TITLE 8 SOCIAL SERVICES
CHAPTER 371 DEVELOPMENTAL DISABILITIES
PART 5 SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY

8.371.5.1 ISSUING AGENCY: New Mexico Health Care Authority, Developmental Disabilities Supports Division.
[8.371.5.1 NMAC - N, 7/1/2024]

8.371.5.2 SCOPE:

A. For each individual with developmental disabilities receiving services in the community, either through state general funds or federal funding through the developmental disabilities medicaid waiver, there shall exist a single, unified individual service plan, or ISP. This ISP shall be developed by a single interdisciplinary team, or IDT, consisting of the individual, the guardian, parents, family, and representatives from all key community service provider agencies servicing to the individual, regardless of their source of funding, as well as advocates and others invited to participate by the individual.

B. These regulations shall apply to all individuals with developmental disabilities living in the community, regardless of whether their services are funded through the developmental disabilities medicaid waiver or through state general fund contracts with community providers. The following groups are *excluded* from these regulations, as their services and service delivery are addressed in other regulations:

(1) children, aged birth to three, who are recipients of services covered by the federal Individuals with Disabilities Education Act (IDEA), Part C as administered under the New Mexico family, infant and toddler program;

(2) early periodic screening, diagnosis and treatment (EPSDT) case management recipients, unless allocated to the DD waiver;

(3) medically fragile waiver recipients;

(4) state general funded recipients of only ancillary services (non-residential and non-day program services), such as respite and the various therapies;

(5) community ICF/MR group home residents, covered by federal ICF regulations, except *Jackson* class members.
[8.371.5.2 NMAC - N, 7/1/2024]

8.371.5.3 STATUTORY AUTHORITY: Subsection E Section 9-7-6 NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (authority) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.371.5.3 NMAC - N, 7/1/2024]

8.371.5.4 DURATION: Permanent.
[8.371.5.4 NMAC - N, 7/1/2024]

8.371.5.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.371.5.5 NMAC - N, 7/1/2024]

8.371.5.6 OBJECTIVE:

A. These regulations contain a process for development of an individual service plan for persons with a developmental disability. The requirements set out in these regulations apply, with some exceptions, to providers of services to persons with developmental disabilities living in the community.

B. These regulations are promulgated, in part, to satisfy requirements arising from the implementation of the decision in *Jackson, et al. v. Fort Stanton, et al.*, N.M. Dist. Ct. No. Civ. No. 87-839. These regulations incorporate certain agreements reached by the parties, including the authority, to the *Jackson* lawsuit.

C. The purpose of this regulation is to establish a framework for planning, designing, implementing and modifying the individual service plan for an individual with developmental disabilities living in the community.
[8.371.5.6 NMAC - N, 7/1/2024]

8.371.5.7 DEFINITIONS:

A. The Interdisciplinary Team (IDT):

(1) The **"interdisciplinary team (IDT)"** is responsible for the development of the individual service plan (ISP) and for identifying the agencies and individuals responsible for providing the services and supports identified in the ISP.

(2) The IDT shall consist of the following core members:

(a) **"individual":** the person with a developmental disability for whom the ISP is written;

(b) **"case manager":** the independently-funded professional responsible for service coordination to indviduals with developmental disabilities on the developmental disabilities medicaid waiver; the case manager must be external to, and independent from, the community service provider agency;

(c) **"guardian":** the court appointed guardian of an adult individual or the custodial parent(s) if the individual is a minor;

(d) **"helper":** the individual may choose a helper to assist with communication; in instances where the individual is unable to make this choice, the guardian may choose a helper, if desired; the helper may be a friend, housemate, family member, teacher, co-worker, current or former employee of an agency or facility with which the individual has had contact, foster grandparent, or any other person from the individual's circle of relatives, friends and acquaintances;

(e) **"key community service provider staff"**: "key" community service providers are providers of residential employment, day program and behavioral services specifically designed for persons with developmental disabilities; "key" provider staff participating in the IDT shall include, at a minimum:

(i) **"direct service staff"**: the provider staff member(s) directly responsible for the provision of specified services to the individual with developmental disabilities;

(ii) **"service coordinator":** the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency;

(f) **"ancillary service providers":** the service provider agencies and staff providing non-residential and non-day services, either specifically designed for individuals with developmental disabilities or generic in nature, regardless of funding source; examples of ancillary services include nutritional services, physical therapy, occupational therapy, speech therapy, respite, nursing, etc.; as well as services provided by the individual's physician and other medical personnel;

(g) **"designated healthcare coordinator"** the team member designated to coordinate medical supports and services which the individual requires to manage any chronic health conditions and to access preventative healthcare services;

(h) **"others":** unless the individual objects, other participants may include family members not already mentioned, if invited by the individual or guardian; advocates or other chosen representatives who participate in the ISP development process on the individual's behalf; representatives of generic services, who may participate in the IDT with the individual's or guardian's consent; representatives of the public school system, if the individual is of school age and attends public school; and, any others that the individual wishes to have attend the IDT meeting.

B. **Content of individual service plans:**

(1) **"Demographic information":** The individual's name, age, date of birth, important identification numbers (i.e., medicaid, medicare, social security numbers, level of care), address, phone number, guardian information (if applicable), physician name and address, primary care giver or service provider(s), date of the ISP meeting (either annual, or revision), scheduled month of next annual ISP meeting, and team members in attendance.

(2) **"Long-term vision":** A written statement of the individual's personal vision for the future.

(3) **"Outcomes":** Desired outcomes generated by the individual, guardian and the team. An outcome is a realistic change that can occur in the individual's life, that the individual can achieve and that leads towards the attainment of the individual's long-term vision. For example, an outcome may state that the individual obtain preferred employment or that the individual learn to drive.

(4) **"Individual preference":** The individual's preferences, capabilities, strengths and needs in each life area determined to be relevant to the identified ISP outcomes shall be reflected in the ISP. The long term vision, age, circumstances and interests of the individual, shall determine the life area relevance, if any, to the individual's ISP.

(5) **"Action plans":**

(a) specific action plans designed to assist the individual in achieving each identified desired outcome listed in the ISP, by the team, which include criteria for measuring progress, timelines and responsible parties on each action step.

(b) service providers shall develop specific tasks and strategies (methods and procedures) for implementing each specified action step within timelines established by the IDT.

(6) "Assistive technology": Necessary support mechanisms, devices, and environmental modifications including the rationale for the use of assistive technology or adaptive equipment when a need has been identified, shall be documented in the ISP. The rationale shall include the environments and situations in which assistive technology is used. Selection of assistive technology shall support the individual's independence and functional capabilities in as nonintrusive a fashion as possible.

(7) "Availability of supports and services": Identification of potential supports and services for individuals by the IDT should be undertaken without regard to the cost of the supports and services or whether they are actually available at that time in the community.

(8) "Signature form": A signature form, containing the name, phone number and role on the IDT of all team members shall be included in the ISP. All individuals attending the annual IDT meeting shall sign the signature form to indicate their participation in the planning process. For all team members not in attendence the alternative method of their participation shall be stated on the signature line. (e.g. telephone, written report, premeeting consultation or designated representative).

(9) "Budget page": For individuals receiving services through the developmental disabilities medicaid waiver a proposed budget page developed by the case manager in consultation with the various service providers shall be included in the ISP.

[8.371.5.7 NMAC - N, 7/1/2024]

8.371.5.8 INTRODUCTION:

A. For all recipients of the developmental disabilities medicaid waiver services, this interdisciplinary team shall be chaired by the individual, if they so desire, or by the independent case manager. Services called for in the ISP shall be coordinated by the independent case manager according to the procedures described herein.

B. For all state general fund recipients, this interdisciplinary team shall be chaired by the individual, if he or she desires, or by the designated service coordinator of a community service provider agency. Services called for in the ISP shall be coordinated by the service coordinator staff of the key community service provider agency according to the procedures described herein.

C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by accreditation entities approved and adopted by the developmental disabilities supports division and the health care authority. It is the policy of the developmental disabilities support division (DDSD) that to the extent permitted by funding, each individual receive supports and services that will assist and develop independence and productivity in the community and take affirmative action to prevent regression or loss of current capabilities. Services and supports include specialized and generic services, training, education or treatment as determined by the IDT and documented in the ISP.

D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities.

[8.371.5.8 NMAC - N, 7/1/2024]

8.371.5.9 GUIDING PRINCIPLES: The following principles shall provide direction and purpose in planning with individuals with developmental disabilities.

A. Principle No. 1: The individual with developmental disabilities has choices in, and ownership of, the planning process. If the individual is unable to independently communicate, the team shall use observed preferences and consultation with close friends, family members, guardians, helpers, direct service staff and advocates to guide decisions.

B. Principle No. 2: A person-centered planning process shall be used to maintain the self-esteem of the person with developmental disabilities.

C. Principle No. 3: The individual's long-term vision statement shall guide assessments, planning, plan implementation and service evaluation. The plan shall describe reasonable accommodations and supports to assist the individual in the realization of the individual's vision.

D. Principle No. 4: Planning shall focus on outcomes or results which the individual wishes to achieve.

E. Principle No. 5: The plan shall address individual strengths and capabilities in developing action plans and strategies for reaching desired outcomes.

F. Principle No. 6: Visions shall usually reflect results which can be reached within one (1) year. Action plans will delineate which activities will be completed within one year and those which will be detailed in future plans or plan modifications.

G. Principle No. 7: The team developing the action plan shall recognize and understand that behavior is a form of communication.

H. Principle No. 8: 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.

I. Principle No. 9: The planning process shall be tailored to each individual's culture, communication style, physical requirements, learning style and personal preferences.

[8.371.5.9 NMAC - N, 7/1/2024]

8.371.5.10 AVAILABILITY OF SUPPORTS, SERVICES AND FUNDS AND DDSD APPROVALS:

A. The case manager assures that identification of potential supports and services for the individual by the IDT is undertaken without regard to the cost of the supports and services or whether they are actually available at that time in the community. If needed supports and services are not available this shall be reported to the DDSD regional office by the case manager.

B. For individuals who are not *Jackson* class members, in specifying the supports and services in the ISP required to be provided, the IDT, exercising professional judgment, may take into account the availability of supports and services. If supports or services are identified in the ISP, but not required to be provided in the exercise of professional judgment taking into account the availability of services, the IDT shall promptly submit a list of these unavailable supports and services to the DDSD. The DDSD shall use these lists to identify appropriate community resource needs and develop strategies to add community supports and services for persons with developmental disabilities, subject to appropriations for this purpose.

C. For *Jackson* class members, the ISP shall include the supports and services identified by the IDT.

D. The ISP for individuals who are on the developmental disabilities medicaid waiver, including *Jackson* class members, must be reviewed and approved by the DDSD, as to the cost of the individual's ISP, and aggregate costs of ISPs, and as to compliance with medicaid regulations and DDSD standards. If the DDSD does not approve the ISP because of cost or non-compliance with DDSD standards, the ISP will be returned to the IDT with appropriate instructions to develop an ISP that meets requirements and is within the DDSD's budget parameters. The ISP for these individuals will not be implemented unless and until it is approved by the DDSD.

E. Because cost limitations are established upfront in the contracting process for persons funded solely by state general funds, the above ISP review and approval process (per Subsection D of 8.371.5.10 NMAC above) is not required. The DDSD reserves the right to conduct on-site reviews for compliance with applicable policy and regulation.

[8.371.5.10 NMAC - N, 7/1/2024]

8.371.5.11 THE INTERDISCIPLINARY TEAM:

A. The interdisciplinary team (IDT) is responsible for the development of the individual service plan (ISP) and for identifying the agencies and individuals responsible for providing the services and supports identified in the ISP.

B. The IDT shall consist of the following core members:

(1) individual: the individual shall be actively encouraged to participate in all IDT meetings and the ISP development process; this participation shall include, but not be limited to, expressing a personal vision statement for the future, indicating desired outcomes that help to realize that vision, identifying action plans that will achieve those outcomes, and personally chairing the IDT meeting, if desired and when able to do so;

(2) case manager: the duties of the case manager in relation to the individual with developmental disabilities and the IDT shall include:

(a) coordinating the development, modification and implementation of the ISP in consultation with the IDT and the individual;

(b) monitoring the integration and coordination of the individual's services;

(c) serving as the IDT chairperson, or assisting the individual in chairing the IDT meeting if he or she is capable of doing so and wishes to do so;

(d) scheduling IDT meetings annually, or more often as needed, to review or modify the ISP, and encouraging optimum participation by all IDT members;

(e) monitoring supports and services being delivered as specified in the ISP as determined by the IDT;

(f) reviewing progress on chosen outcomes, and action plans and through consultation with the IDT, amending the ISP, if needed;

(g) through timely consultation with the IDT, modifying unsuccessful service programs and developing service programs for previously unaddressed but significant individual needs that may arise prior to the next scheduled ISP meeting;

(h) advocating on behalf of the individual by making recommendations and requests on behalf of the individual;

(i) ensuring objective, quantifiable data has been systematically recorded, analyzed and used to determine effectiveness of service provided in order to justify needed changes in services;

(j) coordinating and monitoring any follow-up needed as a result of reviews;

(k) serving as liaison between the IDT and the public school system, the special education division, or any other community service teams relevant to the individual served; and

(l) assisting the community service providers in community placement or other services as needed and as specified by the IDT;

(3) the case manager ensures that the IDT identified services and supports for the individual without regard to their current availability; at the conclusion of the IDT meeting the case manager shall document unavailable services on the appropriate page of the ISP form, which is provided for this purpose, and submits this list to the DDSD, regional office;

(4) guardian: the guardian shall convey to the IDT information about the individual, historical or otherwise, which shall be useful in the development of the ISP;

(5) helper: the helper is someone who knows the individual's capabilities, interests, likes, and dislikes and who can assist the individual in communicating these with the IDT; in turn, the helper may assist the individual in understanding the ISP development process and the individual service plan that is developed;

(6) "key" community service provider staff: "key" community service providers are providers of residential, employment day program and behavioral services specifically designed for persons with developmental disabilities; "key" provider staff participating in the IDT shall include, at a minimum:

(a) direct service staff: the participation of direct service staff in the development of the individual service plan is crucial, as they are the persons who work directly with the individual within their respective domains; at least one provider staff member from each of the "key" service areas (residential, day/work-related and behavioral), who is directly involved in the provision of services to the individual in those areas, must be in attendance at all IDT meetings;

(b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the individual's progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more "key" community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows:

(i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;

(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;

(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;

(iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;

(7) ancillary service providers: ancillary service providers shall participate in the IDT meeting and the ISP development process through written assessments, evaluations or reports to the IDT, or in person; the case manager, in consultation with the individual and the IDT, shall determine the need for personal participation at IDT meetings on the part of any ancillary service provider;

(8) designated healthcare coordinator: the team member designated to coordinate medical supports and services which the individual requires to manage any chronic health conditions and to access preventative healthcare services;

(9) others: unless the individual objects, other participants may include family members not already mentioned, if invited by the individual or the ISP development process on the individual's behalf; representatives of general services, who may participate in the IDT with the individual's or guardians' consent; representatives of the public school system, if the individual is of school age and attends public school; and, any others that the individual wishes to have attend the IDT meeting.

[8.371.5.11 NMAC - N, 7/1/2024]

8.371.5.12 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - PARTICIPATION IN AND SCHEDULING OF INTERDISCIPLINARY TEAM MEETINGS:

A. Prior to the initial IDT meeting the case manager shall provide the individual and guardian, if any, with an orientation to the person-centered planning process, purpose of the ISP and roles and responsibilities of IDT members. After completion of the ISP, the individual and guardian shall be offered the opportunity to meet with the case manager and ask questions regarding the completed ISP within 30 days of the meeting, if desired.

B. The IDT shall be convened at least annually and may be convened as frequently as conditions or circumstances warrant to review and modify the ISP. If an ISP includes programs or services which restrict an individual or a behavioral program subject to the DDSD behavior support policy, the IDT shall review the relevant program or service at least quarterly. In situations where an individual is at risk of significant harm, the team shall convene within one working day, in person or by teleconference. If necessary, the ISP shall be modified accordingly within 72 hours.

C. The IDT meeting shall be scheduled and conducted by the case manager who will solicit and facilitate the full participation of all team members. The individual shall be present unless he/she chooses not to attend. If any member is unable to attend IDT meetings, arrangements for their involvement shall be made through teleconference, designated representatives, or in the case of ancillary services, written reports provided to the case manager prior to the meeting.

D. The case manager shall provide written notice of the annual IDT meeting at least 21 days prior to the meeting. Notice shall be provided to the individual, their representative, guardian, providers and other invited participants. The case manager shall consult IDT members prior to scheduling the meeting in order to determine the best dates and times. The case manager shall attempt to accommodate team member's scheduling needs shall be accomodated as long as the timing does not jeopardize continued eligibility for the DD Waiver. A request for a change of meeting date made by the individual and guardian. Written documentation of notice and scheduling activities will be maintained by the case manager in the individual's records.

E. For state general funded services, the initial IDT meeting shall be held within 60 days of the start of services, and then annually thereafter. For all other developmental disabilities medicaid waiver recipients, the IDT meeting shall be held annually based upon the previous or initial ISP approval date.

F. In the event the individual or guardian requests that others be invited to attend the IDT meeting, the case manager shall also provide them with notification of the meeting.

G. The case manager will convene the IDT on an "as needed" basis to modify (revise or amend) the ISP once it has been developed. Participants may attend through teleconference.

H. The IDT shall be convened to discuss and modify the ISP, as needed, to address:

(1) a significant life change, including a change in medical condition or medication that affects the individual's behavior or emotional state;

(2) situations where an individual is at risk of significant harm. In this case the team shall convene within one working day, in person or by teleconference; if necessary, the ISP shall be modified accordingly within 72 hours;

(3) changes in any desired outcomes, (e.g. desired outcome is not met, a change in vocational goals or the loss of a job);

(4) the loss or death of a significant person to the individual;

(5) a serious accident, illness, injury or hospitalization that disrupts implementation of the ISP;

(6) individual, guardian or provider requests for a program change or relocation, or when a termination of a service is proposed; the DDSD's policy no. 150 requires the IDT to meet and develop a transition plan whenever an individual is at risk of discharge by the provider agency or anticipates a change of provider agency to identify strategies and resources needed; if the individual or guardian is requesting a discharge or a change of provider agency, or there is an impending change in housemates the team must meet to develop a transition plan;

(7) situations where it has been determined the individual is a victim of abuse, neglect or exploitation;

(8) criminal justice involvement on the part of the individual (e.g., arrest, incarceration, release, probation, parole);

(9) any member of the IDT may also request that the team be convened by contacting the case manager; the case manager shall convene the team within 10 days of receipt of any reasonable request to convene the team, either in person or through teleconference;

(10) for any other reason that is in the best interest of the individual, or any other reason deemed appropriate, including development, integration or provision of services that are inconsistent or in conflict with the desired outcomes of the ISP and the long term vision of the individual;

(11) whenever the DDSD decides not to approve implementation of an ISP because of cost or because the DDSD believes the ISP fails to satisfy constitutional, regulatory or statutory requirements.

[8.371.5.12 NMAC - N, 7/1/2024]

8.371.5.13 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) ASSESSMENTS:

A. Assessment information, as described in Subsection C of 8.371.5.13 NMAC, shall be utilized to develop and revise the ISP. The individual, helper, family members and friends shall be provided an opportunity to present their perceptions regarding the individual's progress and current status. The observations and perceptions of people who know the individual well shall be considered when decisions regarding the ISP are made.

B. All IDT members shall review clinical and other assessments and evaluations completed on behalf of the individual. These assessments must be prepared with enough time for adequate review prior to the annual IDT meeting. Service providers preparing written assessment reports shall be responsible for submitting these documents to the IDT members at least two weeks prior to the scheduled annual IDT meeting. The case manager shall review written assessment reports with the individual and guardian prior to the IDT meeting.

C. Relevant IDT members, including ancillary service providers, shall prepare reports at least two weeks in advance of the IDT meeting, based on their assessments of the individual's progress and current status in the domain for which they are responsible. Reports shall include, at a minimum, a client individual assessment (CIA) and a long term care abstract (LOC) completed by the case manager at least annually in consultation with the IDT; adaptive behavior scales completed by relevant IDT members; assessments from the various disciplines providing services to the individual (such as vocational evaluations, physical therapy evaluations, history and physical, etc.); objective data to corroborate evaluation information; reports by progress residential and day program providers; information, historical or otherwise, provided by guardians or family members; direct observations, especially during transitional periods. IDT members shall report other relevant information depending on the individual's service needs. Assessments shall be performed in settings normally utilized whenever possible.

D. When the IDT determines further independent assessment is needed, the team shall develop action plans within the ISP that addresses the need for such an assessment, including responsibility and timelines. Implementation of any action plan related to independent assessment shall be monitored by the case manager.

E. At the IDT meeting, team members shall:

(1) elicit and develop the individual's long term vision statement;

(2) review and discuss clinical and other assessments and evaluation reports in relation to the individual's abilities, interests, preferences and desired outcomes;

(3) review objectives, quantifiable data information from the previous ISP to determine the effectiveness of services and interventions and use this information when determining new or revised outcomes, action plans and strategies for the ISP under development;

(4) use the comprehensive compilation of client assessment information and the long term vision statement to perform a functional assessment; this functional assessment identifies the supports and services needed in assisting the individual in the attainment of the long term vision; for example, the functional assessment may evaluate the use of an interpreter as a support or assistive communication devices, environmental modifications, etc.; and

(5) the functional assessment shall reflect the experience, choices, cultural background, skills, needs and abilities of the individual; this functional assessment precedes the development of the action plan at

the IDT meeting; functional assessments shall reflect the individual's current skills and abilities in relation to the individual's environment and community; functional assessments shall include the interpretation of clinical assessments and evaluations in assisting the individual in meeting the long term vision.
[8.371.5.13 NMAC - N, 7/1/2024]

8.371.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain.

A. Demographic information: The individual's name, age, date of birth, important identification numbers (ie., medicaid, medicare, social security numbers), level of care address, phone number, guardian information (if applicable), physician name and address, primary care giver or service provider(s), date of the ISP meeting (either annual, or revision), scheduled month of next annual ISP meeting, and team members in attendance.

B. Long term vision: The vision statement shall be recorded in the individual's actual words, whenever possible. For example, in a long term vision statement, the individual may describe him or herself living and working independently in the community.

C. Outcomes:

(1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP.

(2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities meadicaid waiver.

D. Individual preference: The individual's preferences, capabilities, strengths and needs in each life area determined to be relevant to the identified ISP outcomes shall be reflected in the ISP. The long term vision, age, circumstances, and interests of the individual, shall determine the life area relevance, if any to the individual's ISP.

E. Action plans:

(1) Specific ISP action plans that will assist the individual in achieving each identified, desired outcome shall be developed by the IDT and stated in the ISP. The IDT establishes the action plan of the ISP, as well as the criteria for measuring progress on each action step.

(2) Service providers shall develop specific action plans and strategies (methods and procedures) for implementing each ISP desired outcome. Timelines for meeting each action step are established by the IDT. Responsible parties to oversee appropriate implementation of each action step are determined by the IDT.

(3) The action plans, strategies, timelines and criteria for measuring progress, shall be relevant to each desired outcome established by the IDT. The individual's definition of success shall be the primary criterion used in developing objective, quantifiable indicators for measuring progress.

(4) Provider agencies shall use formats to complete strategies relating to the ISP action plans during or after the IDT meeting. Separate provider agencies working to coordinate specific strategies to achieve the same action plans shall develop their strategies jointly. Service provider agencies shall develop strategies that are clearly integrated and associated with the individual's long term vision, outcomes, action plans and therapy recommendations identified by the IDT. Therapists shall provide input into the development of strategies either directly or through review and revision prior to submission to the case manager. Provider agencies shall submit strategies for inclusion into the ISP to the case manager within two weeks following the ISP meeting. The case manager shall review the strategies for consistency.

(5) Supports and services, including services available to the general public, determined by the IDT and indicated in the ISP, shall be relevant to the individual's long term vision, desired outcomes and action plans. Supports and services shall be the least restrictive, not unduly intrusive and not excessive in light of the individual's needs.

F. Assistive technology: Necessary support mechanisms devices, and environmental modifications including the rationale for the use of assistive technology or adaptive equipment when a need has been identified, shall be documented in the ISP. The rationale shall include the environments and situations in which assistive

technology is used. Selection of assistive technology shall support the individual's independence and functional capabilities in as nonintrusive a fashion as possible.

G. Availability of supports and services:

(1) Identification of potential supports and services for individuals by the IDT should be undertaken without regard to the cost of the supports and services or whether they are actually available at the time in the community.

(2) For individuals who receive services through state general fund or developmental disabilities medicaid waiver but who are NOT *Jackson* class members, the IDT, exercising professional judgment, may take into account the availability of supports and services in specifying in the ISP the supports and services required to be provided. If supports or services are identified in the ISP, but not required to be provided in the exercise of professional judgment taking into account the availability of services, the IDT shall promptly submit a list of these unavailable supports and services to the DDSD.

(3) For *Jackson* class members, the ISP shall include the supports and services identified by the IDT.

(4) The DDSD shall use these lists to identify appropriate community resource needs and develop strategies to add community supports and services, generally, for persons with developmental disabilities, subject to appropriations for this purpose.

H. Signature form:

(1) A signature form, containing the name, phone number and role on the IDT of all team members shall be included in the ISP. All individuals participating in the annual IDT meeting shall sign the signature form to indicate their participation in the planning process.

(2) Signing this form does not affect the individual's or guardian's right, if any, to dispute all or part of the ISP or to initiate a complaint or grievance procedure. The case manager shall explain the right to dispute or to file a grievance to the individual and guardian at the IDT meeting. The case manager shall inform the individual and guardian of the DDSD, office of quality assurance, its role and function in monitoring services in the community, as well as the role and function of any other relevant monitoring agencies, such as the licensing and certification bureau of the division of health improvement and adult protective services program of the aging and long term services department. The case manager shall give the individual and guardian their business address and phone number, as well as the 800 number of the DDSD's office of quality assurance and other relevant numbers.

I. Budget page: For individuals receiving services through the developmental disabilities medicaid waiver, a proposed budget page developed by the case manager in consultation with the various service providers shall be included in the ISP.

[8.371.5.14 NMAC - N, 7/1/2024]

8.371.5.15 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - APPROVAL OF THE ISP BY THE DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION:

A. The ISP for recipients of the medicaid developmental disabilities waiver services (including *Jackson* class members) must be reviewed by the DDSD as to the cost of the individual's ISP and aggregate costs of ISPs and as to compliance with DDSD standards and medicaid regulations. If the DDSD does not approve an ISP because of cost or non-compliance, the ISP will be returned to the IDT with appropriate instructions to develop an ISP that meets requirements and is within the DDSD's budget parameters. The ISP for developmentally disabled medicaid waiver recipients (including *Jackson* class members) shall not be implemented until approval by the DDSD.

B. Because cost limitations are established upfront in the contracting process for persons funded solely by state general funds, the above ISP review and approval process (per Subsection A of 8.371.5.15 NMAC above) is not required. The DDSD reserves the right to conduct on-site review for compliance with these regulations.

[8.371.5.15 NMAC - N, 7/1/2024]

8.371.5.16 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - IMPLEMENTATION OF THE ISP: The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan.

[8.371.5.16 NMAC - N, 7/1/2024]

8.371.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:

A. The case manager shall provide copies of the completed ISP, with all relevant service provider strategies attached, within 14 days of ISP approval to:

(1) the individual;

(2) the guardian (if applicable);

(3) all relevant staff of the service provider agencies in which the ISP will be implemented, as well as other key support persons;

(4) all other IDT members in attendance at the meeting to develop the ISP;

(5) the individual's attorney, if applicable;

(6) others the IDT identifies, if they are entitled to the information, or those the individual or guardian identifies;

(7) for all developmental disabilities mediciad waiver recipients, including *Jackson* class members, a copy of the completed ISP containing all the information specified in 8.371.5.14 NMAC, including strategies, shall be submitted to the local regional office of the DDSD;

(8) for *Jackson* class members only, a copy of the completed ISP, with all relevant service provider strategies attached, shall be sent to the *Jackson* lawsuit office of the DDSD.

B. Current copies of the ISP shall be available at all times in the individual's records located at the case management agency. The case manager shall assure that all revisions or amendments to the ISP are distributed to all IDT members, not only those affected by the revisions.

C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed.

D. The ISP shall be consistent with all relevant health care authority and DDSD rules, policies, procedures operational guidelines, including, but not limited to, the HCA operational procedures; standards and applicable accreditation standards approved by the authority and DDSD; the behavioral support policy, the *Jackson* management manual (appendices A and B); the medicaid waiver operations manual; the program standards for DD community agencies; the case manager standards and client rights regulations. Confidentiality and individual rights shall be protected at all times.

E. For *Jackson* class members, the request to initiate a dispute under appendix B of the *Jackson* management manual shall automatically delay implementation of the disputed portions of the ISP until the dispute is resolved unless the health or safety of the individual would be adversely affected. Any dispute raised under appendix B shall be decided under the hearing officer guidelines for decisions contained in the appendix.

F. Nothing in this regulation shall provide an entitlement to programs, supports, services or benefits or create any legal rights that do not otherwise exist under other law or regulation.

G. The health care authority's decision regarding the allocation of resources to any ISP is final, (within the HCA) in the authority's sole discretion, and is not reviewable in the dispute resolution process or other agency administrative review process.

H. Community service provider agencies and case management agencies shall modify or amend their internal policies and procedures regarding ISP development to reflect the provisions stated within the ISP regulations. All ISPs and all modifications to ISPs shall be developed in compliance with these regulations.
[8.371.5.17 NMAC - N, 7/1/2024]

8.371.5.18 SANCTIONS. The authority or other governmental agency having regulatory enforcement authority for community based services provider agencies who have entered into contracts or medicaid provider agreements with the health care authority, developmental disabilities supports division, may sanction in accordance with applicable law if the service provider fails to provide services as set forth by this rule. Such sanctions may include revocation or suspension of license, directed plan of correction, intermediate sanctions or civil monetary penalty up to $5000 per instance, or termination or non-renewal of any contract with the authority or other governmental agency.
[8.371.5.18 NMAC - N, 7/1/2024]

HISTORY OF 8.371.5 NMAC: RESERVED