# INDEX

## 8.307.18 COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES WAIVER

8.307.18.1 ISSUING AGENCY ....1
8.307.18.2 SCOPE ....1
8.307.18.3 STATUTORY AUTHORITY ....1
8.307.18.4 DURATION ....1
8.307.18.5 EFFECTIVE DATE ....1
8.307.18.6 OBJECTIVE ....1
8.307.18.7 DEFINITIONS ....1
8.307.18.8 MISSION STATEMENT ....1
8.307.18.9 COLTS 1915 (C) HOME AND COMMUNITY BASED SERVICES WAIVER ....1
8.307.18.10 ELIGIBLE PROVIDERS ....1
8.307.18.11 PROVIDER RESPONSIBILITIES ....4
8.307.18.12 ELIGIBLE RECIPIENTS ....4
8.307.18.13 COVERED WAIVER SERVICES ....4
8.307.18.14 NON-COVERED SERVICES ....10
8.307.18.15 INDIVIDUALIZED SERVICE PLAN (ISP) ....10
8.307.18.16 PRIOR AUTHORIZATION AND UTILIZATION REVIEW ....10
8.307.18.17 REIMBURSEMENT ....10

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**TITLE 8 SOCIAL SERVICES**
**CHAPTER 307 COORDINATED LONG TERM SERVICES**
**PART 18 COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES WAIVER**

**8.307.18.1 ISSUING AGENCY:** New Mexico Human Services Department (HSD).
[8.307.18.1 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.2 SCOPE:** The rule applies to the general public.
[8.307.18.2 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.3 STATUTORY AUTHORITY:** The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by HSD pursuant to state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.307.18.3 NMAC - N, 12-15-12; Repealed. 10-15-12]

**8.307.18.4 DURATION:** Permanent.
[8.307.18.4 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.5 EFFECTIVE DATE:** October 15, 2012, unless a later date is cited at the end of a section.
[8.307.18.5 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.6 OBJECTIVE:** The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.307.18.6 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.7 DEFINITIONS:** [RESERVED]

**8.307.18.8 MISSION STATEMENT:** To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.307.18.8 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.9 COLTS 1915 (C) HOME AND COMMUNITY-BASED SERVICES WAIVER (CCW):** To assist New Mexicans, the medical assistance division (MAD) administers the CoLTS 1915 (c) waiver (CCW). The CCW provides home and community-based services to eligible recipients who are disabled or elderly, as an alternative to institutional residency.
[8.307.18.9 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.10 ELIGIBLE PROVIDERS:**

A. Eligible independent providers and provider agencies must have been approved by MAD or its designee. The provider must have an approved MAD provider participation agreement with MAD or its designee.

B. Individual service providers participate as employees or contractors of approved agencies, except as otherwise recognized by these rules. Providers may subcontract only with individuals who are qualified and must follow the general contract provisions for subcontracting.

C. Providers are required to follow state licensing regulations, as applicable. This includes, but is not limited to nurses, social workers, physical therapists (PTs), physical therapy assistants (PTAs), occupational therapists (OTs), certified occupational therapy assistants (COTAs), and speech language pathologists (SLPs). Refer to the New Mexico regulation and licensing department for information regarding applicable licenses.

D. Once enrolled, providers receive information including medicaid program policies, and other pertinent materials from MAD. As MAD sends new materials, providers are responsible for ensuring they receive, read and adhere to information contained in the materials.

E. **Requirements for home health care agencies that provide private duty nursing and respite services through the waiver:**

(1) Services can be provided only through eligible agencies.

(2) Agencies must be licensed by the department of health (DOH) as a home health agency pursuant to state law.

(3) A provider must:

(a) comply with all applicable federal, and state waiver regulations regarding services;
(b) provide supervision to each respite staff at least quarterly including an on-site observation of the services provided and a face-to-face interview of the eligible recipient being served; and
(c) comply with the Department of Health Act, NMSA 1978, Section 9-7-1, et seq. and the Employee Abuse Registry Act, NMSA 1978, Sections 27-7A-1, et seq.
(4) Providers must have available and maintain a roster of trained and qualified employees for back-up of regular scheduling and emergencies.
(5) A provider must ensure that each staff meets the following requirements:
(a) completes a services training program that may include, but is not limited to, agency in-service training or continuing education classes and that all training is documented:
(i) new staff must complete 10 hours of training prior to providing services;
(ii) following the first year of service provision, staff must complete a minimum of 10 hours of training annually;
(iii) new staff must complete a written competency test that demonstrates the skill and knowledge required to provide services with a minimum passing score of 85 percent or better, prior to or within 30 days of providing services; and
(iv) staff assigned to new clients must receive instructions specific to the individual recipient prior to providing services to the recipient;
(b) possesses a minimum of one year experience as an aide in a hospital, nursing facility (NF) or rehabilitation center; or two years experience in managing a home or family;
(c) successfully passed nationwide criminal history screening pursuant to 7.1.9 NMAC and in accordance with the Caregivers Criminal History Screening Act, NMSA 1978, Section 29-17-1, et seq.; documentation that the screen has been successfully passed must be maintained in the employee's personnel file;
(d) a current tuberculin (TB) skin test or a chest x-ray upon initial employment by the provider as defined by the DOH; a copy of these results must be maintained in the employees personnel file;
(e) a current cardiopulmonary resuscitation (CPR)/heart saver certification; a copy of this certification must be maintained in the employee's personnel file;
(f) a current first aid certification; a copy of this certification must be maintained in the employee's personnel file; and
(g) a valid state driver's license and a motor vehicle insurance policy if the eligible waiver recipient is to be transported by staff; copies of the driver's license and motor vehicle insurance policy must be maintained in the employee's personnel file.

F. **Requirements for skilled maintenance therapy provider agencies:** Skilled maintenance therapy includes PT for adults, OT for adults, and speech and language therapy (SLT) for adults.
(1) Skilled maintenance therapy services must be provided by eligible skilled maintenance therapy agencies or independent therapists.
(2) A physical, occupational and speech and language therapist and a physical therapist assistant (PTA) must possess a therapy license in their respective field from the New Mexico regulation and licensing department. A certified occupational therapist assistant (COTA) must possess an occupational therapy assistant certification from the New Mexico regulation and licensing department. A speech clinical fellow must possess a clinical fellow license from the New Mexico regulation and licensing department.
(3) Skilled maintenance therapy providers must:
(a) comply with all applicable federal and state waiver regulations and service standards regarding therapy services;
(b) ensure that all PTAs, COTAs and speech clinical fellows are evaluated by a licensed therapist supervisor licensed in the same field at least monthly in the setting where therapy services are provided; bi-monthly supervision must be provided;
(c) ensure all therapy services are provided under the order of the eligible waiver recipient's primary care provider; the therapy provider will obtain the order; the original of this order must be maintained by the therapy provider in the recipient's therapy file and the therapy provider must give a copy of the order to the service coordinator; and
(d) meet all other qualifications set forth in the CCW service standards.

G. **Requirements for assisted living facilities:**
(1) Assisted living services can be provided only by an eligible assisted living facility.
(2) An assisted living facility must:

(a) meet all the requirements and regulations, and be licensed by DOH as an adult residential care facility pursuant to 7.8.2 NMAC;

(b) provide a home-like environment; and

(c) comply with the provisions of Title II and III of the Americans with Disabilities Act (ADA) of 1990, (42 U.S.C. Section 12101, et seq.).

(3) An assisted living facility must:

(a) comply with all applicable federal, state and waiver regulations and service standards regarding services;

(b) ensure that individuals providing direct services meet all requirements for service provision; and

(c) ensure that individuals providing private duty nursing and skilled therapy services meet all requirements for these services if provided.

H. **Requirements for adult day health provider agencies:**

(1) Adult day health services can be provided only by eligible adult day health agencies.

(2) Adult day health facilities must be licensed by DOH as an adult day care facility.

(3) Adult day health facilities must meet all requirements and regulations set forth by DOH as an adult day care facility.

(4) An adult day health care provider agency must comply with the provisions of Title II and III of the Americans with Disabilities Act of 1990, (42 U.S.C. Section 12101 et seq.).

(5) An adult day health care provider agency must comply with all applicable city, county or state regulations governing transportation services.

I. **Requirements for environmental modifications providers:**

(1) Environmental modification services can be provided only by eligible environmental modification agencies.

(2) An environmental modification provider must have valid New Mexico regulation and licensing department, construction industries division, GB-2 class construction license pursuant to the Construction Industries Licensing Act NMSA 1978, Section 60-13-1 et seq.

(3) An environmental modification provider must:

(a) comply with all New Mexico state laws, rules, and regulations, including applicable building codes, and the laws and regulations of the Americans with Disability Act Accessibility Guidelines (ADAAG), the Uniform Federal Accessibility Standards (UFAS), and the New Mexico state building code; and

(b) provide at minimum a one-year warranty on all parts and labor.

J. **Requirements for emergency response providers:**

(1) Emergency response services can be provided only by eligible emergency response agencies.

(2) An emergency response provider must comply with all laws, rules and regulations of the New Mexico state public corporation commission for telecommunications and security systems, if applicable.
[8.307.18.10 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.11 PROVIDER RESPONSIBILITIES:**

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor’s instructions for billing and for authorization of services.

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

C. A MAD CCW provider must comply with all applicable federal regulations, MAD rules regarding the provision of covered waiver services and investigation requirements for providers of community based services pursuant to 7.1.13 NMAC or its successor.

D. Comply with DOH incident reporting.

E. Maintain a continuous quality management program with annual reports of the program implementation and outcomes. Reports must be submitted to MAD or its designee. See 8.302.1 NMAC, *General Provider Policies*.
[8.307.18.11 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.12 ELIGIBLE RECIPIENTS:**
A. CCW services are limited to the number of federally authorized unduplicated recipient (UDR) positions (slots) and program funding. Financial, non-financial and medical factors are used by HSD to determine an recipient's CCW eligibility. See: 8.200.400 NMAC through 8.200.500 NMAC, *Medicaid Eligibility-General Recipient Policies*, 8.290.500 NMAC through 8.290.600 NMAC, *Home and Community Based Waiver Services (Categories 090, 091, 092*, *093, 094, 095, 096)* and long term care services utilization review instructions for nursing facility (NF) level of care (LOC) located on the HSD/MAD website.
B. CCW services are provided to an eligible recipient who is enrolled in the CCW program.
C. In addition to meeting eligibility criteria specified above, an eligible recipient must be elderly (age 65 or older), or have a disability (blind or disabled) as determined by the disability determination unit utilizing social security disability guidelines, including duration and prognosis with respect to ability to be employed, and require a NF LOC or is currently residing in an institutional facility and is requesting a return to community living.
[8.307.18.12 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.13 COVERED WAIVER SERVICES:** The CCW covers the following services for a specified and limited number of MAD waiver eligible recipients as a cost effective alternative to institutionalization in a NF.
A. Service coordination operates independently within a CoLTS MCO using recognized professional standards adopted by the MCO and approved by the MAD, based on the service coordinator's independent judgment to support the needs of the eligible recipient and is structurally linked to the other MCO systems, such as quality assurance, recipient services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations. The MCO's service coordinator, who has experience in working with the elderly, individuals with disabilities, and others in need of long-term services, is responsible for ensuring that all applicable federal regulations and state rules involving service plan development are followed. Eligible service coordinator include: registered nurses (RN), licensed practical nurses (LPN), social workers, or individuals with at least a bachelor's degree in counseling, special education or a closely related field. Service coordination activities include **s**pecialized service management that is performed by a service coordinator, in collaboration with the eligible recipient or his personal representatives as appropriate, which are person-centered, and includes, but are not limited to:
(1) identification of the eligible recipient's needs, including physical health services, behavioral health services, social services, and long-term support services; and development of the eligible recipient's ISP or treatment plan to address those needs:
(2) assistance to ensure timely and coordinated access to an array of providers and services;
(3) attention to addressing unique needs of an eligible recipient; and
(4) coordination with other services delivered in addition to those noted in the ISP, as necessary and appropriate.
B. **Private duty nursing services for adults:** Private duty nursing services must be provided under the order and the direction of the eligible recipient's PCP. Eligible practitioners are RNs or LPNs. Services rendered are within the nurse's practice board scope of licensure, developed in conjunction with the interdisciplinary team and the eligible recipient's service coordinator.
(1) Private duty nursing services must be provided in accordance with all applicable federal regulations and state rules and service standards. Depending on the age of the eligible recipient, services may be covered under MAD's early periodic screening, diagnostic and treatment (EPSDT) services.
(2) Private duty nursing services include activities, procedures, and treatment for a physical condition, physical illness or chronic disability. Services include the following:
(a) medication management, administration and teaching;
(b) aspiration precautions;
(c) feeding tube management;
(d) gastrostomy and jejunostomy care;
(e) skin care and wound care;
(f) weight management;
(g) urinary catheter management and bowel and bladder care;

(h) health education;
(i) health screening;
(j) infection control and environmental management for safety;
(k) nutrition management;
(l) oxygen management;
(m) seizure management and precautions;
(n) anxiety reduction;
(o) staff supervision; and
(p) behavior supports and self-care assistance.

C. **Respite services:** Respite services are provided to an eligible recipient that is unable to care for him/herself and are furnished on a short term basis due to the absence or need for relief of the unpaid primary caregiver normally providing the care.

(1) Respite services may consist of non-nursing services or non-private duty nursing services, based on the eligible recipient's needs.

(2) Respite services may be provided in the eligible recipient's home, the respite provider's home, or the community.

(3) Services include assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities, and allowing community integration opportunities.

(4) Respite services are limited to a maximum of 100 hours annually per ISP year.

D. **Skilled therapy services for adults:** Skilled maintenance therapy services for adults include PT, OT and SLT services. Children receive these services through MAD EPSDT benefits.

(1) PT promotes gross and fine motor skills, facilitates independent functioning and works to prevent other progressive disabilities.

(a) Specific services may include:
(i) professional assessment(s), evaluations and monitoring for therapeutic purposes;
(ii) PT treatment interventions;
(iii) providing PT activity instruction to the eligible recipient;
(iv) usage of equipment and technologies while rendering a PT service to the eligible recipient;
(v) the designing, modifying or monitoring use of related environmental modifications;
(vi) the designing, modifying and monitoring the usage of related activities for use by the eligible recipient to support the ISP goals and objectives; and
(vii) with the approval of the eligible recipient, the therapist may consult and collaborate with other service providers and with the eligible recipient's caregivers.

(b) PT services must be provided in accordance with all applicable federal regulations and state and state and waiver rules.

(2) OT promotes fine motor skills, coordination, sensory integration, facilitates the use of adaptive equipment and assistive technology, facilitates independent functioning, and works to prevent other progressive disabilities.

(a) Specific services may include:
(i) teaching daily living skills instruction to the eligible recipient;
(ii) assisting the eligible recipient develop perceptual motor skills and sensory integrative functioning;
(iii) the designing, fabricating or modifying assistive technology or adaptive devices for use by the eligible recipient;
(iv) providing assistive technology services for use by the eligible recipient;
(v) the designing, fabricating or applying selected orthotic or prosthetic devices or selecting adaptive equipment for use by the eligible recipient;
(vi) utilizing the occupational therapist's specifically designed crafts and exercise to enhance the functioning of the eligible recipient;
(vii) providing OT activity training to the eligible recipient; and
(viii) with the approval of the eligible recipient, the therapist may consult and collaborate with other service providers and with the eligible recipient's caregivers.

(b) OT services must be provided in accordance with all applicable federal regulations, state and waiver rules.

(3) SLT preserves abilities for independent function in communication, facilitates oral motor and swallowing function, facilitates use of assistive technology, and works to prevent other progressive disabilities.

(a) Specific services may include:

(i) identifying and assessing the communicative or oropharyngeal disorders and delays in the development of communication skills of the eligible recipient;

(ii) working to prevent other communicative or oropharyngeal disorders and delays in the development of communication skills;

(iii) developing and implementing the eligible recipient's eating or swallowing plans, monitoring their effectiveness, and adjusting the plans as necessary;

(iv) utilizing the therapist's specifically designed equipment, tools, and exercises to enhance the functioning of the eligible recipient;

(v) the designing, fabricating or modifying assistive technology or adaptive devices for use by the eligible recipient;

(vi) providing assistive technology services for use by the eligible recipient;

(vii) adapting the environment to meet the needs of the eligible recipient;

(viii) providing SLT activity training to the eligible recipient; and

(ix) with the approval of the eligible recipient, the speech and language therapist may consult and collaborate with other service providers or with the eligible recipient's caregivers.

(b) SLT services must be provided in accordance with all federal regulations, state and waiver rules and service standards.

E. **Assisted living services:** Assisted living is a residential service that includes assistance with activities of daily living (ADL) services, companion services, medication management (to the extent required under state law and medication oversight as required by state law), 24-hour on-site response capability to meet scheduled or unpredictable needs of the eligible recipient, and to provide supervision, safety and security services to the eligible recipient. Services also include social and recreational programming. Coverage does not include 24-hour skilled care or supervision.

(1) Rates for room and board are excluded from the cost of services and are either billed separately by the provider or listed on an itemized statement that separates the costs of waiver services from the costs of room and board.

(2) Nursing and skilled therapy services are incidental, rather than integral to assisted living services. Nursing and skilled therapy services may be provided by third parties and must be coordinated with the assisted living facility.

(3) An assisted living facility must enter into an agreement with the eligible recipient that details all aspects of care to be provided including identified risk factors. The original agreement must be maintained in the eligible recipient's file and a copy must be provided by the assisted living facility to the eligible recipient's service coordinator.

(4) An assisted living facility must be provided by an assisted living facility that has been licensed and certified by DOH as an adult residential care facility, pursuant to 7.8.2 NMAC and all other applicable federal regulations, state and waiver rules.

F. **Adult day health services:** Adult day health services offer health and social services to assist an eligible recipient achieve optimal functioning and activates, motivates and rehabilitates the eligible recipient in all aspects of his or her physical and emotional well-being, based on the eligible recipient's specific needs.

(1) Services include:

(a) a variety of activities for an eligible recipient to promote personal growth and enhance the eligible recipient's self-esteem by providing opportunities to learn new skills and adaptive behaviors, improve capacity for independent functioning, or provide for group interaction in social and instructional programs and therapeutic activities; all activities must be supervised by program staff;

(b) supervision of self-administered medication ;

(c) the eligible recipient's involvement in the greater community;

(d) transportation of the eligible recipient to and from the adult day health program; and

(e) meals that do not constitute a "full nutritional regime" of three meals per day.

(2) Services are generally provided for two or more hours per day on a regularly scheduled basis, for one or more days per week, through a MAD enrolled assisted living facility. Services must be provided as set forth by DOH pursuant to 7.13.2 NMAC.

(3) The provider must assure the inside and outside of its facility meets federal, state and waiver health and safety requirements.

(4) Adult day health services include nursing services and skilled maintenance therapies (OT/PT/SPT) that must be provided in a private setting at the eligible recipient's adult day health facility. The nursing and skilled maintenance therapies do not have to be directly provided by the facility. If directly provided, the facility must meet all federal regulations, state and waiver rules for the provision of these services.

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

(1) Adaptations include the following:

(a) installation of ramps and grab-bars;

(b) widening of doorways or hallways;

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

(d) purchase and installation of lifts or elevators;

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

(f) turnaround space adaptations;

(g) specialized accessibility, safety adaptations and additions;

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

(i) purchase and installation of automatic door openers or doorbells, voice-activated, light-activated, motion-activated and electronic devices;

(j) fire safety adaptations;

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

(l) purchase and installation of alarm and alert systems or signaling devices;

(m) air filtering devices;

(n) heating/cooling adaptations; and

(o) glass substitute for windows and doors.

(2) Service coordinators must consider alternative methods of meeting the eligible recipient's needs prior to listing environmental modifications on the ISP.

(3) Environmental modifications have a limit of up to $5,000 every five years.

(4) The environmental modification provider must ensure proper design criteria is addressed in planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction or remodeling services, provide administrative and technical oversight of construction projects, provide consultation to the eligible recipient's family members as appropriate, waiver providers and contractors concerning environmental modification projects to the eligible recipient's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

(5) The environmental modification provider must submit the following information:

(a) an environmental modification evaluation;

(b) a service cost estimate including equipment, materials, supplies, labor, travel, per diem;

(c) a letter of acceptance of service cost estimate signed by the eligible recipient;

(d) a letter of permission from owner of property;

(e) a construction letter of understanding detailing the work proposed;

(f) photographs of the proposed modification; and

(g) documentation demonstrating compliance with the American with Disabilities Act Accessibility Guidelines (ADAAG), the uniform federal accessibility standards (UFAS), and the New Mexico state building code.

(6) After the completion of work, the environmental modification provider must submit the following to the MCO:

(a) a letter of approval of work completed, signed by the eligible recipient; and

(b) photographs of the completed modifications.

(7) Environmental modification services must be managed by professional staff available to provide technical assistance and oversight for environmental modification projects.

(8) Environmental modification services shall be provided in accordance with all applicable federal regulations, state and waiver rules.

H. **Emergency response services:** Emergency response services provide an electronic device that enables an eligible recipient to secure help in an emergency.

(1) Emergency response services include:
(a) testing and maintaining equipment;
(b) training to the eligible recipient, caregivers and first responders on use of the equipment;
(c) 24 hour monitoring for alarms;
(d) checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.
(2) The response center must be staffed by trained professionals.
(3) Emergency response service categories are emergency response and emergency response high need.
(4) An emergency response provider shall provide the eligible recipient with information regarding services rendered, limits of services and information regarding agency service contracts.
(5) The emergency response center will provide within 24 hours a report to the eligible recipient's CoLTS MCO all emergencies and changes in the eligible recipient's condition that may affect service delivery, complete and submit a quarterly report to the eligible recipient's MCO, of which the original report must be maintained in the eligible recipient's.
(6) Emergency response services shall be provided in accordance with all applicable federal regulations, state and waiver rules.
(7) The eligible recipient may also wear a portable "help" button to allow for mobility. The system is connected to the eligible recipient's phone and programmed to signal a response center when a "help" button is activated. The response center reacts to the signal to ensure the eligible recipient's health and safety.

I. **Service coordination**: Service coordination operates independently within the MCO using recognized professional standards adopted by the MCO and approved by MAD, based on the service coordinator's independent judgment to support the needs of the eligible recipient and is structurally linked to the other MCO systems, such as quality assurance, eligible recipient services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations. The MCO's service coordinator, who has experience in working with the elderly, individuals with disabilities, and others in need of long-term services, is responsible for ensuring that all applicable federal regulations, state and waiver rules and CCW services standards involving service plan development are followed. Service coordinators can be RNs, LPNs, social workers, or individuals with at least a bachelor's degree in counseling, special education or a closely related field. Service coordination activities include specialized service management that is performed by a service coordinator, in collaboration with the eligible recipient or the eligible recipient's family or representatives as appropriate, which are person-centered, and includes, but is not limited to:
(1) identification of the eligible recipient's needs, including physical health services, behavioral health services, social services, and long-term support services; and development of the eligible recipient's ISP or treatment plan to address those needs;
(2) assistance to ensure timely and coordinated access to an array of providers and services;
(3) attention to addressing unique needs of the eligible recipient; and
(4) coordination with other services delivered in addition to those noted in the ISP, as necessary and appropriate.

J. **Community transition goods and services:**
(1) CCW community transition goods and services: These are non-recurring set-up expenses for an eligible recipient who is transitioning from a qualified institution to a qualified community setting. In order to be eligible for this service, the eligible recipient must have a minimum 30-calendar day NF stay prior to transition to his/her community. Allowable expenses are those necessary to enable the eligible recipient to establish a basic household that do not constitute room and board and may include:
(a) security deposits that are required to obtain a lease on an apartment or home where the eligible recipient will reside;
(b) essential household furnishings required to occupy the eligible recipient's residence including furniture, window coverings, food preparation items, and bed/bath linens;
(c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
(d) services necessary for the eligible recipient's health and safety such as pest eradication and one-time cleaning prior to occupancy;
(e) moving expenses related to the eligible recipient's change of residence;
(f) within 180 calendar days prior to the eligible recipient's occupancy of the new residence, necessary home environmental modifications to support the eligible recipient;

(g) specialized medical equipment and supplies not otherwise covered by MAD and purchased within 60 days of the scheduled transition;

(h) assistive technology and durable medical equipment not otherwise covered by MAD purchased within 60 calendar days of the scheduled transition;

(i) nutrition support services such as short-term nutritional counseling and education in food preparation skills;

(j) non-medical transportation;

(k) non-medical transportation supports such as vehicle modification;

(l) family services to support or educate the informal support network; and

(m) the purchase and related costs of service dogs up to service limits.

(2) Community transition goods and services are furnished only to the extent that the goods or services:

(a) are reasonable and necessary as determined through the service plan development process;

(b) are clearly identified in the service plan;

(c) cannot be obtained from other sources;

(d) are not prohibited by federal regulations and state rules and service standards;

(e) are not experimental in nature; and

(f) the eligible recipient has no other access to these services.

(3) Community transition goods and services do not include monthly rental or mortgage expense, food, regular utility charges, or household appliances or items that are intended for purely diversion/recreation purposes.

(4) CCW community transition goods and services are limited to $3,500.00 per person every five years. In order to be eligible for this service, the eligible recipient must have a minimum of a 30-calendar day NF stay prior to transitioning to his/her community. The individual's eligibility status as an eligible recipient must be verified prior to discharge from the NF. CCW transition goods and services are limited to an eligible recipient who has established medicaid eligibility prior to discharge from the NF or qualifying facility.

K. **Community relocation specialist services:** The CoLTS MCO is responsible for the designation and the oversight of the community transition relocation specialist (CTRS). CTRS services are specialized services, provided while the eligible recipient is in a NF and at a minimum, during the first 60 calendar days of the transition period.

(1) The CTRS must assess the eligible recipient's needs, complete a service plan, assist the eligible recipient arrange for and procure needed resources for the move from the NF to the community, and monitor transition service delivery. The CTRS provides the eligible recipient information on MAD's home and community-based service options, its transition process, and other relevant issues. The CTRS works with the eligible recipient, his support network when applicable, and his MCO service coordinator to develop a person-centered, community-based transition plan. This plan includes a detailed transition plan and budget, and is as part of the eligible recipient's ISP.

(2) The CTRS and the eligible recipient in the NF work together to ensure that the needed services, goods and supports are in place prior to the eligible recipient's move. The CTRS is to ensure the caregiver has specific education to provide the necessary services to the eligible recipient. The CTRS works with the MCO service coordinator to ensure transition services are included in the comprehensive ISP and are implemented and monitored by the service coordinator.

(3) The CTRS must provide services for an eligible recipient:

(a) a minimum of 60 calendar days if institutionalized for six or more months; or

(b) a minimum of 14 calendar days if institutionalized for less than six months;

(c) services are limited to 10 hours or up to $500 per transition per eligible recipient;

(d) services are limited to no more than 180 calendar days prior to transition from the NF to the community; and

(e) services are limited to no more than 60 calendar days following transition from the NF to the community.

[8.307.18.13 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.14 NON-COVERED SERVICES:** A CCW eligible recipient receives full state plan medicaid benefits in addition to the CCW services listed as covered waiver services in this rule. MAD does not cover room and board as a waiver service or as ancillary services. See 8.301.3 NMAC, *General Noncovered Services* for an overview of non-covered services.

[8.307.18.14 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.15 INDIVIDUALIZED SERVICE PLAN (ISP):** An ISP must be developed by an interdisciplinary team of professionals in collaboration with the eligible recipient and others involved in the eligible recipient's care. The ISP must be in accordance with the CCW service standards.

A. The interdisciplinary team must review the ISP at least every six months or more often if indicated.

B. The individualized services plan must contain the following information:

(1) a statement of the nature of the specific problem and the specific needs of the eligible recipient;

(2) a description of the functional level of the eligible recipient;

(3) a statement of the least restrictive conditions necessary to achieve the purposes of treatment;

(4) a description of intermediate and long-range goals for the eligible recipient, with a projected timetable for their attainment and the duration and scope of services;

(5) a statement and rationale of the ISP for achieving the eligible recipient’s intermediate and long-range goals, including provision for review and modification of the eligible recipient’s plan;

(6) the specification of responsibilities for areas of care, description of needs, and orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the eligible recipient; and

(7) a person-centered service plan for community-based transition benefits, services and budget for a recipient eligible for such benefits and services.

[8.307.18.15 NMAC - N, 12-15-10; Repealed, 10-15-12]

**8.307.18.16 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:** All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews by medicaid or its designee may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, CCW providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior authorization:** To be eligible for CCW services, recipients must meet the LOC requirements for services provided in a NF. LOC determinations are made by medicaid or its designee. The ISP must specify the type, amount and duration of services. All services specified in the ISP require prior authorization from medicaid or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid and CCW services or other health insurance prior to the time services are furnished. Recipients may not be institutionalized, or hospitalized, or receive other HCBS waiver services at the time CCW services are provided with the exception of transition goods and services and relocation specialist services. See 8.290.400.10 NMAC, *basis for defining the group*.

C. **Reconsideration:** Providers who disagree with the denial of a prior authorization request or other review decisions may request a re-review and reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [8 NMAC 4.MAD.953].

[8.307.18.16 NMAC - N, 12-10-12; Repealed, 10-15-12]

**8.307.18.17 REIMBURSEMENT:** Once enrolled, agencies receive instructions on documentation, billing, and claims processing. Claims must be filed per the billing instructions in the medicaid policy manual for FFS or by the CoLTS MCO in managed care. Providers must follow all medicaid billing instructions. FFS reimbursement to providers of waiver services is made at a predetermined reimbursement rate. See 8.302.2 NMAC, *Billing For Medicaid Services.*

[8.307.18.17 NMAC - N, 12-15-10; Repealed, 10-15-12]

**HISTORY OF 8.307.18 NMAC:**

**Pre-NMAC History:** The material in this part was derived from that previously filed with the State Records Center.

ISD-Rule 310.2000, Coordinated Community In-Home Care Services, 3/19/84.

**History of Repealed Material:**

ISD-Rule 310.2000, Coordinated Community In-Home Care Services, Repealed 1/18/95.

8 NMAC 4.MAD.733, Disabled and Elderly Home and Community-Based Services Waiver, filed 1/10/97 - Repealed effective 8/1/2006.
8.314.2 NMAC, Disabled and Elderly Home and Community-Based Services Waiver, filed 7/18/2006 - Repealed effective 12-15-2010.
8.307.18 NMAC, CoLTS 1915 (c) Home and Community-Based Services Waiver, filed 11-29-2010 - Repealed effective 10-15-2012.