



Mi Via Self-Directed Waiver Program

Service Standards

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all previous editions of the Mi Via Service Standards*

MI VIA WAIVER SERVICE STANDARDS

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1. INTRODUCTION TO MI VIA

A. Purpose

Mi Via, which means ‘my path,’ ‘my way,’ or ‘my road,’ is New Mexico’s Medicaid self-directed home and community-based services (HCBS) waiver program. Mi Via is the result of the efforts of many individuals and groups state-wide, starting in 1999, to realize the inclusion of self-direction as an option in New Mexico’s HCBS waivers. Mi Via is intended to provide a community-based alternative to institutional care that facilitates greater participant choice, direction and control over services and supports.

Mi Via provides self-directed home and community-based services to eligible participants who have intellectual and/or developmental disabilities (I/DD), or medically fragile conditions (MF) with I/DD.

Mi Via participants receiving waiver services access acute and ancillary services through a Centennial Care Managed Care Organization (MCO).

The program is administered through a partnership between the Department of Health (DOH) and Human Services Department (HSD). The Medicaid Mi Via Waiver application, regulations (8.314.6 NMAC) and these Service Standards determine the direction for the Mi Via program.

B. Guiding principles

All participants:

- Are able to self-direct their program with appropriate supports;
- Have value and potential;
- Will be viewed in terms of their abilities;
- Have the right to participate and be fully included in their communities; and
- Have the right to live, work, learn, and receive services and supports to meet their individual needs, in the most integrated settings possible within their community.

C. Philosophy of Self-Direction

Self-direction is a tool that leads to self-determination, through which participants can have greater control over their lives and have more freedom to lead a meaningful life in the community. Within the context of Mi Via, self-direction means participants choose which services, supports and goods they need. Participants also decide when, where and how those services and supports will be provided and who they want to provide them. Participants decide who they want to assist them with planning and managing their services and supports. Self-direction means that participants have more choice, control, flexibility, freedom, and responsibility.

D. Participant Rights and Freedoms

As a person with an intellectual and/or developmental disability (I/DD), and a person receiving services, I have the same basic legal, civil, and human rights and responsibilities as everyone else. My rights shall never be limited or restricted unnecessarily; without due process and the ability to challenge the decision, even if I have a guardian. All my rights should be honored through any assistance, support, and services I receive.

Some Examples of My Rights Include:

- Get paid competitive wages to work in an inclusive setting
- Contribute to my community
- Access services in the community the same way people who don't receive services do
- Full inclusion in community and cultural life
- Have access to education and information in a way I can understand
- Choose where I live based on what I can afford
- Choose who I live with
- Lock my doors and home, and choose those who may come in
- Access common places in my home
- Exercise tenant rights in accordance with state law
- Accessibility wherever I go
- Choose to be alone and my privacy respected
- Privacy and confidentiality
- Access to all my personal information (financial, medical, programmatic, behavioral, legal)
- Receive information to make informed decisions regarding my health care.
- Choose supports that I need and want
- Choose from all available supports
- Independence
- Choose/develop my own schedule
- Go out at any time
- Develop my own person-centered plan of support
- Be treated with dignity and respect
- Control my money
- Be free from coercion, restraint, seclusion, and retaliation
- Have visitors at my home at any time
- Choose when/what to eat, and have access to food at any time
- Choose my clothing
- Be part of a family or start one
- Live with my partner or get married
- Form loving relationships, either platonic or sexual, with whomever I choose
- Be free from abuse, neglect, exploitation
- Have access to advocacy supports and resources
- Participate in any discussion about restricting my right
- Vote
- Exercise religion or belief of my choice

Any restriction or modification to these rights:

- Must demonstrate informed consent by me.
- Must have an assurance that interventions and supports will cause no harm to me.
- Must be the result of a documented health and safety issue.
- Must be reflected in the person-centered plan.
- Must have documented less intrusive supports that were attempted prior to the modification/restriction.
- Will be communicated to me; in a way I can understand.
- Requires regular review to measure and assess effectiveness of restriction/modification.
- Requires a fade-out plan for the restriction/modification.

E. Participant Responsibilities

Mi Via participants have certain responsibilities in order to participate in the program. Failure to comply with these responsibilities or other program rules and regulations can result in disenrollment from the Mi Via program, through voluntary or involuntary termination, which could include transfer to the traditional model of DD or MF HCBS waiver programs.

The most basic responsibility of a Mi Via participant is to maintain their financial and medical eligibility to be in the program. This includes completing the required HSD documentation and participating in the annual comprehensive in-home assessment (IHA) of the Level of Care (LOC) conducted by the Third-Party Assessor (TPA). The Mi Via consultant is available to assist with the Medicaid application and recertification process as needed.

On-going participant responsibilities include:

- Comply with the rules and regulations that govern the program; and
- Maintain an open and collaborative relationship with the consultant and work together with the consultant to determine support needs related to the activities of self-direction, develop an appropriate Service and Support Plan (SSP)/budget request, receive necessary assistance with carrying out the approved SSP/budget and with documenting service delivery.

If a participant is utilizing employees, they must designate an Employer of Record (EOR). An eligible recipient may be his or her own EOR unless the eligible recipient is a minor or has plenary or limited guardianship or conservatorship over financial matters in place. A Power of Attorney (POA) or other legal designation made by the legal guardian, may be used to assign the EOR responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR as designated in this rule.

- An eligible recipient may also designate an individual of his or her choice, through a POA or other legal designation, to serve as the EOR, subject to the EOR meeting the qualifications specified in 8.314.6 NMAC. If a participant is utilizing vendor services only, an EOR is not necessary, however, an employee, contractor or sub-contractor of the vendor may not sign off on the invoice or Payment Request Form (PRF) for the participant. If a participant has vendors only and chooses not to have an EOR the participant must identify an Authorized Representative. The participant may be his or her own Authorized Representative provided the participant is not a

minor and does not have a plenary or limited guardianship or conservatorship over financial matters. In some instances, an EOR may be required by the state. The PRF may only be signed by the EOR or Authorized Representative.

- Communicate with the consultant face to face monthly with at least four of those face-to-face visits occurring in the home, report concerns or problems with any part of Mi Via to the consultant;
- Use program funds appropriately by only requesting services and goods covered by the Mi Via program and only purchasing services and goods after they have been approved by the TPA;
- Comply with the approved SSP and not spend more than the authorized annual budget (AAB);
- Work with the TPA by attending scheduled meetings and IHA's and providing documentation as requested;
- Respond to requests for additional documentation and information from the consultant provider, Fiscal Management Agency (FMA), and the TPA within the required deadlines;
- Report to the local Income Support Division (ISD) office, within ten (10) calendar days, any change in circumstances, including a change in address, which might affect eligibility for the program. Changes in address or other contact information must also be reported to the consultant provider and the FMA within 10 days calendar;
- Report to the TPA and consultant provider if hospitalized for more than three (3) nights so that a new appropriate LOC can be obtained; and
- Communicate with Mi Via supports, State contractors and State personnel in a non-abusive and non-threatening manner.

The participant/EOR also have specific responsibilities related to being an employer. These include:

- Submit all required documents to the FMA. Documents must be completed and provided to the FMA according to the timelines and rules established by the State of NM. Documents include, but are not limited to, vendor and employee enrollment agreements, vendor information forms, criminal background check forms, timesheets, payment request forms (PRFs) and invoices, and other documentation needed by the FMA to enroll and/or process payment to employees and vendors;
- Report any incidents of abuse, neglect or exploitation by any employee or other support to the appropriate State entity;
- Arrange for the delivery of services, supports and goods
- Hire, train, schedule, supervise or dismiss Mi Via supports (vendors and/or employees);
- Maintain employee and service records and documentation (for at least six (6) years from date of service and ongoing) in accordance with Mi Via regulations and Federal and State employment rules; and
- When necessary, request assistance from the consultant with any of these responsibilities.

Human Rights

Civil rights apply to everyone, including all waiver participants, family members, guardians, natural supports, and vendors or employees. Everyone has a responsibility to make sure those rights are not violated.

CMS Final Rule: Home and Community-Based Services (HCBS) Settings Requirements

On January 16, 2014, CMS published a Final Rule addressing several sections of the Social Security Act. The Final Rule amends the federal regulations which govern 1915 (c) HCBS waiver programs. These rules are an important step forward in federal policy, supporting inclusion, and integrating people with I/DD into the community. Providers, vendors and employees must ensure they are meeting the new requirements and be in full compliance with all CMS settings requirements by 2024.

The intent of the CMS Final Rule is to ensure that people receiving long-term services and supports through the 1915 (c) HCBS waiver programs under Medicaid authority, have maximum independence and choice, have full access to benefits of community living, and can receive services in the most integrated setting appropriate. The CMS Final Rule works to enhance the quality of HCBS and provides protections to participants. The HCBS setting requirements focuses on the nature and quality of individual experiences. All HCBS settings must:

1. be integrated in and facilitate full access to the greater community;
2. ensure the person receives services in the community to the same degree of access as people not receiving Medicaid HCBS services;
3. maximize independence in making life choices;
4. be chosen by the person (in consultation with the guardian if applicable) from all available living and day options, including non-disability specific settings;
5. ensure the right to privacy, dignity, respect, and freedom from coercion and restraint;
6. optimize individual initiative, autonomy, and independence in making life choices;
7. provide an opportunity to seek competitive employment; and
8. facilitate choice of services and who provides the services.

All providers, vendors, employees and supports have a responsibility to:

1. monitor settings for compliance;
2. monitor that waiver recipients receive choices; and
3. ensure rights are respected.

F. Conflicts of Interest

Mi Via Consultant agencies shall not engage in any activities in their capacity as a provider of services to an eligible participant that may be a conflict of interest.

Consultant Agencies are required to mitigate real or perceived conflict of interest issues.

Consultants are agents responsible for the development of the SSP and as such must also adhere to the following:

1. Consultant Agency owners and their employed or contracted Consultants may not:

- a. Be related by blood or affinity to the person supported, or to any paid caregiver of the individual supported.
 - b. Have material financial interest in any entity that is paid to provide DD Waiver or Mi Via services. A material financial interest is defined as anyone who has, directly or indirectly, any actual or potential ownership, investment, or compensation arrangement.
 - c. Be empowered to make financial or health related decisions for people on their caseload.
 - d. Be related by blood or affinity to any Mi Via Waiver service provider for individuals on their caseload. Provider Agencies are identified as Mi Via consultants, Mi Via vendors, BSC's and therapists.
2. A Mi Via Consultant may not serve as the EOR, personal representative or authorized representative, or authorized signer for an eligible participant for whom they are the consultant.
 3. A Consultant Agency may not be a Provider Agency for any other Mi Via Waiver service.
 4. A Consultant Provider Agency must disclose to, both DDS and to people supported by their agency, any familial relationships between the agency's employees/subcontracting consultants and employees or subcontractors of services of other Mi Via Waiver services.
 5. A Consultant or Director of a Consultant Agency may not serve on the Board of Directors of any Mi Via Waiver support services.
 6. Consultant Agency staff and subcontractors must maintain independence and avoid all activity which could be perceived as a potential conflict of interest.
 7. A Consultant Agency may not provide guardianship services to an individual receiving Consultant services from that same agency.
 8.
 - i. that is not reimbursed to the Consultant under separate payment from the vendor or employee (e.g., review of individual preferences or other aspects of the ISP).

Mi Via Waiver Consultant Agencies must mitigate any conflict of interest issues by adhering to at least the following:

1. Any individual who is an employee or subcontractor of an entity that is compensated for providing Mi Via Waiver services to an individual must not serve as guardian or Power of Attorney for that individual, except when related by affinity or consanguinity [§ 45-5-31(1) A NMSA (1978)]. Affinity which stems solely from the caregiver relationship is not sufficient to satisfy this requirement.
2. Mi Via Waiver Consultant Agencies may not employ or subcontract with a spouse or domestic partner to support the person in services.

Conflict-Free Service and Support Coordination

Mi Via Waiver Provider Agencies, vendors and employees are responsible for assuring person centered planning occurs, including considerations for conflict free service planning which:

1. prevents program-centered versus person-centered planning;
2. avoids patterns of vendor or employee budget requests being made prior to the SSP development;
3. avoids undue influence of the Mi Via Waiver vendor or employee on the person's schedule and/or choice of activities; and
4. prevents desired outcomes from being developed before the person's vision has been discovered, clarified, and analyzed.

If any of the above have occurred or appear to be occurring, Mi Via Waiver Provider Agencies, vendors and employees have the right to use the Regional Office Request for Assistance (RORA) process detailed below.

Regional Office Request for Assistance (RORA)

DDSD has statewide Regional Offices to provide information and technical assistance to anyone at any time. Specifically, each Regional Office is staffed with generalists and program area experts (e.g. Mi Via Liaisons, Community Inclusion Coordinators, Nurses, Behavior Specialists, Trainers, and Crisis Specialists) to assist with any specific Mi Via Waiver questions and to provide technical assistance.

DDSD's RORA system is the mechanism to track any formal requests for Regional Office assistance. The system operates as follows:

1. Provider Agencies, vendors or employers can make requests for assistance for various reasons.
2. Typical requests are listed in specific categories on the RORA template available on the DOH website <https://nmhealth.org/about/ddsd/>.
3. The RORA form should be completed in its entirety by the requestor and submitted to the appropriate Regional Office via Therap S-Comm or via fax.

G. Solicitation

Employees/Vendors/Providers may market their services but are prohibited from soliciting participants under any circumstances such as offering a participant or their authorized representative gratuities in the form of entertainment, gifts, financial compensation to alter the participant's selection of providers, vendors or employees, service agreements, medication, supplies, goods or services.

H. Coordination with MCO Services

"Centennial Care" is New Mexico's comprehensive managed care delivery system that offers the full array of current Medicaid services, including acute, behavioral health, and home and

community based services/long term care (for those programs that require a nursing facility level of care) through a person-centered care coordination system for which those at the highest level of acuity and risk for poor health outcomes will be guided through the system and assisted in developing personalized plans to assure that all necessary services are provided.

The Centennial Care Managed Care Organizations (MCOs) cover existing services under the current Medicaid benefit package for their members. This includes acute, ancillary, specialty, behavioral, and home and community-based services/long-term care services (for those programs that require a nursing facility level of care).

The MCOs provide acute and ancillary medical and behavioral health services to Home and Community Based Services (HCBS) waiver recipients/MCO members. The MCO is responsible for ensuring a Comprehensive Care Plan is initiated upon enrollment and assigning a Care Coordinator for coordinating all services in the MCO Comprehensive Care Plan. The MCOs and respective Care Coordinators assigned to HCBS waiver recipients cannot make recommendations or changes to the Mi Via participant's Service and Support Plan (SSP) and budget. A Comprehensive Needs Assessment (CNA) completed by the MCO is not required for eligibility for the HCBS waiver programs. HCBS waiver recipients undergo a medical eligibility process that is conducted separately from the MCO.

The process to ensure coordination of care for MCO members includes:

- a. Coordination of the member's health care needs through the development of the care plan;
- b. With the member's consent to share information, the care plan should be shared and utilized by those involved in providing care to the member;
- c. Collaboration with the member, member's family, friends, member's PCP, specialists, Behavioral Health providers, other providers, communities, and interdisciplinary team experts, as needed when developing the care plan;
- d. Verification of all decisions made regarding the member's needs and services, and ensures all information is documented in a written, comprehensive plan.

For Mi Via participants, the process to ensure coordination of the MCO Comprehensive Care Plan with Mi Via services includes the following components:

- a. The TPA is authorized to provide to the MCO a copy of the LOC abstract (MAD 378 form or DOH 378 forms as applicable) and, as applicable, the Comprehensive Individual Assessment (CIA) or comprehensive family centered review for the purpose of obtaining a complete, comprehensive picture of the participant and their needs.
- b. The MCO will utilize the LOC and CIA information to complete certain portions of CNA.
- c. While the MCO is responsible for the annual CNA visits and the Consultant assists the participant with the Mi Via LOC assessment process and SSP development, the MCO and Consultant are encouraged to coordinate the CNA visits and TPA LOC in-home assessment at the same time to reduce the burden to the participant/member and the participant's family.

2. GENERAL AUTHORITY AND REQUIREMENTS

The Centers for Medicare and Medicaid Services (CMS) approves the Mi Via Self-Directed Waiver.

Mi Via provides self-directed home and community-based services (HCBS) to individuals who are both financially eligible and medically eligible under the ICF/IID Level of Care (LOC) guidelines (8.314.6. NMAC). Eligible waiver participants include people who are eligible to receive services through the Home and Community Based Services Waivers for those that are Developmentally Disabled (DD) or Medically Fragile (MF).

The Mi Via Self-Directed Waiver is established in New Mexico regulation by 8.314.6 NMAC. (NMAC is the New Mexico Administrative Code which is the official compilation of current rules filed by State agencies). According to 8.314.6 NMAC, the Mi Via Service Standards set forth the processes necessary to implement and administer the Mi Via Waiver.

The State prohibits the use of any restraints, restrictive interventions and/or seclusion in the implementation of Mi Via Waiver services. Examples of these could include the use of forced physical guidance, over correction, isolation, physical restraint, mechanical restraint and/or chemical restraint designed as aversive methods to address and/or preclude challenging behaviors. Mi Via participants have the right to be free from restraint, restrictive interventions, seclusion and coercion.

Mi Via services must be provided in integrated settings and facilitate full access to the community; ensure the participant receives services in the community to the same degree of access as those individuals not receiving Home and Community-Based Services (HCBS) services; maximize independence in making life choices; be chosen by the participant in consultation with the guardian as applicable; ensure the right to privacy, dignity, respect, and freedom from coercion and restraint; optimize participant initiative, autonomy and independence in making life choices; provide an opportunity to seek competitive employment; and facilitate choice of service and who provides them.

3. DEFINITIONS AND ACRONYMS

Affiliated Agency - An affiliated agency is defined as a direct service agency providing Mi Via services that has a marital, domestic partner, blood, business interest or holds financial interest in providing direct care for individuals receiving Mi Via services.

Authorized Annual Budget (AAB) - The Authorized Annual Budget (AAB) is the amount of the annual budget approved for a participant by the Third-Party Assessor (TPA). Participants work with their consultant to develop an annual budget request, which is submitted to the TPA for review and approval. The total amount approved by the TPA is the AAB.

Authorized Representative – The individual designated to represent and act on the participant’s behalf. The participant or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, conservator, or any other individual or individuals designated in writing by the

participant to make decisions on their behalf. The participant's authorized representative may be a service provider (depending on what the participant or court order allows) for the participant. An authorized representative cannot approve his or her own timesheet. The authorized representative cannot serve as the participant's consultant.

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

Chemical Restraint-The administration of medication at a dose and/or frequency (regularly scheduled or on an “as needed-PRN” basis) to intentionally and exclusively preclude behavior without identifying an underlying anxiety, fear or severe emotional distress or other symptoms of psychiatric/emotional disturbance to be eased, managed, and/or treated by a licensed medical professional.

Money Network Card - The Money Network Card is an option that is available to employees. It works similarly to direct deposit on a bank account, but the money is deposited onto their card. There are fees associated with using the card (ATM charges, balance inquiry charges, etc.) so if someone has a bank account, it seems direct deposit into their checking/savings account would be preferable (instead of having a Money Network Card).

Consultant Provider Agency (CA) – Provides consultant and support guide services to Mi Via participants that assist the participant (or the participant's family, personal representative or the authorized representative, as appropriate) in arranging for, directing and managing Mi Via services and supports as well as developing, implementing and monitoring the SSP and AAB. Individual consultants work for State approved Consultant Provider Agencies.

Department of Health (DOH) – State Agency responsible for operating the Mi Via Home and Community Based Services (HCBS) waiver for populations (intellectual/developmentally disabled or medically fragile) that meet the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) LOC.

Department of Vocational Rehabilitation (DVR) Vocational Rehabilitation (VR) is a State and Federally funded program designed to help eligible individuals with documented disabilities find suitable employment. VR is a voluntary program, and services persons who want to work. With a long history of success and proven methodology for making the best fits, time and again, DVR is committed to helping our clients succeed. In addition, we partner with companies and agencies seeking opportunities to enhance and diversify their workforce.

Developmental Disabilities Waiver (DDW) – Medicaid HCBS waiver program for individuals who meet the definition of intellectual/developmental disability (I/DD) or a specific related condition as determined by Department of Health (DOH) in accordance with approved DDW criteria and the LOC provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities.

Electronic Visit Verification (EVV)- a technological solution used to electronically verify whether providers/supports delivered or rendered services as billed

Employee- person who is employed by and provides services to a Mi Via participant. In order to provide services to a Mi Via participant and receive payment for delivered services, the employee must meet qualifications set forth in the waiver, regulations and standards; complete and sign an employee agreement and all required tax documents.

Employer of Record (EOR) – Individual responsible for directing the work of Mi Via employees. A participant may be his or her own EOR unless the participant is a minor or has an authorized representative over financial matters in place. A Mi Via participant may be his or her own EOR if he or she does not have a plenary or limited guardianship or conservatorship over financial matters. A participant may also designate an individual of his or her choice to serve as EOR, subject to EOR meeting the qualifications specified in the Mi Via Regulation. If a participant is utilizing employees, they must designate an Employer of Record (EOR). An EOR is responsible for recruiting, hiring, managing and terminating all employees. The EOR will establish work schedules and tasks, provide training and will determine payment rates (within the State-determined range of rates) and negotiate with vendors or employees. The EOR will keep track of money spent on paying employees and for services and goods if utilized for vendor services. EORs authorize the payment of timesheets by the Financial Management Agency (FMA). The EOR may not be paid for any other services utilized by the participant for whom he or she is the EOR, whether as an employee of the participant, a vendor, or an employee or contractor or subcontractor of an agency. The EOR cannot be paid for performing the EOR functions. A power of attorney (POA) or other legal instrument may not be used to assign the EOR responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR as designated in the rule. The Mi Via EOR Questionnaire is required to be used to determine if an individual meets the requirements to serve as an EOR.

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

FMA On-line System – The FMA on-line system used by the FMA for receiving and processing payments. The FMA on-line system is also used by participants and consultants to develop and submit SSP/budget requests for TPA review and to monitor spending throughout the SSP/budget year.

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

Human Services Department (HSD) – Designated by the Center for Medicare and Medicaid Services (CMS) as the Medicaid administering agency in New Mexico.

Individual Budgetary Allotment (IBA) – The maximum amount of funding for each participant is determined by the individual’s assessed LOC and age. This amount of funding will allow the participant to develop a plan to meet functional, medical and habilitative assessed need(s) in order to enable the participant to remain in his or her community.

In-Home Assessment- Assessment conducted in the participant’s current living environment (or a location approved by the State) by the Third-Party Assessor to help determine initial and ongoing medical eligibility. Completion of the In-Home Assessment annually is a requirement to remain in the Mi Via Waiver program.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) – Facilities that are licensed and certified by DOH to provide room and board, continuous active treatment, and other services for eligible Medicaid recipients with a primary diagnosis of intellectual disability.

Legally Responsible Individual (LRI) – A person who has a duty under State law to care for another person. This category typically includes: the parent (biological, legal or adoptive) of a minor child; the guardian of a minor child who must provide care to the minor child; or the spouse of a waiver participant. Payment may not be made to a legally responsible individual for the provision of certain Mi Via Services except under extraordinary circumstances approved by the State, utilizing documentation specified by the State and only after approval by the Department of Health (DOH).

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

Medically Fragile (MF) Waiver – Medicaid HCBS waiver program for individuals diagnosed with a developmental disability, developmental delay or who are at risk for a developmental delay and diagnosed with a medically fragile condition before reaching 22 years old and who require an ICF/IID LOC and meet other defined criteria.

Mi Via Waiver – Mi Via, which means “my path,” “my way,” or “my road,” is the State's 1915 (c) Medicaid self-directed HCBS waiver program through which eligible participants have the option to access Medicaid funds, using the essential elements of person-centered planning, individualized budgeting, accessing approved services/supports/goods, managing personal risk (participant protections), and self-directing quality assurance and quality improvement which allows him or her to remain in his or her community.

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

NMAC-New Mexico Administrative Code

Participant – An individual who meets medical and financial eligibility and is approved to receive services through the Mi Via program.

Personal Representative (PR) – The participant may choose to appoint a personal representative designated to have access to information for the purpose of offering support and assisting the participant in understanding Mi Via waiver services. The participant can designate a person to act as a personal representative by signing a release of information form indicating the participant's consent to the release of confidential information specific to Mi Via services. The participant does not need a legal relationship with his or her personal representative. The

personal representative will not have the authority to direct Mi Via waiver services or make decisions on behalf of the eligible recipient. Directing services remains the sole responsibility of the participant or his/her authorized representative. While the participant's personal representative can be a service paid support for the participant, the personal representative cannot serve as the participant's consultant. If the personal representative is an employee, he/she cannot approve his/her own timesheet.

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

Quality Assurance and Quality Improvement (QA/QI) – Processes utilized by State and Federal governments, programs and providers whereby appropriate oversight and monitoring of HCBS waiver programs of waiver assurances and other measures provide information about the health and welfare of participants and the delivery of appropriate and services. This information is collected, analyzed and used to improve services and outcomes and to meet requirements by State and Federal agencies. Quality plans, systems and processes are designed and implemented to maintain continuous quality improvement.

Reconsideration – Participants who disagree with a review decision made by the TPA may submit a written request through a consultant to the TPA for a reconsideration of the decision. These requests must include new, additional information that is different from, or expands on, the information submitted with the initial request.

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

RORA-Regional Office Request for Assistance- DDS's mechanism to track any formal requests for Regional Office assistance.

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

Self- Direction – Process applied to the service delivery system wherein participants have choices (among the state-determined waiver services and goods) in identifying, accessing and managing the services they obtain to meet their personal assistance and other health-related needs. Self-direction means more choices and flexibility in planning for needed supports, services, and goods.

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

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

Third Party Assessor (TPA) – Provides services related to medical eligibility determination and re-determination, also referred to as LOC determination and re-determination for Mi Via participants. The TPA also performs utilization management duties – review and approval or denial of individual SSP/budget.

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

Waiver – A program in which the federal government has ‘waived’ certain statutory requirements of the Social Security Act to allow states to provide an array of home and community-based service options through Medicaid as an alternative to providing long-term care services in an institutional setting.

4. MI VIA CONTRACTORS AND SUPPORTS

In the Mi Via program, there are three (3) important sources of support and direction for participants. The TPA determines initial and on-going medical eligibility as well as reviews and authorizes SSP/budgets. The FMA acts as the intermediary between the participant and the Medicaid payment system and assists the participant or the EOR with employer/vendor related responsibilities. The Consultant Agency (CA) provides assistance and support to the participant with all aspects of the program.

A. Third Party Assessor

The Third-Party Assessor (TPA) is under contract with the HSD/MAD to provide the following services in the Mi Via program:

- Determine initial Level of Care (LOC) for individuals who choose Mi Via including conducting in-home assessments and reviewing and determining LOC;
- Notify the participant and CA at least ninety (90) calendar days in advance of the need for annual LOC determination, and provide the participant with the appropriate assessment forms to take to their physician;
- Conduct the in-home LOC assessment in person with the participant in their current living environment, or in a location approved by the state;
- Review the information from the LOC documents that include a current History and Physical and Long-Term Care Assessment Abstract (LTCAA) completed by the Primary Care Physician and the in-home assessment to make an LOC determination and assign the IBA for the participant. The TPA may re-evaluate the LOC more often than annually if there is an indication that the participant’s medical condition or LOC has changed; and

- Review each Mi Via participant's individual SSP/budget and using the SSP/budget and other submitted documentation, review and make a determination regarding each Mi Via participant's SSP/budget request and any SSP/budget revision requests. The TPA uses the Mi Via Program Regulations and Standards to determine approval and denial of services and goods.

B. Financial Management Agent

The Financial Management Agent (FMA) is under contract with the HSD/MAD to provide the following services in the Mi Via program:

- Assure program compliance with State and Federal employment and Internal Revenue Service (IRS) requirements;
- Assist each participant to set up a unique Employer Identification Number (EIN) if they intend to hire employees;
- Answer participant inquiries, solve related problems, and offer periodic trainings for participants and their representatives on how to handle the Mi Via billing and invoicing processes. The FMA will provide all participants with necessary documents, instructions and guidelines;
- Collect all documentation necessary to verify that providers, employees, and vendors have the qualifications and credentials required by Mi Via regulations;
- Collect all documentation necessary to support the participant's specific arrangements with each employee and vendor, including employment agreement forms and vendor agreement forms;
- Complete criminal history and/or background investigations for service providers/supports, pursuant to 7.1.9 NMAC and in accordance with 1978 Section 29-17-1 NMAC of the Caregivers Criminal History Screening Act;
- Check the Department of Health Employee Abuse Registry, pursuant to 7.1.12 NMAC Consolidated Online Registry (COR), to determine whether service providers/vendors or employees of participants are included in the registry. If a provider, vendor, or employee is listed in the Abuse Registry, that person may not be employed by a Mi Via participant;
- Check the Certified Nurse Aide Registry, pursuant to 16-12.20 NMAC to determine whether service providers, vendors or employees of participants are included in the registry. If a provider, vendor or employee is listed in the Registry, that person may not be employed by a Mi Via participant;
- Check the Office of Inspector Exclusion List, pursuant to Section 1128B(f) of the Social Security Act, to determine whether service providers, vendor, or employees of participants are included in the list. If a provider, vendor, or employee is listed in the List, that person may not be employed by a Mi Via participant;
- Check the National Sex Offender Registry, pursuant to 6201 as federal authority for active programs, to determine whether service providers, vendors or employees of participants are included in the registry. If a provider, vendor, or employee is listed in the Registry, that person may not be employed by a Mi Via participant
- Process and pay invoices for services and goods that are approved in the participant's SSP and AAB, when supported by required documentation;
- Handle all payroll functions on behalf of the participants who hire direct service employees and other support personnel, including collecting and processing timesheets of support

workers, processing payroll and withholding, filing and payment of applicable Federal, State and local employment-related taxes and insurances; and

- Track and report on employee payment disbursements and balances of participant funds, including providing the participant and their consultant with a monthly report of expenditures and budget status.

The FMA Online System

In addition to the above functions, the FMA operates the FMA online system through which the Mi Via program is operated. The FMA online system is a web-based system that is used for traditional FMA functions like tracking the credentialing status of employees and vendors, timesheet submission, payment processing for employees and vendors, and tracking SSP and budget expenditures.

The FMA online system is also used by participants and consultants to develop and submit SSP and budgets for TPA review. The TPA uses the FMA online system to receive SSP and budget requests and request additional information from the participant and consultant, and to indicate what services and supports have been approved or denied.

The FMA will provide participants and consultants with training and access for the FMA online system as well as on-going technical assistance and help with problem solving.

C. Consultant Agencies and Consultants

Consultant Agency (CA) services are direct services intended to educate, guide and assist the participant to make informed planning decisions about services and supports, to develop an SSP/budget that is based on the participant's assessed needs and to assist the participant with quality assurance and monitoring related to the SSP and AAB.

Consultants are responsible for knowing the participants they serve and having an awareness of each of their participants' unique dreams, strengths, goals, health and safety needs and individualized support needs. Consultant services provide a level of support to a participant that is unique to their individual needs to maximize their ability to self-direct in the Mi Via Program. Participants may choose to work with any Mi Via approved CA in their region.

Consultants are required to follow a Mi Via Consultant Code of Conduct. The Mi Via Consultant Code of Conduct is required to be reviewed and signed by each individual Consultant and kept in each Consultant Agency's personnel files. This ensures all Consultants are acting in accordance with DDS expectations and professional standards.

Consultant Agencies are required to have a Quality Assurance Plan and submit to DDS at the time of their Provider Agreement renewal. This is intended to outline each agency's continuous approach to quality service delivery and monitoring.

Pre-Eligibility and Enrollment Services

Consultant Pre-Eligibility/Enrollment Services are intended to provide information, support, guidance, and/or assistance to individuals during the Medicaid eligibility process, which includes both financial and medical components. During this phase, consultants will:

- Meet with the participant for an initial orientation and enrollment meeting;
- Inform, support, and assist as necessary with the requirements for establishing the LOC;
- Assist with financial eligibility application and paperwork as needed;
- Verify that the county ISD office of the HSD has completed a determination that the individual meets financial and medical eligibility to participate in the Mi Via Waiver program; and
- Coordinate with MCO Care Coordinator or Traditional Waiver Case Manager to plan for and complete transitions to the Mi Via Waiver.

On-going Consultant Functions

After eligibility has been verified, consultants assist the participant with virtually every aspect of the Mi Via program. The extent of assistance is based upon individual participant needs, and may include (but is not limited to) help and guidance related to:

- Understanding participant and EOR roles and responsibilities;
- Identifying resources outside the Mi Via program, including natural and informal supports, that may assist in meeting the participant's needs;
- Understanding the array of Mi Via covered supports, services, and goods including non-covered services and limitations;
- Developing a thoughtful and comprehensive SSP/budget that includes services and supports, covered by the Mi Via program, to address the needs of the participant;
- Developing, documenting and submitting an appropriate SSP/budget request to implement the SSP/budget;
- Employer-related activities such as identifying an EOR, finding and hiring employees and contractors, and completing all documentation required by the FMA;
- Identifying and resolving issues related to the implementation of the SSP/budget;
- Assist the participant with quality assurance activities to ensure implementation and monitoring of the participant's SSP/budget, and utilization of the authorized budget; and
- Recognizing and reporting critical incidents, including abuse, neglect, exploitation, suspicious injury, environmental hazards, and the death of a participant.

Consultants shall make contact with the participant in person at least monthly for routine follow up. Consultants shall meet face to face with the participant at least 12 times a year; at least four visits per year, one per quarter, must be conducted in the participant's residence with the participant.

Consultant contacts and visits will be conducted to include monitoring of the following:

- Health and safety to include monitoring of current health status, recommended appointments and any medical follow up needed;
- Progress of the SSP/budget implementation;
- Spending patterns;
- Purchase of goods, environmental modifications, assistive technology, personal support technology, and coordination with MCO to ensure receipt of durable medical equipment needs,
- Usage and effectiveness of the twenty-four (24) hour emergency backup plan;
- ANE training and reporting, or incidents;

- Resources and assistance to participants where needed;
- Service setting;
- Informed choice and decision making;
- Self-direction of program by participant;
- Access to the community;
- Access to employment; and
- Coordination of services: issues with vendors or employees.

5. Initial Allocation and Ongoing Eligibility

Waiver eligibility is determined by the DDS Regional Intake and Eligibility Bureau (IEB), located statewide in the DDS Regional Offices. While Provider Agencies are not directly involved in the eligibility determination process, they are an important point of contact. Provider Agencies must refer people to the appropriate DDS Regional Office where pre-service activities are initiated.

Definition of Developmental Disability

Mi Via Waiver services are for eligible recipients who have developmental disabilities limited to an intellectual disability (ID) or a specific related condition as determined by the DOH-DDSD. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary or generic treatment or other supports and services that are lifelong or of extended duration and are individually planned and coordinated. The person must also require the level of care provided in an ICF/IID, in accordance with 8.313.2 NMAC and meet all other applicable financial and non-financial eligibility requirements.

Intellectual Disability (ID)

A person is considered to have ID if she/he has significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Related Condition (RC)

An individual is considered to have a related condition if she/he has a severe, chronic disability that meets all of the following:

- a. Is attributable to a condition, other than mental illness, found to be closely related to ID because this condition results in limitations in general intellectual functioning or adaptive behavior similar to that of persons with ID and requires similar treatment or services
- b. Is manifested before the person reaches age twenty-two (22) years
- c. Likely to continue indefinitely
- d. Results in Substantial Functional Limitations (Adaptive Behavior scores ≤ 70) in 3 or more of the following areas:
 - i. Self-care
 - ii. Receptive and expressive language
 - iii. Learning
 - iv. Mobility
 - v. Self-direction
 - vi. Capacity for independent living
- vii. Economic self-sufficiency

Central Registry

To qualify for services through an ICF/IID or HCBS Waiver (DD or Mi Via Waiver), a person must:

1. meet the Developmental Disability definition criteria in accordance with NMAC 8.290.400;
2. have a registration date on the DDS Central Registry;
3. submit the DD Waiver application and supporting documentation with a “Complete” status as determined by DDS;
4. meet the Medicaid financial and medical eligibility criteria; and
5. be a resident of New Mexico.

The Central Registry Unit (CRU), in the IEB of DDS, assists the applicant with the completion of the registration and application process for the waiver. The registration can be completed either in person or via telephone with the DDS Regional Office. Once the person has completed the registration, he/she will receive an application packet. This packet includes:

1. the Central Registry Application Form,
2. HIPAA Notification, and
3. Release of Information Forms.

The application packet requires supporting documentation including clinical reports which indicate an ID or specific related condition. For intellectual disabilities, this documentation may include clinical tests indicating significant limitations in intellectual functioning and adaptive behaviors. For specific related conditions, this documentation may include medical reports including the qualifying diagnosis and reports indicating substantial functional limitations.

The CRU makes the determination of whether the person matches the definition of Developmental Disability. If the person matches the definition, the applicant receives a “yes” match letter and stays on the waiting list for allocation to the DD Waiver. If the person does not match the definition, the applicant receives a Denial of DD Waiver Registration letter, which includes notice of rights to an Administrative Fair Hearing.

If the applicant is a child younger than eight years old *with* documentation confirming a qualifying medical diagnosis but *without* conclusive documentation to determine a “yes” match, the child’s application may be placed in a “Pending” status until the child reaches age 9. At that time, documentation obtained will be reviewed to accurately determine eligibility.

Allocation Process

When funding is available for an allocation, the next eligible applicant on the DDS Central Registry (based on registration date) will receive a Letter of Interest and two attachments: (1) Primary Freedom of Choice (PFOC) form and (2) Refusal form. The PFOC notifies the applicant of their right to choose between an ICF/IID or a HCBS Waiver (i.e. DD waiver or Mi Via). The

applicant has 30 days to return either the PFOC or the Refusal form before the allocation may be closed.

Primary Freedom of Choice (PFOC)

The applicant completes the PFOC form to select between:

1. an Intermediate Care Facility-Intellectual/Developmental Disability) ICF/IID; or
2. the DD Waiver and a Case Management Agency or the Mi Via self-directed waiver and a Consultant Agency.

Expedited Allocation

In special circumstances, a person may be allocated to the DD Waiver by means other than the person's date of registration in the Central Registry. To qualify for an expedited allocation, the applicant must be on the Central Registry, be determined to have a Developmental Disability, meet specific criteria, and be approved by a DDS/D review team and the DDS/D Division Director or designee. An expedited allocation must meet at least one of the specific criteria a, b or c, and the criterion d as follow:

- a. The person's current situation meets the statutory definition of abuse, neglect, or exploitation as substantiated by Adult or Child Protective Services or the Division of Health Improvement (DHI).
- b. The person's primary caregiver is no longer able to provide continued care for the person due to death, disability, or progressive decline of the primary caregiver's health, and an alternate primary caregiver is not available.
- c. The person was most recently on a civil DD commitment pursuant to NMSA 1978, 43-1-13 (as referenced in NMSA 1978, 31-9-1.6,) and continues to need developmental disabilities services to assure health and safety.
- d. Current available resources are inadequate to maintain and/or assure the health and safety of the person.

The expedited allocation process includes the following steps:

1. The DDS/D Regional Office is the point of contact for applicants to determine whether an expedited allocation request would be appropriate. If a person is approved for an expedited allocation, and if that person is ultimately determined to meet all financial and clinical criteria, services would not begin immediately, but would be available sooner than if the person had to wait for allocation based upon the date of registration.
2. The decision to expedite the allocation process for a person is at the discretion of DDS/D Division Director or designee. DDS/D may grant or deny an application for expedited allocation, and may limit the number of allocations, based upon factors that may include (but need not be limited to) the availability of funds under the current fiscal year appropriation, the relative merits of an application, the availability of alternative supports for an applicant, and other considerations.

Letter of Allocation

When the IEB, receives the PFOC form choosing the Mi Via Waiver, copies are made and sent with a Letter of Allocation to the appropriate parties, including the applicant, the chosen Consultant Agency, the Medicaid Third Party Assessor (TPA), and the Human Services Department's (HSD) Income Support Division (ISD). If the person wants to change between waivers or case management agencies during the allocation process, and no medical or financial eligibility has begun, the transfer is permitted and coordinated through IEB with an updated PFOC. If the person has already begun the eligibility process, medical and financial eligibility must be completed before they may request a transfer between waivers or case management agencies through Intake and Eligibility Bureau (IEB) with an updated PFOC. All changes between waivers or case management agencies during the allocation process are processed through an updated PFOC.

Medical and Financial Eligibility

After allocation, the applicant must continue to meet financial and medical eligibility. The Income Support Division (ISD) is responsible for approving the Category of Eligibility (COE) based on both medical and financial eligibility requirements. Once eligibility is established, the 096 COE for the Mi Via Waiver will be assigned.

Initial Allocation

Once the Consultant receives a copy of the PFOC, their responsibilities assisting and monitoring this process begin. In general, the Consultant and/or Employer of Record (EOR) is responsible for:

1. Monitoring whether the person/guardian/EOR completes the Application for Assistance form, MAD 100, and submits the form electronically or takes a copy of the completed MAD 100 to the local ISD office and requests a proof of receipt. (If the person and their guardian or EOR is not contacted to schedule a meeting with ISD within 10 days from the date of MAD 100 application submission, it is their responsibility to call ISD to get an appointment scheduled.)
2. If the process of determining financial and medical eligibility takes longer than 90 days, informing the applicant, guardian, and/or representative payee, as applicable, that a request for an extension from the ISD for their Mi Via Waiver eligibility determination is needed.
3. Compiling the Level of Care (LOC) packet which includes the LOC Abstract Form (MAD 378), History and Physical, completed by the applicant's medical provider, completed by the Consultant, as well as the Client Individual Assessment (CIA) completed by the FMA contractor.
4. Submitting the LOC packet to the Medicaid TPA.
5. Monitoring the status of the TPA approval of the LOC and responding to requests for information (RFIs) within required timeframes.
6. Monitoring the applicant's eligibility status at ISD.
7. Submitting the Allocation Reporting Form to the DDS Central Registry Unit on

the 15th of each month.

Annual Recertification of Eligibility

All Mi Via Waiver participants must recertify eligibility annually. This includes financial and medical eligibility. An application is mailed to the participant and guardian/EOR 45 days prior to the expiration of the COE. The Consultant and EOR play a critical role in assisting and assuring that all required steps are taken by the Mi Via Waiver participant to complete annual recertification according to the following:

1. Participants and EORs are responsible for monitoring that a person's COE is current and for informing the Consultant as soon as possible, if the COE is expired or near expiring.
2. EORs and participants should be aware of the COE expiration date and assist the Mi Via Waiver participant and family, as needed, to assure necessary steps are taken to recertify.
3. A budget cannot be processed, and Mi Via supports cannot bill for services without a current 096 COE indicating Mi Via Waiver eligibility.

Annual Financial Eligibility

The steps to meet annual financial eligibility are:

1. The person/guardian/EOR completes the recertification form, the ISD 122, electronically or takes the completed ISD 122 recertification to the County ISD office.
2. If the person/guardian/EOR is not contacted to schedule a meeting with ISD within 10 days from the date of ISD 122 recertification submission, it is their responsibility to call ISD to get an appointment scheduled.
3. Supports can assist with supports needed for the waiver participant to attend ISD appointment.

Annual Medical Eligibility

Consultants and EORs should support the person to complete activities related to annual medical eligibility as follows:

1. assist with supports needed for the waiver participant to attend medical appointments timely for an annual History and Physical as determined by the IDT.
2. The Consultant submits the annual (LOC packet which includes the completed LOC Abstract Form-MAD 378, CIA and the History and Physical for medical eligibility) to the TPA between 45 calendar days and 30 calendar days prior to the LOC expiration date.

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

The CIU is a tool for internal communication among the following entities: HSD-ISD, HSD-Medical Assistance Division (HSD/MAD), Managed Care Organizations (MCO), TPA, DD Waiver Case Management Agencies, Mi Via Consultant Agencies, Support Brokers, and other partnering state agencies. The CIU/MAD 054 is available with instructions for completion on the NM Medicaid Portal (<https://nmmedicaid.acs-inc.com/webportal/home>). The CIU shall be completed by the Consultant, Mi Via Waiver participant, legal guardian, authorized

representative, EOR, or other partnering state agencies to request an update in the following circumstances:

1. change in address,
2. change in state of residence,
3. change of Case Management Agency or CM/Consultant Agency/Care Coordinator/Support Broker,
4. Level of Care,
5. status of allocation or transition,
6. reason for denial or closure,
7. Plan of Care/ISP/SSP dates,
8. death of the person in services,
9. nursing facility admission,
10. hospital facility admission,
11. move out of the state,
12. incarceration,
13. request for a Setting of Care change,
14. request for a COE Extension, and
15. waiver services not accessed.

A. The Initial Level of Care-Process

- The Level of Care (LOC) process is an important part of determining medical eligibility. The LOC must be completed in initial allocation and also annually as part of the participant's recertification for the Mi Via Waiver program.
- The TPA is notified of the need for an in-home assessment (IHA) via a copy of the allocation letter/completed Primary Freedom of Choice (PFOC) from the Department of Health. The TPA will arrange for an IHA in the applicant's current living environment or in a location agreed upon by the participant and the TPA and approved by the State, or in an inpatient setting, utilizing the assessment tools prescribed by the waiver through which the individual is applying. The TPA provides copies of the assessment(s) to the CA for use in developing the participant's SSP/budget.
- The TPA reviews the LTCAA, the IHA(s), the current history and physical; and other relevant medical information submitted. The TPA reviewer applies the ICF/IID LOC criteria to determine the participant's medical eligibility. The TPA notifies the applicant, the CA, and ISD whether the applicant meets the medical eligibility criteria. Additionally, the TPA determines the participant's IBA based on the LOC and age.

6. PLANNING AND BUDGETING FOR SERVICES AND GOODS

A. Service and Support Plan Development Processes

Person-Centered Planning (PCP)

Essential Elements of Person-Centered Planning (PCP)

Person-centered planning is a process that places a person at the center of planning their life and supports. It is an ongoing process that is the foundation for all aspects of the Mi Via Waiver, and all supports who work with people with I/DD. The process is designed to identify the strengths, capacities, preferences, and needs of the person. The process may include other people chosen by the person, who are able to serve as important contributors to the process. Overall, PCP involves person-centered thinking, person-centered service planning, and person-centered practice. PCP enables and assists the person to identify and access a personalized mix of paid and non-paid services and supports to assist him or her to achieve personally defined outcomes in the community. The CMS requires use of PCP in the development of the SSP.

Person-Centered Thinking

Person-centered thinking involves values, tools, and skills to set the foundation for SSP development. Person-centered thinking respects and supports the person with I/DD to:

1. have informed choices;
2. exercise the same basic civil and human rights as other citizens;
3. have personal control over the life he/she prefers in the community of choice;
4. be valued for contributions to their community; and
5. be supported through a network of resources, both natural and paid.

Person-centered thinking must be employed by all Mi Via Waiver employees and/or vendors involved in PCP and the development and/or modification of a person's SSP. Person-centered thinking involves the use of discovery tools and techniques. Person centered thinking must involve one or more activities that:

1. Develop specific assessments that may be required per service type.
2. Document discovery interviews with (at a minimum) the person, the guardian and or family member(s) (if applicable) which may include:
 - a. what is working/not working,
 - b. specific aptitudes, skills, and abilities,
 - c. Good Day/Bad Day for the person,
 - d. what is important to/important for the person, and
 - e. what the person does and does not want in their overall employment or retirement life.
3. Identify characteristics of people who support the person best.

4. Identify what people like and admire about the person.
5. Use relationship maps.
6. Use communication charts explaining communication style and best ways to communicate.
7. Use religious/cultural and ethnic considerations, preferences, restrictions.
8. Use other person-centered thinking tools available

Person-Centered Planning

The person with I/DD is at the center of the process. PCP is facilitated by the participant or Consultant and the person is encouraged and supported to direct the process as much as possible. No matter what the nature or severity of a person's disability, there are many ways to identify a person's strengths, abilities, preferences, needs, and goals with the person's participation.

The required elements of person-centered planning are to:

1. allow the process to be driven by the person;
2. allow the process to include people chosen by the person;
3. provide necessary information and support to the person to ensure that he/she directs the process as much as possible;
4. schedule the meetings at times/locations convenient to the person, preferably chosen by the person;
5. respect cultural considerations for the person;
6. use plain language, and communicate in a format that the person prefers such as English, Spanish or American Sign Language and/or aided with use of Assistive Technology (AT);
7. use strategies and ground rules for solving disagreements or conflict among supports;
8. offer choices regarding the services and supports that the person receives, without fear of retaliation or undue influence by an employee and/or vendor;
9. follow established methods to request updates to the SSP;
10. use what is important to the person as the key factor to ensure delivery of services in a manner that reflects personal preferences and ensures optimal health and welfare;
11. clearly identify the strengths, preferences, needs (clinical and support), and desired outcomes of the person;
12. include personal goals and preferences related to the development of relationships, community participation, employment, income and savings, healthcare and wellness, education, etc. based on informed choice;
13. identify risk factors;
14. create plans to minimize adverse outcomes and manage risk; and
15. include assessments for review prior to the development of an SSP.

Person-Centered Practice

Person-centered practice is aligning services and resources to support people to achieve individual-specific goals and outcomes.

The participant, with the assistance of the Consultant, is responsible for:

1. developing the SSP; and
2. identifying the employees and/or vendors responsible for providing the services and supports described in the SSP.

Informed Choice

Person-centered practice must include informed choice. Informed choice is when a person makes a decision based on a solid understanding of all available options and consequences of how that choice will impact their life. Options are developed through a partnership with the person and knowledgeable supports, including paid and nonpaid supports who empower the person to make informed choices.

Informed choice generally includes the following activities:

- a. assessing the person's interests, abilities and needs;
- b. discussing with the person/guardian what was learned through assessment;
- c. providing information about different options and resources available to the person in a way that is understandable by the person;
- d. providing opportunities for trial and error; and
- e. considering potential impact on the person's life, health and safety and creating strategies to address any related issues that may arise.

Individuals, family members, guardians, natural supports, and paid supports have a responsibility to support people with I/DD to make informed choices and to encourage them to speak up about their lives without feeling intimidated.

Mi Via Waiver paid supports are required to:

1. support informed choice about employment;
2. increase a person's experiences with other paid, unpaid, publicly funded and community support options;
3. listen to the person in services and respect their choices;
4. support people to lead their meetings, programs and plan development and speak openly about their services, without being fearful of retaliation;
5. support and not replace use of natural and non-disability specific resources available;
6. work with the Consultant to document efforts demonstrating choice of non-waiver and non-disability specific options in the SSP through meeting minutes or companion documents, especially when a person only has Mi Via Waiver funded supports;
7. ensure the people have access to augmentative communication and AT which aid the person in participating in meaningful activities;
8. be aware of the levels of guardianship, the timelines for appointment and the parameters of authority for each person; and

9. understand the Court Order appointing guardianship and appropriately involve the guardian in decisions when providing services to DD waiver participants.

Choice of Non-Waiver and Non-Disability Specific Options

PCP must include documentation of a discussion with local paid and unpaid resources that may be available to meet a person's needs. This must include options for supports resources, employment, activities, and relationships with non-waiver-related programs and non-disability specific options.

Upon eligibility for the Mi Via Waiver and choosing their consultant, each participant shall receive an IBA and information from the consultant about covered/non-covered Mi Via services and the requirements for the content of the SSP.

B. Service and Support Plan (SSP) Components

The CMS requires a person-centered service plan for every person receiving HCBS. The Mi Via Waiver's person-centered service plan is the SSP.

SSP Development

The SSP is developed annually through an ongoing PCP process. The SSP development must:

1. involve those whom the person wishes to attend and participate in developing the SSP;
2. use assessed needs to identify services and supports;
3. include individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, and others;
4. identify roles and responsibilities of supports who are implementing the SSP;
5. include the term of the SSP and how and when it is updated; and
6. outline how the person is informed of services which include natural and community resources as well as those funded by the Mi Via Waiver.

The Mi Via SSP template is available on the Department of Health (DOH) Mi Via web site and is included in the Service Standards (Appendix B). A paper document can be obtained from the consultant.

Assessments are useful tools to help identify a person's strengths, interests, possible goals and to identify what may best assist in meeting the person's goals. However, assessments and evaluations are not a substitute for input from the person concerning his or her strengths and weaknesses.

1. It is the responsibility of the participant's circle of support to recognize the potential need for a specific assessment through the MI Via Waiver (e.g., therapy, BSC, nursing).
 - a. Areas of concern should be identified to be included in the assessment.
 - b. All referrals to a provider for assessment or treatment must be documented in the person's SSP.

- c. Initial assessments may be conducted at any time during the SSP year.
2. When possible, challenging behaviors should be evaluated medically to determine if there is an underlying medical condition that is causing and/or contributing to the expression of a behavior. Behavioral assessment in collaboration with medical and/or psychiatric consultation is encouraged.
3. It is the responsibility of the participant's circle of support to recognize when individual, family or group behavioral health benefits or medical benefits through Medicaid state plan benefits or Medicare would be beneficial.

The SSP is developed at least annually and revised as needed. The SSP term of 365 days is established at initial entry into Mi Via Waiver services and cannot be changed.

The SSP is a dynamic document that changes with the person's desires, circumstances, and need. Revisions to the SSP are required under the following circumstances:

1. When immediate action is needed after a report of ANE is made or if ANE is substantiated.
2. Within ten days of an ANE Closure letter if issues still need to be addressed.
3. Transition to new provider, vendor, employee, program, waiver or location is requested.
4. Changes in goals.
5. Loss or death of a significant person.
6. Within one business day after any identified risk of significant harm.
7. When a person experiences a change in condition including a change in medical condition or medication that affects the person's behavior or emotional state.
8. When a termination of a service is proposed.
9. When there is an impending change in housemates a transition plan must be developed.
10. When there is criminal justice involvement (e.g., arrest, incarceration, release, probation, parole).
11. Whenever DDS decides not to approve the implementation of an SSP due to the cost or because DDS believes the SSP fails to satisfy constitutional, regulatory or statutory requirements.
12. For any other reason that is in the best interest of the person, or deemed appropriate, including development, integration or provision of services that are inconsistent or in conflict with the person's goals of the SSP.

The SSP is organized by the four (4) categories of services and includes questions in each section that help identify the participant's strengths, goals, natural and informal supports, concerns and challenges, and how the participant will know whether the plan he/she has developed is working well.

Each section of the SSP must be completed by the participant, even if he/she does not plan to request services or goods from that section. The SSP section for Non-Mi Via Paid Supports and Unpaid Supports must also be completed. This is because the SSP is a comprehensive planning tool, and all areas need to be considered carefully to ensure all of the participant's needs are being addressed.

Detailed descriptions of every Mi Via service, as well as the required qualifications for providers, vendors, and employees, are found in Appendix A of this document.

Living Supports

The SSP covers Living Supports, which are individually determined supports that help the participant stay in their own home and community. Mi Via participants are allowed to reside in provider owned or operated homes only if they have legal protections in place, such as a lease or other legal agreement. These supports can provide needed assistance with activities of daily living, home management, supports for health and safety as well as independent living skills. Supports can be provided using three (3) different models: Homemaker/Direct Support Services; Home Health Aide; and In-Home Living Supports.

Community Membership Supports

Community Membership Supports, which help the participant participate in community life to enhance relationships with others, work or participate in meaningful activities are also covered in the SSP. These supports include Community Direct Support, Employment Supports and Customized Community Group Supports (CCGS). CCGS services must be provided in an integrated community setting that supports opportunities for participants to access community resources and activities with others in their community.

New Mexico is an Employment First state and Consultants have requirements to document strategies supporting Employment First in the SSP.

1. **Assessment:** The first step in making an informed choice about employment starts with the assessment process.
2. **Experience:** If a person has no volunteer or work history, then the participant and guardian should consider trying new discovery experiences in the community to determine interests, skills, abilities, and needs. These new experiences must be clearly documented in the SSP, as well as any reason(s) not to pursue new experiences.
3. **Opportunity for Trial Work or Volunteering:** The employer/vendor must also offer/provide the person with access to job exploration activities including volunteer work and/or trial work opportunities, if the participant and guardian are interested. These opportunities must be documented in the SSP.
4. Once the first three steps have been fulfilled, then the person, in conjunction with a legal guardian, if appropriate, can determine whether employment shall be pursued.

5. If employment is the preferred option, then the Consultant should have a discussion of potential impact on the person's benefits and services. This process may require accessing community resources to determine the potential impact. Details of the discussion must be documented in the SSP.
6. If a person is retired, then this information must be clearly documented in the SSP. The reasons for the choice to retire, the activities that were explored to make this decision, and other pertinent information shall be included.

Health and Wellness Supports

A very important section in the SSP covers Health and Wellness Supports. These supports are available in Mi Via to assist participants with medically related or behavioral health needs that are not covered by their health plan and will enhance the participant's ability to remain in their home and community. These supports are provided by a licensed health professional and include Skilled Therapy for Adults, Occupational, Physical and Speech Therapy; Behavior Support Consultation; Nutritional Counseling; Private Duty Nursing for Adults; and the specific list of Specialized Therapies that are covered by Mi Via. It is critical that all health and wellness supports are addressed here, even if they are non-Mi Via Waiver services or unpaid supports.

Other Supports

Other supports that are available to enhance or enable the participant to receive other services on their plan, or to decrease the need for more direct services, thereby increasing their independence must be included in the SSP. In Mi Via these supports include Transportation; Emergency Response Services; Respite; Individual Directed Goods and Services, and specialized therapies to list a few. Any supports that transport participants must have a valid driver's license and vehicle insurance.

Other Sections of the SSP

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

The 24-Hour Emergency Back-up Plan

This section lists who the participant will contact in an emergency or if regularly scheduled employees or vendors are unable to report to work. The backup plan details all relevant supports in a participant's life and who should be contacted and when. It is critical that this section of the SSP remain current and be available to all identified staff and family members. The Emergency Back-Up Plan is mandatory and must be completed in the SSP.

Completing and Submitting the SSP

The SSP can be written out by hand, or the consultant can use the Word version of the form to type in the answers. However, in order for the SSP to be submitted to the TPA, all sections completed with detailed descriptive information must be entered into the FMA online system SSP by the consultant.

**C. Budget Development Process
Individual Budgetary Allotment (IBA)**

The IBA is the amount of funding provided to the participant. This amount is provided to the consultant with the Level of Care (LOC). The IBA levels for each population are determined by age and living supports and are as follows:

Age	IBA Amount	
0-17 years old	\$23,443.00	
18-20 years old	\$54,589.00	\$68,589.00 if using In-Home Living Supports
21 and older	\$72,710.00	

Once the SSP has been completed and the participant has identified the supports he/she would like to obtain through the Mi Via program, the consultant and participant work together to develop the SSP/budget request. The participant and consultant may need to research the estimated cost of services and goods and will use the Mi Via Range of Rates chart (Appendix C) to determine appropriate rates of pay for potential employees and vendors.

The budget is developed one (1) goal at a time. Each goal includes a clear and complete explanation of the requested service(s) or good(s), how they are related to the participant’s condition and why they are appropriate for the participant.

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

The budget request is developed by the Mi Via participant and the consultant. Once the budget request is complete and approved by the participant, the consultant will submit it to the TPA for consideration using the FMA online system. Annual SSP/budget requests shall be submitted to the TPA no later than thirty (30) calendar days prior to the end of the current SSP/budget year. Initial SSP/budget requests should be completed and submitted within sixty (60) calendar-days of eligibility determination so that it will be in effect within ninety (90) calendar days of eligibility determination.

D. Request for Exception to the Range of Rates

Mi via participants, or EORs, are required to negotiate and determine the rate for their employees and services within the range of rates established by the state. Justification for paying more than the established rates must be submitted, in writing, to the TPA for consideration.

The established rate may not be exceeded in order to pay for additional services the employee or vendor may provide which are outside the scope of the specific service for which the employee or vendor is approved; nor can a rate exception be approved for credentials that exceed those required to provide the service unless the credentials specifically meet criteria below. To exceed the established range of rates one of the four following criteria must be met:

1. Behavioral Conditions

The participant's behaviors are of a severity that pose considerable risk to the participant, caregivers, or the community; and require a frequency and intensity of assistance to ensure the eligible recipient's health and safety in the home or the community or supervision or consultation requiring specialized or unique behavioral supports; these services cannot be accessed through other services.

2. Medical Conditions

The participant has ongoing need for intense medical supports including oxygen monitoring, diabetic monitoring, skin breakdown, J and G tube feedings, ostomy and urology care, catheter insertion, digital extractions, suctioning, nebulizer treatments, routine order treatments in the prevention of infections, and responsive awareness to severe allergic reactions.

3. Specialized Supports

To support the participant's inclusion in the community the participant requires specialized support that can enhance communicative or functional skills such as American Sign Language or programming of adaptive communication devices.

4. Location

the participant lives in a geographic location, within New Mexico, with limited providers, vendors, and employees. The recipient, or guardian, has researched multiple supports and has been unable to identify another support in the geographic location available to provide the service within the range of rates. The service goal must specify the participant's need for this service and contact with available local vendor or employee within six months of the date of request including reason why alternate supports are not available.

E. Participant's Budget-Related Authority

There are three (3) elements to the authority participants have related to their budgets: budget making authority, employer authority, and budget spending authority.

1. Budget-Spending Authority

Participants have authority to expend waiver funds for services through an AAB that shall be expended monthly over the course of the budget year and according to the participant's approved SSP/budget.

2. Employer Authority

The Employer of Record (EOR) is the employer of service providers. The FMA serves as the participant's agent in conducting payroll and other employer-related responsibilities that are required by Federal and State law.

3. Decision-Making Authority

Participants shall have authority to do the following:

- Identify service providers (employees/vendors) and refer them to the FMA for enrollment;
- Complete the employer paperwork to be submitted to the FMA if utilizing employees. All participants who plan to hire employees are required to designate an Employer of Record following the process established by the FMA to do so.
- Complete the vendor paperwork to be submitted to the FMA if utilizing a vendor or vendors.
- Determine the amount paid for services within the State's limits;
- Schedule the provision of services;
- Specify staff qualifications of the participant's choice, consistent with the qualifications specified in the Mi Via regulations and service descriptions in Appendix A;
- Specify how services are provided, consistent with the Mi Via regulations and the service descriptions in Appendix A;
- Arrange to have staff paid for their services by ensuring that all proposed employees and vendors complete all FMA required paperwork, including a criminal background check when necessary. The participant shall work with the FMA to have all employees, providers and vendors approved and enrolled prior to service delivery or the provision of any service or good. Payment for services cannot be made until paperwork is complete, submitted to the FMA and approved by the FMA.
- Review, approve and submit completed timesheets to the FMA within established timeframes. Timesheets may be submitted to the TPA by fax or through the FMA online system. Failure to submit timesheets within the required timeframes could result in employees not being paid;
- Approve payment, according to the AAB, for waiver services and goods identified in the approved SSP. The participant must submit an invoice or receipt from a vendor for any item he/she has planned and budgeted to purchase.
- ***Participants cannot be reimbursed directly for any services and goods or supports;***
- The participant shall follow the AAB; and
- The participant shall be accountable for the use of Mi Via funds.

7. NON-COVERED SERVICES

All Mi Via services are subject to the approval of the TPA.

Services and goods that are not covered by the Mi Via program include, but are not limited to the following:

- a. Services covered by the Medicaid State plan (including EPSDT), Medicaid school-based services, Medicare, and other third-parties. This includes services that are covered under Centennial Care and/or EPSDT. The Mi Via Program is the payer of last resort;
- b. Any service or good, the provision of which would violate Federal or State statutes, regulations, or guidance.
- c. Any goods or services that are considered primarily recreational or diversional in nature. Recreational and diversional in nature is defined as inherently and characteristically related to or denoting activities done for amusement, enjoyment, a pastime or hobby, distinct from what might be intended.
- d. Formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the Public Education Department (PED), Division of Vocational Rehabilitation (DVR);
- e. Room and board, meaning food and shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing(s), home and property maintenance, utilities and utility deposits, and related administrative expenses. Utilities include gas, electricity, propane, firewood, wood pellets, water, sewer, and waste management;
- f. Experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC;
- g. Home schooling materials and/or related supplemental materials and activities;
- h. Any goods or services that a household that does not include a person with a disability would be expected to pay for as a routine household or personal expense;
- i. Personal goods or items not related to the participant's condition or disability;
- j. Purchase of animals and the costs of maintaining animals, including the purchase of food, veterinary visits, grooming and boarding but with the exception of training and certification for service dogs;
- k. Gas cards and gift cards. Items that are purchased with Mi Via program funds may not be returned for gift cards;
- l. Purchase of insurance, such as cell phone, car, health, life, burial, renters, home-owners, service warranties or other such policies. This includes purchase of cell phone insurance;
- m. Purchase of a vehicle, and long-term lease or rental of a vehicle;
- n. Purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items;
- o. Firearms, ammunition or other weapons;
- p. Gambling, games of chance (such as bingo or lottery), alcohol, tobacco, or similar items;

- q. Vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses. This also includes mileage or driver time reimbursement for vacation travel by automobile;
- r. Purchase of usual and customary furniture and home furnishings, *unless* adapted to the participant's disability or use, or of specialized benefit to the participant's condition. Requests for adapted or specialized furniture or furnishings must include a recommendation from the participant's health care provider and, when appropriate, a denial of payment from any other source;
- s. Regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, *except* upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the participant's qualifying condition or disability;
- t. Regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, *except* upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the participant's qualifying condition or disability. Requests must include documentation that the adapted vehicle is the participant's primary means of transportation;
- u. Clothing and accessories, except specialized clothing based on the participant's disability or condition;
- v. Training expenses for paid employees;
- w. Conference or class fees may be covered for participants or unpaid caregivers, but costs associated with such conferences or classes cannot be covered, including airfare, lodging or meals;
- x. Consumer electronics such as computers (including laptops or any electronic tablets), printers and fax machines, or other electronic equipment that does not meet the criteria specified in Section 15 Subsection A of 8.314.6.15 NMAC. No more than one (1) of each type of item may be purchased at one (1) time, and consumer electronics may not be replaced more frequently than once every three (3) years, including those consumer electronics previously purchased through any other MAD program;
- y. Cell phone services that include more than one (1) cell phone line per participant. Cell phone service, including cell phone service that includes data, is limited to the cost of one hundred dollars per month.
- z. Dental services utilizing the Mi Via IBA

When a participant requests a service or good the consultant, the TPA and the State can work with the participant to find other (including less costly) alternatives.

8. SERVICE AND SUPPORT PLAN AND BUDGET APPROVAL PROCESSES

A. Initial SSP/Budget Approval Processes

The consultant, in cooperation with the participant, shall forward the SSP/budget request to the TPA for review and approval. The participant's SSP/budget request must be approved by the TPA before any services under Mi Via may begin.

Request for Information

The TPA may request additional information, through the Request for Information process (RFI), from the participant and/or the consultant during the process of reviewing the SSP/budget request. The consultant may assist the participant in obtaining requested documents and responding to the RFI but providing a timely and complete response to the TPA is primarily the participant's responsibility. The TPA will issue a RFI as soon as they identify an issue that needs correction. The RFI is due within seven (7) calendar days, before the next RFI is issued. The TPA will issue a total of three (3) RFI's before they issue a technical denial.

Request for Administrative Action

Requests for Administrative Actions (RFAs) are issued by the Third-Party Assessor (TPA) and must be responded to within seven (7) calendar days. The TPA cannot proceed with the request until this is corrected/addressed. Failure to respond timely to the RFA may result in a technical denial.

RFA Process

- The TPA will issue the RFA in the FMA online system and an alert will be created in the TPA system for the Consultant.
- The TPA will issue the RFA Technical Denial Letter to the participant and Consultant providing notice of necessary action needed and the date of the scheduled denial if not responded to.
 - Fair Hearing Rights will also be provided in the RFA Technical Denial Letter.
- Consultants will have seven (7) calendar days to respond to the RFA.
- The TPA will also notify the Department of Health weekly of RFAs that have not been responded to.

At a minimum, the SSP/Budget must be reviewed, revised, if needed, updated and approved annually, prior to the expiration of the existing SSP/budget.

SSP Review Criteria

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

- the services or goods must be responsive and directly related to the participant's qualifying condition or disability; and
- the services or goods must address the participant's clinical, functional, medical or habilitative needs; and
- the services or goods must accommodate the participant in managing their household; or
- the services or goods must facilitate activities of daily living; or
- the services or goods must promote the participant's personal health and safety; and
- the services or goods must afford the participant an accommodation for greater independence; and
- the services or goods must support the participant to remain in the community and reduce their risk for institutionalization; and
- the services or goods must be documented in the SSP and facilitate the desired outcomes in the participant's SSP; and
- the SSP contains the quality assurance criteria to be used to determine if the service or goods meet the participant's need as related to the qualifying condition or disability; and
- the services or goods must decrease the need for other Medicaid services; and
- the participant receiving the services or goods does not have the funds to purchase the services or goods; or
- the services or goods are not available through another source. The participant must submit documentation that the services or goods are not available through another source, such as the Medicaid State plan or Medicare; and
- the service or good is not prohibited by Federal and State statutes, regulations and any other guidance; and
- each service or good must be listed as an individual line item whenever possible; when services or goods are 'bundled' the SSP must document why bundling is necessary and appropriate.

Budget Review Criteria

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

- the proposed annual budget request is within the participant's IBA; and
- the proposed rate for each service is within the Mi Via range of rates for that chosen service; and
- the proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and

- the estimated cost of the service or good is specifically documented in the participant's SSP/budget; and
- no employee of any type may be paid more than 40 hours in a consecutive seven-day work week for any one participant or EOR, unless an exception is made by DDS for extraordinary circumstance.

The Mi Via Range of Rates (Appendix C) shall be used as a guide in evaluating proposed rates for waiver services that a participant plans to purchase. When the participant wants to pay a rate for any service that exceeds the suggested range of rates for the chosen service(s), the participant must justify, in writing, the rate(s) he/she wishes to pay and submit the justification with the SSP/budget for the TPA's review.

Rates for services and related goods shall be evaluated by the TPA for reasonableness and appropriateness. The primary factor in determining whether to approve a higher rate is the condition and need of the participant. Other factors may include, but are not limited to, specialized skills or training of the vendors or employees (if the specialized training or skills are related to the participant's condition and needs), and/or whether the participant has received the same service at the higher rate in previous years. If the TPA has questions about a participant's proposed rates for services or reasonable cost of requested goods, they may request additional information and/or documentation from the participant through the RFI process.

B. Approval of the SSP/Budget

The TPA will notify the participant and consultant in writing when a determination has been made on the SSP/budget request. The determination may be a full approval, a partial approval, or a denial.

The TPA shall indicate which goal(s) of the SSP/budget have been approved or denied in the FMA online system. This action will send an auto-alert to the consultant; this is a secondary form of notification of determination.

The FMA will utilize the authorized annual budget, as entered into the FMA online system to process payment for Mi Via services and goods in the approved amount and at the approved rate.

The participant's SSP and Authorized Annual Budget (AAB) must be approved before services under Mi Via can begin. Mi Via will not pay for any services, supports and goods provided or purchased prior to the approval of the SSP/budget.

C. Requests for Additional Funding over the IBA

The amount of the AAB cannot exceed the participant's annual IBA. The rare exception would be a participant whose assessed or documented needs for services, based on their qualifying condition, cannot be met within the annual IBA, in which case the participant would initiate a request for an adjustment through their consultant.

If the participant requests an increase in their budget above their annual IBA or AAB, as applicable, the participant must show at least one (1) of the following four (4) circumstances:

1. Chronic physical condition

The participant has one (1) or more chronic physical conditions, which are identified during the initial or reevaluation of the LOC, that result in a prolonged dependency on medical services or care, for which daily intervention is medically necessary and the participant's needs cannot be met within the assigned IBA, AAB, or other current resources, including natural supports, Medicaid State plan services, Medicare, or other sources.

The participant must submit a written, dated, and signed evaluation or letter from a medical specialist, either a medical doctor (MD), doctor of osteopathy (DO), certified nurse practitioner (CNP) or physician's assistant (PA) that documents the change in the chronic physical condition in the eligible recipient's health status relevant to the criteria. The evaluation or letter must have been completed after the last LOC assessment or less than one (1) year from the date the request is submitted, whichever is most recent.

The chronic physical conditions are characterized by at least one (1) of the following:

- a. A life-threatening condition with frequent or constant periods of acute exacerbation that:
 - places the participant at risk for institutionalization.
 - could result in the participant's inability to remember to self-administer medications accurately even with the use of assistive technology devices; or
 - requires a frequency and intensity of assistance, or consultation to ensure the participant's health and safety in the home or in the community; or,
 - in the absence of such skilled intervention, assistance, medical supervision, or consultation, would require hospitalization or admission to a Nursing Facility (NF) or an ICF/IID.
- b. The need for administration of specialized medications, enteral feeding, or treatments that:
 - are ordered by a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant,
 - require frequent and ongoing management or monitoring or oversight of medical technology.

2. Change in physical health status

The participant has experienced a deterioration or permanent change in her/her health status such that the participant's needs for services and supports can no longer be met within the AAB or other current resources, including natural supports, the Medicaid State plan, Medicare or other sources.

The participant must submit a written, dated, and signed evaluation or letter from a medical specialist, either a medical doctor (MD), doctor of osteopathy (DO), certified nurse practitioner (CNP) or physician's assistant (PA) that documents the change in the chronic physical condition in the eligible recipient's health status relevant to the criteria. The evaluation or letter must have been completed after the last LOC assessment or less than one (1) year from the date the request is submitted, whichever is most recent.

The participant may submit additional supportive documentation by others involved in the participant's care, such as a current Individual Service Plan (ISP) if the participant is transferring from another waiver, a recent evaluation from a specialist or therapist, a recent discharge plan, relevant medical records or other documentation or recent statements from family members, friends or other support individuals.

These are the types of physical health changes that may necessitate an increase in the IBA or current AAB, as applicable:

- the participant now requires the administration of medications via intravenous or injections on a daily or weekly basis;
- the participant has experienced recent onset or increase in aspiration of saliva, foods or liquids;
- the participant now requires external feedings, e.g., naso-gastric, percutaneous endoscopic gastrostomy, gastric-tube or jejunostomy-tube;
- the participant is newly dependent on a ventilator;
- the participant now requires suctioning every two (2) hours, or more frequently, as needed;
- the participant now has seizure activity that requires continuous monitoring for injury and aspiration, despite anti-convulsant therapy; or
- the participant now requires increased assistance with activities of daily living as a result of a deterioration or permanent changes in his or her physical health status.

3. Chronic or intermittent behavioral conditions or cognitive difficulties

The participant has chronic or intermittent behavioral conditions or cognitive difficulties, which are identified during the initial or reevaluation LOC assessment, or the participant has experienced a change in their behavioral or mental health status, for which the participant requires additional services, supports, assistance, or supervision to address the behaviors or cognitive difficulties to keep the participant safe. These behaviors or cognitive difficulties are so severe and intense that they:

- result in considerable risk to the participant, caregivers, or the community; and
- require a frequency and intensity of assistance, supervision, or consultation to ensure the participant's health and safety in the home or the community; and
- are likely to lead to incarceration or admission to a hospital, NF or ICF/IID;
- require intensive intervention or medication management by a doctor or mental health practitioner or care practitioner, which
- cannot be effectively addressed within the IBA, current AAB or other resources, including natural supports, the Medicaid State plan services, Medicare, or other sources.

Examples of chronic or intermittent behaviors or cognitive difficulties are such that the participant injures him/herself frequently or seriously; has uncontrolled physical aggression toward others; disrupts most activities to the extent that their SSP/budget cannot be implemented or routine activities of daily living cannot be carried out; withdraws personally from contact with most others; and/or leaves or wanders away from the home, work or service delivery environment in a way that puts him/her or others at risk.

The participant must submit a written, dated, and signed evaluation or letter from a medical doctor (MD), doctor of osteopathy (DO), certified nurse practitioner (CNP), physician's assistant (PA), psychiatrist or psychologist licensed by the Regulation and Licensing Department that documents the participant's mental health or behavioral status relevant to the criteria. The evaluation or letter must have been completed after the last LOC assessment or less than one (1) year from the date the request is submitted, whichever is more recent.

The participant may submit additional supportive documentation including a current Individual Service Plan (ISP) if the participant is transferring from another waiver, a positive behavioral support plan or assessment, recent notes, a summary or letter from a behavioral health practitioner or professional with expertise in intellectual and/or developmental disabilities, recent discharge plan, recent recommendations from a rehabilitation facility, any other relevant documentation or recent statements from family members, friends or other support individuals involved with the participant.

4. Change in natural supports

The participant has experienced a loss, as a result of situations such as death, illness, or disabling condition, of their natural supports, such as family members or other community resources that were providing direct care or services, whether paid or not.

This absence of natural supports or other resources is expected to continue throughout the period for which supplemental funds are requested. The type, intensity or amount of care or services previously provided by natural supports or other resources cannot be acquired within the IBA and are not available through the Medicaid State plan services, Medicare,

other programs, or sources in order for the participant to live in a home and community-based setting.

9. CHANGES, DENIALS AND REVIEWS OF THE SSP/BUDGET

A. Amending the SSP/Budget

Modification of the SSP

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

If the modification is to provide new or additional services than originally included in the SSP/budget, these services must not be able to be acquired through other programs or sources. The participant may be required to document the fact that the services are not available through another source. The consultant shall assist the participant with exploring other available resources.

The participant must provide written documentation of the change in needs or circumstances as specified in the Mi Via service standards. The participant submits the documentation to the consultant. The consultant initiates the process to modify the SSP/budget by forwarding the request for modification to the TPA for review.

The SSP/budget must be modified before there is any change in the AAB.

The SSP/budget may be modified once the original SSP/budget has been submitted and approved. Only one (1) SSP/budget revision may be submitted at a time, for example, an SSP/budget revision may not be submitted if an initial SSP/budget request or prior SSP/budget revision request is under initial review by the TPA. This requirement also applies to any reconsideration of the same revision request.

Other than for critical health and safety reasons, SSP/budget revision requests may not be submitted to the TPA within the last sixty (60) calendar days prior to the expiration date of the current SSP/budget.

Modifications to the Authorized Annual Budget

Revisions to the AAB may occur within the SSP/budget year, and the participant is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. The SSP/budget must be amended first to reflect a change in the participant's needs or circumstances before any revisions to the AAB can be requested.

SSP/budget revisions involve requests to add new goods or services to a budget or to reallocate funds from any line item to another approved line item. Budget revisions must be submitted to the TPA for review and approval.

Only one (1) SSP/budget revision may be submitted at a time, for example, an SSP/budget revision may not be submitted if a prior SSP/budget revision request is still in process.

Other than for critical health and safety reasons, AAB revision requests may not be submitted to the TPA for review within sixty (60) calendar days of the expiration date of the current SSP/budget year. Revision requests for review within sixty (60) days calendar of the expiration date of the current SSP/budget year must be submitted to the DOH Mi Via Program Manager or their designate for approval. An SSP/budget revision that is requested by a participant due to health and safety reasons may also be processed expeditiously. Expedited review requests must be submitted to the DOH Mi Via Program Manager or their designate for approval.

Criteria that constitute health and safety considerations for these types of requests may include but not be limited to:

- The participant has experienced a significant change in their health status, including physical, behavioral, and cognitive health status; or
- The participant has experienced a significant loss of their natural support(s), such as family members, friends or other community resources that were providing direct care or services, whether paid or not.

B. SSP/Budget Denials

The TPA shall send final decisions to the participant in writing with Fair Hearing Rights, including steps to follow if he/she disagrees with the decision and wants to pursue reconsideration and/or a Fair Hearing. Written denial notices from the TPA includes the reasons for the proposed action, the specific regulations that support the proposed action, or the change in the Federal or State law that requires the action.

Reconsideration

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

Fair Hearing

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

A Fair Hearing may be requested when:

- a Mi Via applicant's LOC has been denied;
- a Mi Via applicant has not been given the choice of HCBS as an alternative to institutional care;
- a Mi Via applicant is denied the services of their choice or the provider, vendor, or employee of their choice;
- a Mi Via participant services are denied, suspended, reduced or terminated;
- a Mi Via participant has been involuntarily terminated from the program; or
- a Mi Via participant request for a budget adjustment has been denied; and
- when any other adverse action is taken by MAD against the participant.

Agency Conference

Agency conferences are available to all participants who have filed for a fair hearing. An agency conference is an informal meeting between the participant, their consultant, guardian, or other representative or supports, and the TPA. The meeting is scheduled before the fair hearing. The agency conference is an opportunity for the participant to provide new or additional information that supports their request for a service or good that has been denied during budget review. When a fair hearing is requested, the TPA will reach out to the participant and their consultant to schedule an agency conference,

Continuation of Benefits

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

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

10. IMPLEMENTATION OF THE SERVICE AND SUPPORT PLAN AND BUDGET

A. Enrolling Employees and Vendors

Pre-Hire Packet

Before providing services to a Mi Via participant, most employees and vendors must submit the appropriate pre-hire packet to the FMA and pass the New Mexico Consolidated On-line Registry (NMCOR) screening. The exception to this requirement is when the vendor has a professional license, such as a registered nurse or SLP that qualifies them to provide the approved service. To obtain the pre-hire packet, the EOR shall contact the FMA or Consultant.

1. Employees and independent contractors (without an appropriate professional license) are required by NM law through the Caregivers' Criminal History Screening Act (7.1.9 NMAC) to pass a criminal background check (CBC) which must first be processed against the NMCOR.
2. This NMCOR screening is completed by the FMA, usually within forty-eight (48) hours, once the complete and correct pre-hire packet is received by the FMA.
3. Once the NMCOR check is completed, and the provider, vendor or employee has passed the NMCOR check, the EOR will receive an e-mail notification that the employee has passed their NMCOR Background Check. If the EOR does not have an e-mail address listed in the Mi Via online system, the FMA will contact the EOR, via telephone to let the EOR know that the employee has passed the NMCOR check. *Although an employee may begin providing services as soon as they have passed their NMCOR Background Check, payment will not be issued until all required paperwork as indicated below is complete and has been processed by the FMA.
4. If an employee or vendor does not pass the CBC, as required by NM law, he/she may not provide services to the Mi Via participant. The FMA will be notified by the Department of Health if he/she does not pass the CBC. The FMA will also contact the Employer of Record (EOR) by telephone and letter that the employee must be terminated immediately.
5. The NMCOR screening will be done prior to initial hiring and every three years after initial hire for employees. Vendors must assure employees pass the NMCOR and CBC.

Credentialing Requirements

In the approved Mi Via waivers, the State has set credentialing requirements for credentialing providers of Mi Via services, and these requirements have been approved by the Centers for Medicare and Medicaid Services (CMS). The FMA must ensure that these requirements are met. These requirements include certain licenses which must be submitted to the FMA and are described in Appendix D & E (Vendor and Employee Credentialing Requirements).

The initial hiring of Legally Responsible Individuals (LRIs) must be approved in writing by the Department of Health (DOH). After the initial approval, ongoing approval is not required unless a participant requires changes or additional services that an LRI would need to provide. At that time, a new request for the use of an LRI must be approved in writing by the Department of Health (DOH). A request for LRI approval (initial or any changes) must be provided on the appropriate request form with only one service request per form.

Other Required Documents

There are other documents that must be correctly completed by the employee or vendor and submitted to the FMA before payment can be made.

- For Employees, the required documents are included in the Employee Packet:
 1. Employment Agreement
 2. Employee Information Form
 3. Declaration of Relationship form
 4. Federal W-4
 5. State W-4 (optional form)
 6. LRI form (if applicable)

- For Vendors who are providing services (for example: acupuncture), the required documents are included as part of the Vendor Packet:
 1. Vendor Agreement
 2. Vendor Information Form
 3. Federal W-9

Vendors who are providing goods only (such as a large retailer) do not need to provide such documentation, however the participant or vendor must submit the Vendor Information Form to the FMA before payment is issued.

Direct Deposit is provided and strongly recommended for all employees and vendors when possible. The FMA also offers the service of providing payment through a Money Network Card. Please contact the FMA if interested in using this service. Direct deposit forms can be completed as part of the initial hire documentation or may be completed and submitted to the FMA later.

B. Payment of Employees, Vendors, Services and Goods

Employee and Vendor Pay Rates

Employee and vendor pay rates must be approved in the participant's SSP/budget. Once the rate is approved, Employee Agreements and Vendor Agreements must be submitted to the FMA in order to indicate their rate of pay. If an employee or vendor does not submit an Agreement, the FMA will not know the correct rate of pay for the service the employee or vendor is providing. For the FMA to pay an employee or vendor, an Employee Agreement or Vendor Agreement needs to be submitted to the FMA. If the pay rate for an employee or vendor needs to be changed, the new rate must be approved in the SSP/budget and a new Employee Agreement or Vendor Agreement must be submitted to the FMA at least fifteen (15) calendar days before the effective date of the rate change. Please remember that if a change to an employee's rate of pay is made after the SSP/budget has started, the change will not be effective until the beginning of the next pay period.

Payment of Employees

Upon completing the FMA online system training, a new user will receive a FMA online system Account Authorization form (via e-mail). Once the new user completes the FMA online system Account Authorization form and faxes it to the FMA, the user will receive an e-mail with their password and login instructions.

If a participant is utilizing employees, they must designate an Employer of Record (EOR).

Timesheets:

Employees hired directly by the EOR must submit online timesheets through the FMA online system. The EOR is required to review and approve the timesheet through FMA online system.

Timesheets are created in two ways:

1. Manual entry – the employee enters their time in the FMA online system. If the employee is unable to enter their time in the FMA online system, the EOR can enter the employee's time.
2. Electronic Visit Verification (EVV) system enters the employees time in the FMA online system from the clock and clock out data the employee enters through the EVV mobile app or Interactive Voice Response (IVR) system. This only applies to employees who are required to use EVV. These are employees directly hired by the EOR provide services under the following EVV services: Homemaker Direct Support and Respite.

Timesheets are submitted and processed on a two-week pay schedule according to the Mi Via Payroll Payment Schedule. The payroll workweek starts on Saturday and ends the following

Friday. The payment schedule is included in the January Mi Via newsletter that is mailed to all participants by the FMA and is also available online at <https://nmhealth.org/about/ddsd/pgsv/sdw/>. Timesheets are due at the end of the two-week pay period and must be received at the FMA no later than Saturday at 11:59 pm. Timesheets must be completed per instructions on the form, which includes the description of services provided. Incomplete timesheets could delay processing and payment timelines.

A Personal Representative (PR) may also complete the training and gain access to the FMA online system. If a PR has access, they will be able to view payments and monitor budget spending, however, they will not have authorization to perform the functions of the EOR and approve timesheets. To designate a PR, a participant must complete the PR Form, which may be requested through the FMA or the consultant. Direct Deposit is provided and strongly recommended for all employees and vendors when possible. The FMA also offers the service of providing payment through a *Money Network* Card. Please contact the FMA if interested in using this service. Direct deposit forms can be completed as part of the initial hire documentation or may be completed and submitted to the FMA later.

The EOR must review and approve the timesheets in the FMA online system for the employees to be paid.

Exceptions to Online Timesheets

Exceptions to online submission of timesheets may be requested under the following circumstances:

1. An EOR may request an exception from HSD/MAD if they are in a geographical location in New Mexico with no internet access; or
2. An EOR may request an exception from HSD/MAD if there are limitations due to disability.

Exception requests can be made anytime to HSD/MAD and remain effective indefinitely unless the EOR's circumstances change such that the reason for exception is no longer applicable. If the EOR's circumstances change such that the reason for exception no longer prevents the EOR from entering timesheets online, the EOR may then be required to submit timesheets electronically.

Payment of Vendor or Goods

Vendor Invoices

Vendor Payment Request Forms (PRF) and invoices may be submitted to the FMA on any day of the week. PRFs may not be signed prior to the delivery of services. If a participant is only utilizing vendor services, an EOR is not necessary, however, an EOR can be identified by a participant to assist with the use of vendors. In some instances, an EOR for vendor services may

be required by the State. Those signing a PRF for vendor services rendered to a participant may not serve as an employee, contractor, or sub-contractor of that vendor for that participant. The Form must be signed by the participant (unless there is an authorized representative over financial matters), their authorized representative or an EOR. The processing time for a PRF/invoice is approximately two (2) weeks. Please see the Vendor Payment Schedule for details. The vendor payment schedule may be found in the January Mi Via newsletter that is emailed to participants by the FMA. Vendor checks will be mailed directly to the participant, authorized representative or the EOR. Payments are not mailed to the vendor unless the vendor has elected to utilize direct deposit. After the participant, authorized representative or the EOR receives the vendor check, they must remit/send/forward the check to the vendor as soon as possible to ensure prompt payment. For phone/internet payments, the participant, authorized representative or EOR should send the payment to the phone/internet company's main billing address (with the payment coupon). Phone/internet payments should not be attempted through kiosks or at local phone/internet stores as these payments are frequently rejected.

PRFs and invoices must be submitted to the FMA for processing. A participant, authorized representative or EOR has access to the FMA online system they may review the payments to vendors and monitor them as they are being processed through the FMA online system. In addition, the participant, authorized representative, EOR, or PR may run reports through the FMA online system to monitor spending activity. Vendors of direct services are required to complete service documentation as required in the Mi Via Regulations.

Return to Participant Process:

Return-to-Participant (RTP) emails are an effective means used by the FMA to assist in communicating with the participant, authorized representative or EOR when there are problems in processing payment. For example, if a timesheet or invoice is submitted to the FMA and it does not contain the appropriate signatures. The FMA uses the RTP process as a means to inform the participant, authorized representative or EOR that payment could not be made and reason why payment could not be made. Since contact is attempted by the FMA to the participant, authorized representative or EOR, it is extremely important that the FMA online system contain the correct contact information for the participant, authorized party or EOR. If the participant, authorized representative or EOR contact information needs to be updated, please contact the FMA for assistance. Updates to phone or e-mail contact information may also be sent to the FMA.

Timely-Filing Requirements

In New Mexico, there is a ninety (90) calendar daytime limit for filing all Medicaid claims and since Mi Via is a Medicaid program, the same requirements apply. If timesheets or invoices are submitted more than ninety (90) calendar days after the service has been provided, payment will not be processed and the timesheet or invoice and PRF will be returned to the authorized party/EOR through the RTP process.

Electronic Visit Verification

EVV is a telephone and computer-based system that electronically verifies that the direct care worker visits occur and documents the time the service begins and ends. EVV is required by the 21st Century Cures Act that was enacted by Congress in December 2016 and mandates those states require EVV use for Medicaid-funded Personal Care Services (PCS) by 1/1/20 and Home Health Care Services (HHCS) by 1/1/23 for in-home visits by a paid staff. The federal Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have identified personal care and home health services as situations in which Medicaid recipients are particularly vulnerable to fraud, abuse, neglect, and exploitation. EVV data will assist both providers' and the State's efforts to protect the health and safety of Medicaid recipients who use these services. Personal Care Services are defined as those services which aid with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Mi Via Waiver Services Requiring EVV

- Homemaker (99509 & 99509 E)

- Respite Standard (T1005 SD & T1005 SD E)

EVV system has potential for benefits that may include:

- a. Improved practices inherent in the use of EVV.
- b. Centralized, real-time monitoring and comprehensive reporting on services provided.
- c. Use of EVV data to identify delivery issues and make care delivery more efficient.
- d. Improving program integrity and higher quality of services.
- e. Improving risk management and fraud protection.
- f. Secure, HIPAA compliant automated claims.

The EVV system verifies the:

- a. Type of service performed.
- b. Individual receiving the service.
- c. Date of service.
- d. Location of service delivery.
- e. Individual providing the service.
- f. Time the service begins and ends.

The state supplies agencies with a single approved EVV system that must be used. Effective January 1, 2021, Mi Via Waiver employees or vendors of Home Maker Direct and Respite are

required to implement the use of EVV. As home health care services are phased in according to federal and state requirements, additional services may require the use of EVV.

Vendors or employees of services that require use of EVV must:

1. Effective January 1, 2021, Mi Via Waiver vendors or employees of Home Maker Direct and Respite are required to implement the use of the state approved EVV system.
2. As home health care services are phased in according to the federal and state requirements, additional services may require the use of EVV.
3. Vendors or employees of required services (Personal Care beginning 1/1/2021 and Home Health beginning 1/1/23) must use the state approved EVV system to meet EVV requirements and:
 - a. Establish an agency point of contact for EVV operations and state updates.
 - b. Enter and delete of agency participants and employees in the system timely.
 - c. Confirm all applicable service authorizations data to operate the EVV system.
 - d. Correct errors in the system when allowed by state.
 - e. Ensure that employees have access to the state approved EVV system and can clock in and out for all assigned work.
 - f. Assure employees are trained and are using the EVV system.
 - g. Adjust operations as needed that relate to agency's payroll, scheduling, and/or claims system as needed to accommodate the agency's business practices and the requirements for EVV system use.

Provide requested data and information about the agency's implementation of EVV in the format and schedule established by DOH.

C. Budget Expenditure Safeguards

The participant holds the primary responsibility for monitoring and ensuring that their approved SSP/budget is spent appropriately; however, the consultant must support the participant in this activity. The FMA also assists in ensuring that funds are spent appropriately through payment of approved services and goods according to the approved SSP/budget and Employee/Vendor Agreements. Per the Mi Via program regulations, if a participant fails to properly allocate or track expenditures and the budget is prematurely depleted, this is not justification for an increase in the SSP/budget amount.

The participant should review their monthly spending report which is mailed out by the FMA monthly. The participant may also obtain "real-time" information on service usage and spending through direct access to the FMA online system. It is highly recommended that participants obtain access to the Mi Via online system so that they can effectively monitor their budget and track spending. In addition, the EOR and employees may obtain access to the FMA online system. With the FMA online system access, the EOR will have the capability to approve timesheets that an employee has entered online or through Electronic Visit Verification (EVV).

Training for the FMA on-line system is offered for employees, participants and EOR. If interested in training, the employee, participant or EOR may contact the FMA for assistance.

The consultant is required to review the participant's SSP/budget expenditures during each monthly contact with the participant. The consultant will provide the participant with expenditure information and discuss any concerns. If the participant needs to revise their SSP/budget, the consultant will assist with drafting the revision and will submit it to the TPA for consideration per established procedures.

The FMA is responsible for processing payments for approved Mi Via services and goods. When an invoice or timesheet is received by the FMA, they verify that the service or good is approved in the participant's SSP/budget and payment is processed according to the approved SSP/budget and Employee/Vendor Agreement. In regard to internet and phone services (landline or cell), the FMA will pay up to the approved monthly amount. This helps to ensure that this category of service is not overspent which could put the participant at-risk of losing these services due to possible non-payment later in the SSP/budget year. If the FMA is unable to make payment as requested due to lack of funds remaining in the SSP/budget, the FMA will contact the participant, authorized representative or EOR once with instruction for them to contact the Consultant for assistance.

11. WAIVER CHANGE

After initial allocation, waiver participants may choose to switch to another waiver that they are eligible for after they have made an initial choice to receive services from the Mi Via Waiver Program. If the participant has received services in one waiver and would like to change to another waiver, they are eligible for then the participant must contact their local DOH, DDS Regional Office or the DDS Medically Fragile Waiver Manager to request a Waiver Change Form (WCF). Transitions between waivers should occur within ninety (90) calendar days from receipt of the WCF unless there are circumstances related to the participant's services that require more time. The participant must always end existing waiver services on the last day of a month and start new waiver services on the first day of a month. There must not be a break in waiver services.

A. Participants Transferring from another Waiver to Mi Via

- Participants wishing to transfer from the Traditional DD or MF waiver to Mi Via must request a WCF from DOH. Transfers are not allowed if the LOC is due to expire within ninety (90) calendar days from the WCF request.

B. Participants Transferring from Mi Via to Another Waiver

- Participants wishing to transfer from Mi Via to the traditional DD or MF waiver need to request a WCF from DOH. Transfers are not allowed if the LOC is due to expire within ninety (90) calendar days from the WCF request.

12. CONSULTANT AGENCY CHANGE REQUESTS

Mi Via participants may choose to switch to another Consultant Agency (CA) while they are in early transition into Mi Via after they have met medical and financial eligibility.

Participant contacts appropriate Regional Mi Via Liaison to request a Consultant Agency Change form.

When “Consultant Agency Change” form is returned, Regional Office (RO) liaison date stamps front of form and faxes to current and new Consultant Agency, a transition meeting is then scheduled between current and new Consultant Agency.

When RO liaison receives transfer notes the Consultant Agency Change form is then faxed to the TPA and HSD office. The change on the online system is made by RO liaison and transition is complete.

Consultant Agency changes can only occur on the 1st of the month. There must be no break in services.

13. TERMINATION FROM THE MI VIA PROGRAM

A. Voluntary Termination

Current waiver participants are given a choice of receiving services through an existing waiver or Mi Via.

Mi Via participants, who transition from the traditional DD or MF waivers and decide to discontinue self-directing their services, may return to the traditional DD or MF waivers in accordance with the Mi Via regulations.

B. Involuntary Termination

A Mi Via participant may be terminated involuntarily and offered services through the traditional DD or MF waiver or the Medicaid State plan under the following circumstances:

1. The participant refuses to follow Mi Via rules and regulations after receiving focused technical assistance on multiple occasions, support from the program staff, consultant, or FMA, which is supported by documentation of the efforts to assist the participant;
2. The participant is in immediate risk to their health or safety by continued self-direction of services, e.g., the participant is in imminent risk of death or serious bodily injury related to participation in the waiver. Examples include but are not limited to the following:
 - a. The participant refuses to include and maintain services in their SSP and AAB that would address health and safety issues identified in their medical assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, consultant, or FMA.

- b. The participant is experiencing significant health or safety needs, and, after having been referred to the State (which includes the appropriate State agencies and additional parties as deemed necessary by the State) for level of risk determination and assistance, refuses to incorporate the team's recommendations into their SSP and AAB;
 - c. The participant exhibits behaviors which endanger him/her or others.
- 3. The participant misuses Mi Via funds following repeated and focused technical assistance and support from program staff, the consultant or FMA, which is supported by documentation of efforts to assist the participant. Focused technical assistance is defined as a minimum of three (3) separate occasions where a participant, participant's authorized representative, and/or the Employer of Record (EOR) have received training, education or technical assistance, or a combination of both; and
- 4. The participant commits Medicaid fraud.
- 5. DOH notification that the participant continues to utilize an employee and/or vendor who have consistently been substantiated against for abuse, neglect, exploitation while providing Mi Via services after notification of this on multiple occasions by DOH.

A participant who is involuntarily terminated from Mi Via will be offered a traditional waiver alternative that they are eligible for. If transfer to another waiver is authorized by the State, he/she will continue to receive the services and supports from Mi Via until the day before the new waiver services start. This will ensure that a break in service does not occur. The Mi Via consultant and the case manager with the traditional waiver will work closely together with the participant to ensure that the participant's health and safety is maintained.

Any participant who is involuntarily terminated has the right to contest that termination by requesting a Fair Hearing. Notification from the State that the participant has been involuntarily terminated will be made in writing and will include instructions for how to appeal the decision.

14. Appendices

Appendix A: Service Descriptions in Detail

Appendix B: Service and Support Plan Template

Appendix C: Range of Rates and Service Codes

Appendix D: Vendor Credentialing Requirements

Appendix E: Employee Credentialing

Appendix F: Compliance Oversight and Monitoring

Appendix G: Training

Appendix H: EOR Guidebook

Appendix I: State Agencies, Divisions and Bureaus

DDSD Contact Information

DDSD Community Programs Bureau

DD Waiver Unit

810 San Mateo, suite 104

Santa Fe, NM 87505

505-476-8913

DDSD Regional Offices

Metro Regional Office
5300 Homestead
Albuquerque, NM 87110
505-841-5500 (Phone)
800-283-5548 (Toll-Free)
505-841-5554 (Fax)

Northeast Regional Office
224 Cruz Alta, Suite B
Taos, NM 87571
575-758-5934 (Phone)
866-315-7123 (Toll-Free)
575-758-5973 (Fax)

Northwest Regional Office
2910 East Route 66
Gallup, NM 87301
505-863-9937 (Phone)
866-862-0448 (Toll-Free)
505-863-4978 (Fax)

Southeast Regional Office
726 South Sunset, Suite B
Roswell, NM 88203
575-624-6100 (Phone)
866-895-9138 (Toll-Free)
575-624-6104 (Fax)