. Supports and services are provided *only* to the extent there is a demonstrated individual need and link to the ISP.

Please Note: For children, utilize the Children's ISP document.

The Child ISP includes the following components that serve as a guide in the person-centered planning process:

1. Life Experiences:

- a. ISP Life Experience section must capture any background information such as prenatal, birth and early childhood history, successful past experiences, and major life events. A Description of what is important to the child and family's life, (e.g., personal, cultural, spiritual). This area is where information related to personal challenges and obstacles can ensure that there is focus on the nature and quality of individual experiences. The individual, guardian and IDT must work together to determine opportunities for activities and experiences which provides an opportunity for the individuals to explore new experiences in the community to determine interests, abilities, skills and needs.

2. The Individual's Definition of a Meaningful day:

- a. The ISP's section of a Meaningful day must capture a summary description of what is meaningful to the child during a typical day, week, month and year at home, school and in the community. This section should capture what is

- meaningful to the individual above and beyond the realm of the DD Waiver
- b. and should capture what the individual does and hopes to achieve in order to have a meaning in life. This section can include any purposeful and meaningful work, substantial and sustained opportunity for optimal health, self-empowerment, personalized relationships, skill development and/or maintenance as well as social, educational, and community inclusion activities that are directly linked to the Vision, Desired Outcomes and Action plans found throughout the ISP.
3. Early Childhood or Preschool Recreational Programs and School, History (This section would only apply to children 3-14 years of age) and School, Work and/or Volunteer History (This section would apply to older children 14-18 years of age and young adults including transition from school to work).
 - a. This ISP's section would describe the individual's successes and goals in school (past and/or current), including his/her areas of interest (e.g., favorite subjects and activities) and particular learning style. Any school based vocational training, life skill training, transitional plan and date of DVR referral must be provided in this section. This section should include information about the individual's interests concerning future education, volunteer, and/or work opportunities.
 4. Relationships: Who is in the Child's life?
 - a. The Relationship section of the ISP is to identify important relationships in the individual's life. This section must include family, friends, classmates, community supports and specialized supports. This section assists the IDT in developing and/or maintaining social, spiritual and individual relationships, including the development of generic and natural supports of the person's choosing.
 5. Health and Safety:
 - a. The Health and safety section of the ISP helps identify significant health/medical/behavioral/environmental concerns (past and present) that impact the individuals health and safety. This section should include the efforts made to ensure the individuals health and safety. Dignity of Risk is balanced with the person's ability to assume responsibility for that risk and a reasonable assurance of health and safety.
 6. Strengths, Gifts, Preferences, and Interests:
 - a. The strengths, gifts, preferences and interests describe what makes the individual unique. This section should include detailed information about talents, interests, and strengths and should also include favorite activities, entertainment, toys/games, sports, recreational opportunities, routines etc. This section is designed to identify the strengths, capacities, preferences,

- needs and goals of the individual as well as identifying potential barriers.
7. Services Provided other than DD Waiver:
 - a. In order to receive other services that are not covered under the DD Waiver, additional referrals are required. This section of the ISP must include dates of referrals made by DD waiver CM, type of services received including funding source, total hours services are being provided, a brief summary of therapy goals/IEP goals when applicable and references to supporting therapy reports included in the DD Waiver CM file.
 8. Services Provided by the DD Waiver
 - a. The Services Provided by the DD Waiver section of the ISP must capture DD Waiver Services. DD Waiver Services are only available to individuals under the age of 21 to the extent that they are different from and do not duplicate services offered under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, Medicaid School Based Services, services offered by the New Mexico State Department of Education, or services offered through the Early Childhood Education and Care Department- Family Infant Toddler Program.

The Adult ISP includes the following components that serve as a guide in the person-centered planning process:

1. Life Experiences:
 - a. The Life Experiences section of the ISP must include background information, including successful past experiences and major life events. This section must describe what life is like now and important relationships. It must also include a description of the individual's values and beliefs that have resulted from these life experiences (e.g., personal, cultural, spiritual, political). Be sure to include information regarding personal challenges when applicable. The IDT must ensure that this section does not duplicate information for other sections on work, education, health and safety, strengths/gifts, preferences, and hobbies.
2. Description of What is Meaningful to This Individual (Meaningful Day Definition):
 - a. Describe age-appropriate choices and activities (with approximate frequencies) that the individual finds meaningful in their life. This section must include such things as purposeful desired work, opportunities for optimal health, self-empowerment, memberships, desired skill development, social, education and community inclusion activities, valued roles, new things to try and hobbies. This description may be broader than the individual's vision statements but should support progress toward achieving the vision and desired outcomes. Individuals receiving

Customized Community Supports are required to have a Person-Centered Assessment (PCA)

3. Work, Education, and/or Volunteer History:

- a. This section will include individual's successes and goals in school (past and/or current), including his/her areas of interest (e.g., favorite subjects and activities) and learning style. It must include detailed information about the individual's complete volunteer and paid work history. The ISP should include any awards or certifications the individual has received. This section must be reviewed annually to update/integrate vocational assessments into the ISP. Individuals receiving Supported Employment are required to have a Person-Centered Assessment (PCA).

4. Health and Safety:

- a. The Health and Safety section of the ISP must provide a summary about significant health/medical/dental/behavioral/environmental concerns (past and present) and diagnosis(es) that have implications for planning or impact on the individual's health and safety, including what has been done to date to address these concerns. If the person's health or skills are regressing, include that information in this section.

5. Strengths, Gifts, Preferences, and Hobbies

- a. The strengths, gifts, preferences, and interests describe what makes the individual unique. This section should include individual's talents, hobbies, interests, strengths, gifts, preferences as well as what works for and motivates the individual.

The above describe sections of the ISP that helps to develop the Vision Statements, Desired outcomes, and Teaching Support Strategies. Below is information that should be included in the vision statements, desired outcomes, and teaching support strategies:

1. Vision Statements

ISPs should have Vision Statements for each life area based on what the person wants for their life. Visions should reflect results which can be reached within one to three years. The ISP shall describe reasonable accommodations and supports to assist the individual in the realization of the individual's vision(s). Vision Statements are required for each life area for which the person receives paid services. Vision Statements should not be repeated verbatim from one plan to the next. Visions should change or be modified to reflect the growth of the person. An exception to this rule, however, would be if the Vision has not been accomplished at all, despite documented clear and consistent work towards the Vision, and/or the Vision Statement is still the desired dream of the individual.

2. Desired Outcomes

All planning shall focus on outcomes or results which the individual wishes to achieve. Paid services and supports should be budgeted last after natural supports are considered. There are no starting assumptions based on models of service; rather, supports are tailored to meet the needs of the individual.

The Interdisciplinary Team (IDT) will complete Vision analysis questions in the ISP to prepare for Outcome development, and then create measurable and meaningful Desired Outcome(s) that support the person's Vision. Outcomes will lead back to each Vision and should be person centered and *not be written to simply justify a particular service delivery model*. If the Outcome does not directly connect to a Vision, the Outcome must be changed.

The plan shall address individual strengths and capabilities in developing action plans and strategies for reaching desired outcomes. Each type of service does not need a separate outcome but should be connected to at least one desired outcome. Some Visions warrant more than one Outcome and some Outcomes tie to more than one Vision. Actions plans delineate which activities will be completed within one year and those which will be detailed in future or plan modifications. Multiple service types may be included in Action Steps under a single Outcome. Multiple providers can and should be contributing action steps toward each Outcome. Action steps should include actions the individual will take; not just actions the staff will do for them.

3. Teaching and Support Strategies

After the ISP meeting, IDT members conduct any task analysis and assessments necessary to create effective Teaching and Supports Strategies (TSS) and Written Direct Support Instructions (WDSI) to support those Action Steps that require this extra detail. All of this should support the individual in achieving their Vision and Desired Outcomes. Each waiver service and support must be related to the ISP.

Linking Services to the ISP:

Visions are developed and Desired Outcomes are identified before identifying DD Waiver service types and service amounts to include on the individual budget. The budget submitted by the CM must focus on the individual needs of the person. Linking services to the ISP may occur in various sections or components of the ISP depending on the type of service requested and the reason for the services including:

- Vision analysis questions,
- Desired Outcomes,
- Action steps, teaching, and support strategies (TSS), behavioral strategies outlined in a Positive Behavior Supports Plan (PBSP) or other

behavioral support plan (e.g., Behavioral Crisis Intervention Plan (BCIP)), and Written Direct Support Instructions (WDSIs),

- Health and Safety section: summary information, implications for planning, impact on health and safety, and
- Meaningful Day

The ISP is revised/updated throughout the year, when necessary, to reflect all budget revisions and should document any changes in the individual's status, supports needed, demographic information, etc.

CLINICAL JUSTIFICATION AND CLINICAL REVIEW

To be considered for a covered service authorized by the Developmental Disabilities (DD) Waiver approved by the Centers for Medicare and Medicaid Services (CMS) the following needs to be justified and met. The service must:

1. Meet the DD Waiver participant's clinical, functional, medical, behavioral or habilitative needs;
2. Promote and afford the DD Waiver participant support for greater independence and
3. Contribute and support the DD Waiver participant to:
 - remain in the community;
 - contribute and engage in the community; and
 - reduce the risk of institutionalization.
4. Address the DD Waiver participant's physical, behavioral, social support needs (not including financial support) that arise as a result of their functional limitations (i.e. self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency) and/or condition; and
5. Relate to the ISP.

CLINICAL DOCUMENTATION

Sufficient information and documentation are required to demonstrate that the request for each DD Waiver service is reasonable, necessary, and appropriate based on the service specific Clinical Criteria established by the DDS. The ISP is required for all service requests. Some service requests also require specific forms and documentation to be completed. If a specific document is not required, the IDT must identify the documents within the individual's case record that would justify the need for the service and service amount according to the Clinical Criteria. Any pertinent and concise supporting information and documentation is acceptable and will be considered. Examples of suggested clinical documentation are:

1. Person Centered Assessment,
2. Provider reports,
3. Adult Nursing Services or Intensive Medical Living Services (IMLS) parameter tool

4. Electronic Comprehensive Health Assessment Tool (e-CHAT), Aspiration Risk Screening Tool (ARST) and Medication Administration Assessment Tool (MAAT)
5. Behavior Support Consultation Positive Behavior Supports Assessments (PBSAs) presented at the annual IDT, Positive Behavior Supports Plans (PBSPs), Behavior Crisis Intervention Plan (BCIPs), PRN Psychotropic Medication Plans (PPMPs), Risk Management Plans (RMPs) currently in place, or Preliminary Risk Screening & Consultation screening reports
6. Therapy (OT, PT, SLP) Documentation Form
7. Clinical notes,
8. Progress notes,
9. IDT meeting minutes,
10. Client Individual Assessment and
11. Level of Care Abstracts.

CLINICAL REVIEW SCHEDULE

A clinical review schedule is published as a supplement to these criteria. The Clinical Review Schedule began on March 1, 2018. For any initial, waiver transfer, or BWS revision received by the C.O.R.E. Team, a full clinical review of the entire budget will be completed. Teams must plan accordingly to ensure the appropriate documentation to demonstrate clinical justification is included in the submission.

1. The typical review schedule is every three years.
2. The services which do not require a clinical review are expanded, e.g., case management.
3. Services characterized by intensive levels of support may be reviewed annually.
4. The number of units requested triggers clinical reviews for specific services.
5. Revisions involving an increase in units may require a clinical review.
6. The separate evaluation units for clinical services have been eliminated.
7. Child Budgets also follow the clinical review schedule.

Validation

The OR uses the prior authorization to validate that a submission does not trigger a clinical review. A validation ensures that the request does not exceed what was previously approved and does not require a clinical review for the entire budget or one or more services.

SERVICE AVAILABILITY BY AGE

Clinical Criteria is applicable to children and adults who are not Jackson Class Members. Children under age 21 who are enrolled in the DD waiver program can access services to the extent that services do not duplicate Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, school-based programs or through the Individuals with Disabilities Education Act (IDEA). The Living Care Arrangements are

available to individuals 18 years old and older.

If the OR review process for a child's budget determines that a child's need for services is less than what the child received under the ARA limit, the OR will approve the child's budget at the previously approved ARA amount to ensure no reduction of budget services.

PROPOSED BUDGET LEVELS AND SUGGESTED BUDGET AMOUNTS FOR ADULTS

Proposed Budget Level (PBL) (1-7) are for adults and are based on the knowledge of the individual's support needs, history and any relevant assessments. PBLs are written descriptions of seven (7) levels of support needs (See Appendix A; Table 1) Linked to each PBL are suggested dollar amounts based on Living Care Arrangements and typical service options (See Appendix A Table 2) which were developed in 2012. Suggested Budget Amounts found in Table 2 and on the Budget Worksheet. The Suggested Budget Amounts are used as a guide for the IDT in understanding what a typical budget amount may look like. However, regardless of the PBL and Suggested Budget Amount, the IDT focuses on the fact that the individual's DD Waiver support needs must be identified through Person Centered Planning and be clinically justified. Budgets may be approved over or under the suggested dollar amount. The Outside Reviewer does not approve PBLs.

CHANGES IN SERVICE PROVIDER AGENCIES

The Case Manager is responsible for completing and/or submitting a budget revision for any provider agency changes. If there is not an increase in units, the Outside Reviewer may complete a validation of the units and approve the revision without the need for a clinical review. There is no need to request further documentation if the requested units have already gone through the clinical review process and have been approved during a prior annual or revision budget submission.

CLINICAL CRITERIA

The IDT must compile and attach any documents necessary to justify the requested services and supports. The following is the DDS DD Waiver Service/Clinical Criteria.

ASSISTIVE TECHNOLOGY

Assistive Technology (AT) service 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 outlined in the ISP, increase functional participation in employment, community activities, activities of daily living, personal interactions, and/or leisure activities, or increase the individual's safety during participation of the functional activity.

Assistive Technology services allow individuals to purchase needed items to develop low-tech augmentative communication, environmental access, mobility systems or



purchase devices for augmentative communication, environmental access, mobility systems and other functional AT, not covered through the individual’s Medicaid State Plan benefits.

Software applications or adaptive devices related to supporting the person’s functional needs and goals for use in daily life and on iPads/tablets, smartphones, and other similar devices used to increase the person’s level of independent functioning can be funded through the AT fund application process.

Purchase of devices (iPads/tablets, smartphones, and other similar devices) used to access remote telehealth services and social/community access may be purchased utilizing AT funds. This may also include mounts, holders, protective cases, screen protectors, warranty, etc.

Adaptive clothing, footwear or accessories that are specifically designed to support the individual’s comfort, social integration and independence may be purchased utilizing AT funds.

The focused use of Assistive Technology (AT) benefits individuals on the waiver program to engage more fully in life through increasing communication, independence, and community access. Increased communication allows the individual to freely express their wishes and supports socialization. AT also supports individuals in the work setting thereby increasing their earning potential and independence.

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

SERVICE	CRITERIA
<p>Assistive Technology Available to Children</p>	<ul style="list-style-type: none"> • The specific AT must relate to a Vision or desired outcome in the Individual Service Plan (ISP); or • The specific AT must support participation or independence during activities such as, but not limited to employment, community activities, leisure activities and activities of daily living, personal interactions, or personal safety during these types of activities. • The cost of shipping and taxes may be included in the purchase price. <p>Frequency of Clinical Reviews</p> <ul style="list-style-type: none"> • Initial • Every request

Additional Required Documentation (ISP is required for all services):

- Budget Based AT Application with its required attachments.
- AT 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 DD Waiver Budget. It is the responsibility of the person completing the AT Fund application to also provide proof of denial or attempts to explore funding from other sources that may be available through insurance, Managed Care Organizations, Division of Vocational Rehabilitation, and/or IDEA if available.

Applicable Limits on Amount, Frequency and Duration:

- Amount available not to exceed \$500.00 inclusive of up to 15% (for purchasing agency only) administrative fees for the AT Purchasing Agency per ISP year.
- Purchase of batteries to power AT devices are limited to \$50.00 per ISP year.
- Items used primarily for sensory stimulation shall not be approved.
 - Items that incorporate a sensory input component are not to be used primarily for sensory stimulation. The items requested need to be related to a therapist plan/Therapy Documentation Form (TDF) objective or outcome and are clinically justified for use that results in improvement in functional performance, participation and/or decrease behavioral incidents with use.
- Devices, materials, or supplies used primarily during therapy services or directed primarily toward a therapeutic outcome such as increasing range of motion shall not be approved.
- Software or equipment directly related to an educational or employment function/need shall not be approved under the DDW because of alternative funding through IDEA or the Division of Vocational Rehabilitation (DVR) if related to school and/or work.
- Software or equipment directly related to an employment function/need should be requested as part of a reasonable accommodation through an employer.
- It is preferred that new AT devices be purchased with the exception of limited fund availability in which a refurbished item can be purchased at the request of the individual/guardian.
- AT funds do not cover incontinence products such as diapers, pull ups or depends, chux or bed pads.
- Items intended to prepare a person for a functional activity rather than perform the functional activity should not be approved.

- The purchase of items or services that are prohibited by federal, state, or local statutes and standards shall not be authorized or reimbursed.

BEHAVIOR SUPPORT CONSULTATION

Behavior Support Consultation (BSC) services for children and adults are intended to enhance the DD Waiver participant’s quality of life by providing positive behavioral supports as the individual (child or adult) works on functional and relational skills. BSC services identify distracting, disruptive, and/or destructive behavior that impact quality of life; and provides specific prevention and intervention strategies to manage and lessen the risks these behaviors present. BSC includes Initial Assessments and Ongoing BSC services which are clinically justified primarily through the Positive Behavioral Supports Assessments. BSC services do not include individual, group, or family therapy, or any other mental health, behavioral health, or other behavior supports and services that would typically be provided through the Medicaid State Plan benefits or through Individuals with Disabilities Education Act (IDEA), Parts B and C.

SERVICE	CRITERIA
<p>Behavior Support Consultation (BSC)</p> <p>Available to Children</p>	<p>Initial BSC Assessments:</p> <ul style="list-style-type: none"> • Recommended by Interdisciplinary Team (IDT) and do not require clinical review. <p>Ongoing BSC: One or more of the following clinical necessity criteria is met for ongoing BSC (information outlined in Positive Behavioral Support Assessment (PBSA):</p> <ul style="list-style-type: none"> • Behavior of concern impacts individual’s ability to retain a baseline level of independence, or <ul style="list-style-type: none"> • For children, the baseline level of independence is also related to the developmental period that the child has obtained. • Behavior of concern interferes with quality of life, or • Behavior of concern involves a health and safety risk needing professional behavioral recommendations to establish a safety net, or • Recommended replacement behavior or skills require BSC to initiate & monitor implementation, or • Interdisciplinary Team (IDT), Direct Support Personnel (DSP), family and or natural supports need specific training in at least one area in clinical necessity criteria, • Exclusion Criteria is not met i.e., BSC is not authorized if recommended behavior change, and skill development can be

	<p>addressed exclusively through:</p> <ul style="list-style-type: none"> • Socialization and Sexuality Education, or • Basic changes to routines, the environment, and safe access to choices, or • Individual or group therapy, or any other mental health or behavioral health services, typically provided through the behavioral health system, e.g., individual, group, or family therapy, or psychiatric assessment and medication management, or • EPSDT or school-based programs (e.g. positive behavioral interventions, strategies and supports provided through the local education authority). <p>BSC Core Amounts are based on one or more of the following:</p> <ul style="list-style-type: none"> • New job or school situation if otherwise in fading status; • New move to a different home or living situation if otherwise in fading status; • New move to a more independent living situation if otherwise in fading status; • Completely new BSC goal for an individual already working with BSC which is related to a new ISP desired outcome or new diagnosis with a BSC related health and safety concern; or • Individual has a severe behavioral or psychiatric condition that makes fading unsafe for self or others. Fading hours are based on one or more of the following: <ul style="list-style-type: none"> • Strategies need to be revised: re-training and monitoring is needed; • The individual is ready to expand upon the previous year’s goal(s) to further enhance their skill or level of independence related to that same goal or set of goals; • Progress has been made on the previous year’s BSC goal(s) but additional consultation and training is needed to achieve consistent successful implementation of strategies; or • Ongoing consultation and monitoring by BSC needed due to a demonstrated health and safety risk if BSC discharged the individual entirely. • Complexity Factor additional units for an individual experiencing certain Complex Service Needs are based on one or more of the following: <ul style="list-style-type: none"> • Mental health diagnosis or severe behavioral or psychiatric condition that is not currently well-managed or severe; puts person at risk for reduced access to community, loss of affiliation, and/or increased likelihood of psychiatric
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hospitalization, criminal justice involvement, or exploitation and abuse;

- Psychiatric and/or psychotropic medication evaluation requiring specialized data collection and analysis;
- Initiation and/or management of behavioral strategies requiring Human Rights Committee approval;
- Ongoing BSC support and associated DSP training needed for specialized and essential instructions supporting focused skill building needs;
- Significant change in psychiatric or medical condition requiring BSC re-assessment, Positive Behavioral Support Plan (PBSP) development or revision, DSP and or family training and monitoring. Aspiration risk management is included in this category to address Comprehensive Aspiration Risk Management Plan (CARMP) requirements; or
- **New Safety Issues:** Development of new significant safety issues that require BSC re-assessment, Positive Behavioral Support Plan (PBSP) development or revision, additional DSP and or family training, and monitoring.
- **New Allocation Factor** additional units are automatically approved to assure that a more comprehensive assessment to acquaint the BSC with the individual is completed when the participant is:
 - Newly allocated to the DD Waiver, or
 - The individual has NOT had BSC for at least two complete budget cycles.
- **Preliminary Risk Screening & Consultation (PRSC) Add On:** Preliminary Risk Screening that indicates the need for a Risk Management Plan (RMP).
- **Crisis Supports Add On:** The individual must be approved for Crisis Supports by the Bureau of Behavioral Supports (BBS) and a description submitted regarding how the BSC intends to utilize the units.

Frequency of Clinical Reviews

- Initial
- Every three years
- Request exceeds 60 hours (240 units) per year for initial requests and new allocations
- Request exceeds 50 hours (200 units) per year for ongoing supports

Additional Required Documentation (ISP is required for all services):

- Positive Behavioral Support Assessment (PBSA) presented at the annual IDT with applicable requested units,

- Positive Behavioral Support Plan (PBSP) currently in place,
- Behavioral Crisis Intervention Plan (BCIP) currently in place and PRN Psychotropic Medication Plan (PPMP) when applicable.
- **For Initial or Ongoing PRSC Add-On:**
 - PRSC Meeting Minutes (that support the request); or
 - PRSC Consultation Note; or
 - PRSC Report Recommending Risk Management Plan; or
 - Current Risk Management Plan.
- **For Crisis Supports Add-On**
 - DD Waiver Crisis Supports prior authorization memo; or
 - State General Fund Authorization memo of crisis staffing; and
 - IDT minutes from crisis IDT.

Applicable Limits on Amount, Frequency and Duration:

- Proposed Core BSC Amounts 1 (Basic), 2 (Moderate), and 3 (Extensive) are suggestion that can be exceeded with clinical justification. (See Appendix B)
- **For 1st PRSC add-on:** Eighty (80 units) can be available for development, training, and monitoring of initial Risk Management Plan.
- Children and young adults who receive counseling or behavioral health services through their local school may also receive BSC services through the DD Waiver; the focus of their PBSP is limited to home and community, rather than the school setting. No more than five hours of service per year may occur in the school setting for school age children and young adults, only for attending IEP meetings and cross-over training.

Ongoing PRSC add on: Forty-eight (48 units) can be available for ongoing revision, training, and monitoring of the Risk Management Plan (RMP) during subsequent year.

Crisis Supports Add On: Up to eighty (80) additional units (up to 40 units per 90-day approvals of Crisis Supports) is available.

CASE MANAGEMENT SERVICES

Case Management Services assist participants in gaining access to needed Developmental Disabilities (DD) Waiver and State Plan services. Case Management services also emphasize and promote the use of natural and generic supports to address a person’s assessed needs. Case Management services are person- centered and intended to support individuals in pursuing their desired life outcomes while gaining independence and access to needed services and supports.

SERVICE	CRITERIA
<p>Case Management Services</p> <p>Available to Children</p>	<p>Frequency of Clinical Reviews</p> <ul style="list-style-type: none"> Clinical review is not required <p>Additional Required Documentation (ISP Required for all Services):</p> <ul style="list-style-type: none"> Not applicable. <p>Applicable Limits on Amount, Frequency and Duration:</p> <ul style="list-style-type: none"> No more than 12 units can be authorized in a single ISP term, no more than 1 monthly unit in a 30-day span can be authorized. Minimum of 4 units per year and a maximum of 12 units per year for Children.

COMMUNITY INTEGRATED EMPLOYMENT SERVICES

The objective of Community Integrated Employment (CIE) is to provide supports to DD Waiver recipients that result in jobs in the community which increase economic independence, self- reliance, social connections, and the ability to grow within a career.

Community Integrated Employment services are geared to place people with disabilities in employment settings with non-disabled co-workers within the general workforce; or assist people in business ownership. This service may include small group employment. People are supported to explore and seek opportunity for career advancement through growth in wages, hours, experience, promotions and/or movement from group to individual employment. People are provided the opportunity to participate in negotiating his/her work schedule, break/lunch times, and leave and medical benefits with his/her employer. Each of these activities is reflected in individual career plans. In other words, a career development plan is required for all job seekers and those who are employed. For those who are employed, the career development plan addresses topics such as a plan to fade paid supports from the worksite or strategies to improve opportunities for career advancement.

Community Integrated Employment: CIE includes Job Development, Short-term Job Coaching, Job Maintenance, Self-Employment, Intensive Community Integrated Employment (ICIE), and CIE- Group models. All the models may incorporate elements of customized employment, which includes job carving, job restructuring, and negotiated responsibilities. Reasonable accommodations are essential to employment, when needed. A Community Inclusion Aide may be provided to assist individuals with personal care needs related to ADLs in individual community employment settings when natural supports are not available. Services must be provided in a way that does not embarrass, disrespect, or restrict a person from making friendships and co-worker relationships. Natural/peer supports should be explored and encouraged in order to potentially fade the paid supports. Fading paid

supports is most successful when natural/peer supports are in place and stable.

Clinical reviewers at the OR apply Clinical Criteria to determine what CIE-Group category is most appropriate for each individual. The CIE- Group rate categories are designed to allow for providers to adjust staffing patterns and ratios throughout the day to accommodate basic to moderate and more extensive support needs. Under each rate category minimum staffing ratios are required, and individualized attention may also be needed at times within the group model.

The CIE – Group rates were developed to allow for the following staffing ratio requirements based on individual need:

1. **CIE Group Category 1:** While individuals may require one-to-one attention, they are supported in a group with a staffing ratio of no more than six service recipients per direct support professional.
2. **CIE Group Category 2 Extensive Support** While individuals may require one-to-one attention, they are never supported in a group with a staffing ratio of more than four service recipients per direct support professional.

If Clinical Criteria is not met for a higher rate category, the Outside Reviewer has the authority to lower the category on the Budget Worksheet and approve if justified.

SERVICE	CRITERIA
<p>Community Integrated Employment Services</p>	<ul style="list-style-type: none"> Job Development Desire to work, job placement, or a job offer pending job coaching: Work section of the ISP to include a Vision Statement for “Work/Learn” and a related desired outcome for employment. Requests to utilize the DD Waiver for job development must have prior written approval by DDS. Failure to follow partner agency requirements does not constitute justification for services being otherwise unavailable (i.e., does not want to use these services, missing appointments, etc.) <p>Frequency of Clinical Reviews</p> <ul style="list-style-type: none"> Initial Annually <p>Short Term Job Coaching:</p> <ul style="list-style-type: none"> A newly acquired job, a new job task/skill, to maintain employment or a job offer pending: Work section of the ISP to include a Vision

Community Integrated Employment Services
(continued)

Statement for “Work/Learn” and a related desired outcome for employment.

- Requests to utilize the DD Waiver for short-term job coaching services must have prior written approval by DDS.
- Failure to follow partner agency requirements, such as Department of Vocational Rehabilitation (DVR), does not constitute justification for services being otherwise unavailable (i.e. does not want to use these services, missing appointments, etc.)

Frequency of Clinical Reviews

- Initial
- Annually

Job Maintenance:

- Currently working: Work section of the ISP to include a Vision Statement for “Work/Learn” and a desired outcome for employment; and
- Currently working and receiving a minimum of four (4) hours of supports per month.

Frequency of Clinical Review

- Initial
- Annually
- No more than 1 monthly unit in a 30-day span can be authorized.

CIE Self-Employment:

- Desire to work: Work section of the ISP to include a Vision Statement for “Work/Learn” and a desired outcome for employment.
- Requests to utilize the DD Waiver for initial Self-Employment for business start- up must have prior written approval by DDS.
- Currently working: Work section of the ISP to include a Vision Statement for “Work/Learn” and a related desired outcome for employment.

Frequency of Clinical Review

- Initial
- Annually

Job Aide/Community Inclusion Aide

- ISP to include a Vision Statement for “Work/Learn” and a desired outcome for employment; and
- Currently working in CIE, and
- Documented need for assistance with Activities of Daily Living (ADLs) and/or assistance integration into the work culture in the ISP.

Frequency of Clinical Review

- Clinical Review is not required.

Community Integrated Employment Services
(continued)

- Intensive- CIE (ICIE)**
- Must have CIE Job Maintenance on the most current budget; and
 - Currently working; and
 - The Work/Learn sections of the ISP need to reflect the team’s agreement for the need to request additional hours (over 40 hours per month).
- Frequency of Clinical Review**
- Initial
 - Annually
 - Requests that exceed ten (10) hours per week.
- CIE Group (Does not include Job Development or Short-Term Job Coaching):**
- CIE Group Category 1**
- Desire to work: Work section of the ISP to include a Vision Statement for “Work/Learn” and a desired outcome for employment; and
 - Currently working; and
 - Range of minimal, intermittent, or significant staff support, and guidance is needed to complete job tasks including training, set up, and fulfillment of job responsibilities; and
 - May have support needs that are medical or behavioral in nature, that require accessing Adult nursing services including nursing training and oversight of Direct Support Personnel (DSP) for persons with specific medication and health needs.
- Frequency of Clinical Review**
- Initial
 - Annually
- CIE Group Category 2 Extensive Support**
- Must have met criteria for CIE Group Category 1; and
 - Demonstrated a need for close supervision in order to complete job tasks; and
 - Support needs for this group are typically high and continuous throughout the workday; and
 - Support needs which are extensive or complex in nature and may relate to general, medical, and/or behavioral support needs drive the need for increased staff attention during all employment activities; and
 - May have support needs that are medical or behavioral in nature, that require accessing Adult nursing services including nursing training and oversight of Direct Support Personnel (DSP) for persons with specific medication and health needs; and
 - May occasionally require one-to-one attention for specific tasks.
- Frequency of Clinical Reviews**
- Initial
 - Annually
 - If there is a request to increase the category from the previous approval or the

- previous ISP year
- If a request is for an increase in total units previously approved or from the previous ISP year

Additional Required Documentation (ISP is required for all services):

All service codes under CIE:

- Person-Centered Assessment (PCA) conducted by the chosen provider agency of the services under CIE.
Exception: PCA is NOT required when the budget is an initial Individual Service Plan (ISP), the individual is new to the service area or provider, the individual is 18 and is transitioning to the adult waiver, a job is obtained or there is a pending job offer before the assessment can be completed.
- Career Development Plan (unless the budget is an initial ISP, the individual is new to the service area or provider, the individual is 18 and is transitioning to the adult waiver, or a job is obtained before the assessment can be completed.) CDP can be an addendum to the PCA.
- Verification of Employment in a Community Integrated setting with name of employer, employment location and schedule demonstrating a minimum of four (4) hours of work per month.

CIE- Self Employment

- Business Plan.

Intensive CIE (ICIE)

- Letter of justification for additional hours to include:
 - The number of ICIE hours requested; and
 - The reason the additional support is needed/justification as to why forty (40) hours per month of services is not sufficient.
- Individual’s scheduled work hours and/or proposed schedule if additional hours are approved. A copy of the two (2) most recent pay stubs can be used to meet this requirement or Job Coach schedule and/or proposed schedule if additional hours are approved.
- Must have CIE-Job Maintenance on the budget worksheet.

Applicable Limits on Amount, Frequency and Duration: Intensive CIE-

Requests that exceed ten (10) hours per week require a clinical review.

Applicable Limits on Amount, Frequency and Duration:

Job Development; not to exceed thirty (30) hours/month for more than 6 months without DDS written approval.

Short Term Job Coaching not to exceed thirty (30) hours/month for more than three (3) months without DDS written approval.

Job Maintenance-No more than twelve (12) units can be authorized in a single ISP term, no more than 1 monthly unit in a thirty (30) day span can be authorized.

Community Integrated Employment Services

(continued)

CUSTOMIZED COMMUNITY SUPPORTS

Customized Community Supports (CCS) for adults are designed to assist an individual to increase their independence and potentially reduce the amount of paid supports, establish or strengthen interpersonal relationships, join social networks, and participate in typical community life.

Customized Community Supports are based upon the preferences and choices of each individual and designed to measure progress toward outcomes specified in the Individual Service Plan (ISP). Activities include adaptive skill development, adult educational supports, citizenship skills, communication, social skills, self-advocacy, informed choice, community integration and relationship building. Outcomes from this service may include an enhanced capacity for self-determination, development of social networks that allow the individual to experience valued social roles while contributing to his or her community and establishing lasting community connections.

Fiscal Management for Adult Education Opportunities (FMAE) allows the individual to designate funds from their ISP budget for registration fees, tuition, fees, and or related materials associated with in person or virtual classes, lessons or conferences designed to promote personal growth, development and community integration as determined necessary for the person. FMAE is not intended to support coursework toward a college degree. Services available through other federal resources such as Vocational Rehabilitation and Federal Financial Aid should be explored and exhausted for college coursework. Related materials do not include electronics or assistive technology. CCS Agencies serve as the fiscal intermediary to administer the FMAE funds on behalf of the individual. FMAE may not be utilized for CCS Agencies to bill/cover the cost for registration fees, tuition fees or related materials to support individuals in service. This service must be related to a Vision-driven Desired Outcome in the live, work, or develop relationships/have fun area or the meaningful day area of the ISP. FMAE is permissible as a stand-alone service under CCS on the budget. CCS providers administering FMAE expectations include:

- Processing request for payments, review of financial documents, and issuing checks to vendors on behalf of the individual; and
- Establishment of an account for each individual receiving this service; and
- Tracking and accounting for approved expenditures on behalf of the individual.

Customized Community Supports should be provided in the community to the fullest extent possible. Services should lead to participation and integration in the community and support the individual to reach his or her personal goals for growth and development.

When planning Customized Community Supports, the Interdisciplinary Team (IDT) members must recognize the individual's right to make life choices that may include risk. The IDT members must assess risk on an individual basis and develop or enhance risk mitigation strategies, as needed. The assumption of risk shall be balanced with the

individual’s ability to assume responsibility for that risk and a reasonable assurance of health and safety while maintaining compliance with DDS Standards and the NM Nurse Practice Act for those with health-related supports.

The CCS-Group rate categories are designed to allow for providers to adjust staffing patterns and ratios throughout the day to accommodate basic to moderate and more extensive support needs. Under each rate category minimum staffing ratios are required, and individualized attention may also be needed at times within the group model. The rates were developed to allow for the following staffing ratios requirements based on individual need:

1. **CCS Group Category 1:** While individuals may require one-to-one attention, they are supported in a group with a staffing ratio of no more than six service recipients per direct support personnel.
2. **CCS Group Category 2 Extensive Support:** While individuals may require one-to-one attention, they are never supported in a group with a staffing ratio of more than four (4) service recipients per direct support personnel.

If Clinical Criteria is not met for a higher rate category, the Outside Reviewer has the authority to lower the category on the Budget Worksheet and approve if justified.

SERVICE	CRITERIA
<p>Customized Community Supports</p> <p>CCS-I is the only service available to children.</p>	<p>CCS - Individual</p> <ul style="list-style-type: none"> Service must be related to a Vision-driven desired outcome in the Live, Work, Fun area, or the Meaningful Day area of the Individual Service Plan (ISP); and Service must be planned to be delivered exclusively in the community or remotely with 1-1 staffing; and May have support needs that are medical or behavioral in nature, that require accessing Adult nursing services including nursing training and oversight of Direct Support Personnel (DSP) for persons with specific medication and health needs. <p>For Children, CCS is to be provided outside of school hours and may not be provided in a school, a school related setting, or in the community that would otherwise be supported by school-based programs. DDW services must not duplicate services that are provided to individuals covered under IDEA. Frequency of Clinical Review</p> <ul style="list-style-type: none"> Initial Every three (3) years If request if for an increase in total units previously approved or from the previous ISP year <p>CCS – Small Group</p> <ul style="list-style-type: none"> Service must be related to a Vision-driven desired outcome in addition to the Live, Work, Fun, or the Meaningful Day area of the ISP; and

**Customized
Community
Supports**

(continued)

- Service must be planned so that majority of CCS-Group services occur in the community or remotely except for those individuals who also receive Intensive Medical Living Services (IMLS) and are in the community as able; and
 - May have support needs that are medical or behavioral in nature, that require accessing Adult nursing services including nursing training and oversight of Direct Support Personnel (DSP) for persons with specific medication and health needs.
- Frequency of Clinical Reviews**
- Initial
 - Every three (3) years
 - If request is for an increase in total units previously approved or from the previous ISP year
- CCS Group Category 1**
- Service must be related to a Vision-driven desired outcome in addition to the Live, Work, Fun, or the Meaningful Day area of the ISP; and
 - May require one-to-one attention and may have support needs that are medical or behavioral in nature but are supported in a group with a staffing ratio of as many as six (6) service recipients per direct support personnel; and
 - Nursing training and oversight of Direct Support Personnel (DSP) and nursing services may be needed for persons with specific medication and health needs; and
 - Range of minimal, intermittent, or significant staff support and guidance is needed to engage in many activities semi-independently or even independently in group, remote and community settings.
- Frequency of Clinical Review**
- Initial
 - Annually
- CCS Group Category 2 Extensive Support**
- Must have met criteria for CCS Group Category 1; and
 - Demonstrated a need for close, dedicated supervision to safely participate in group services in community settings; and
 - Extensive or complex support needs that are medical or behavioral in nature, or which relate to general support needs drive the need for increased staff attention during all activities; and
 - Nursing training and oversight of Direct Support Personnel (DSP) and nursing services may be needed for persons with specific medication and health needs.
- Frequency of Clinical Review**
- Initial
 - Annually

- If a request is for an increase in total units previously approved or from the previous ISP year.
- If there is a request to increase the category from the previous approval or the previous ISP year

CCS Aide:

- Service must be related to a Vision-driven desired outcome in addition to the Live, Work, Fun, or the Meaningful Day area of the ISP; and
- Service must be related to a documented need for assistance with ADLs, behavioral support and/or transportation in the ISP.

Frequency of Clinical Review

- Clinical review is not required.

Fiscal Management for Adult Education Opportunities:

- Request is related to a Vision-driven desired outcome in addition to the Live, Work, or Fun or the Meaningful Day area of the ISP; and
- Money is needed for registration fees, tuition, fees, and/or related materials associated with in person or virtual community based classes, lessons or conferences designed to promote personal growth, development, and community integration supporting full access to the greater community and optimizing individual initiative, autonomy and independence, as determined necessary for the person.
- Examples include: Computer courses, art courses, yoga classes, photography, literacy, Spanish, cooking, theatre, etc. Individuals can be assisted to participate in these courses by staff in any service area; habilitation, residential or with natural supports, family or friends, depending on schedule or preference.

Frequency of Clinical Review

- Every request
 - Validation of units and administrative processing fee only

Additional Required Documentation (ISP is required for all services):

All service codes under CCS

- Person-Centered Assessment (PCA) conducted by the chosen provider agency of the services under CCS.

Exception: PCA is NOT required when the budget is an initial Individual Service Plan (ISP), the individual is new to the service area or provider, the individual is 18 and is transitioning to the adult waiver. PCA also not required when FMAE is only CCS related code on the budget.

For FMAE

- Documentation that demonstrates cost and community setting such as flyer, advertisement, catalogue, invoice.
- PCA is not required for someone who is only receiving FMAE services.

	<p>Applicable Limits on Amount, Frequency and Duration For FMAE: Total amount purchased inclusive of up to 10 % administrative fee shall not exceed \$550 per ISP year.</p>
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CUSTOMIZED IN-HOME SUPPORTS

Customized In-Home Supports is not a twenty-four (24) hour residential service model but rather intermittent services and/or supports that are individually designed to instruct or enhance home living skills, community skills and to address health and safety as needed. Customized In-Home Supports provides individuals the opportunity to design and manage the services and/or supports needed to live in their own home or their family home.

Customized In-Home Supports include a combination of instruction and personal support activities provided intermittently as they would normally occur to assist the individual with activities of daily living, health related supports, meal preparation, household services and money management. Supports also include providing support to acquire, maintain or improve interaction skills in the community or at the individual’s place of employment.

Customized In-Home Supports is not intended for individuals that do not require the amount/intensity of support provided under Living Supports services.

Customized In-Home Supports consists of two (2) types of living arrangements:

- Living independently; and
- Living with paid or unpaid families or natural supports.

SERVICE	CRITERIA
Customized In-Home Supports	<ul style="list-style-type: none"> • The person’s choice of where to live/cultural views related to where they want to live must be reflected in the Individual Service Plan (ISP) (Vision Statement); and • ISP reflects desire and need for intermittent Direct Support Professional (DSP) support in instruction and personal support activities to promote the opportunity to live successfully in the community and to maintain a safe and healthy living environment; and • May have support needs that are medical or behavioral in nature, that require accessing Adult nursing services including nursing training and oversight of Direct Support Professional (DSP) for persons with specific medication and health needs. • For requests with routine supports (i.e. more than 21 days a year) for more than 11 hours per day: <ul style="list-style-type: none"> • Paid supports are not considered intermittent, and a residential support should be considered

	<ul style="list-style-type: none"> • Routinely providing more than 11 hours per day of paid support by the same person who also lives in the home with the participant is considered Family Living model of support. • A general schedule of hourly support, connection to ISP, and justification that 24/7 residential models will not better serve the individual are required for approval by Regional Office for requests more than 11 hours per day. • CIHS may not replace or substitute for CCS or CIE during the day when these support models are better suited during the day to support the person’s needs, preferences, and goals • Daily companionship, natural support or and simply overnight presence offered by members of household is not a paid support under CIHS • Fading of hours must be discussed by the team semiannually including use of technology to support more independence and clinical justification must be provided annually <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial • Every three (3) years • Annually for all requests for over thirty (30) hours per week <p>Applicable Limits on Amount, Frequency and Duration: The service model is for individuals assessed to need less than 24/7 hours of paid residential supports.</p>
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CRISIS SUPPORTS

Crisis Supports are designed to provide an intensive level of supports by trained staff to an individual experiencing a behavioral or medical crisis either within the individual’s present residence or in an alternate residential setting.

SERVICE	CRITERIA
	<ul style="list-style-type: none"> • Individual is in crisis and other attempts to remediate the situation have not been effective. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Clinical review is not required. <p>Additional Required Documentation (ISP is required for all services):</p> <ul style="list-style-type: none"> • DD Waiver Crisis Supports Prior Approval Memo or SGF Authorization Memo of Crisis Staffing; and

<p>Crisis Supports</p>	<ul style="list-style-type: none"> • Interdisciplinary Team (IDT) minutes from Crisis IDT that outline: <ul style="list-style-type: none"> • Specific reason(s) why the individual is in crisis; and • IDT attempts to remediate situation, if any, before crisis IDT; and • Plan(s) to stabilize the situation, including how crisis supports will be used for that purpose; and • Proposed plan for fading supports. <p>Applicable Limits on Amount, Frequency and Duration: Crisis Supports must be prior authorized by the Developmental Disabilities Supports Division (DDSD) Bureau of Behavioral Supports (BBS). Crisis Supports may be authorized in fourteen (14) to thirty (30) calendar day increments, typically not to exceed ninety (90) calendar days. In situations requiring crisis supports in excess of ninety (90) calendar days, the DDSD Director must approve such authorization upon submittal of a written plan to transition the individual from crisis supports to typical menu of DD Waiver services.</p>
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ENVIRONMENTAL MODIFICATION SERVICE

Environmental Modifications are physical adaptations identified in the individual’s ISP, which provide direct medical or remedial benefits to the individual’s physical environment. All environmental modifications must address the individual’s disability and enable the individual to function with greater health, safety, or independence in their residence. All services shall be provided in accordance with applicable federal, state, and local building codes.

SERVICE	CRITERIA
<p>Environmental Modification Service</p> <p>Available to Children</p>	<ul style="list-style-type: none"> • Need for environmental modification must be identified in the Health and Safety section of Individual Service Plan (ISP); and • Service must provide direct medical, safety, or functional benefit to the individual. • Installation of grab bars will be covered. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial • Every request <p>Additional Required Documentation (ISP required for all services):</p> <ul style="list-style-type: none"> • IDT meeting minutes indicating the team discussed the need and is in agreement; and • Occupational or Physical Therapy evaluation or if Occupational Therapist (OT) or Physical Therapist (PT) are not available an alternative evaluation as approved by the Regional Office; and • Brief description of work to be done (e.g., build ramp to front entrance, modify shower) itemized cost for equipment and materials

	<p>with a description and cost of labor.</p> <ul style="list-style-type: none"> • Total Environmental Modification Service Cost Quote, including all applicable taxes, approved and signed by the participant, the property owner (if not the same) and the contractor. • DDSD Verification of Benefit Availability form. <p>Applicable Limits on Amount Frequency and Availability:</p> <ul style="list-style-type: none"> • Amount available inclusive of 15% administrative fees not to exceed \$5,000.00 every five (5) years. Grab bars are not covered using waiver funds.
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INDEPENDENT LIVING TRANSITION SERVICE

- Independent Living Transition Service is a one-time expense for individuals who transition from a twenty-four (24) hour living supports setting into a home or apartment of their own with intermittent support that allows the individual to live more independently in the community. Funds may not be used to pay for food, clothing or rental/mortgage costs excluding deposits specified in the scope of service.

SERVICE	CRITERIA
Independent Living Transition Service	<ul style="list-style-type: none"> • Must be related to a Vision-driven desired outcome in the Individual Service Plan (ISP); and • Must be a need for this demonstrated in transition details; and • Funds may not be used to pay for food, clothing or rental/mortgage costs excluding deposits specified in the scope of service. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial (this is a one-time only service) <p>Additional Required Documentation (ISP required for all services):</p> <ul style="list-style-type: none"> • Itemized list of expenditures allowable in the scope of service; and • Documentation that demonstrates need and the individual is moving into their own home or apartment of their own with intermittent support that allows the individual to live more independently in the community; and • DDSD Verification of Eligibility form. <p>Applicable Limits on Amount Frequency and Availability:</p> <ul style="list-style-type: none"> • Amount available inclusive of 15% administrative fees not to exceed \$1,500.00

LIVING SUPPORTS—FAMILY LIVING SERVICES

Living Supports- Family Living: Family Living (FL) services are intended for individuals who are assessed to need residential habilitation to ensure health and safety while providing the opportunity to live in a typical family setting. Family Living services are intended to increase and promote independence, provide the skills necessary to prepare individuals to live on their own in a non-residential setting, and is designed to address assessed needs and identified individual outcomes. Family Living services provide direct support and assistance to no more than two (2) individuals in a home. Services and supports are furnished by a natural or host family member, or companion, who meets the requirements and is approved to provide Family Living Services in the individual’s home or the home of the Family Living direct support provider. The individual lives with the paid direct support provider. Support providers are responsible for providing an appropriate level of services and supports twenty-four (24) hours per day, seven (7) days per week. The provider agency is responsible for substitute coverage for the primary caregiver when the primary care giver is sick or taking time off as needed.

SERVICE	CRITERIA
<p>Living Supports—Family Living Services</p>	<ul style="list-style-type: none"> • Service is related to a Vision-driven desired outcome in the ISP related to increasing and promoting independence and to support the individual to live as independently as possible in the community in a setting of their own choice; and • The service reflects person’s choice of where to live/cultural views related to where they want to live and is reflected in ISP; and • The individual’s needs cannot be met through Customized In-Home Supports, a less restrictive service option, and there are reasons the individual needs Family Living support; and • One or more of the following criteria is met: <ul style="list-style-type: none"> ○ A medical or behavioral issue, or lack of skills do not allow the person to live safely in a less restrictive service model and which exceeds what can be provided by Customized In-Home Supports or by natural resources which require daily, critical observation, monitoring, and a quick response to assure health and safety. Examples may include: Individual has a dysfunctional or non-existent natural support network and is at risk of homelessness, criminal justice involvement, or exploitation and abuse, or ○ The individual demonstrates moderate to extraordinary behavioral support needs (Examples of “moderate to severe” behavioral support needs can include but are not limited to aggressive behavior, property destruction, stealing, self-injury, pica, sexually inappropriate, frequent emotional outbursts, wandering, substance

	<p>abuse and/or support to maintain mental health treatment); or</p> <ul style="list-style-type: none"> • Behavioral needs must indicate significant supervision needs due to a high frequency of disruptive behavior and/or presence of destructive behavior. Examples include behavior that impacts the individual's ability to retain a baseline level of independence, that interferes with quality of life, or that involves a health and safety risk needing professional behavioral recommendations to establish a safety net. Behavioral needs for these individuals, however, do not preclude them from engaging in many activities of daily living independently or semi-independently; or • The individual demonstrates moderate to extraordinary medical support needs such as requiring support for personal care and/or medical or safety related issues routinely to multiple times per day; or • The individual demonstrates need for maximum assistance with activities of daily living to meet their extensive physical support needs and personal hygiene including lifting/transferring and positioning. Feeding tubes and other feeding supports (e.g., aspiration risk management), oxygen therapy or breathing treatments, suctioning and seizure management may be common as well; or • The individual may require a range of Adult Nursing services to assist the natural or host Family Living Provider with delivery of nursing supports to meet the individual's medical, health or behavioral needs, or • The individual may demonstrate a mental health condition in addition to a developmental disability and pose a safety risk to themselves or the community without continuous support. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial • Every Three (3) years <p>Applicable Limits on Amount Frequency and Availability:</p> <ul style="list-style-type: none"> ○ Service Amount: 340 daily units to cover 365 calendar days of service
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LIVING SUPPORTS—SUPPORTED LIVING SERVICES

Living Supports—Supported Living: Supported Living (SL) is intended for individuals eighteen (18) years and older who are assessed to need residential habilitation to assure their health and safety. It is intended to increase and promote independence, and to provide the skills necessary to prepare individuals to live on their own in a non-residential setting. Supported Living services are designed to address assessed needs and identified individual outcomes. The service is provided to two (2) to four (4) individuals in a home that is leased or owned by the individual. Living Supports providers are responsible for providing an appropriate level of services and supports twenty-four (24) hours per day, seven (7) days per week.

the OR will apply Clinical Criteria to determine what SL category is most appropriate for

each individual. The SL rate categories are designed to allow for providers to adjust staffing patterns and ratios throughout the day to accommodate basic, moderate, and extensive support needs. Under each rate category specific staffing ratios are not strictly required on a daily or hourly basis. However, agencies are required to ensure staffing ratios that support the health and safety and ISP outcomes of each individual. The rates were developed to allow for the following based on individual need:

1. Supported Living Category 1 (Basic Support)-up to seven (7) hours a week of individualized staff attention apart from shared staffing and rare nursing services.
2. Supported Living Category 2 (Moderate Support)-between eight (8) to fourteen (14) hours a week of individualized staff attention apart from shared staffing and some (up to five (5) hours monthly of nursing services.
3. Supported Living Category 3 (Extensive Support)-between fifteen (15) to twenty-eight (28) hours a week of individualized staff attention apart from shared staffing and frequent (up to ten (10) hours a month) of nursing services.
4. Supported Living Category 4 (Extraordinary Medical/Behavior Support)-exceeds twenty-eight (28) hours a week of individualized staff attention apart from shared staffing (up to ten (10) hours a month) of nursing services.

Within the Supported Living model, one other service is available when clinically justified: Non- Ambulatory Stipend. The non-ambulatory stipend is available to categories 1-3 when a person is non-ambulatory. The service assists with funding for staffing **only** through the nighttime hours in case an emergency evacuation is needed.

Supported Living Services cannot be provided in conjunction with any other Living Supports, Respite, Adult Nursing Services (unless provided during participation in Customized Community Supports and or Community Integrated Employment), or budgeted Nutritional Counseling.

SERVICE	CRITERIA
<p>Living Supports— Supported Living Services</p>	<ul style="list-style-type: none"> • Service is related to a Vision-driven desired outcome in the Individual Service Plan (ISP) related to increasing and promoting independence and to support the individual to live as independently as possible in the community in a setting of their own choice; and • The individual’s needs cannot be met through Customized In-Home Supports, a less restrictive service option, and include reasons the individual needs Supported Living support; and • The individual lives with at least one other person receiving SL or has DDSD approval for SL for one person. • The service reflects the person’s choice of where to live/cultural views related to where they want to live and is reflected in the ISP (Vision

Statement); and

- A medical or behavioral issue, or lack of skills that allow the person to live safely in a less restrictive service model which exceeds what can be provided by Customized In-Home Supports or by natural resources requiring daily, critical observation, monitoring, and a quick response to assure health and safety. Examples may include: Individual has a dysfunctional or non-existent natural support network and is at risk of homelessness, criminal justice involvement, or exploitation and abuse; or
- Individuals who were fifty-five (55) years or older at the time of their annual ISP between March 1, 2013 and February 28, 2014 and who had been receiving DD Waiver Supported Living services prior to March 1, 2013 are authorized to continue use of Supported Living services if desired. This should be indicated on OR coversheet, and criteria met for one of the following SL Categories.

SL Category 1 Basic Support (in addition to above criteria)

- Minimal or intermittent staff support needs due to demonstrated ability to engage in many activities semi-independently or even independently at times; and
- Personal care and health-related support needs are minimal to moderate. Nursing training and oversight of Direct Support Personnel (DSP) and nursing services may be needed for persons with specific medication and health needs; and
- May need up to seven (7) weekly hours of individualized staff attention apart from shared staffing.

Frequency of Clinical Review

- Initial
- Every three (3) years

SL Category 2 Moderate Support (If Clinical Criteria are not met for this category the OR has the authority to lower the category on the Budget Worksheet and approve if justified.)

- Moderate to significant support needs relative to activities of daily living which include partial to full physical support in activities such as meal preparation, taking medications, and completing daily hygiene routines; and
- Need for at least seven (7) and up to fourteen (14) weekly hours of individualized staff attention apart from shared staffing; and
- Nursing training and oversight of Direct Support Professional (DSP) and nursing services are needed for persons with specific medication and health needs that occasionally require nursing services (approximately five (5) hours per month). This may include health assessments and reassessments, health and emergency plan development, revision, training, and monitoring; nursing oversight, evaluation, and management; consultation; care management and direct, hands-on care as needed to manage or support

- health issues; and/or
- Moderate behavior support needs.

Frequency of Clinical Review

- Initial
- Every three years
- If there is a request to increase the category from the previous approval or the previous ISP year

SL Category 3 Extensive Support (If Clinical Criteria are not met for this category, the OR has the authority to lower the category on the Budget Worksheet and approve if justified).

All the following 3 criteria must be met:

- Must meet criteria for SL Categories 1 & 2; and
- Demonstrate a high level of general support needs, particularly extensive behavioral support needs, and/or complex medical support needs, and
- Need for at least fourteen (14) and up to twenty-eight (28) weekly hours of individualized staff attention apart from shared staffing.

Additionally, one (1) or more of the following criteria must also be met:

- Require maximum assistance for activities of daily living, including full and frequent physical support in multiple areas; or Nursing training and oversight of Direct Support Personnel (DSP) and nursing services are needed for complex medication or health needs that require frequent (approximately ten (10) hours per month) nursing services. These services may vary based on medical support needs but can include health assessments and reassessments, health and emergency plan development, revision, training and monitoring; nursing oversight, evaluation and management; consultation; care management and direct, hands-on care as needed to manage or support health issues.(Medical supports may include multiple medications given multiple times per day, extensive feeding supports and enteral tubes and other feeding supports, respiratory supports, aspiration risk management, oxygen therapy or breathing treatments, suctioning, extensive seizure management, ketogenic diets, spasticity management, neurological supports, routine and frequent preventive or active skin care etc.,) or
- May also exhibit extraordinary behavioral support needs such as aggressive behavior, property destruction, stealing, self-injury, pica, sexual inappropriateness, frequent emotional outbursts, wandering, and/or substance abuse that if left unsupported expose the individual to risk of doing significant harm to themselves or others.

Frequency of Clinical Review

- Initial

- Annually
- If there is a request to increase the category from the previous approval or previous ISP year.

Supported Living Category 4 Extraordinary Behavioral Support (If Clinical Criteria are not met for this category, the OR has the authority to lower the category on the Budget Worksheet and approve if justified).

- Must meet criteria for **SL Category 3 Extensive Support** and need more than twenty-eight (28) weekly hours of individualized staff attention apart from shared staffing; and
- Must exhibit extraordinary behavior support needs. Extraordinary behavior support needs are defined as high frequency disruptive behaviors that pose serious health and safety concerns to self or others (e.g., making risky decisions about one’s own health and safety, including problematic choices of friends and/or sexual partners, illicit drug and alcohol abuse) and/or intermittent *or* chronic destructive behaviors that may or will result in physical harm or injury to self or others (e.g., physical acts that may require stitches or extensive wound care to potentially lethal acts such as stabbing someone). Extraordinary behavioral support needs may also include acts that may have or have caused great emotional harm to self or others (e.g., sexual assault). Individuals engaging in such behaviors may have also experienced intermittent *or* chronic involvement with the criminal justice system (e.g., detainment or arrest(s) for physically aggressive, sexually inappropriate, or assaultive behavior); and
- Enhanced or additional staffing required for health and safety assurances and is unable to be provided without additional supports above and beyond what is available in extensive support; and
- Enhanced or additional staffing required to ensure the health and safety of the individual and others must be defined in the health and safety section of the ISP and must be included in a current PBSP; and
- Cannot be provided unless the individual receives services from a BSC (BSC is approved on the budget). The BSC must address the level of enhanced needed to reduce the risk of harm to self or others in the home or community setting. Specific strategies on how the level of staffing (and, more importantly, DSP intervention) will reduce the likelihood of harm to self and/or others must be addressed in the PBSP, and if indicated the BCIP; and
- Must have documentation detailing the level of DSP intervention needed to assure the health and safety of the individual and/or to assure the health and safety of others because of the person’s extraordinary behavior needs. The documentation must provide evidence that additional or enhanced staffing is required to secure the health and safety of the individual and/or the health and safety of others; and
- IDT must have discussed additional means of addressing the extraordinary behavior support needs other than increasing the level of staffing support, the reasons why increased or enhanced staffing is necessary, why the current

level is not sufficient, what may occur in the absence of the enhanced supports, and what the IDT has already pursued and exhausted.

Frequency of Clinical Review

- Initial
- Annually
- If there is a request to increase the category from the previous approval or previous ISP year

Supported Living Category 4 Extraordinary Medical Support (If Clinical Criteria are not met for this category, the OR has the authority to lower the category on the Budget Worksheet and approve if justified).

- Must meet criteria for **SL Category 3 Extensive Support** and need more than twenty-eight (28) weekly hours of individualized staff attention apart from shared staffing; and
- Must exhibit extraordinary medical support needs- Extraordinary medical support needs are defined as a chronic physical or medical condition requiring prolonged dependency on medical treatment for which skilled nursing intervention is necessary. The person’s physical or medical condition may be characterized by one of the following: Life threatening condition characterized by frequent periods of acute exacerbation that requires regular/frequent medical supervision, physician treatment/consultation and which in absence of such medical supervision or physician treatment/consultation would require hospitalization or admission to a nursing home or rehabilitation facility, or administration of specialized treatments that are medically necessary such as suctioning, I.V. medication, injections, wound care for decubitus ulcers, etc., or dependent on medical technology requiring nursing oversight such as enteral (feeding tube) or parenteral (intravenous tube) nutrition support or continuous oxygen, or administration of specialized treatments that are ordered by a physician or nurse practitioner which will take place over a period of recovery of at least thirty (30) days; and
- Enhanced or additional staffing hours are required to implement the applicable HCPs and MERPs plans to ensure the health and safety of the person. The additional enhanced staffing hours and how the additional staffing supports relate to implementing HCPs and MERPs must be defined in the health and safety section of the ISP; and
- The IDT must address the level of enhanced staffing needed to implement HCP and MERPs. Specific strategies on how the level of increased or enhanced staffing will reasonably ensure the health and safety of the person, long-term prognosis for recovery, or what may occur in the absence of such enhanced supports must be addressed in the Health and Safety section of the ISP; and
- The interdisciplinary team must develop and document in the ISP a plan

	<p>for returning to a typical staffing pattern once the medical condition requiring increased staffing has ended (fade out plan). If the team, in collaboration with agency nurse, and treating physician(s), believe a fade out plan is not possible, the team must address and document in the ISP the specific medical condition and support needed that will not allow for fading supports; and</p> <ul style="list-style-type: none"> • The Supported Living Category 4 Provider Agency must have documentation and evidence that the IDT discussed additional means of addressing the extraordinary medical support needs other than increasing the level of staffing support, the reasons why increasing staff is necessary, why the current level of staffing is not sufficient, and what the IDT has already pursued and exhausted; and • Medical support needs do not meet clinical criteria for IMLS. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial • Annually • If there is a request to increase the category from the previous approval or previous ISP year. <p>Non-Ambulatory Stipend</p> <ul style="list-style-type: none"> • Assessment or documentation from any of the following that verifies that the DD Waiver recipient is non-ambulatory: licensed Physical Therapist, Occupational Therapist, Registered Nurse, Primary Care Provider or Specialist, Durable Medical Equipment (DME) evaluation regarding mobility services or Specialty Seating Clinic evaluation; and • Documentation from the Supported Living Provider indicating the need for additional staff support and how they will use the stipend. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial • Every three (3) years • Revision to delete service is required if a change in household make up that includes Category 4 support <p>Applicable Limits on Amount Frequency and Availability:</p> <ul style="list-style-type: none"> • Supported Living Rate Categories 1-4: 340 daily units to cover 365 calendar days of service. • SL Categories 1-4 must be provided with 2-4 people in the home and cannot be provided to a single person without DDS approval. • Non-Ambulatory Stipend: 340 daily units to cover 365 calendar days of service. Cannot be used with SL Category 4.
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LIVING SUPPORTS—INTENSIVE MEDICAL LIVING SERVICES

Intensive Medical Living Services (IMLS) is a Living Supports option for persons with complex medical needs who require intensive direct nursing care and oversight. This service promotes health and supports each person to acquire, retain or improve skills necessary to live in the community and prevent institutionalization.

SERVICE	CRITERIA
<p>Living Supports—Intensive Medical Living Services</p>	<ul style="list-style-type: none"> • Highly frequent and maximum assistance with activities of daily living is required to meet their extensive physical support needs and personal hygiene; including lifting/transferring and positioning; and • Individuals may qualify for IMLS if they are at High acuity level with extensive to very complex medical support needs. This includes: <ul style="list-style-type: none"> ○ Severe to significant needs in a variety of clinical areas including medication administration, medical care and supervision, feeding and nutrition, respiratory, neurological, skin assessment and treatment and other complex medical needs; ○ Require intensive clinical nursing oversight and health management that must be provided directly by a Registered Nurse (RN) or License Practical Nurse (LPN) in accordance with the New Mexico Nursing Practice Act; and ○ Short term intense needs due to recent hospitalization or a nursing home or rehabilitation facility stay, to allow time to update health care plans, train staff on new or exacerbated conditions, and to ensure the person is stabilized and routine home environment is appropriate to meet the needs of the individual. ○ If eligibility parameters for Intensive Medical Living Services (IMLS) are met with score of twenty (20) points or above. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial • Every three (3) years <p>Additional Required Documentation (ISP is required for all services.):</p> <ul style="list-style-type: none"> • IMLS Parameter Tool and Worksheet with score twenty (20) points or above; and • Clinical documentation that clearly supports the request for IMLS services and reflects the results of the IMLS parameter tool; <ul style="list-style-type: none"> • Includes current Physician Orders; current and prior month Medication Administration Record (MAR); current and prior month treatment sheet (if applicable); current Electronic Comprehensive Health Assessment Tool (eCHAT)/Medication Administration Assessment Tool (MAAT)/

	<p>Aspiration Risk Screening Tool (ARST); pertinent Health Care Plans/ Comprehensive Aspiration Risk Management Plan (CARMP) and Medical Emergency Response Plan (MERPs); sample of Nursing notes from the last month that reflects pertinent complex medical needs and the last Nursing Reports to the Interdisciplinary Team (IDT).</p> <ul style="list-style-type: none"> • Additional, concise clinical documents only if <u>pertinent</u> to support IMLS parameter scoring (e.g., Hospital discharge summary or recent discharge orders; pertinent imaging or lab information; Hospice orders or plans or additional pertinent data). <p>Applicable Limits on Amount Frequency and Availability:</p> <ul style="list-style-type: none"> • Long Term: Amount available is 340 units per ISP year. • Short Term: Allowable for 90 calendar days
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NON-MEDICAL TRANSPORTATION SERVICE

Non-Medical Transportation Service enables individuals to gain access to waiver and non- medical community services, events, activities, and resources as specified in the Individual Service Plan (ISP).

SERVICE	CRITERIA
<p>Non-Medical Transportation Service</p> <p>Available to Children</p>	<ul style="list-style-type: none"> • The need for Non-Medical Transportation is to fulfill activities and supports specified in the Vision-driven outcomes or meaningful day activities and to gain access to non-medical community services, events, and activities; and • For individuals who receive Family Living, Supported Living or Intensive Medical Living Services, Non-Medical Transportation services may ONLY be provided under situations where: <ul style="list-style-type: none"> ○ Extensive travel (more than one hundred (100) miles round trip) is required to meet desired outcomes in the Individual Service Plan (ISP); or ○ For the purchase of a pass for public transportation to support or fulfill activities associated with the ISP goals or desired outcomes. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial • Every request <p>Additional Required Documentation: (ISP is required for all services.):</p> <ul style="list-style-type: none"> • Not applicable.

Applicable Limits on Amount Frequency and Availability

- Amount available: per mile is \$0.44 not to exceed \$810 per ISP year and per transportation Pass/Ticket is \$1.00 per item not to exceed \$460.00 per ISP year.

ADULT NURSING SERVICES

Adult Nursing Services (ANS) are designed to meet a variety of health conditions experienced by adults receiving services on the Developmental Disabilities (DD) Waiver. Adult Nursing Services support the delivery of professional nursing services in compliance with the New Mexico Nurse Practice Act and in accordance with professional standards of practice. Adult Nursing Services are a model of nursing intended to support the individual and their family towards a goal of maximum practicable independence and access to the general health care system, while providing a framework of ongoing DD Waiver nursing supports as needed. The service is not intended to provide in home nursing in lieu of the family care giver, but rather allows the delivery of a variety of nursing services in order to support the individual, natural or host Family Living Provider and non- related Direct Support Staff (DSP).

Adult Nursing Services are available to adults eighteen (18) and older with specific limitations as listed in this document. With the exception of the limitations for young adults listed below, these individuals receive all other medically necessary nursing services through the Medicaid State Plan Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

There are two categories of Adult Nursing Services:

- **Nursing Assessment and Consultation Services** provides an initial and annual electronic comprehensive health assessment (eCHAT) and subsequent consultation from the nurse to the individual, health decision maker/guardian and, as requested, with the team. This activity is required for all participants in Family Living, including young adults from age eighteen (18) through twenty (20), and is available to all individuals in the service settings listed below. This service includes the development and training of interim health care plans as needed for safety. Clinical review is not required for this portion of the ANS.
- **Ongoing Adult Nursing Services (OANS)** provides focused nursing supports that are based on the needs identified in the electronic comprehensive health assessment (eCHAT) and the ANS parameter tool. It includes optional services that can be selected by individuals, their health decision maker, or guardians. Several elements of Ongoing Adult Nursing Services are required for certain individuals when health related supports are delivered by non-related Family



Living Providers or DSP in settings other than Supported Living or Intensive Medical Living services in order to comply with nursing oversight required by the New Mexico Nurse Practice Act. Prior authorization is required for Ongoing Adult Nursing hours.

SERVICE	CRITERIA
<p>Adult Nursing Services</p> <p>Available to 18 -21 in addition to EPSDT for ARM support only</p>	<p>Nursing Assessment and Consultation Clinical review is not required for up to twelve (12) hours (48 units) per year.</p> <p>Ongoing Adult Nursing Services (OANS) The service is not intended to provide in home nursing in lieu of the family care giver, but rather allows the nurse to support the family care giver and DSP while completing nursing tasks. This service is allowed when the ANS Parameter Tool and clinical documentation demonstrates the need for:</p> <ul style="list-style-type: none"> Healthcare planning and training based on acuity and complexity of medical conditions. Aspiration Risk Management by a DD Waiver licensed nurse. Delegation of specific nursing functions based on medical condition and number and stability of delegation relationships. Medication Oversight provides oversight of the Certified Medication Aide (CMA); Direct Support Personnel (DSP) trained in “Assisting with Medication Delivery”. Medication Administration by a DD Waiver licensed nurse rather than by a Home Health Agency; Specialty Clinic; CMA; DSP trained in “Assisting with Medication Delivery”; or biological family member. Coordination of Complex Conditions based on medical needs, and residential circumstances. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> Initial Increase in units Annually Request exceeds twelve (12) hours (48 units) per year <p>Additional Required Documentation (ISP is required for all services.):</p> <ul style="list-style-type: none"> Completed Adult Nursing Services Parameter Tool Electronic Comprehensive Health Assessment Tool (eCHAT) For Initial Aspiration Risk: Aspiration Risk Screening Tool (ARST) For Ongoing Aspiration Risk: Aspiration Risk Screening Tool (ARST) and Comprehensive Aspiration Risk Management Plan (CARMP) For Medication Administration by a Licensed Nurse: Medication

Administration Assessment Tool (MAAT) and *Justification Report for Administration of Medication by a Licensed Nurse*

- **For Coordination of Complex Conditions:** *Justification Report for Coordination of Complex Conditions.*
- **For budget adjustment of the ratio of RN and LPN hours:** *No additional documentation or justification is required. The nurse communicates the needed budget adjustment directly with the Case Manager.*

Applicable Limits on Amount Frequency and Availability:

- All medically necessary nursing services for children under the age of twenty-one (21) are covered in the State plan pursuant to the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit.
- Adult Nursing Services (ANS) are available for the following individuals in the following settings:
 - Young Adults, age eighteen (18) through twenty (20), who reside in Family Living and only as needed to address Aspiration Risk Management (ARM) services or have health related needs and require services that are delivered by non-related Direct Support Personnel (DSP) in Family Living; or
 - Adults, over age twenty-one (21) who reside in Family Living and/or who have health related needs and require services that are delivered by non-related DSP in substitute care or in community supports such as Customized Community Supports (CCS) individual or small group or Community Integrated Employment (CIE); or
 - Adults over twenty-one (21) who have health related needs and require services that are delivered by non-related DSP in Customized In-Home Supports (CIHS), Customized Community Supports (CCS) individual or small group or Community Integrated Employment (CIE) regardless of residential setting.
- Nursing Assessment and Consultation is available for up to twelve (12) hours (48 units) for an initial or annual assessment. Nursing from two (2) agencies may request hours for this service. Clinical review is not required. OANS needs listed above are required in non-related Family Living situations and do not require a clinical review in these situations.

NUTRITIONAL COUNSELING SERVICES

Nutritional Counseling services allow for the assessment, evaluation, collaboration, planning, teaching, consultation and implementation and monitoring of a nutritional plan provided by Licensed or Registered Dietitians or Nutritionists that supports the individual to attain or maintain the highest possible level of health. Nutritional Counseling services are provided by Licensed or Registered Dietitians or Nutritionists and shall not duplicate those nutritional or dietary services allowed in the individual’s Medicaid state plan benefit, or other funding source.

SERVICE	CRITERIA
<p>Nutritional Counseling Services</p> <p>Available to Children</p>	<ul style="list-style-type: none"> Individuals needs regarding dietary, medical, behavioral, or sensory concerns that may benefit from dietary/nutritional consultation; and Needs include but are not limited to over/underweight; unplanned weight loss/gain; difficulty eating, food allergies or selectivity; enteral (tube) feedings; dietary and nutritional planning and complex clinical issues such as gastrointestinal, aspiration, neurological, endocrine/metabolic, renal, cardiac, cancer or other diagnoses. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> Initial Every Three years <p>Additional Required Documentation (ISP is required for all services):</p> <ul style="list-style-type: none"> IDT meeting minutes regarding dietary, medical, behavioral, or sensory concerns that may benefit from dietary/nutritional consultation. <p>Applicable Limits on Amount Frequency and Availability:</p> <ul style="list-style-type: none"> Nutritional counseling services are included in the rate for Family Living, Supported Living, and Intensive Medical Living services and cannot be added as a separate service on the individual budget when these services are on the budget.

REMOTE PERSONAL SUPPORT TECHNOLOGY

Remote Personal Support Technology Service is an electronic device or monitoring system that supports individuals with developmental disabilities to be independent in the community or in their place of residence with limited assistance or supervision by paid staff. This service is intended to promote increased independence and quality of life, offer opportunities to live as safely and with as much privacy as possible in one’s home, and to ensure the health and safety of the individual in service.

RPST provides up to 24-hour alert, monitoring, or personal emergency response capability. RPST is available to people who have a demonstrated need for timely response due to health or safety concerns, and who may be afforded increased independence, freedom, privacy, and quality of life by using PST. RPST includes but is not limited to supports with or without alert capabilities and or monitoring such as: home sensors, mobility, safety and health management devices; remote task/event cueing, prompting, or interactions; location assistance or monitoring; personal emergency response systems; remote video, audio or other “check in” monitoring systems; and environmental control devices or systems that are associated with a monitoring device/system. This may include “smart” devices for home, day travel or mobility that

are purchased or obtained by the individual for use in a variety of life settings.

RPST services include:

- Installation of electronic devices and education in the use of the devices
- Rental of electronic device
- Maintenance for the electronic device
- Warranty, shipping and handling fees
- Subscription costs which may include a customized response plan, maintenance costs, remote call center staff response, monitoring fees and some education/training costs
- Daily monitoring and reporting
- Provision of assistance in response to events identified through monitoring.

RPST may be accessed through an approved waiver provider acting as a purchasing agent for technology vendors whose products meet definition and needs or directly through an approved technology provider who is the direct vendor of the service and approved DDW provider. RPST can include an array of monitoring, contacts, interaction, and responses.

SERVICE	CRITERIA
<p>Remote Personal Support Technology</p> <p>Available to Children</p>	<ul style="list-style-type: none"> • Service must be related to a Vision-driven outcome that reflects a desire to increase or maintain independence in the community or in their place of residence with limited assistance or supervision by paid staff; or • The need for the service is to fulfill activities and supports in the Individual Service Plan (ISP) and associated outcomes; or • Alternatively, support of the service may be demonstrated through justification in the Health and Safety Section of the ISP. • Interdisciplinary Team (IDT) agrees that technology is important for the individual to support additional health and safety needs that would otherwise require staff and could restrict the individual’s independence and/or privacy; and • Meets Human Rights Committee approval when the proposed device and/or system impacts the individual’s right to privacy. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial • Every request <p>Additional Required Documentation (ISP is required for all services):</p> <ul style="list-style-type: none"> • If applicable, Human Rights Committee approval is needed when the proposed device and/or system impacts the individual’s right to privacy; and <ul style="list-style-type: none"> • IDT Meeting Minutes.

	<p>Applicable Limits on Amount Frequency and Availability:</p> <ul style="list-style-type: none"> • Amount available not to exceed \$5,000 per ISP year, inclusive of a 15% (for purchasing agency only) allowable administrative fee. • This service is not intended to provide for paid, in-person on-site response. On site response must be planned through response plans that are developed using natural and/or other paid supports for on-site response. • Non-waiver funds shall not be permitted to upgrade an existing RPST system that was purchased with waiver funds. • The device is for the sole use of the individual and may not be routinely used by other family members, staff and/or housemates. Exceptions may include systems that support general environmental control or safety of the household such as thermostats or alarm systems.
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PRELIMINARY RISK SCREENING AND CONSULTATION

This service is part of a variety of behavior support services (including Behavior Support Consultation (BSC) and Socialization and Sexuality Services) that promote community safety and reduce the impact of interfering behaviors that compromise the quality of life. Preliminary Risk Screening and Consultation (PRSC) This service is provided by a licensed mental health professional who has been trained and approved as a Risk Evaluator by the Bureau of Behavioral Support (BBS) for this service. Preliminary Risk Screening and Consultation is a structured risk screening process which provides:

- a. Identification of individual level and type of risk-related concerns for inappropriate sexual behavior;
- b. Strategies for risk management under the least restrictive conditions; and
- c. Technical assistance related to the management of risk.

SERVICE	CRITERIA
Preliminary Risk Screening and Consultation Related to Inappropriate Sexual	<ul style="list-style-type: none"> • Interdisciplinary Team (IDT) member(s) report(s) presence of sexually inappropriate and/or sexually offending behavior and/or a history of particular risk factors that may relate to increased potential for harm to self or others; and • Sexually inappropriate or sexually offending behaviors and related risk factors may include, but are not limited to: <ul style="list-style-type: none"> • Masturbation or possible sexual self-stimulation in public areas or at a rate, duration, or topography that interferes with daily functioning or relationships and/or has or may potentially cause physical harm to self; • Verbal interactions of a possible sexual content with individuals or in locations seen as inappropriate, concerning, or interfering; • Physical interactions/contact with others that potentially violates personal boundaries, violates current legal statutes, or is potentially dangerous;

<p>Behavior (PRSC)</p>	<ul style="list-style-type: none"> • Demonstrated or speculated sexual interest in persons, images, or other media that violates current societal or cultural norms; <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial • Every three (3) years for subscription costs • Every request for new installation of purchase <p>Applicable limits on amount frequency and availability</p> <ul style="list-style-type: none"> • The initial preliminary risk screening shall not exceed twenty-five (25) hours per Individual Service Plan (ISP) year. An additional screening, if needed in a subsequent ISP shall not exceed fifteen (15) hours per ISP year. If periodic consultation is needed beyond the screening, additional units to provide technical assistance shall not exceed fifteen (15) hours per ISP year.
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RESPITE SERVICE

Respite is a flexible family support service. The primary purpose of respite is to provide support to the individual and give the unpaid primary caregiver time away from their duties. Respite services include assisting with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation, and eating), enhancing self-help skills, increasing social and community awareness; providing opportunities for leisure, recreation, neighborhood involvement, social activities, and providing opportunities for the individual to make their own choices with regard to daily activities.

SERVICE	CRITERIA
<p>Respite Service</p> <p>Available to Children</p>	<ul style="list-style-type: none"> • Available to any individual of any age living with an unpaid primary caregiver including Customized In-Home Supports-Family; and • Service need determined by the primary caregiver in consultation with the Interdisciplinary Team (IDT) and recorded in the individual’s Individual Service Plan (ISP). • A daily level of respite for children should not replace or duplicate service hours provided under EPSDT like home health aide and Private Duty Nursing <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial • Every three (3) years • Requests over 750 hours annually <p>Additional Required Documentation: (ISP is required for all services.):</p> <ul style="list-style-type: none"> • For high amount requests (specifically for children) the ISP must specify if other services such as home health aide or private duty nursing has been utilized or can be utilized.

	<p>Applicable Limits on Amount Frequency and Availability</p> <ul style="list-style-type: none"> Individuals receiving Family Living, Supported Living, Intensive Medical Living Services, and Customized In-Home Supports living independently (not with a family or natural support) may not access respite. Medication administration is not a support in respite and must be arranged for separately by the primary caregiver. DSP providing Respite cannot also be a primary caregiver or a person who resides in the same dwelling as the person supported. For Children, Respite is to be provided outside of school hours and may not be provided in a school, a school related setting, or in the community that would otherwise be supported by school-based programs. Respite should not be provided to children within a group setting. DDW services must not duplicate services that are provided to individuals covered under IDEA.
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SOCIALIZATION AND SEXUALITY EDUCATION

Socialization & Sexuality Education is provided in a class format called the Friends & Relationships Course (FRC). The FRC is a comprehensive lifelong education program that combines an inclusive and safe environment with differentiated instruction strategies to foster the continuous development and training of knowledge and skills to: 1) increase social networks with healthy, meaningful relationships; and 2) increase personal safety including decreasing interpersonal and intimate violence in relationships, sexual victimization, exploitation and abuse. The FRC requires a support guide to participate in classes with every student, teaching them to support the social and sexual lives of persons with I/DD while building a healthy interdependent connection. The support guide is selected from the person’s network of support (natural supports, paid supports, teachers, nurses, family members, guardians, friends, advocates, and/or other professionals). FRC classes include trained and paid self-advocate peer mentors with I/DD who serve as role models and leaders to ensure an integrated and coordinated approach to service delivery.

SERVICE	CRITERIA
Socialization and Sexuality Education	<p>Qualifying Criteria for SSE:</p> <ul style="list-style-type: none"> Service must be related to a Vision-driven desired outcome or meaningful day activity outlined in the Individual Service Plan (ISP); and Individual needs to acquire or improve social skills necessary for the development and maintenance of healthy friendships and/or intimate relationships; or Individual is currently at risk for abuse, neglect, and exploitation and needs to acquire or improve self-advocacy and self-protection skills, to become more independent in their relationships and their lives; or

<p>(SSE)</p> <p>Available to Children</p>	<ul style="list-style-type: none"> • Acquisition or improvement of social skills and healthy relationships will reduce the barriers in people’s lives that result in isolation. <p>Frequency of Clinical Review</p> <ul style="list-style-type: none"> • Initial • Every request <ul style="list-style-type: none"> ○ Validation of units <p>Additional Required Documentation: (ISP is required for all services.):</p> <ul style="list-style-type: none"> • Not applicable. <p>Applicable Limits on Amount Frequency and Availability: Amount available is twenty-four (24) classes (total of 48 hours per ISP term).</p>
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SUPPLEMENTAL DENTAL CARE

Supplemental Dental Care provides one routine oral examination and cleaning to adults on the Developmental Disabilities (DD) Waiver for the purpose of maintaining and/or preserving oral health. Supplemental Dental Care provided through the DD Waiver is for adults who require more than the number of cleanings in an Individual Service Plan (ISP) year than is available through the Medicaid State Plan.

SERVICE	CRITERIA
<p>Supplemental Dental Care</p>	<ul style="list-style-type: none"> • The need for an additional routine oral examination and cleaning in addition to what is allowable under the Medicaid State Plan to maintain and/or preserve oral health as indicated on a Doctor Visit Form signed by the treating dentist. <p>Additional Required Documentation (ISP is required for all services):</p> <ul style="list-style-type: none"> • Written Dental order or a Doctor Visit Form including the recommendation for the additional Dental visit. <p>Applicable Limits on Amount Frequency and Availability: Amount available is one (1) visit per Individual Service Plan (ISP) year in addition to the visits provided under the Medicaid State Plan.</p> <p>All Medically necessary dental services for individuals 18-21 years old are available through the EPSDT benefit.</p>

THERAPY SERVICES

Within the Developmental Disabilities (DD) Waiver, therapy services are to be delivered consistent with the Participatory Approach philosophy and the Collaborative-Consultative model of therapy. The Participatory Approach philosophy and the Collaborative-Consultative model of therapy support and emphasize increased participation, independence and community inclusion in combination with health and safety. Therapy services are designed to support achievement of Individual Service Plan (ISP) Visions and desired outcomes and prioritized areas of need identified through therapeutic assessment. Physical Therapy (PT), Occupational Therapy (OT), and Speech, Language Pathology (SLP) are skilled therapies that are recommended by an individual’s Interdisciplinary team (IDT) members and a clinical assessment that demonstrates the need for therapy services. A licensed practitioner, as specified by applicable state laws and standards, provides the skilled therapy services.

SERVICE	CRITERIA
<p>Therapy Services</p> <p>Available to 18 - 21 in addition to EPSDT for ARM support only</p>	<p>Qualifying Criteria for Therapy Services:</p> <p>There is a need for therapy to support an ISP Vision and/or Outcome as demonstrated by one or more of the following conditions:</p> <ol style="list-style-type: none"> 1. A health or safety issue has been identified that requires skilled therapy intervention; or 2. A need for targeted therapy services related to environmental modifications or assistive technology has been identified; or 3. A decline in baseline functional ability has been identified that requires skilled therapy intervention; or 4. Skilled therapy intervention is needed to increase, maintain, or slow loss of functional ability baseline; or 5. Skilled therapy intervention is needed to address unstable life circumstances, which may include but are not limited to: the person has a new home, the person has a new work responsibility, there is unusually high turn-over of DSP; or 6. There are other circumstances specific to the person that indicate the need for skilled therapy services; or 7. Primary Care Practitioner (PCP)/physician or outside assessment such as Supports and Assessment for Eating Clinic for Adults (SAFE), Transdisciplinary Evaluation and Support Clinic (TEASC), etc. have recommended therapy intervention that cannot be provided through the State Plan. <p>One or more of the criteria listed above will justify a therapist’s request for funding in the following instances:</p> <ol style="list-style-type: none"> 8. Initial Therapy Services with follow up activities. <ol style="list-style-type: none"> a. New Allocation to DD Waiver <p style="text-align: center;">Specialized/Focused/Targeted Evaluation requested by the IDT with</p>

related follow up.

9. Ongoing Therapy Services:

- a. Core
 - i. Stage of therapy
 - 1. Assessment/Evaluation
 - 2. Plan development and trials
 - 3. Active training (WDSI and/or TSS not yet consistently implemented)
 - ii. Individual’s life circumstances
 - 1. Not stable
 - 2. Recent move or new work task
- b. Fading
 - i. Stage of therapy
 - 1. Monitoring, observing
 - 2. Assessing progress
 - ii. Individual’s life circumstances
 - 1. Stable

3. Deliverables as identified on the Therapy Documentation Form:

- a. The individual has a need for the deliverable
- b. Using the Therapy Documentation Form, the therapist has provided information about plan for providing the deliverable

4. CARMP-Only Service

Frequency of Clinical Review

- Initial
- Request exceeds 45 hours (180 units) per year, per discipline, for initial requests and new allocations
- Request exceeds 35 hours (140 units) per year per discipline, for ongoing supports
- If request is for an increase in total units previously approved or from the previous ISP year
- Every three years

Additional Required Documentation (ISP is required for all services):

- DD Waiver Therapy Documentation Form, inclusive of justification for requested amount of therapy service units as detailed on the form; and the signature of the therapist with all applicable sections completed.

Applicable Limits on Amount Frequency and Availability:

- All medically necessary therapy services for children under the age of 21 are covered in the State plan pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.
- Individuals ages 18-20 who are receiving Family Living or Supported Living services and screened for moderate or high aspiration risk, may be approved only for therapy services to directly support aspiration risk management (ARM) in the home and community setting.

	<ul style="list-style-type: none">○ TDF indicates initial CARMP only services up to 100 units or ongoing CARMP units up to 68 units. Additional clinical documentation must be provided to support any level of service that is higher than the suggested unit thresholds on the TDF. Therapy services must relate specifically to CARMP strategies to address aspiration risk management.
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APPENDIX A: PBLs AND SUGGESTED BUDGET AMOUNTS

Table 1 Proposed Budget Levels

PBL	Table 1 Proposed Budget Levels (PBLs) 1-7, with descriptions of typical support needs
1	Adults in Proposed Budget Level 1 have minimal needs and require the least amount of staff support. Most of these adults have mild intellectual disabilities and can manage many aspects of their lives independently. Supports are typically of an intermittent nature, and people can spend significant amount of time alone and/or with unpaid natural supports. In general, they can engage independently in the community.
2	Adults in Proposed Budget Level 2 require more support than those in Budget Level 1, but typically only receive intermittent, rather than 24/7, paid supports. People in this Budget Level spend some alone, engaging independently in certain community activities and/or with unpaid natural supports. Many of these people have mild intellectual disabilities, although broader ranges of intellectual disabilities do occur in this Level. Although these people require more support to meet personal needs than those in Budget Level 1, their support needs are still minimal in several life areas.
3	Adults in Proposed Budget Level 3 include those who have mild to above average support needs and moderate to above average behavioral challenges but do not meet the extensive behavior support criteria of people in Budget Level 7. Adults in this group may be appropriate for 24/7 supports due to their behavioral issues and/or mental health diagnosis. Behavioral needs must indicate significant supervision needs due to a high frequency of disruptive behavior and/or presence of destructive behavior. Examples include behavior that impacts the person’s ability to retain a baseline level of independence, that interferes with quality of life, or that involves a health and safety risk needing behavioral recommendations to establish a safety net. Behavioral needs for these people, however, do not preclude them from engaging in many activities independently or semi-independently.
4	Adults in proposed Budget Level 4 have above average support needs relative to ADL. Support needs of those in Budget Level 4 may be associated with their level of intellectual disability. For people in this Budget Level, behavioral support needs range from mild to average and medical support needs are minimal. People in this level will require at least semi-regular 1-to-1 support in ADL or hands-on nursing support for medical needs.
5	Adults in Proposed Budget Level 5 have the highest support needs relative to ADL, which may also include significant physical supports. Some people in this group have medical support needs, although not in an amount to meet criteria for Budget Level 6. Support needs of those in Budget level 5 may be associated with their level of intellectual disability and some people may have mild to above average behavioral support needs.
6	Adults in Proposed Budget Level 6 have extensive to very complex medical support needs that require nurse management to minimize medical risk factors. Typically, maximum assistance with ADL is required to meet their extensive physical support needs and personal hygiene; including lifting/transferring and positioning. Someone in this Budget Level may be medically unstable or receiving hospice services due to diagnosed medical conditions. Having conditions that require regular significant medical attention or the need for regular hand-on support due to tube feedings, frequent seizures, etc. warrant inclusion in this Budget Level.
7	Adults in Proposed Budget Level 7 have extraordinary behavior support needs. These people typically require one-to-one supervision for at least a significant portion of each day. Many people in this group may have a mental health condition in addition to a developmental disability. Typically, these people would pose a safety risk to themselves or the community without continuous support. Placement in this group is generally not correlated to the person’s degree of ID.



Developmental Disabilities Supports Division
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Table 1 Suggested Dollar Amounts²

PBL 1	CIHS: Living Independently 12 hours /week of paid in-home supports, 5 hours a week of CCS Group and 12 months of employment support.	\$ 35,020
	CIHS: Living at Home with Family 10 hours a week of paid in-home supports, 5 hours a week of CCS Group and 12 months of employment support. Additionally, 500 hours per year of paid respite.	\$ 41,502
	Family Living: 365 days of residential support. 12 months of employment supports and 5 hours per week of CCS-Group.	\$ 58,495
	Supported Living: 365 days of residential support including 18 hours of nursing support per year, 12 months of employment supports and 20 hours per week of CCS-Group.	\$ 97,431
2	CIHS: Living Independently: 18 hours a week of paid in-home supports, 10 hours a week of CCS Group and 12 months of employment support.	\$ 46,273
	CIHS: Living at Home with Family: 15 hours a week of paid in-home supports, 10 hours a week of CCS Group and 12 months of employment support, and 500 hours per year of paid respite.	\$ 51,327
	Family Living: 365 days of residential support, 12 months of employment supports and 10 hours per week of CCS Group.	\$ 61,175
	Supported Living: 365 days of residential support including 18 hours of nursing support / year, 12 months of employment and 20 hours/ week of CCS-Group	\$ 97,431
3	CIHS: Living Independently: 20 hours a week of paid in-home supports, 15 hours a week of CCS Group and 12 months of employment support.	\$ 51,811
	CIHS: Living at Home with Family: 20 hours a week of paid in-home supports, 15 hours a week of CCS-Group and 12 months of employment support, 750 hours per year of paid respite.	\$ 65,821
	Family Living: 365 days of residential support, 12 months of employment supports and 20 hours per week of CCS Group.	\$ 66,535
	Supported Living: 365 days of residential support including 60 hours of nursing support/ year. Day service assumptions include 12 months of employment supports and 20 hours/ week of CCS Group.	\$ 113,867
4	CIHS: Living Independently 25 hours a week of paid in-home supports, 20 hours a week of CCS Group and 12 months of employment support.	\$ 61,636
	CIHS: Living at Home with Family: 20 hours a week of paid in-home supports, 20 hours a week of CCS-Group and 12 months of employment support. Additionally, 750 hours per year of paid respite.	\$ 68,501
	Family Living: 365 days of residential support, 12 months of employment supports and 20 hours per week of CCS-Group.	\$ 66,535
	Supported Living: 365 days of residential support including 60 hours of nursing support/ year, 12 months of employment supports and 20 hours/week of CCS-Group.	\$ 113,867



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PBL	Table 2 (cont.) ²	
5	Living Independently and receiving Customized In-Home Supports: 30 hours a week of paid in-home supports, 5 hours a week of CCS-I and 20 hours per week of CCS-Group .	\$ 69,901
	Living at Home with Family and receiving Customized In-Home Supports: 28 hours a week of paid in-home supports, 20 hours a week of CCS-Group and 5 hours a week of CCS-I, and 750 hours per year of paid respite.	\$ 85,813
	Family Living: 365 days of residential support.,5 hours per week of CCS-I and 20 hours per week of CCS-Group.	\$ 72,415
	Supported Living: 365 days of residential support including 120 hours of nursing support per year, 10 hours per week of CCS-I and 20 hours per week of CCS-Group.	\$ 154,263
6	Living Independently and receiving Customized In-Home Supports: 30 hours a week of paid in-home supports, 5 hours a week of CCS-I and 20 hours per week of CCS-Group.	\$ 74,661
	Living at Home with Family and receiving Customized In-Home Supports: 28 hours a week of paid in-home supports, 20 hours a week of CCS-Group and 5 hours a week of CCS-I, and 750 hours per year of paid respite.	\$ 85,813
	Family Living: 365 days of residential support. Day service assumptions include 10 hours per week of CCS-I and 15 hours per week of CCS-Group.	\$ 74,385
	Supported Living: 365 days of residential support including 120 hours of nursing support per year, 10 hours per week of CCS-I and 20 hours per week of CCS-Group.	\$ 154,263
7	Living Independently and receiving Customized In-Home Supports: 30 hours a week of paid in-home supports, 5 hours a week of CCS-I and 20 hours per week of CCS-Group.	\$ 74,661
	Living at Home with Family and receiving Customized In-Home Supports: 28 hours a week of paid in-home supports, 20 hours a week of CCS-Group and 5 hours a week of CCS-I, and 750 hours per year of paid respite.	\$ 85,813
	Family Living: 365 days of residential support, 10 hours per week of CCS-I and 15 hours per week of CCS-Group.	\$ 74,385
	Supported Living: 365 days of residential support including 120 hours of nursing support per year. Day service assumptions include 10 hours per week of CCS-I and 20 hours per week of CCS-Group.	\$ 154,263

¹ Dollar amounts may change based on current published fee schedule. Check budget worksheets for current amounts.

APPENDIX B: PROPOSED CORE BUDGET AMOUNTS FOR BSC

Children and Adults in **Core BSC Amount 1-Basic (30 hours/120 units)** range from individuals with mild intellectual disabilities and minimal intermittent support needs that can spend time alone and engage in the community independently (for children, level of independence is also related to the developmental period that the child has obtained), to those individuals who require maximum assistance with Activities of Daily Living (ADLs) due to cognitive or physical support needs. Behavioral support needs for this level range from mild to average; they may receive BSC to learn positive skills (e.g., better social skills and thus greater access to friendships/natural supports; better compliance with medical or psychiatric recommendations/care; successful employment and/or greater independence in a variety of settings, to include school environments for children) and to address behavior that is undesirable, may disrupt relationships and result in harm to self or others.

Children and Adults in **Moderate Core BSC Amount 2- Moderate (48 hours/192 units)** include those who have mild to above average support needs and moderate to above average behavioral challenges and/or skills deficits, but do not meet the extensive behavior support criteria of individuals in **Core BSC Amount 3 (Extensive)** The individuals receive support in development of positive skills that contribute to outcomes such as successful school and community adjustments, employment and greater independence (e.g., through improved social skills or better individual and team management/maintenance of emotional well-being) and/or to address behavior that is undesirable, may disrupt relationships and potentially result in harm to self or others.

Children and Adults in **Core BSC Amount 3 -Extensive (72 hours/288 units)** have extraordinary behavioral support needs; individuals receive BSC support in development of positive skills that contribute to successful school and community adjustments, employment, greater independence, and/or reduced behavioral challenges (e.g., such as improved capacity to control physical aggression toward self or others, or sexually inappropriate or offensive behavior toward others), particularly of those behaviors that result in physical injury and/or great emotional harm and that jeopardize the health and safety of the individual, his or her peers, staff, family, and community members.

APPENDIX C: ACRONYM LIST

Acronym	Clinical Criteria List of Acronyms July 1, 2017
ADLs	Activities of Daily Living
ANS	Adult Nursing Services
ARST	Aspiration Risk Screening Tool
AT	Assistive Technology
BBS	Bureau of Behavioral Supports
BCIP	Behavioral Crisis Intervention Plan
BSC	Behavioral Support Consultation
CARMP	Comprehensive Aspiration Risk Management Plan
CCS	Customized Community Supports
CIA	Client Individual Assessment
CIE	Community Integrated Employment
CIHS	Customized In-Home Supports
CMA	Certified Medication Aide
CMS	Centers for Medicare and Medicaid Services
DDW	Developmental Disabilities Waiver
DME	Durable Medical Equipment
DSP	Direct Support Professional
e-CHAT	Electronic Comprehensive Health Assessment Tool
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FL	Family Living
FMAE	Fiscal Management for Adult Education
I/DD	Intellectual/Developmental Disabilities
ICIE	Intensive Community Integrated Employment
IDT	Interdisciplinary Team
IMLS	Intensive Medical Living Services
ISP	Individual Service Plan
LOC	Level of Care Abstract
LPN	License Practical Nurse

MAAT	Medication Administration Assessment Tool
MAR	Medication Administration Record
MERP	Medical Emergency Response Plan
OR	Outside Review(er)
OT	Occupational Therapy/Therapist/Certified OT Assistant
PBL	Proposed Budget Level
PBSA	Positive Behavior Support Assessment
PBSP	Positive Behavior Support Plan
PCA	Person-Centered Assessment
PCP	Person Centered Planning
PPMP	PRN Psychotropic Medication Plan
PRSC	Preliminary Risk Screening & Consultation
PT	Physical Therapy/Therapist/PT Assistant
RMP	Risk Management Plan
RPST	Remote Personal Support Technology
RN	Registered Nurse
SAFE	Supports and Assessment for Eating Clinic for Adults
SL	Supported Living
SLP	Speech Therapy/Speech-Language Pathologist
TEASC	Transdisciplinary Evaluation and Support Clinic
TSS	Teaching and Support Strategies
WDSI	Written Direct Support Instructions