Mi Via Waiver

Service Standards



Effective Date:

This version updates and replaces all previous editions of the Mi Via Service Standards.

HEALTH CARE
AUTHORITY

Acknowledgements

The Developmental Disabilities Supports Division (DDSD) would like to acknowledge the assistance, time, and expertise of the many people who contributed to the development of these Mi Via Waiver Service Standards. DDSD received input over many months from people receiving services, family members, providers/vendors, organizations, and subject matter experts within DDSD. Many stakeholders participated in meetings and/or provided written comments. Their time and input were invaluable to the completion of the final Mi Via Waiver Service Standards.

Mi Via holds a unique place within New Mexico's system of supports because it is grounded in the principles of self-direction, personal authority, and individual responsibility. It is designed to ensure that individuals have meaningful control over their services and the freedom to shape supports that align with their goals, preferences, and vision for a fulfilling life. This emphasis on flexibility and personal choice sets Mi Via apart from more traditional service models and reflects the belief that people thrive when they have genuine ownership over how their supports are planned and delivered.

DDSD is grateful for the commitment, time, energy, and creativity of all who worked so hard on this project to improve the lives of people with intellectual and developmental disabilities (IDD) in New Mexico. We share a common goal and core values to establish a system that provides person-centered services in support of people with IDD to achieve quality outcomes, to have choice, to live meaningful lives, and to engage in meaningful relationships in the community of their choice. These Service Standards are the framework for providers to operate a quality system of services and supports for people with IDD, while honoring the distinctive self-directed foundation that makes the Mi Via Waiver an empowering and innovative option for participants and their families.

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INTRODUCTION TO THE MI VIA WAIVER

A. Purpose of the Mi Via Waiver

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. The Mi Via Waiver, or simply, 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 (IDD), or medically fragile conditions (MF) and are at risk of IDD.

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

B. Purpose of the Mi Via Service Standards

The Developmental Disabilities Supports Division (DDSD) has established Service Standards to guide service delivery and promote the health and safety of participants supported by Mi Via provider/vendor agencies, employees, and natural supports. All Mi Via providers are required to comply with all applicable Federal and State rules in addition to these Service Standards.

Mi Via Waiver Service Standards establish provider qualifications and requirements for service delivery through the MI Via Waiver program. These requirements are enforceable and apply to all provider agencies and their staff whether directly employed or subcontracted with the approved provider agency.

These Service Standards may be updated periodically to communicate changes in policy and program requirements or to reflect amendments to the Mi Via Waiver as approved by the Centers for Medicare and Medicaid Services (CMS). When supplements, corrections and page replacements are issued, Mi Via participants, provider/vendor agencies, employees, and natural supports will be notified through e-blasts, website postings, numbered memos or direct mailings. DDSD will provide a public feedback period before issuing any substantial changes and will issue a memo with guidance and transition periods when applicable.

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C. Developmental Disabilities Supports Division Mission

Developmental Disabilities Supports Division Mission Statement:

To serve those with intellectual and developmental disabilities by providing a comprehensive system of person -centered community supports so that individuals live the lives they prefer, where they are respected, empowered, and free from abuse, neglect and exploitation.

Key Objectives of DDSD:

1. Person-Centered Support: DDSD aims to ensure that individuals are respected, empowered, and free from abuse, neglect, and exploitation. The division focuses on creating a supportive environment that promotes individual choice and independence.
2. Comprehensive Services: The division provides a range of services designed to meet the unique needs of individuals with IDD. This includes access to community resources, behavioral support services, and enabling technology to enhance independence.
3. Collaboration and Partnership: DDSD emphasizes collaboration with individuals, families, and community partners to share expertise and work towards common goals. This approach fosters a network of support that benefits those served by the division.
4. Commitment to Quality: The division is dedicated to ensuring high-quality services that are accessible and cost-effective, aiming to improve the overall health and well-being of New Mexicans with IDD.

By focusing on these objectives, DDSD strives to create a system that not only meets the immediate needs of individuals but also supports their long-term growth and integration into the community across their lifespan.

D. General Authority and Requirements

The Centers for Medicare and Medicaid Services (CMS) authorizes, oversees, and provides federal funding for the Mi Via Waiver. CMS's oversight ensures that Mi Via operates within federal standards while supporting the state's commitment to offering individuals a flexible, self-directed alternative that prioritizes personal choice, autonomy, and meaningful control over their services.

The Health Care Authority administers and operates the Mi Via Waiver through the Developmental Disabilities Supports Division (DDSD). The Centers for Medicare and Medicaid Services (CMS) federal Waiver application, New Mexico Administrative Code (NMAC) 8.314.6, and these Service Standards determine the program rules and requirements for the Mi Via program.

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Mi Via provides self-directed home and community-based services (HCBS) to individuals who are both Financial eligible and medically eligible under the Intermediate Care Facilities and Intellectual and Developmental Disabilities ICF/IID Level of Care (LOC) guidelines (8.314.6 NMAC). Eligible waiver participants include people who are eligible to receive services through the HCBS waivers for those that are developmentally disabled (DD) or medically fragile (MF).

The Mi Via 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 the 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 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.

Federal Oversight of States Quality Improvement Strategy (QIS)

The Centers for Medicare and Medicaid Services (CMS) expects the State to follow a Quality Improvement Strategy (QIS) for the operation of the Mi Via Waiver. CMS monitors the State to ensure that it has the capacity to identify and remediate performance issues on an individual, provider and at systemic levels. The following are the waiver assurances required by CMS:

1. Administrative Authority: The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
2. Level of Care (LOC): The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/re-evaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital,

Nursing Facility , or ICF/IID. An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.

3. Qualified Providers: The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services. The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
4. Service Plan: The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs. Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan. Participants are afforded choice between/among waiver services and providers.
5. Health and Welfare**:** The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible. State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed. The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.
6. Financial Accountability: The state must demonstrate that it has designed and implemented an adequate system for ensuring Financial accountability of the waiver program. The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. The state provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

E. Abuse, Neglect and Exploitation Prevention

DDSD is committed to promoting the health and safety of the individuals served in our programs. Any incident of abuse, neglect, or exploitation (ANE) is unacceptable. People with intellectual and

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developmental disabilities have significantly higher risk of ANE. ANE prevention strategies are a part of all of our waiver programs. The following are examples of ANE prevention strategies:

1. DDSD Wellness Home Visits: A person receiving the Mi Via Waiver services is subject to mandatory in-home visitation by trained DDSD or other State of NM staff to promote the health and safety of the individual. All service providers and waiver participants must comply to facilitate these visits.
2. Service providers must monitor all environments to verify and promote that the participant is safe and free from ANE.
3. Assessment of and identification of potential ANE risk factors of everyone served.
4. Comprehensive ANE training requirements for DDSD, and providers. ANE training is available and required for waiver participants with accommodations if needed.
5. Information materials are provided to participants, families and providers on how to identify ANE and reporting requirements.

F. Mi Via Waiver Self-Directed Guiding Principles

All participants:

1. Are able to self-direct their program with appropriate supports;
2. Have value and potential;
3. Will be viewed in terms of their abilities;
4. Have the right to participate and be fully included in their communities; and
5. 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.

G. 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 the Mi Via Waiver, 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 with planning and managing their services and supports. Self-direction means that participants have more choice, control, flexibility, freedom, and responsibility.

H. Human Rights / CMS Final Rule: HCBS Settings Requirements

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.

On January 16, 2014, CMS published the CMS Final Rule: Home and Community-Based Services (HCBS) Settings Requirements 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 IDD into the community.

The intent of the CMS Final Rule is to ensure that people receiving long-term services and supports through Medicaid's 1915(c) HCBS waiver programs have the greatest possible independence and choice, full access to the benefits of community living, and the opportunity to receive services in the most integrated setting appropriate to their needs. The CMS Final Rule works to enhance the quality of HCBS and provides protections to participants. The HCBS setting requirements focus 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.

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I. Participant Rights and Freedoms

As a person with an intellectual and/or developmental disability (IDD) 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, and exploitation
- Have access to advocacy supports and resources
- Participate in any discussion about restricting my rights
- Vote
- Exercise religion or belief of my choice

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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.

J. 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 Developmental Disabilities (DD) or Medically Fragile (MF) Home and Community-Based Services (HCBS) waiver programs.

The most basic responsibility of a Mi Via participant is to maintain his/her Financial and medical eligibility to be in the program. This includes completing the required HCA documentation and participating in the annual comprehensive in-home assessment (IHA) of the Level of Care (LOC) conducted by the Medicaid 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:

i. Comply with the rules and regulations that govern the program; and
ii. 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.
iii. If a participant is utilizing employees, they must designate a Support Broker an eligible recipient may be his or her own Support Broker 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 Support

Broker responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the Support Broker as designated in this rule.

iv. An eligible recipient may also designate an individual of his or her choice, through a POA or other legal designation, to serve as the Support Broker, subject to the Support Broker meeting the qualifications specified in 8.314.6 NMAC.
    A. If a participant is utilizing vendor services only, a Support Broker 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.
    B. If a participant has vendors only and chooses not to have a Support Broker, the participant must identify an Authorized Representative. The participant may be his or her own Authorized Representative (AR) provided the participant is not a minor and does not have a plenary or limited guardianship or conservatorship over Financial matters. The PRF may only be signed by the Support Broker or Authorized Representative.

v. Communicate with the consultant through face-to-face monthly visits, with one visit per quarter occurring in the home, and report concerns or problems with any part of their Mi Via program to the consultant;
vi. Use program funds appropriately by only requesting services and goods covered by the Mi Via Waiver and only purchasing services and goods after they have been approved by the Medicaid Third Party Assessor (TPA);
vii. Comply with the approved SSP and not spend more than the authorized annual budget (AAB);
viii. Work with the TPA by attending scheduled meetings and IHA's and providing documentation as requested;
ix. Respond to requests for additional documentation and information from the consultant, Fiscal Management Agent (FMA), and the TPA within the required deadlines;
x. 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 and the FMA within 10 days calendar;
xi. Report to the TPA and consultant if hospitalized for more than three (3) nights so that a new appropriate LOC can be obtained; and
xii. Communicate with Mi Via State contractors and State personnel in a non-abusive and non-threatening manner.

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

i. Submit all required employee and vendor 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;
ii. Report any incidents of abuse, neglect or exploitation by any employee or other support to the appropriate State entity;
iii. Arrange for the delivery of services, supports and goods
iv. Hire, train, schedule, supervise or dismiss Mi Via vendors and/or employees;
v. Maintain employee and service records and documentation (for at least seven (7) years from date of service and ongoing) in accordance with Mi Via regulations and Federal and State employment rules; and
vi. When necessary, request assistance from the consultant with any of these responsibilities.
vii. Service delivery documentation must comply with applicable Medicaid regulations and waiver service standards. Providers are responsible for maintaining documentation that substantiates the delivery of authorized services and supports Medicaid billing. Service delivery documentation must be completed within two business days of service delivery.

The relevant New Mexico Administrative Code (NMAC) regulations regarding provider service delivery documentation are located : 8.302.1 NMAC: MEDICAID GENERAL PROVIDER POLICIES

K. Mi Via Contactors, and Participant Supports

In the Mi Via Waiver, there are three (3) important sources of support for participants:

1. The Third-Party Assessor (TPA) determines initial and on-going medical eligibility as well as reviews and authorizes Service and Support Plan (SSP)/budgets.
2. The Fiscal Management Agent (FMA) acts as the intermediary between the participant and the Medicaid payment system and assists the participant or the Support Broker with employer/vendor related responsibilities.
3. The Consultant Agency (CA) provides assistance and support to the participant with all aspects of the program.

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Medicaid Third Party Assessor

The Medicaid Third-Party Assessor (TPA) is under contract with the Medical Assistance Division (MAD) of the Health Care Authority (HCA) to provide the following services in the Mi Via program:

i. Determine initial Level of Care (LOC) for individuals who choose the Mi Via Waiver including conducting in-home assessments and reviewing and determining LOC;
ii. Conduct the in-home LOC assessment in person with the participant in his/her current living environment, or in a location approved by the state;
iii. Review the information in the LOC documents, including the current History and Physical and Long-Term Care Medical Assessment Abstract (LTCAA) completed by the Primary Care Physician, along with the in-home assessment, to determine the participant's level of care (LOC) and assign the Individual Budget Allotment.
iv. The TPA may re-evaluate the LOC more often than annually if there is an indication that the participant's medical condition has changed; and
v. Review each Mi Via participant's individual Service and Support Plan (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 NMAC and Service Standards to determine approval and denial of services and goods.

Fiscal Management Agent

The Fiscal Management Agent (FMA) is under contract with MAD to provide the following services in the Mi Via Waiver:

i. Assure program compliance with State and Federal employment and Internal Revenue Service (IRS) requirements;
ii. Assist each participant to set up a unique Employer Identification Number (EIN) if they intend to hire employees;
iii. Answer participant inquiries, solve related problems, and offer assistance for participants and their representatives on how to complete Mi Via billing and invoicing processes. The FMA will provide all participants with necessary documents, instructions and guidelines;
iv. Collect all documentation necessary to verify that providers, employees, and vendors have the qualifications and credentials required by Mi Via regulations;
v. Collect all documentation necessary to support the participant's specific arrangements with each employee and vendor, including employment agreement forms and vendor agreement forms;

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vi. Complete criminal history and 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;
vii. Check the Division of Health Improvement 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;
viii. 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;
ix. 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 Exclusion List, that person may not be employed by a Mi Via participant;
x. 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
xi. Process and pay invoices for services and goods that are approved in the participant's SSP and Authorized Annual Budget (AAB) when supported by required documentation;
xii. Handle all payroll functions on behalf of the participants who hire direct service employees and other support personnel, including collecting and processing time sheets of support workers, processing payroll and withholding, filing and payment of applicable Federal, State and local employment-related taxes and insurances; and
xiii. Track and report on employee payment disbursements and balances of participant funds, including providing the participant and his/her consultant with a monthly report of expenditures and budget status.

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 SSPs

and budgets for TPA review. The TPA uses the FMA online system to receive SSP and budget requests, to 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 a job aid and access for the FMA online system as well as on-going technical assistance and help with problem solving.

Consultant Agencies and Consultants

The Consultant Agencies are contracted through the Developmental Disabilities Supports Division (DDSD).

Consultant Agency (CA) services are direct services intended to educate, guide and assist the participant during the Medicaid eligibility process, to make informed planning decisions about services and supports, to develop a Service and Support Plan (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 Annual Approved Budget (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 Waiver. Participants may choose to work with any DDSD contracted 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 annually by each individual Consultant and kept in each Consultant Agency's personnel files. This ensures all Consultants are acting in accordance with DDSD expectations and professional standards.

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

L. 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 goals and desires have 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.

M.Coordination with Managed Care Organizations (MCOs)

"Turquoise Care" is New Mexico's Medicaid managed care program. It provides a wide range of Medicaid services, including medical, behavioral health, and home and community-based services (HCBS) and long-term care for individuals who meet the level of care required for nursing facility services. Turquoise Care uses a person-centered approach to help individuals, particularly those with more complex needs or a higher risk of poor health outcomes, navigate the Medicaid system and develop a personalized plan to make sure they receive the services and supports they need. The Turquoise Care Managed Care Organizations (MCOs) provide medical, behavioral health, and other healthcare services to people enrolled in the Mi Via waiver.

The MCO is responsible for ensuring a Comprehensive Care Plan (CCP) 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 Mi Via waiver participants cannot make recommendations or changes to the Mi Via participant's Service and Support Plan (SSP) and budget; however, works with the Consultant to coordinate services and ensure Mi Via Waiver participants are receiving medical, ancillary services.

Consultants are responsible for ensuring that care coordination, provided by MCOs, for Mi Via Waiver participants includes the following:

i. Coordination of the participants' health care needs through the development of the care plan;
ii. With the participants' consent to share information, the care plan should be shared and utilized by those involved in providing care to the member;
iii. Collaboration with the participant, participant's family, friends, member's primary care provider (PCP), specialists, Behavioral Health providers, other providers, communities, and interdisciplinary team experts, as needed when developing the care plan;

iv. Verification of all decisions made regarding the members' 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:

i. The Third-Party Assessor (TPA) is authorized to provide, to the MCO, a copy of the Long-Term Care Medical Assessment Abstract (LTCAA) (MAD 378 form or DOH 378 forms as applicable) and the Medically Fragile Comprehensive Individual Assessment and Family Centered Review for the purpose of obtaining a complete, comprehensive picture of the participant and their needs.
ii. MCO will utilize the LTCAA and CIA information to complete certain portions of Comprehensive Needs Assessment (CNA).
iii. While the MCO is responsible for the annual CNA visits and the Consultant assists the participant with the Mi Via Level Of Care 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 and the participant's family.

N. Grievance System – Filing a Concern or Compliant

In accordance with the CMS 2024 Ensuring Access to Medicaid Services final rule, also known as the Access Rule, a Mi Via participant, guardian or representative, family member, or other support, has the opportunity to register a grievance or complaint including but not limited to the states or a provider's performance of person-centered planning processes, the 2024 CMS Settings Rule service requirements, or any other concerns regarding the Mi Via program. The Developmental Disabilities Supports Division (DDSD) Office of Constituent Support (OCS) grievance system provides another avenue participants or their representative(s) can pursue to register a complaint or grievance about any issue they are dissatisfied with as it relates to the Mi Via Waiver.

The filing of a complaint or grievance does not preclude an eligible recipient from pursuing an HCA administrative hearing and filing a grievance or complaint is not a prerequisite or substitute for requesting an HCA administrative hearing.

Grievances or complaints may be filed via:

i. E-mail to the DDSD OCS at DDSD.Constituents@hca.nm.gov;
ii. Mail to Developmental Disabilities Supports Division Constituent Support, PO Box 2348, Santa Fe, NM 87504-2348

iii. Phone 505-699-6775;
iv. Or online at https://app.smartsheet.com/b/form/b2de329d2c5044e58b898f2dd52147fd

Grievance process overview:

i. When a grievance or complaint is received, it will be referred to the appropriate HCA division for resolution.
ii. For all complaints the DDSD will address, the DDSD follows up within two (2) business days from the date the complaint is received and informs the participant or their representative that the complaint has been received. A database is used to intake and track all grievances or complaints, and record any actions taken and issue resolutions.
iii. The filer of the complaint may contact the division at any time via phone, email, online, or standard mail after they have filed their complaint to add information to the complaint.
iv. Complaints may be resolved using state policies and procedures or other mechanisms as appropriate to the program.
v. Complaints sent directly to the DDSD must be resolved by the division within fifteen (15) days. The DDSD can extend this timeframe as needed to resolve a complaint.
vi. If the participant or their representative does not agree with the outcome of the complaint resolution, they have fifteen (15) days to contest the resolution by contacting the DDSD OCS directly via email, phone, online, or though standard mail, to request a reevaluation of the decision.
vii. The Policy and Programs Deputy Director will determine if the initial resolution was or was not sufficient to address the points raised in the complaint.
    a. If the Policy and Programs Deputy Director determine that the initial resolution addresses the complaint, the DDSD OCS will contact the participant or their representative via email or standard mail to inform them that the appeal of this decision has been reviewed, and it has been determined that the decision is upheld.
    b. If the Policy and Programs Deputy Director determine that the initial resolution does not address the complaint, the participant or their representative will be contacted by the DDSD OCS to understand their dissatisfaction with the resolution.
    c. A new complaint resolution will be created and approved by the Policy and Programs Deputy Director before being sent to the participant or their representative.
viii. At any point during the grievance process, filers of a complaint will never receive any retribution, retaliation, or be penalized for voicing their issues and/or seeking resolutions to

problems. Punitive or retaliatory action will not be taken against a participant, their representative, or anyone who files a complaint.

ix. As applicable, clients or their representatives will be informed that they can request a hearing with the HCA Office of Fair Hearing.

O. 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. Mi Via Participants, families, Support Brokers and Provider Agencies, vendors or employers can make requests for assistance for various reasons.
2. The RORA form should be completed in its entirety by the requestor and submitted. Typical requests are listed in specific categories on the RORA template available on the DDSD Website. The RORA form should be completed in its entirety by the requestor and submitted: RORA Link: Regional Office Request for Assistance (RORA) Form

P. Billing and Documentation Requirements

Consultants and vendor agencies participating in the Mi Via Waiver are required to maintain complete, accurate, and timely documentation that fully discloses the extent and nature of the goods and services furnished to Mi Via participants.

Billing Requirements

Consultant Agencies must have the following items in place prior to billing:

i. A fully executed provider agreement with DDSD
ii. An approved Provider Participation Agreement (MAD 335)
iii. An active Medicaid provider number

Direct hired employees must have the following items completed and approved before they begin providing services and billing:

i. Complete and processed Employee Packet
ii. Completed New Mexico Consolidated On-line Registry (CCHSP) and federal criminal history background check
iii. A signed and approved Employee Agreement
iv. Linked to an approved service

Vendor agencies must have the following items completed and approved before providing services and billing:

i. Complete and processed Vendor Forms
ii. A signed and approved Vendor Agreement
iii. Linked to an approved service

Documentation Requirements

Mi Via Waiver providers, vendor agencies, and direct hire employees are required to complete all service documentation within two (2) business days of service delivery. Mi Via providers, vendor agencies, and direct hire employees must maintain all records necessary to demonstrate the proper provision of services for Medicaid billing purposes. In addition, 8.302.1.17 NMAC*, Medicaid General Provider Policies*, requires all Medicaid providers to maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. Failure to provide required documentation during an audit may result in recoupment of funds, denial of claims, sanctions, or termination from Medicaid participation.

A. Consultant Agencies: Consultants agencies are responsible for maintaining documentation of all consultant service activities completed with or on behalf of the participant. This includes records of monthly visits, monitoring contacts, and any other required interactions outlined in the Mi Via Service Standards, Section 5: Administrative Requirements. Documentation must clearly show the date, time and duration, nature, and outcome of each activity to support compliance and audit requirements.

B. Vendor Agencies: Vendors and their employees and sub-contractors must maintain documentation for every date of service billed. Documentation must clearly show what service was provided, when, and scope or amount of services provided.

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C. Prior to approval of timesheets and Vendor Payment Request Forms (VPR), the Support Broker is responsible for ensuring that all documentation related to employees, vendors, services, and expenditures is complete, accurate, and compliant with program rules. This includes daily progress notes as they relate to services received and maintaining receipts for goods or services purchased with the Money Network Card.

State and Federal Audits

Mi Via Waiver Support Broker and vendor agencies are subject to audits conducted by the Health Care Authority (HCA) and the Centers for Medicare and Medicaid Services (CMS). These audits are designed to verify that all services billed to Medicaid were authorized, delivered as documented, and supported by complete and accurate records. All Support Brokers, vendors, and consultants must ensure that documentation is:

i. Accurate, complete and reflects actual services delivered as outlined in NMAC 8.314.6 and these Mi Via Service Standards.
ii. Timely: Records are created and maintained at the time services occur, or within two (2) business days of service delivery. The two (2) business day requirement ensures that documentation is completed while information is still accurate, reliable, and reflective of the service provided.
iii. Accessible: Documentation must be available upon request.

Q. HIPAA and Protected Health Information

Passed in 1996, HIPAA stands for Health Insurance Portability and Accountability Act. The purpose of HIPAA is to set national standards for the protection of health information and improve healthcare deliver and set basic privacy protections for individuals.

HIPAA is comprised of:

1. The Privacy Rule: The Privacy Rule created protection for protected health information (PHI) held by covered entities. Examples of covered entities are health care providers such as HCA, or healthcare plans, etc. The Privacy Rule ensures that an individual's PHI is only shared on a need-to-know basis. The Privacy Rule protects health information in all forms such as electronic, verbal and written.

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2. The Security Rule: The Security Rule is a set of guidelines protecting PHI that is created, received, maintained or transmitted electronically by covered entities. The Security Rule includes administrative, physical and technical safeguards.

HIPPA ensures confidentiality, integrity, and availability of electronic protected health information.

R. Exceptions to the Standards

To request an exception, a provider agency, consultant, or case manager will submit the Exception Authorization Review Form to the DDSD Regional Office. In addition, providers must submit a letter of justification outlining why they are requesting the exception, relevant meeting minutes and the current/revised SSP. Providers should submit exception requests via Secure Communication (SComm) in Therap, or through a secure email to the Regional Office Director.

The Regional Office (RO) where the individual receives services will receive completed Exception Authorization Review Forms. Exception requests will be reviewed by the RO Director or designee to determine if a specific Bureau or Subject Matter Expert (SME) should be consulted. Exception requests will be routed to the appropriate SME.

If additional information is needed, or if the form requires one or more revisions, the designated staff member will send the form back to the Provider. The Provider has five (5) business days to make requested revisions or provide additional information. If no additional information is provided within the five (5) business day timeline, the request will be denied.

The RO Director, Bureau Chief, Mi Via Program Manager, DDSD staff member, or DDSD Deputy and/or Director as needed, will approve or deny the request. Exception requests that reasonably describe the extenuating circumstances are time limited, do not conflict with the NMAC or CMS approved waiver applications, do not compromise the health or safety of the participant, and do not place the participant or others at risk of harm will be considered for approval.

Exceptions should only be allotted for the shortest amount of time possible to ensure the health and safety of the person. An extended timeframe for exception requests may be granted in certain situations after consultation with the DDSD Deputy and/or Director.

Any Provider Agency operating under an approved exception must have supporting documentation on file for quality review activities. Exceptions may be time limited or revoked based on individual and/or agency circumstances.

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INITIAL ALLOCATION AND ONGOING ELIGIBILITY

Waiver eligibility is determined by the DDSD Intake and Eligibility Bureau (IEB), located statewide in the DDSD 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 DDSD Regional Office where pre-service activities are initiated.

Participants can enter the Mi Via waiver two different ways.

- Complete the Home and Community Based Waivers and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) application and receive a 096 Category of Eligibility (COE) or:
- They can enter through the Medically Fragile Waiver application process after receiving a 095 COE

A COE is the Medicaid eligibility category assigned to an individual based on the program through which they qualify.

The Mi Via Waiver provides services to two COEs:

- Intellectual Developmental Disability (COE 096)
- Medically Fragile (COE 095)

A COE 095 is tied to a person's current medical fragility. If their health improves, they may no longer meet the medical criteria for that category. Because of that, continued eligibility under COE 095 is not guaranteed over time.

A COE 096 is based on a lifelong intellectual or developmental disability, not on fluctuating medical conditions. Once a person is formally determined eligible under COE 096, their Mi Via participation is much more secure because the underlying disability does not "improve out" of eligibility.

When a participant enters the Mi Via Waiver through the COE 095 , the Mi Via Consultant is responsible for explaining the difference between a 095 COE and a 096 COE. Participants with a 095 COE are strongly encouraged to apply with the Pre Service Intake Bureau completing the Home and Community Based Waivers and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) application in order to receive a 096 COE. 096 COE's can offer more comprehensive service options and insures long term program eligibility.

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A. Definition of Developmental Disability and Medical Fragility

Mi Via Waiver services are for eligible recipients who have developmental disabilities limited to an intellectual disability (ID) or a specific related condition as defined in NMAC8.290.400 and as determined by the Health Care Authority (HCA) Developmental Disabilities Supports Division (DDSD).

For an applicant whose developmental disability is based on a related condition, DDSD will review documentation to determine whether the disability is indefinite in duration and is expected to result in substantial functional limitations that are likely to continue for an extended or indefinite period. The developmental disability must reflect the person's need for a combination and sequence of special interdisciplinary 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 [Long Term Care Services – Intermediate Care Facilities] and meet all other applicable financial and non-financial eligibility requirements.

Intellectual Disability

A person is considered to have an intellectual disability (ID) if he/she has significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period as outlined in 8.290.400 NMAC Medicaid Eligibility – Home and Community Based Waiver Services (Categories 090, 091, 093, 094, 095 and 096) Recipient Policies.

Related Condition

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

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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

B. Applying for Mi Via Waiver Services

Individuals can apply for the Mi Via Waiver through the following process:

Central Registry

The DDSD Central Registry is the database used to maintain information on individuals seeking access to New Mexico's Developmental Disabilities Home and Community-Based Services (HCB) Waivers. It supports the tracking of individuals through the intake and eligibility process and helps DDSD manage individuals awaiting access to waiver services.

To qualify for services through an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or a Home and Community Based Services (HCBS) Waiver (Developmental Disabilities (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 DDSD Central Registry;
3. Submit the DD Waiver application and supporting documentation with a "Complete" status as determined by DDSD;
4. Meet the Medicaid financial and medical eligibility criteria; and
5. Be a resident of New Mexico.

The Central Registry Unit (CRU), in the Pre-Service Intake Bureau (PSIB) of DDSD, 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 DDSD Regional Office. Once the person has completed the registration, he/she will receive an application packet. This packet includes:

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1. 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 allocation schedule 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.

Allocation Process

The Pre- Service Intake Bureau sends out offers for the waiver, known as an allocation, offer, monthly. The eligible applicant 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 his/her 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. Mi Via self-directed waiver and a Consultant Agency or the DD Waiver and a Case Management Agency

Expedited Allocation

In special circumstances, a person may be allocated to the Mi Via Waiver by means other than the person's date of registration in the Central Registry. To qualify for an

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expedited allocation, the applicant must be on the Central Registry, be determined to have Developmental Disability, meet specific criteria, and be approved by a DDSD review team and the DDSD 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 DDSD 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 DDSD Division Director or designee. DDSD 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 PSIB 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 Health

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Care Authority (HCA) Income Support Division (ISD). If the person has already begun the eligibility process, the person must meet medical and financial eligibility before he/she may request a transfer to DD Waiver.

C. Medical and Financial Eligibility Requirements

After allocation, the applicant must initially and continuously 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.

Financial Eligibility Requirements

The person/guardian completes the recertification form, HSD 100, electronically or takes the completed ISD 122 recertification to the County ISD office. The ISD may request additional documentation as part of their review of the application.

Medical Eligibility Requirements - 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 participants' 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 DDSD PSIB. 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.

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Role of the Consultant

Once the Consultant receives a copy of the PFOC, his/her responsibilities assisting and monitoring this process begin to assist the participant in completing requirements to establish both financial and medical eligibility. Financial eligibility is determined through the Income Support Division (ISD). Medical eligibility is determined by the Third-Party Assessor (TPA)In general, the Consultant is responsible for:

1. Monitoring whether the person/guardian completes the Application for Assistance form, HSD 100, and submits the form electronically or takes a copy of the completed HSD 100 to the local ISD office and requests a proof of receipt.
2. If the process of determining financial and medical eligibility takes longer than 90 days, informing the applicant and/or guardian, , as applicable, that a request for an extension from the ISD for his/her Mi Via Waiver eligibility determination is needed.
3. Compiling the Level of Care (LOC) packet which includes the Long-Term Care Medical Assessment Abstract (LTCAA) Form (MAD 378), History and Physical, completed by the applicant' s medical provider, completed by the Consultant, as well as the In-Home Assessment completed by the TPA.
   - The Medically Fragile (COE 095) Registered Nurse Case Manager is responsible for submitting the annual Level of Care (LOC) determination to the Third-Party Assessor (TPA) to support the participant's continued waiver eligibility.
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 DDSD PSIB Central Registry Unit on the 15th of each month.

A Service and Support Plan (SSP) and budget cannot be submitted or processed, and Mi Via supports cannot bill for services without a current 096 COE indicating Mi Via Waiver eligibility.

D. Annual Recertification of Eligibility

All Mi Via Waiver participants must recertify eligibility annually. This includes financial and

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medical eligibility. An application is mailed to the participant and guardian 45 days prior to the expiration of the category of eligibility (COE). The Consultant plays 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 are responsible for monitoring whether a person's COE is current and for informing the Consultant as soon as possible if the COE is expired or near expiring.
2. Consultants 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 Service and Support Plan (SSP) and budget cannot be submitted or processed,, and Mi Via supports cannot bill for services without a current 096 COE indicating Mi Via Waiver eligibility.

Annual Financial Eligibility Requirements

The steps to meet annual financial eligibility are:

1. The person/guardian can use the HCA100 or the ISD122,
2. completes the recertification form, can submit electronically (Yes NM) or takes the completed ISD 122 or HCA 100 recertification form to the County ISD office ,or mail it in
3. The ISD may request additional documentation as part of their review of the application.

Annual Medical Eligibility Requirements

Consultants should support the person to complete activities related to annual medical eligibility by assisting with supports needed for the waiver participant to attend medical appointments timely for an annual completion of the LTCAA and History and Physical (H&). The Consultant keeps the completed and signed LTCAA and H&P in their agency participant files.

E. Use of the Client Information Update Form

The Client Information Update form MAD 054, (CIU) is a tool for internal communication among the following entities: Income Support Division (ISD) , Medical Assistance Division (MAD) Managed Care Organizations (MCO), TPA, DD Waiver Case Management Agencies,

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

i. Change in address;
ii. Change in state of residence;
iii. Change of Case Management Agency or CM/Consultant Agency/Care Coordinator/Support Broker;
iv. Change of Level of Care;
v. Status of allocation or transition;
vi. Reason for denial or closure;
vii. Plan of Care/ISP/SSP dates;
viii. Death of the person in services;
ix. Nursing facility admission;
x. Hospital facility admission;
xi. Move out of the state;
xii. Incarceration;
xiii. Request for a Setting of Care change;
xiv. Request for a COE Extension; and
xv. Waiver services not accessed.

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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 a participant wants to switch waivers within the first thirty (30) calendar days of allocation, *and* no medical or financial eligibility has begun, the transfer is permitted. The participant must contact the Developmental Disabilities Supports Division (DDSD) Pre-Service Intake Bureau (PSIB) to request a new Primary Freedom of Choice (PFOC).

If the participant has already begun the eligibility process, the participant must meet medical and financial eligibility *before* he/she may request a transfer. At that time, the participant must contact the DDSD Mi Via Unit If you need to request a Waiver Change Form, please use the email address provided : mi.via@hca.nm.gov

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.

Participants Transferring From Another Waiver to Mi Via

Participants wishing to transfer from the Traditional Developmental Disabilities (DD) or Medically Fragile (MF) waiver to Mi Via must request a WCF: mi.via@hca.nm.gov from the Mi Via Unit . Transfers are not allowed if the LOC is due to expire within ninety (90) calendar days from the WCF request. 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. If there are circumstances related to the participant's services, change in supports or health condition, an exception can be requested and sent to the DDSD Mi Via Program Manager.

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 the DDSD Mi Via Unit: mi.via@hca.nm.gov . Transfers are not allowed if the LOC is due to expire within ninety (90) calendar days from the WCF request.

- The WCF is faxed to ISD, TPA, Outgoing Agency, Receiving Agency
- Online system shell for New Participant is created

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- Once the Individual Transition Plan is received from discharging agency.
- Changes will be reflected the first of the month in FoCos and Therap.

If there are circumstances related to the participant's services, change in supports or health condition, an exception can be requested and sent to the DDSD Mi Via Program Manager.

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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.

To request a change in Consultant Agency, the participant contacts appropriate Regional Office Mi Via Liaison to request a Consultant Agency Change form (CACF) If you need to request a Consultant Agency Change Form, please use the email address provided : mi.via@hca.nm.gov

1. When the Consultant Agency Change form is returned to the appropriate Regional Office, the Mi Via liaison date stamps front of form and faxes to current and new Consultant Agency, CASA and Comagine.
2. A transition meeting is then scheduled between current and new Consultant Agency.
3. Consultant Agency Change form is then faxed to the TPA and ISD office.
4. Assignment updates in the online system are made by Regional Office Mi Via liaison and transition is complete.

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

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TERMINATION FROM THE MI VIA PROGRAM

A. Voluntary Termination

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.

When a participant decides to leave the Mi Via Waiver:

1. The participant, legal guardian or Consultant agency will contact the Mi Via Program Manager or designee to notify the participant's intent to terminate waiver services. The Mi Via Program Managers' contact information can be found on the Mi Via Program Directory.

2. Within two business days, the Mi Via Program Manager/designee and consultant will meet with the participant to discuss the following:
    a. Confirm the participant's or legal guardians' request to terminate from the program.
    b. Review the termination process with the participant and legal guardian.
    c. Discuss alternatives to termination such as transitioning to the Developmental Disabilities Waiver (DD Waiver), Medically Fragile Waiver (MF Waiver), changing consultant agencies; or alternative services such as placement in an Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities (IID).
    d. Explain how termination may affect the participant moving forward, including impact to other Health Care Authority (HCA) Medicaid benefits, services and supports; and
    e. Provide guidance on how to reapply for the Mi Via Waiver after termination, if they choose to do so.

3. If the participant requests transfer to the DD Waiver, MF Waiver, or placement in an ICF, the Mi Via Program Manager will facilitate such transfer with assistance from their consultant and appropriate DDSD staff.
    a. The Mi Via Program Manager will provide the Mi Via Waiver Voluntary Disenrollment Request Form to the participant and or legal guardian. The Mi Via Waiver Voluntary Disenrollment Request Form is the participant's written confirmation that they wish to disenroll from the program.

4. The participant and/or legal guardian must return the signed Mi Via Waiver Voluntary Disenrollment Request Form by mail, fax or drop it off at their regional office.

5. Upon receipt of the signed Mi Via Waiver Voluntary Disenrollment Request Form, the Mi via Program Manager will provide a copy of the form to the consultant agency for their records within two business days.

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6. The Mi Via Program Manager will send a letter, via certified mail to the participant or legal guardian, confirming voluntary termination from the Mi Via program.

7. Within two business days after the consultant receives the Mi Via Waiver Voluntary Disenrollment Request Form, they must:
    a. Upload a copy of the Mi Via Waiver Voluntary Disenrollment Request Form into the participant's Therap profile.
    b. Close out the participant's profile in Therap.
    c. Create a Therap note documenting the completion of this process as well as submitting a close out budget in the Fiscal Management Agent (FMA) online system within two business days.

8. The Consultant will send a Client Information Update form (CIU) and a copy of the Mi Via Waiver Voluntary Disenrollment Request Form to the Income Support Division (ISD) and Third-Party Assessor to provide notification of the participant's termination from the program and submission of the close out budget.

9. The Consultant will inform the Mi Via Program Manager via Scomm once they have submitted the CIU and copy of Mi Via Waiver Voluntary Disenrollment Request Form to the ISD.

10. The Mi Via Program Manager will notify the Therap Unit via email of the participants termination from for the program

B. Involuntary Termination

A participant may be involuntarily terminated from the Mi Via Waiver when there are significant concerns about their ability to meet program requirements or maintain their health and safety. Examples of issues that may lead to involuntary termination include repeated missed doctor appointments, repeated failure to complete Level of Care requirements, incomplete In-Home Assessments, ongoing inability to secure necessary service or support staff or other violations of program rules as outlined in the Mi Via Service Standards and New Mexico Administrative Code (NMAC) 8.314.6 Mi Via Home and Community-Based Waiver. In these circumstances:

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1. The Mi Via Program Manager and consultant will meet with the participant to:

    i. Review the concerns and health or safety risks reported by the consultant agency or Mi Via vendors.
    ii. Discuss and explain the following:

        a. Discuss and agree upon actions to address concerns and establish a date for resolution.
        b. Discuss alternatives to termination such as transitioning to the DD Waiver, MF Waiver, or alternative services such as placement in an ICF
        c. Review the termination process
        d. How termination may affect the participant moving forward, including impact to Health Care Authority (HCA) Medicaid benefits, services and supports;
        e. Those participants who are involuntarily terminated from the Mi Via Waiver due to an inability to meet program requirements or ensure health and safety may not be appropriate for re-enrollment in the Mi Via program and will be referred to the Developmental Disabilities Waiver (DD Waiver) where they will be required to meet all program requirements, or other appropriate services to ensure their needs can be safely met.
        f. Participants have the right to request a Fair Hearing within 90 calendar days of the date of the notice of adverse action in accordance with NMAC. If a Fair Hearing is requested before the effective date of termination, services may continue if requested, until a final decision is rendered; however, if the outcome is not in favor of the participant, the participant is responsible for payment of services and goods.
2. If the participant requests transfer to the DD Waiver, Medically Fragile Waiver, or placement in an ICF/IDD, the Mi Via Program Manager will facilitate such transfer with assistance of the consultant.
3. The Mi Via Program Manager will send a certified letter to the participant or legal guardian summarizing the discussion and required actions to address concerns. A copy will be saved by Mi Via Program Manager in the participants Therap profile and sent to the consultant agency for their records.
4. If concerns are not resolved by the agreed upon date, the Mi Via Program Manager will send an Involuntary Termination Letter through certified mail to the participant and or legal guardian with a copy to the consultant. The Termination Date will be 30 calendar days from the date of issuance of the Involuntary Termination Letter.
5. The Involuntary Termination Letter will include:

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i. The reason for termination;
ii. The effective date of termination; and
iii. The participant's right to request a Fair Hearing in accordance with NMAC; with language regarding continuation of benefit during the appeal process.

6. Participants have up to 90 calendar days from the date of the notice to request a Fair Hearing.
    a. If a participant wants to continue their participation in Mi Via Waiver (continuation of benefits) during the appeal process, they must notify the Mi Via Program Manager and their consultant, before the termination date of their intent to file a Fair Hearing. If the participant requests a Fair Hearing prior to the effective date of termination, Mi Via services will continue at the current level until a final hearing decision is issued.
    b. If the hearing decision upholds the termination, the participant shall be responsible for any difference in cost between Mi Via services received during the appeal period and the services authorized under the DD Waiver. Additionally, if the outcome is not in favor of the participant, the participant is responsible for payment of any services and goods received during the continuation period.

7. All case closure activities, including closure in Therap and submission of close-out budgets and CIU will occur only after the effective date of termination and in accordance with Fair Hearing requirements.
8. If no Fair Hearing request has been filed, requiring the continuation of benefits, the Consultant is required to complete the following tasks within two business days following the Termination Date:

    i. Close out the participant's profile in Therap;
    ii. Create a Therap note documenting the completion of this process as well as submitting a close out budget in the Focos system.
    iii. Submit a close out budget in the FMA online system.
    iv. The Consultant agency will send a CIU and a copy of the Involuntary Termination Letter to the ISD and Comagine to provide notification of termination from the program and submission of the close out budget.
    v. The Consultant will send an Scomm to the Mi Via Program Manager once they have submitted the CIU and copy of Involuntary Termination Form to ISD.
    vi. The Mi Via Program Coordinator will notify the Therap Unit of the participants termination from for the program.

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A. Service and Support Plan Development Processes

Person-Centered Planning

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 intellectual and developmental disabilities (IDD). 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 Centers for Medicaid and Medicare Services (CMS) require use of PCP in the development of the Service and Support Plan (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 IDD to:

a. Have informed choices;
b. Exercise the same basic civil and human rights as other citizens;
c. Have personal control over the life he/she prefers in the community of choice;
d. Be valued for contributions to his/her community; and
e. 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:

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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 his/her 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 IDD 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 they direct 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;

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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 and Support Broker 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 his/her 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 the 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

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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 IDD to make informed choices and to encourage them to speak up about their lives without feeling intimidated.

Mi Via Waiver Support Broker paid supports/vendors 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

Mi Via Waiver participants have the option to choose among community-based resources providing both disability and non-disability specific services and settings. The person-centered plan (PCP) must include documentation of a discussion about paid and unpaid resources. This must include options for supports resources, employment, activities, and relationships with non-waiver-related programs and non-disability specific options.

Mi Via, , offers participants the opportunity to select providers of direct services from all available community resources.

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B. Service and Support Plan Components

The Centers for Medicare and Medicaid Services (CMS) requires a person-centered service plan for every person receiving Home and Community-Based Services (HCBS). The Mi Via Waiver's person-centered service plan is the Service and Support Plan (SSP).

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

Service and Support Plan Development

The Service and Support Plan (SSP) is developed annually through an ongoing person-centered process (PCP). The SSP development must:

a. Involve those whom the person wishes to attend and participate in developing the SSP;
b. Use assessed needs to identify services and supports;
c. Include individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, and others;
d. Identify roles and responsibilities of supports who are implementing the SSP;
e. Include the term of the SSP and how and when it is updated; and
f. 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 Health Care Authority (HCA) Mi Via web page and is included in the Service Standards. 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,

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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, behavioral support consultation (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 an individual, family or group's 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,

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probation, parole).

11. Whenever DDSD decides not to approve the implementation of an SSP due to the cost or because DDSD 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 eleven (11) 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 they have developed is working well: Living Supports, Community Membership, Health and Wellness, and Other Supports.

Each section of the SSP must be completed by the participant, even if they do 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 participants' needs are being addressed.

Category 1: 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.

Category 2: Community Participation, Employment, and Volunteering 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

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opportunities for participants to access community resources and activities with others in their community.

Mi Via also offers transportation supports for participants to encourage access to the community-based resources and services they wish to utilize. The Mi Via Waiver affords participants the freedom of choice to access both disability and non-disability specific settings for all Mi Via services.

The Developmental Disabilities Supports Division (DDSD) is committed to Employment First principles and practices. Consultants have requirements to document strategies to support informed choice about employment in the SSP. Consultants use the SSP to document the outcome of a participant's informed choice about employment. All services support a person in making and informed choice about employment. Informed choice means making a decision based on a solid understanding of all available options and the consequences of how each decision may impact their life. It is an individualized process that starts with:

Assessment: The first step in making an informed choice about employment starts with the assessment process.

1. 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.
2. 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.
3. 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.
4. 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.

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5. 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.

Category 3: Health and Wellness Supports

A very important section in the SSP covers Health and Wellness Supports. These supports are available in the Mi Via Waiver 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.

Category 4: 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.

Category 5: Related Goods

Related goods are items like equipment, supplies, class fees, or memberships. Related goods do not include services such as housecleaning, yard maintenance, etc. Related goods must help with a need in your plan and support you in being involved in your community. Related goods are requested through Individual Goods and Services.

Category 6: Environmental Modifications

Environmental Modifications are changes or equipment added to a person's home to keep them safe, support their health, or help them be more independent. This benefit does not cover home changes that provide general convenience and are not directly related to your medical or support needs, for example, fences, storage sheds, or other

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outbuildings. It also does not cover projects that increase the home's square footage, unless adding space is required to complete an approved adaptation. If you received environmental modifications in the last five (5) years but need more done, talk to your consultant to see if funds are still available. You may get up to $5,000 for environmental modifications every five (5) years.

Category 7: Technology

This section outlines the participants' use or need of technology.

Category 8: Support Broker Questionnaire

This section helps participants determine whether they can and want to manage Support Broker responsibilities independently or would benefit from assistance. It also identifies situations in which a participant is not eligible to serve as their own Support Broker and explains when the Support Broker questions may not be necessary.

Category 9: Consultant Services

This section describes the consultant support the participant needs to successfully manage their Mi Via services. Participants should work with their consultant to identify the type and amount of support needed and document that support in this section. Consultant services must meet the minimum requirements established in the applicable service standards.

Category 10: SSP Preparation Information

This section lists all people who contributed to the creation of the SSP.

Category 11: Emergency Backup Plan

The Emergency Backup Plan provides quick access to backup information for the participant, their staff, and other people who support them. 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 Service and Support (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.

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Consultant and Back-Up Plan Acknowledgement Forms. The Consultant signs the Consultant and Back-Up Acknowledgement Forms to confirm the Service and Support Plan (SSP) and Emergency Back-Up Plan is complete.

C. Completing and Submitting the Service and Support Plan

The Service and Support Plan (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 Fiscal Management Agent (FMA) online system SSP by the consultant.

D. Budget Development Process

Individual Budgetary Allotment

The Individual Budgetary Allotment (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	$27,208.57
18-20 years old	$63,357.43 $80,468.61 if using In-Home Living Supports
21 and older	$85,757.35

Once the Service and Support Plan (SSP) has been completed and the participant has identified the supports they would like to obtain through the Mi Via program, the consultant and participant work together to develop the SSP/budget request. The

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participant and consultant may need to research the estimated cost of services and goods and will use the Mi Via Fee Schedule 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 Third-Party Assessor (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.

Request for Exception to the Range of Rates

Mi via participants, or Support Broker, 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:

a. 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

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behavioral supports; these services cannot be accessed through other services.

b. Medical Conditions

The participant has ongoing need for intense medical supports including oxygen monitoring, diabetic monitoring, skin breakdown, jejunostomy (J) and gastrostomy (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.

c. 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.

d. 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.

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.

a. Budget-Spending Authority

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

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b. *Employer Authority*

The Support Broker the employer of service providers not employed through vendors. The Mi Via participant can be their own Support Broker. The FMA serves as the participant's agent in conducting payroll and other employer-related responsibilities that are required by Federal and State law.

c. *Decision-Making Authority*

Participants shall have authority to do the following:

i. Identify service providers (employees/vendors) and refer them to the FMA for enrollment;
ii. Complete the employer paperwork to be submitted to the FMA if utilizing employees. All participants who plan to hire employees are required to designate a Support Broker following the process established by the FMA to do so.
iii. Complete the vendor paperwork to be submitted to the FMA if utilizing a vendor or vendors.
iv. Determine the amount paid for services within the State's limits;
v. Schedule the provision of services;
vi. Specify staff qualifications of the participant's choice, consistent with the qualifications specified in the Mi Via regulations and service descriptions
vii. Specify how services are provided, consistent with the Mi Via regulations and the service descriptions
viii. 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.
ix. 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;
x. Approve payment, according to the AAB, for waiver services and goods identified

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ii. 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.

i. Participants cannot be reimbursed directly for any services and goods or supports;

ii. The participant shall follow the AAB; and

iii. The participant shall be accountable for the use of Mi Via funds.

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NON-COVERED SERVICES

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

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 Waiver 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

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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, homeowners, service warrantees 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,

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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: or
z. Dental services utilizing the Mi Via IBA.

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SERVICE AND SUPPORT PLAN AND BUDGET APPROVAL PROCESSES

B. Initial Service and Support Plan and Budget Approval Processes

The consultant, in cooperation with the participant, shall forward the Service and Support Plan (SSP)/budget request to the Third-Party Assessor (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 (RFI)

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, however; 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 (RFA)

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 RFA process is as follows:

1) The TPA will issue the RFA in the Fiscal Management Agent (FMA) online system and an alert will be created in both the TPA and FMA system for the Consultant.
2) 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

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scheduled denial if not responded to. Fair Hearing Rights will also be provided in the RFA Technical Denial Letter.

3) Consultants will have seven (7) calendar days to respond to the RFA.
4) The TPA will also notify the Health Care Authority weekly of RFAs that have not been responded to.

Service and Support Plan (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:

i. The services or goods must be responsive and directly related to the participant's qualifying condition or disability;
ii. The services or goods must address the participant's clinical, functional, medical or habilitative needs;
iii. The services or goods must accommodate the participant in managing his/her household;
iv. The services or goods must facilitate activities of daily living;
v. T=The services or goods must promote the participant's personal health and safety;
vi. The services or goods must afford the participant an accommodation for greater independence;
vii. The services or goods must support the participant to remain in the community and reduce his/her risk for institutionalization;
viii. The services or goods must be documented in the SSP and facilitate the desired outcomes in the participant's SSP;
ix. 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;
x. The services or goods must decrease the need for other Medicaid services; and
xi. The participant receiving the services or goods does not have the funds to purchase the services or goods;
xii. 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;
xiii. The service or good is not prohibited by Federal and State statutes, regulations and any other guidance;
xiv. Each service or good must be listed as an individual line item whenever possible;

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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:

i. The proposed annual budget request is within the participants' IBA;
ii. The proposed rate for each service is within the Mi Via range of rates for that chosen service;
iii. The proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good;
iv. The estimated cost of the service or good is specifically documented in the participant's SSP/budget;
v. No employee of any type may be paid more than 40 hours in a consecutive seven-day work week for any one participant or Support Broker, unless an exception is made by DDSD for extraordinary circumstance.

The Mi Via Fee Schedule, which is comprised of a range of rates, 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) they wish to pay and submit the justification with the SSP/budget for the TPA's review.

Rates for services and related goods will be reviewed by the TPA to determine whether the requested rate is reasonable and appropriate. In evaluating requests for rates above standard levels, the participant's assessed needs, circumstances, and support requirements will be the primary consideration. 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.

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C. Approval of the Service and Support Plan (SSP)/Budget

The Third-Party Assessor (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 Fiscal management Agent (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 (AAB), 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 participants' SSP and 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.

D. Requests for Additional Funding over the Individual Budget Allotment

The amount of the authorized annual budget (AAB) cannot exceed the participant's annual individual budget allotment (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 his/her consultant.

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

a. Chronic Physical Condition

The participant has one (1) or more chronic physical conditions, which are identified during the initial or reevaluation of the level of care (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.

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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:

1) A life-threatening condition with frequent or constant periods of acute exacerbation that:
    i. places the participant at risk for institutionalization.
    ii. could result in the participant's inability to remember to self-administer medications accurately even with the use of assistive technology devices; or
    iii. 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,
    iv. 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.
2) The need for administration of specialized medications, enteral feeding, or treatments that:
    i. are ordered by a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant, which
    ii. require frequent and ongoing management or monitoring or oversight of medical technology.

b. Change in Physical Health Status

The participant has experienced a deterioration or permanent change in their 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),

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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:

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

c. 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 his/her 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

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safe. These behaviors or cognitive difficulties are so severe and intense that they:

i. Result in considerable risk to the participant, caregivers, or the community;
ii. Require a frequency and intensity of assistance, supervision, or consultation to ensure the participant's health and safety in the home or the community;
iii. Are likely to lead to incarceration or admission to a hospital, Nursing Facility or ICF/IID;
iv. Require intensive intervention or medication management by a doctor or mental health practitioner or care practitioner, which
v. 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 themselves 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 them 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.

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d. 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.

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CHANGES, DENIALS AND REVIEWS OF THE SERVICE AND SUPPORT PLAN/BUDGET

A. Amending the Service and Support Plan and Budget

Modification of the Service and Support Plan

The Service and Support Plan (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 Third-Party Assessor (TPA) for review.

The SSP/budget must be modified before there is any change in the Authorized Annual Budget (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.

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Modifications to the Authorized Annual Budget

Revisions to the Authorized Annual Budget (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 Developmental Disabilities and Supports Division (DDSD) 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 DDSD 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:

i. The participant has experienced a significant change in their health status, including physical, behavioral, and cognitive health status; or
ii. 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. Service and Support Plan (SSP)/Budget Denials

The Third-Party Assessor (TPA) shall send final decisions to the participant in writing with Fair Hearing Rights, including steps to follow if they disagree with the decision and wants

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to pursue reconsideration and/or a Fair Hearing. Written denial notices from the TPA include 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 to the TPA 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 the:

i. Mi Via applicant's LOC has been denied;
ii. Mi Via applicant has not been given the choice of home and community-based services (HCBS) as an alternative to institutional care;
iii. Mi Via applicant is denied the services of their choice or the provider, vendor, or employee of their choice;
iv. Mi Via participant's services are denied, suspended, reduced or terminated;
v. Mi Via participant has been involuntarily terminated from the program; or
vi. Mi Via participant request for a budget adjustment has been denied; and
vii. when any other adverse actions is taken by the Health Care Authority against the participant.

To request a Fair Hearing, participants must contact the Office of Fair Hearings at 1-800-283-4465, email: HCA-FairHearings@hca.nm.gov

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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. Requesting an Agency Conference does not limit or take away a participant's right to request a Fair Hearing.

Continuation of Benefits

If the claimant makes a request for Continuation of Benefits (COB), within 10 calendar days of the date of the Comagine Health denial letter, the claimant is allowed to continue receiving the contested goods and/or services while the fair hearing is in process.

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 Level of Care (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.

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IMPLEMENTATION OF THE SERVICE AND SUPPORT PLAN AND BUDGET

Implementing the Service and Support Plan (SSP) and budget is at the heart of successful participation in New Mexico's Mi Via self-directed waiver. Because Mi Via is built on the principles of autonomy, flexibility, and person-centered decision-making, participants play an active role in shaping how their services are delivered. Self-direction allows individuals to choose who provides their supports, determine how services fit into their daily lives, and manage the resources allocated to them in ways that reflect their goals, preferences, and cultural values.

A participant can choose to:

i. use vendors to provide their service and supports, or
ii. hire their own employees to provide services.

A participant who uses vendors to provide all their services does need a Support Broker. If a participants chooses to hire their own employees to provide services, the participant may be or must designate a Support Broker. The Support Broker is the individual legally responsible for hiring, training, supervising, and terminating employees who provide Mi Via services. This role ensures that services outlined in the SSP are delivered safely, effectively, and in alignment with the participant's vision for their life. The Support Broker also works closely with the Fiscal Management Agent (FMA), the entity responsible for processing payroll, managing vendor payments, and ensuring that all expenditures comply with Medicaid and Mi Via program requirements.

Together, the participant, Support Broker, and FMA allow for Mi Via's self-directed model. This section outlines the standards and expectations for implementing the SSP and budget, ensuring that services are delivered as planned, financial resources are used appropriately, and participants maintain meaningful control over the supports that help them live full and self-directed lives in their communities.

A. Selecting a Support Broker

Selecting a Support Broker is an important decision for every Mi Via participant who chooses to self-direct their services. The Support Broker is the individual responsible for carrying out the employer-related duties required under the Mi Via waiver, including recruiting, hiring, supervising, and, when necessary, terminating employees. Because the Support Broker plays a central role in ensuring that services are delivered safely, effectively, and in accordance with the

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participant's Service and Support Plan (SSP) and budget, it is essential to choose someone who is capable, reliable, and committed to supporting the participant's self-direction.

When choosing a Support Broker, the participant should consider the following:

a. Ability to Fulfill Employer Responsibilities: The Support Broker must be willing and able to complete required employer tasks such as reviewing timesheets, maintaining documentation, communicating with the Fiscal Management Agent (FMA), and ensuring employees meet all program requirements.

b. Understanding of Self-Direction: The Support Broker should support the participant's right to make choices about their services, employees, and daily routines. They must respect the participant's preferences, cultural values, and goals.

c. Dependability and Integrity: Because the Support Broker handles sensitive information and oversees essential services, they should be someone the participant trusts to act responsibly, maintain confidentiality, and follow Mi Via program rules.

d. Availability and Communication: The Support Broker must be accessible to employees, the participant, the FMA, and other members of the participant's support team. They should be able to respond to questions, resolve issues, and complete required tasks in a timely manner.

e. Willingness to Collaborate: The Support Broker works closely with the participant, the Support Guide, and the FMA. They should be open to guidance, able to follow established processes, and committed to ensuring that services align with the SSP and budget.

f. A participant may serve as their own Support Broker (SB) if they feel confident managing all employer-related responsibilities. The participant may access the Employer Packet through the Palco website (www.Palcofirst.com), which contains all required documents, including the attestation form necessary to act as the SB. If the participant prefers to designate someone else, they may select a trusted family member, friend, or other individual who understands the participant's needs and is committed to supporting their self-directed services.

A person who becomes a Support Broker for a participant must access the Palco website: www.palcofirst.com to access the Support Broker packet.

What is included in the Packet:

- Support Broker Self-Assessment
- Current Payroll Schedule is provided in the packet

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- Instructions to complete Employer Forms
- Employer IRS forms instructions
- Employer's information & responsibilities
- Designation of Employer (Support Broker information)
- Employer Responsibilities & Attestation
- Tax Disclosure
- SS-4: Application for Employer Identification Number or EIN
- Employer/payer Appointment of Agent form 2678
- Tax Information Authorization form 8821

Entire packet must be completed and submitted to the FMA.

If a participant is unable to be their own Support Broker or does not have natural supports who can be a Support Broker, the participant may use a paid Employer available through a Support Broker agency.

Changing Support Broker

To request a change in Support Broker, the participant contacts appropriate Regional Office Mi Via Liaison to request a Support Broker Change form (SBCF) If you need to request a Support Broker Change Form, please use the email address provided : mi.via@hca.nm.gov

1. When the Support Broker Change form is returned to the appropriate Regional Office, the Mi Via liaison date stamps front of form and faxes to current and new Support Broker Agency, CASA and Comagine.
2. A transition meeting is then scheduled between current and new Support Broker Agency.
3. Support Broker Change form is then faxed to the TPA and ISD office.
4. Assignment updates in the online system are made by Regional Office Mi Via liaison and transition is complete.

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B. 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 Fiscal Management Agent (FMA) and pass the required state and federal background checks, Caregivers Criminal History Screening (CCHS) and the EAR (Employee Abuse Registry).

5. 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 clear the Employee Abuse Registry (EAR) . 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 Support Broker shall contact the FMA or Consultant.
6. This CCHS 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.
7. Once the EAR check is completed, and the provider, vendor or employee has passed the CCHS check, the Support Broker will receive an e-mail notification that the employee has passed their CCHS Background Check. If the Support Broker does not have an e-mail address listed in the Mi Via online system, the FMA will contact the Support Broker via telephone to let the Support Broker know that the employee has passed the CCHS check. Although an employee may begin providing services as soon as they have passed their CCHS Background Check, payment will not be issued until all required paperwork as indicated below is complete and has been processed by the FMA.
8. If an employee or vendor does not pass the EAR and CCHS, 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 Heath if he/she does not pass the CCHS. The FMA will also contact the Support Broker (Support Broker) by telephone and letter that the employee must be terminated immediately.
9. The CCHS screening will be done prior to initial hiring and every three years after initial hire for employees. Vendors must assure employees pass the EAR and CCHS.

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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. Information of how to apply as an employee or vendor, including required forms, are available through the FMA at: https://palcofirst.com/new-mexico/

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, In-Home Living Supports vendor agencies, etc.), the required documents are included as part of the Vendor Packet:

1. Vendor Agreement
2. Vendor Information Form
3. Federal W-9
4. 501(3)(c) or W-9 indicating not -for -profit status (required only for non-profit vendors/entities)

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.

C. Legally Responsible Individuals (LRI) as Service Providers

LRIs are the parent (biological, legal, or adoptive) of a minor child (under age 18) or the

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guardian of a minor child, who must provide care to the child, or a spouse of a Mi Via participant. LRIs may be hired and paid for provision of waiver services (except consultant services, customized community group supports, transportation services when requested for a minor, and related goods) under extraordinary circumstances in order to assure the health and welfare of the participant, to avoid institutionalization, and provided that the state is eligible to receive federal Financial participation (FFP).

Extraordinary circumstances include the inability of the LRI to find other qualified, suitable caregivers when the LRI would otherwise be absent from the home and, thus, the caregiver must stay at home to ensure the participant's health and safety.

LRIs may not be paid for any services that they would ordinarily perform for individuals of the same age who do not have a disability or chronic illness.

Services provided by LRIs must:

i. meet the definition of a service or support and be specified in the participant's approved service and support plan (SSP) and IBA (Individual budget allotment)

ii. be provided by a parent, guardian or spouse who meets the provider qualifications and training standards specified in the Mi Via regulations and these service descriptions and qualifications for that service; and

iii. be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and be approved by the Third-Party Assessor (TPA).

Requesting an LRI

The Health Care Authority (HCA) must be notified of the request to hire LRIs. The initial hiring of Legally Responsible Individuals (LRIs) must be notified in writing by the Developmental Disabilities Supports Division (DDSD). This notification must be provided in writing, on an annual basis, or when a participant requires changes or additional services that an LRI would need to provide. A request for LRI must be provided on the appropriate request form with only one LRI per form. Notification must be sent to the HCA when changes are made to an LRI.

LRI request forms can be found at:
https://api.realfile.rtsclients.com/PublicFiles/6c91aefc960e463485b3474662fd7fd2/5ccbc

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365-8428-422d-a21a-ae4470aae20f/LRI%20_Information_Form.pdf

1. Consultant meets with the Mi Via participant/ family for the Annual Service Support Plan development. If the need for a Legally Responsible Individual (LRI) is needed the LRI Information form is submitted for notification to the Developmental Disabilities Supports Division (DDSD).
2. Consultant uploads the LRI Information form to Smartsheet on behalf of the Mi Via participant and LRI.
3. DDSD is notified by Smartsheet that the LRI Information form has been submitted. DDSD will review the form and make requests for corrections from consultant, if needed. 3.
4. Mi Via faxes an LRI Notification to Conduent to allow the LRI to be linked to the Mi Via participant.
5. Conduent receives the LRI Notification form and links the Mi Via participant to the LRI and the Mi Via services that will be provided.
6. LRI is linked and services are accessed and billing can begin

E. Payment of Employees, Vendors, Services and Goods

Employee and Vendor Pay Rates

Employee and vendor pay rates must be approved in the participant's service and support plan (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. Work by the employee or vendor cannot begin until the Employee Agreement of Vendor Agreement has been received and processed by the FMA and SSP/budget have been approved by the Third-Party Assessor (TPA).

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

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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.

FMA Online Authorization

Upon completing the FMA online system training, the user will receive an 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 a Support Broker .

Payment of Employees

Employees hired directly by the Support Broker must submit online timesheets through the FMA online system. The Support Broker 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 Support Broker can enter the employee's time.
2. Electronic Visit Verification (EVV) system enters the employee's 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.

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 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 MST. 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

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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 Support Broker and approve timesheets. To designate a PR, a participant must complete the PR Form, which may be requested through the FMA or the consultant.

Payment Methods

Direct Deposit is provided and strongly recommended for all employees and vendors when possible. Direct deposit forms can be completed as part of the initial hire documentation or may be completed and submitted to the FMA later.

The FMA also offers the service of providing payment through a *Money Network* Card which is a pre-paid debit card. Please contact the FMA if interested in using this option.

The Support Broker 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. A Support Broker may request an exception from HCA/MAD if they are in a geographical location in New Mexico with no internet access; or
2. A Support Broker may request an exception from HCA/MAD if there are limitations due to disability.

Exception requests can be made anytime to the Developmental Disabilities Supports Division (DDSD) Mi Via Systems Manager and remain effective indefinitely unless the Support Broker's circumstances change such that the reason for exception is no longer applicable. If the Support Broker's circumstances change such that the reason for exception no longer prevents the Support Broker from entering timesheets online, the Support Broker may then be required to submit timesheets electronically.

Payment of Vendor or Goods/Services

Payment for vendor or goods/services is requested through a Vendor Payment Request

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Form (VPR):

i. Vendor Payment Request Forms (VPR) and invoices may be submitted to the FMA on any day of the week.
ii. VPRs may not be signed prior to the delivery of services.
iii. If a participant is only utilizing vendor services, and Support Broker is not necessary, however, a Support Broker can be identified by a participant to assist with the use of vendors. In some instances, a Support Broker 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 a Support Broker.
iv. An invoice must accompany the VPR. Invoice must note the costs for services and cost of the New Mexico Gross Receipts Tax if applicable.

The processing time for a VPR/invoice is approximately two (2) weeks. Please see the Vendor Payment Schedule for details. The vendor payment schedule may be found at: https://www.palcofirst.com/programs/forms/#state-nm.

Vendor checks will be mailed directly to the participant, authorized representative or the Support Broker. Payments are not mailed to the vendor unless the vendor has elected to utilize direct deposit. After the participant, authorized representative or the Support Broker receives the vendor check, they must remit/send/forward the check to the vendor as soon as possible to ensure prompt payment.

For monthly services such as phone or internet payments, the participant, authorized representative, or Support Broker should send the payment to the phone/internet company's main billing address. Monthly service payments should not be attempted through kiosks or at local phone/internet stores as these payments are frequently rejected. Participants, authorized representative or Support Brokers can elect to have payments issued on the Money Network Card. The Money Network Card can be used as a credit/debit card to may payments online or through the phone.

A participant, authorized representative, or Support Broker who has access to the FMA online system 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, Support Broker, or PR may run reports through the FMA online system to monitor spending activity.

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F. 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 Support Broker 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 Support Broker that payment could not be made and reason why payment could not be made.

When an issue arises with payment requests or timesheets, the FMA will contact the participant or Support Broker by email. If the issue is not resolved through email, the FMA will follow up by phone to assist with resolving the issue. Since contact is attempted by the FMA to the participant, authorized representative or Support Broker, it is extremely important that the FMA online system contain the correct contact information for the participant, authorized party or Support Broker. If the participant, authorized representative or Support Broker 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.

G. Timely-Filing Requirements

In New Mexico, there is a ninety (90) calendar daytime limit for filing all Medicaid claims. 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/Support Broker through the RTP process. See New Mexico Administrative Code (NMAC) 8.302.1 General Provider Policies and 8.302.2 Billing for Medicaid Services. Add what to do to get an exception to timely filing,

H. Electronic Visit Verification

Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies that employees and vendor direct care worker visits occur and records when services begin and end. EVV is required under Section 12006(a) of the 21st Century Cures Act, enacted in December 2016, which mandates that states implement EVV for all Medicaid-funded Personal Care Services (PCS) by, and Home Health Care Services (HHCS) when those services involve an in-home visit by a paid provider. Personal Care Services (PCS) include assistance with

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Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Home Health Care Services (HHCS) include nursing services and home health aide services.

The Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have identified PCS and HHCS as areas where Medicaid recipients are particularly vulnerable to fraud, abuse, neglect, and exploitation. EVV data supports both providers and the State in safeguarding the health and safety of individuals receiving these services. The EVV system verifies the:

i. Type of service performed.
ii. Individual receiving the service.
iii. Date of service.
iv. Location of delivery service.
v. Individuals providing the service.
vi. Time the service begins and ends.

All workers providing an EVV service are required to use EVV to clock in and out of the EVV system. Use of the state approved EVV system does not replace other regulatory or program requirements.

Electronic Visit Verification (EVV) Mi Via Waiver Services

The following services require the use of Electronic Visit Verification (EVV)

a. Homemaker Direct (99509 & 99509 E)
b. Respite Standard (T1005 SD & T1005 SD E)

Using the Electronic Visit Verification (EVV) System

The state supplies agencies with a single approved Electronic Visit Verification (EVV) system that must be used. The EVV system sends collected information to the FMA online system and generates timesheets for employees. In addition, the EVV system can be used by vendors to verify date and times worked by their direct support professionals.

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.

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Vendors or employees of required services) must use the state approved EVV system to meet EVV requirements and:

i. Establish an agency point of contact for EVV operations and state updates.
ii. Enter and delete the agency participants and employees in the system timely.
iii. Confirm all applicable service authorizations data to operate the EVV system.
iv. Correct errors in the system when allowed by state.
v. Ensure that employees have access to the state approved EVV system and can clock in and out for all assigned work.
vi. Assure employees are trained and are using the EVV system.
vii. 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.

I. Budget Expenditure Safeguards

The participant holds the primary responsibility for monitoring and ensuring that their approved Service and Support Plan(SSP)/budget is spent appropriately; however, the consultant must support the participant in this activity. The Fiscal Management Agency (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. 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 Support Broker and employees may obtain access to the FMA online system. With the FMA online system access, the Support Broker 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 Support Broker. If interested in training, the employee, participant or Support Broker may contact the FMA for assistance.

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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 monthly services such as 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 Support Broker once with instruction for them to contact the Consultant for assistance.

COMPLIANCE, MONITORING AND OVERSIGHT

A. DEVELOPMENTAL DISABILTIES SUPPORTS DIVISION (DDSD) CONTRACT MANAGEMENT

The Developmental Disabilities Supports Division (DDSD) is authorized, to enforce federal requirements as outlined in Code of Federal Regulations (CFR) 42 CFR § 411 and § 430.25, Mi Via Waiver Service Standards and Mi Via Waiver regulations 8.314.6 New Mexico Administrative Code (NMAC) with Mi Via Waiver participants and service providers including employees, vendor agencies and provider agencies. DDSD can impose sanctions on provider agencies for failure to perform in accordance with standards applicable under statute, regulation, and contract.

As such, the DDSD Mi Via Unit, in collaboration with DDSD Regional Offices and Bureau Chiefs as needed, initially provide technical assistance or administrative actions such as a Performance Improvement Plan (PIP) to assist Provider Agencies.

The DDSD Mi Via Unit, in collaboration with DDSD Regional Offices and Bureau Chiefs as needed, may provide technical assistance or directly impose administrative actions, Civil

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Monetary Penalties (CMP)s, and sanctions on community-based Provider Agencies for non-compliance with (or violations of) regulations, Service Standards, guidance documents, and/or Provider Agreement requirements.

The Mi Via Unit must engage in activities that are less than sanctions to resolve the issue and/or concern prior to the imposition of any CMP or other sanctions. Because each administrative action may not be appropriate to the situation and/or concern, implementation of each or all types of technical assistance or administrative action is not required prior to the imposition of a CMP or sanction. Provider Agency requirements related to technical assistance or administrative actions by the Mi Via Unit may include but are not limited to:

i. providing information, documentation, or follow up;
ii. meeting with Mi Via Unit personnel to assure that agency policies, procedures, guidelines, and practices comply;
iii. following any mandatory directed technical assistance from the Mi Via Unit;
iv. implementing a PIP; and
v. completing a focused survey conducted by DHI-QMB when requested via the IRC.

If the technical assistance and/or administrative actions taken are unsuccessful in resolving the concern, the Mi Via Waiver Program Manager will refer the issue to the Community Programs Bureau Chief and respective Deputy Director for further action. Any determination of a High Impact violation will be referred to the Internal Review Committee (IRC) for consideration of action.

B. QUALITY MANAGEMENT BUREAU SURVEYS

The Health Care Authority (HCA) Division of Health Improvement (DHI) is the regulatory entity providing compliance oversight for the Mi Via Waiver. The Quality Management Bureau (QMB) survey team conducts unannounced on-site/desk (remote), systems-based surveys and other quality improvement activities related to the health, welfare and safety of individuals receiving these supports.

Provider Agencies of Consultant Services and IHLS must submit to QMB compliance surveys based on the New Mexico's approved Mi Via Waiver and waiver assurances, Mi Via Waiver Service Standards, and other rules and regulations. Provider Agencies undergoing a QMB Compliance Survey undergo the following:

1. All deficiencies are identified and cited in the QMB Report of Findings and require

corrective action along with ongoing Quality Assurance/Quality Improvement processes when identified.

2. Routine surveys are conducted based on the provider agreement term, unless requested sooner by the Mi Via Program Manager, based on survey findings, or at the request of the Internal Review Committee. Surveys typically take place 24-36 months prior to the expiration of the provider agreement term and cannot exceed three years.
3. Upon completion of a QMB survey, the Provider Agency, Developmental Disabilities Supports Division (DDSD) and other State entities receive a Report of Findings and directions on required follow-up activities.
4. During the survey process and in the Report of Findings, Provider Agencies are encouraged to seek technical assistance from the Mi Via Unit. If significant issues are identified during the compliance survey, QMB may refer the agency to DDSD for technical assistance. Additionally, failure to comply with the POC may lead to a referral to the IRC for additional sanctions.
5. Once the POC is successfully completed the agency is considered in compliance and survey process is closed. Survey reports may be found on the QMB website. https://www.hca.nm.gov/quality-management-bureau

C. INTERNAL REVIEW COMMITTEE (IRC)

The Internal Review Committee (IRC) within the Developmental Disabilities Supports Division (DDSD) is an internal oversight body that reviews critical incidents, service concerns, and systemic issues affecting individuals receiving DD, Mi Via services. Its purpose is to strengthen safety, quality, and accountability across New Mexico's developmental disability service system.

The Internal Review Committee (IRC) may receive referrals from the DDSD bureaus, Division of Health Improvement (DHI) Quality Management Bureau (QMB) and Incident Management Bureau (IMB), and the Medical Assistance Division (MAD). Based on the severity of deficiencies identified, the IRC has the authority to take administrative action, including directed corrective action, moratorium on new admissions, or civil monetary penalty. The IRC may also recommend high level sanctions including withholding payment, transition of individuals in service, placing the provider under the supervision of a monitor, or reduction of a contract term, amount, or scope.

D. INCIDENT MANAGEMENT SYSTEM

An Incident Management System (IMS) is a critical part of an agency's practice to ensure swift

and appropriate response to any allegations or substantiated findings related to abuse, neglect, and exploitation (ANE), suspicious injury, environmental hazard, or death. All Mi Via Waiver Provider Agencies shall establish and maintain an IMS, which emphasizes the principles of prevention and staff involvement. A comprehensive IMS for Mi Via Waiver Provider Agencies involves training, monitoring, cooperation with HCA-DHI, reporting and continuous risk management activities.

E. ABUSE, NEGLECT AND EXPLOITATION (ANE)

Definition of Abuse, Neglect, and Exploitation

New Mexico defines Abuse, Neglect, and Exploitation (ANE) as intentional or negligent actions by a caregiver or responsible party that cause harm, risk of harm, or improper use of a participant's resources:

a. Abuse includes: (1) knowingly, intentionally, and without justifiable cause inflicting physical pain, injury or mental anguish; (2) the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of a person; or (3) sexual abuse, including criminal sexual contact, incest and criminal sexual penetration.
b. Neglect The failure of the caretaker to provide basic needs of a person, such as clothing, food, shelter, supervision, and care for the physical and mental health of that person.
c. Exploitation is unjust or improper use of a person's money or property for another person's profit or advantage, whether financial or otherwise.

The Centers for Medicare and Medicaid Services (CMS) require states to implement necessary safeguards to protect the health and welfare of participants receiving Home and Community-Based services (HCBS). This includes policies, training, and oversight mechanisms designed to prevent ANE as well as a system of reporting and follow up.

Reporting and Evidence Preservation

All Participants, Support Broker's, employees, vendors, and volunteers will be trained on the ANE awareness training curriculum approved by Developmental Disabilities Supports Division (DDSD). Participants, Employers of Record (Support Brokers), employees, Consultant

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Agencies, Employers of Record (Support Broker), and vendor agencies are responsible for ensuring the DDSD mandatory training requirements are met.

The Mi Via Waiver participant, Support Broker, Consultant, employee, vendor, or volunteer m environmental hazard, or death is ultimately responsible for appropriate reporting. Failure to report, provide or maintain evidence of an existing IMS and employee, subcontractor, or volunteer training; or for failure to adequately protect people from ANE may result in being sanctioned in accordance with NMAC 8.370.10.

All Mi Via Waiver participants, families, Support Brokers, Consultant, employees, vendors, or other supports shall:

1. Immediately report suspected ANE to the DDSD via the ANE hotline at 1-800-445-6242; reports can also be filed online at: Report Abuse, Neglect & Exploitation – New Mexico Health Care Authority
2. Immediately report alleged crimes to law enforcement;
3. Immediately report death to Division of Health Improvement (DHI) 1-800-445-=6242.
4. Once ANE, suspicious injury or environmental hazard is suspected, ensure the person's health and safety, as well as others potentially affected;
5. After health and safety are assured, immediately call the DHI hotline at 1-(800)-445-6242 to report;
6. Ensure the participant, Support Broker, Consultant, employee, vendor or volunteer with firsthand knowledge of the alleged incident makes the report with assistance in reporting, as needed;
7. Refrain from internal investigations until DHI's investigation is completed, except to the extent necessary to make the report and ensure the health and safety of the person;
8. Safeguard, secure and not disturb any records or physical evidence related to an alleged incident of ANE; and
9. If physical evidence must be removed or affected, take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident, including, for example:
    i. Taking overall (wide) photographs, unless prohibited by agency policy;
    ii. Taking close-up photographs of evidence (e.g. bruises, clothing, location of fall);
    iii. diagramming the scene; and
    iv. listing all evidence found including the name of finder, date,

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time, location.

Immediate Action and Safety Plans (IASP)

Upon discovery of any alleged incident of abuse, neglect, and exploitation (ANE), the Mi Via Waiver Consultant shall:

1. Develop an Immediate Action and Safety Plans (IASP) to ensure the participants' safety;
2. Be immediately prepared to report the IASP verbally to the Division of Health Improvement (DHI) during the reporting of the initial allegation;
3. Report the IASP in writing on the DHI- issued IASP form within 24 hours;
4. Revise the plan according to the DHI's direction, if necessary; and
5. Closely follow and not change or deviate from the accepted IASP, without approval from the DHI.

Cooperation During Division of Health Improvement (DHI) Investigations

All Mi Via Waiver participant, family, Support Broker, Consultant, employee, vendor or other supports who are subject to an investigation shall:

1. Facilitate immediate physical or in-person access, and assist with scheduling interviews by Division of Health Improvement (DHI) personnel investigating the incidents;
2. Provide unrestricted access to the DHI for announced or unannounced visits to any facility, building or location;
3. Provide, upon request of DHI, immediate access to formal and informal applicable records, regardless of media, including but not limited to financial records, individual records, SSP, volunteer and personnel records, including training records, incident reports, quality assurance activities and agency policy and procedure manuals; and provide, upon request of the DHI, copies of records within timelines established by DHI.

Reports of Death

Any death should be reported using the Division of Health Improvement (DHI) toll-free

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hotline at 1-800-445-6242. Further instructions can be found at: https://nmhealth.org/about/dhi/ane/racp/

In the event of a death of a person receiving services through the Mi Via Waiver, the following must occur:

1. The Consultant and DHI must immediately be notified of the person's death.
2. Regardless of circumstances, the Consultant must ensure any death is immediately reported to DHI after knowledge of the death.
3. The Consultant must submit the Client Information Update (CIU) form (MAD 054) to the Income Support Division (ISD) to provide notification of the person's death;
4. The person's primary file must be made available to DHI upon request.
5. If systemic issues are identified in the mortality review process, the Developmental Disabilities Supports Division (DDSD) will work with the relevant Support Broker (Support Broker), Consultant, employee, vendor or volunteer to address concerns in a quality improvement process.

Corrective and Preventive Action Plans for Substantiated Findings

Provider and Vendor Agencies will be held accountable for the actions of employees or contractors when incidents are substantiated by the Division of Health Improvement (DHI) investigation. If there isn't a vendor agency, the Corrective and Preventative Actions (CPA) Plans will be requested of the Consultant.

The Mi Via Waiver Vendor Agency shall:

1. Establish and maintain a quality improvement program for reviewing alleged complaints and incidents of ANE made against them as a provider;
2. Provide to the DHI written documentation of corrective actions taken;
3. Take all reasonable steps necessary to prevent further incidents; and
4. Share the approved Corrective and Preventive Action (CPA) plan with the person's Consultant. In the event that the ANE is substantiated against a Consultant Agency, the Corrective and Preventive Action Plan must be shared with DHI.

Support Brokers and employees will be terminated when incidents are substantiated by the DHI investigation.

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A participant may be their own Support Broker if they feel confident managing employer responsibilities. A participant can locate the employer packet on the Palco Website and in the packet will have all required documents and the attestation to be the Support Broker.

Notifications

After an allegation of abuse, neglect, and exploitation (ANE) has been reported to the Division of Health Improvement (DHI), Mi Via Waiver Provider and Vendor Agencies have requirements related to notifying participants, guardians, and Employers of Record (Support Brokers) allegations of ANE. Notification responsibilities are outlined below:

1. The non-responsible reporting provider shall verbally notify the responsible provider within 24 hours of the report being made to IMB.
    a. Verbally notify the Guardian and Consultant within 24 hours of the report being made to IMB;
    b. Verbally notify the accused person and alleged victim, when appropriate and using situational discretion;
    c. The responsible vendor provider will provide the Immediate Action and Safety Plan (IASP) to the Consultant for distribution to the participant, guardian, and/or Support Broker; and

The Consultant shall verbally notify the alleged victim of Closure Letters and outcomes of the investigation at the next monthly contact.

GENERAL QUALIFICATIONS & REQUIREMENTS FOR PROVIDER AGENCIES, VENDOR AGENGIES, EMPLOYEES AND SUPPORT BROKERS

In order to be approved as an individual employee or a vendor, each entity must meet the general and service specific qualifications outlined in the Mi Via New Mexico Administrative Code (NMAC) 8.314.6 and these Service Standards. Employees and vendor agencies must submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the Fiscal Management Agency (FMA). The provider's credentials must be verified

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by the FMA and participant/Support Broker.

Participants, Employers of Record (Support Brokers), employees, independent providers, provider agencies, and vendors must comply with all applicable Federal, State and Waiver regulations, policies and procedures.

A. General Qualifications for Employees and Vendor Agency Employees

The following are general qualifications for individual employees and employees of vendors (provider agencies) who are employed by a Mi Via participant to provide direct services:

i. Be at least 18 years of age;
ii. Meet minimum qualifications and perform job / task / functions based on set standards for applicable position.
iii. Be able to communicate successfully with the participant.
iv. Individual Employees: pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC prior to initial hire and every three years after initial hire.
v. Employees of Vendors (Provider Agencies): pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
vi. Complete mandatory training as required by role and complete participant specific training, as applicable;
vii. Meet any other service specific qualifications, as specified in the Mi Via regulations 8.314.6 NMAC and these Service Standards; and
viii. Maintain documentation of services provided per the Mi Via regulations 8.314.6. NMAC.

B. General Qualifications for Vendors

The following are general qualifications for Vendors (provider agencies), including those providing professional services:

i. Have a current business license issued by the state, county or city government;

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ii. Provide a tax identification number;
iii. Meet Financial solvency;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD;
v. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
vi. Must have proof of records being maintained in accordance with waiver standards;
vii. Develop and adhere to Quality Improvement (QI) strategies as required per the waiver Service Standards and DDSD Waiver Provider Agreement;
viii. shall be in good standing with and comply with their New Mexico practice board or other certification or licensing required to render Mi Via services in New Mexico;
ix. if a consultant provider, meet all the qualifications set forth in Mi Via regulations 8.314.6 NMAC and these Service Standards;
x. must not have a Health Care Authority(HCA) current adverse action against them;
xi. meet any other service specific qualifications, as specified in the Mi Via regulations 8.314.6 NMAC;
xii. maintain documentation of services provided per the Mi Via regulations (8.314.6. NMAC).

C. General Qualifications for Legally Responsible Individuals (LRIs)

A Legally Responsible Individual (LRI) is a person who has a legal duty to care for the Mi Via participant. Because LRIs already have a legal obligation to provide certain types of care, their ability to be paid for providing services is limited and must meet specific Medicaid requirements. LRIs must meet general qualifications outlined above as well as service specific qualifications and requirements.

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D. Required Trainings

To ensure the safety, rights, and well-being of every Mi Via participant, all individuals involved in providing or overseeing services must complete Developmental Disabilities Supports Division (DDSD) mandatory trainings. These trainings help create a consistent understanding of responsibilities, reporting requirements, and participant protections across the entire Mi Via Waiver system. Consultants, Support Brokers, Direct Support Professionals (DSPs) are required to take the following trainings to work with any Mi Via participant.

Trainings can be accessed through the University of New Mexico Training Hub.

https://ddsdtrain.cdd.unm.edu/

courses/index.html

Abuse, Neglect and Exploitation (ANE)

All participants will be given the DDSD Reporting Suspected Abuse, Neglect and Exploitation Flyer (ANE) and will review with their consultant. The participant will sign the ANE acknowledgement form.

All Support Brokers, employees, vendors, and other supports will be required to complete the ANE Awareness training. Support Brokers, Consultant Agencies and vendor agencies are responsible for ensuring the training requirements outlined below are met.

1. DDSD ANE Awareness On-line trainings shall be renewed annually with successful completion of the DDSD ANE Awareness
2. Training shall be conducted in a language that is understood by the participant, Support Broker, Consultant, vendor, employee, or volunteer.
3. Training must be conducted by an HCA certified trainer or through online asynchronous course.
4. Documentation of a participant, Support Broker, Consultant, employee, vendor, or volunteer training must be maintained for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work.

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Required Trainings for Consultants

The following course are required for Consultants. Consultant Agency are responsible for ensuring their employees and contractors meet the training requirements outlined below.

Course Name	Access Location	Compliance	Estimated Time (hours)
Abuse, Neglect and Exploitation (ANE) Awareness	UNM Training Hub Online Courses or Training	Before working with a participant **Must be completed annually**	3 hrs.
Introduction to Person-Centered Planning	UNM Training Hub Online Courses	Within the first 30 days of working with a participant	1 hr.
Keys to Health	UNM Training Hub Online Courses or Training	Within the first 30 days of working with a participant	4 hrs.
Consultant Training	UNM Training Hub Online Courses	Within the first 30 days of working with a participant	1 hr.
Service and Support Plan (SSP)	UNM Training Hub Online Courses	Within the first 30 days of working with a participant	1 hr.
Support Broker	UNM Training Hub Online Courses	Within the first 30 days of working with a participant	1 hr.
Introduction to Waivers	UNM Training Hub Online Courses	Within the first 60 days of working with a participant	1 hr.
CMS Setting Requirement Final Rule	UNM Training Hub Online Course	Within the first 60 days of working with a participant, Complete Once	1 hr.
Social Security Benefits	Partners for Employment	Within the first 60 days of working with a participant. Complete once	0.5 hr.
Community Mapping	Partners for Employment Trainings with Learning Certificates – Partners for Employment (PFE) Training Portal	Within the first 60 days of working with a participant. Complete once	4 hrs.

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Required Trainings for Support Brokers

The following course are required for Support Brokers. The participant's consultant is responsible for ensuring Support Brokers meet the training requirements outlined below.

Course Name	Access Location	Compliance	Estimated Time (hours)
Abuse, Neglect and Exploitation (ANE) Awareness	UNM Training Hub Online Courses or Training Calendar.	Before working with a participant **Must be completed annually**	3 hrs.
Support Broker	UNM Training Hub Online Courses	Within the first 30 days of working with a participant	1 hr.
Introduction to Person-Centered Planning	UNM Training Hub Online Courses	Within the first 60 days of working with a participant	1 hr.
Service and Support Plan (SSP)	UNM Training Hub Online Courses	Within the first 60 days of working with a participant	1 hr.

Required Trainings for Community Support Direct Service Providers

The following course are required for **Direct Support Professionals (DSP)** which *includes Employees, Vendors and Volunteers in the following services: Community Support Services, Home Health Aide, Homemaker/Direct Support, In Home Living Supports, Respite Providers and Volunteers*

Course Name	Access Location	Compliance	Estimated Time (hours)
Abuse, Neglect and Exploitation (ANE) Awareness	UNM Training Hub Online Courses or Training Calendar.	Before working with a participant **Must be completed annually**	3hrs.

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Introduction to Person-Centered Planning	UNM Training Hub Online Courses	Within the first 60 days of working with a participant	1hr.
Keys to Health	UNM Training Hub Online Courses or Training Calendar	Within the first 60 days of working with a participant	4hrs.
Introduction to Waivers	UNM Training Hub Online Courses	Within the first 60 days of working with a participant	1 hr.

The following course is required for direct support providers providing Community Support Direct Services.

Course Name	Access Location	Compliance	Estimated Time (hours)
Supporting Employment First at DDSD	UNM Training Hub	Within the first 30 days of working with a participant	0.75 hr

Required Trainings for Employment Support Services Providers

The following course are required for employees, vendors of Employment Support Services.

Course Name	Access Location	Compliance	Estimated Time (hours)
Abuse, Neglect and Exploitation (ANE) Awareness	UNM Training Hub Online Courses or Training Calendar	Before working with a participant **Must be completed annually**	3 hrs.
Introduction to Person-Centered Planning	UNM Training Hub Online Courses	Within the first 60 days of working with a participant	1 hr.
Keys to Health	UNM Training Hub Online Courses or Training Calendar	Within the first 60 days of working with a participant	4 hrs.
Introduction to Waivers	UNM Training Hub Online Courses	Within the first 60 days of working with a participant	1 hr.
Supported Employment Training Across Waivers	UNM Training Hub Online Courses	Within the first 60 days of working with a participant	3 hrs.

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CMS Setting Requirement Final Rule Requires a Competency Test	UNM Training Hub Online Course	Within the first 60 days of working with a participant. Complete Once	1hr.

Optional Trainings for Employment Support Providers can elect to take the following additional trainings to demonstrate the required knowledge to be an Employment Support Service Provider:

Course Name	Access Location	Compliance	Estimated Time (hours)
Community Mapping	Partners for Employment Trainings with Learning Certificates – Partners for Employment (PFE) Training Portal	Within the first 60 days of working with a participant. Complete once	4hrs.
Social Security Benefits	Partners for Employment	Within the first 60 days of working with a participant. Complete once	0.5

Additionally, the New Mexico Association of Community Rehabilitation Educators (NM ACRE) training is a nationally recognized credential for employment service professionals. Free training is available to anyone providing Community Support Services.

To access the NM ACRE, Community Mapping, and Social Security Benefits trainings, visit the Partners for Employment Training Portal: https://cdd.health.unm.edu/pfe/

Individual providers and staff holding either ACRE credential or the Certified Employment Support Professional (CESP) are exempt from Introduction to Person-Centered Planning and Supporting Employment First at DDSD.

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Accessing Trainings and Assistance

All courses listed can be accessed through the New Mexico Waiver Training Hub, unless otherwise listed. https://www.cdd.unm.edu/other-disability-programs/disability-health-policy/ddsd-courses/index.html

E. Solicitation

Provider agencies, Vendor agencies, and employees may market their services but are prohibited from soliciting participants under any circumstances such as offering a participant or his or her 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.

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SERVICE DESCRIPTIONS AND PROVIDER REQUIREMENTS IN DETAIL

The services covered by the Mi Via Waiver are intended to provide a community-based alternative to institutional care for an eligible recipient that allows greater choice, direction and control over services and supports in a self-directed environment.

SERVICE TYPE	MI VIA SERVICE
Services that Support the Participant in Waiver/Self-Direction	○ Consultant Services (Case Management) ○ Support Broker
Living Supports	○ Homemaker/Direct Support ○ In-Home Living Supports
Community Supports	○ Community Direct Support ○ Customized Community Group Supports ○ Employment Supports
Health and Wellness	○ Behavioral Support Consultation ○ Friends and Relationship Course ○ Home Health Aide ○ Nutritional Counseling ○ Private Duty Nursing ○ Respite ○ Skilled Therapy for Adults ○ Specialized Services
Other	○ Emergency Response Services ○ Environmental Modifications ○ Individual Directed Goods and Services ○ Transportation

The Mi Via Waiver Program is the payor of last resort; all other funding sources must be exhausted before Mi Via coverage applies. Mi Via services must:

i. Specifically address a therapeutic, rehabilitative, habilitative, health or safety need that results from the eligible recipient's qualifying condition;
ii. Not duplicate services offered under the Health Care Authority's (HCA) Medicaid Early and Periodic screening, Diagnostic, and Treatment (EPSDT) benefit, Medicaid school-based services, services offered by the New Mexico's Public Education Department (PED), the state vocational rehabilitation agency, or

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services offered through the Early Childhood Education and Care Department (ECECD);

iii. Be provided in the least restrictive manner. DDSD does not allow for the use of any restraints, restrictive interventions, or seclusion to an eligible Mi Via participant;

iv. Be provided in integrated settings and facilitate full access to the community;

v. Ensure the recipient receives services in the community to the same degree of access as those individuals not receiving HCBS services.

vi. Maximize independence in making life choices;

vii. Be chosen by the recipient in consultation with the guardian as applicable;

viii. Ensure the right to privacy, dignity, respect, and freedom from coercion and restraint;

ix. Optimize recipient initiative, autonomy and independence in making life choices;

x. Provide an opportunity to seek competitive employment; and facilitate choice of service and who provides them;

xi. Must be provided in accordance with 8.314.6 NMAC and these Service Standards.

Waiver participants in all living arrangements are assessed individually, and service plan development is individualized. The Third-Party Assessor (TPA) will assess the service plans of recipients living in the same residence to determine:

1. Whether or not there are services that are common to more than one recipient living in the same household in order
2. Whether one or more employees may be needed to ensure that individual different cognitive, clinical, and habilitative needs are met.

SERVICES THAT SUPPORT PARTICIPANT DIRECTION

A. CONSULTANT SERVICES

Consultant services are required for all Mi Via participants to educate, guide, and assist them to make informed planning decisions about services and supports. The level of support provided is based upon the unique needs of the individual. The consultant:

i. Provides information, support, guidance, and assistance to an individual during the Medicaid financial and medical eligibility process;

ii. Helps the eligible recipient develop the Service and Support Plan (SSP) based on t assessed need by helping the participant identify supports, services and goods

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Mi Via requirements and are covered mi via services. Consultant services provide support to eligible recipients to maximize their ability to self-direct their mi via services.

Pre-Eligibility/Enrollment Services

Consultant Pre-Eligibility/Enrollment Services are intended to provide information, support, guidance, and/or assistance to individuals during the Mi Via enrollment process and Medicaid eligibility process, which includes both financial and medical components. The level of support provided is based upon the unique needs of the individual for the sole purpose of helping them navigate the Medicaid eligibility and enrollment processes.

When an allocation for the Mi Via Waiver is offered to an individual, they must complete a Primary Freedom of Choice (PFOC) form. The purpose of this form is for individuals to select a consultant services provider agency. The chosen consultant services provider agency provides pre-eligibility/enrollment services as well as on-going consultant services. The pre-eligibility/enrollment service is designed to assist individuals through the Medicaid financial and medical eligibility processes as well as the Mi Via enrollment process. Once the individual is determined eligible for Mi Via Waiver services, the consultant will continue to provide consultant services to the newly enrolled participant as set forth in the consultant Service Standards.

Scope of Service

Consultant pre-eligibility/enrollment services are delivered in accordance with the individual's identified needs. Based upon those needs, the consultant provider selected by the individual shall:

A. Assign a consultant and contact the individual within five (5) working days after receiving the PFOC to schedule an initial orientation and enrollment meeting;
B. The actual enrollment meeting should be conducted within 30 days of receiving the PFOC. The enrollment process and activities include but are not limited to:
    i. General program overview including key agencies and contact information;
    ii. Discuss medical and financial eligibility requirements and offer assistance in completing these requirements as needed;

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iii. Provide information on Mi Via participant roles and responsibilities documented by participant signature on the roles and responsibilities form.
iv. Discuss the Support Broker (Support Broker) including discussion and possible identification of a Support Broker and completion of the Support Broker Questionnaire form;
v. Review the processes for hiring employees and contractors and required paperwork;
vi. Review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees;
vii. Discuss the background check and other credentialing requirements for employees and contractors;
viii. Notify participant supports that the DDSD Abuse, Neglect and Exploitation training is required to be taken annually.
ix. Discuss the process for accessing core training requirements through the DDSD Training Database and the FMA online system *e*); and to obtain information on the Fiscal Management Agency (FMA); and New Mexico Waiver Training Hub
x. Provide information on the Service and Support Plan (SSP) including covered and non-covered goods and services, planning tools and community resources available and assist with the development of the SSP.
xi. Review the Mi Via Service Standards with the participant and either provide a copy of the Standards or assist the participant to access the Mi Via Service Standards online.
xii. Ensure the completion and submission of the initial SSP within sixty (60) days of eligibility determination so that it can be in effect within ninety (90) days

C. Consultants will inform, support, assist, and monitor as necessary with the requirements for establishing Level of Care (LOC) within ninety (90) days of receiving the PFOC, to include:

i. Assistance with required LOC documentation and paperwork:
    a. The Long-Term Care Medical Assessment Abstract (LTCAA) forms (MAD 378 or DOH 378 as appropriate);
    b. Current history and physical (H&P) and medical/clinical history;

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c. The Comprehensive Family Centered Review for Category of Eligibity 095- Medically Fragile applicants/participants. The consultant may be asked to assist with the in-home assessment (IHA) when necessary;
d. Norm-referenced adaptive behavioral assessment (for IDD only)

ii. Assist with financial eligibility application and paperwork as needed;
iii. Inform the state, as requested, on the progress with eligibility/enrollment activities and the assistance provided by the consultant;

D. Prior to SSP development or during the development process, obtain a copy of the Approval Letter or verify that the county Income Support Division (ISD) office of the HCA has completed a determination that the individual meets financial and medical eligibility to participate in the Mi Via Waiver program; and Schedule SSP meeting within ten (10) days of the approval verification.

Contact Requirements

Consultants shall make contact with the participant at least monthly for follow up on eligibility and enrollment activities. This contact can either be face-to-face or by telephone.

During the pre-eligibility phase, at least one (1) face to face visit is required to ensure participants are completing the paperwork for medical and financial eligibility, and to provide additional assistance as necessary. Consultants should provide as much support as necessary to assist with these processes.

Reimbursement Pre-Eligibility/Enrollment Services

A. Consultant pre-eligibility/enrollment services shall be reimbursed based upon a per-member/per-month unit:
   i. A maximum of one (1) unit per month can be billed per each participant receiving consultant services in the pre-eligibility phase for a period not to exceed three (3) months;
   ii. Provider records must be sufficiently detailed to substantiate the nature, quality, and amount of consultant pre-eligibility/enrollment services provided and be in compliance with the Medicaid documentation policy NMAC 8.302.1; and
   iii. Consultant providers shall submit all consultant pre-eligibility/enrollment services billing through the HCA in accordance

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with applicable Medicaid billing requirements and HCA-established billing procedures.

B. Consultants must obtain approval in writing from the Mi Via Program Manager or their designate for any pre-eligibility phase exceeding the ninety (90) day timeframe for any participant. The consultant will submit an explanation of why the pre-eligibility phase has exceeded the 90-day timeline.
C. It is the State's expectation that consultants will work with the participant to ensure that an approved service and support plan (SSP) is in effect within ninety (90) days of the start of Medicaid eligibility. Any exceptions to this timeframe must be approved by the State. The consultant will submit an explanation of why the plan could not be effective within the 90-day timeline. Approval must be obtained in writing from the Mi Via Program Manager or their designate for any plan not in effect ninety (90) days after eligibility is approved, prior to billing for that service.
D. Non-billable consultant services include:
    i. Services furnished to an individual who does not reside in New Mexico;
    ii. Participation by the consultant in any educational courses or training;
    iii. Outreach activities, including contacts with persons potentially eligible for the Mi Via Waiver;
    iv. Consultant services furnished to an individual who is in an institution (e.g., Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), nursing facility (NF), hospital) or is incarcerated, except for discharge planning services in accordance with MAD Supplement No. 01-22; and
    v. Services furnished to an individual who does not have a current allocation to the Mi Via Waiver Program Manager or their designate for any plan not in effect ninety (90) days after eligibility is approved, prior to billing for that service

On-Going Consultant Services

Consultant services are intended to educate, guide, assist and monitor the participant to make informed planning decisions about services and supports. This leads to the development of a person-centered plan, called the Service and Support Plan (SSP), based on the participant's wants and assessed needs. The consultant assists the participants with implementation and quality assurance related to the SSP and Authorized Annual

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Budget (AAB). Consultant services provide support to participants to maximize their ability to self-direct their Mi Via services.

Consultant services help the participant identify supports, services and goods that meet their need for covered and noncovered waiver services and are specific to the participant's disability or qualifying condition and help prevent institutionalization.

Consultant services provide a level of support to a participant that is unique to their individual needs in order to maximize their ability to self-direct in the Mi Via Program. Consultant services assist participants to transition from and to other waiver programs. Consultants monitor all aspects of the participant's Mi Via Waiver program to include: SSP development and implementation, budget development and utilization, Level of Care (LOC), health and safety and overall supports.

Scope of Service

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 in order to maximize their ability to self-direct in the Mi Via Program. Participants may choose to work with any Mi Via approved consultant agency in their region.

A. Consultant services and supports are delivered in accordance with the participant's identified needs. Based upon those needs, the consultant shall:
    i. Provide the participant with information, support, and assistance during the annual Medicaid eligibility processes, including the medical level of care (LOC) evaluation and financial eligibility processes;
    ii. Assist existing participants with annual LOC requirements within ninety (90) days prior to the expiration of the LOC;
    iii. Schedule participant enrollment meetings within five (5) working days of receipt of a Waiver Change Form (WCF) for participants transitioning from another waiver. The actual enrollment meeting should be conducted within thirty (30) days. Enrollment activities include but are not limited to:

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a. General program overview including key agencies and contact information;
b. Discuss eligibility requirements and offer assistance in completing these requirements as needed;
c. Discuss participant roles and responsibilities form;
d. Discuss Support Broker (Support Broker) including discussion and possible identification of an Support Broker and completion of the Support Broker Questionnaire form;
e. Review the processes for hiring employees and contractors and required paperwork;
f. Review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees, as applicable;
g. Discuss the background check and other credentialing requirements for employees and contractors;
h. Referral for accessing training for DDSD Mi Via core trainings and through the FMA *online system see Appendix G* and to obtain information on the Fiscal Management Agency (FMA), New Mexico Waiver training hub:

i. Provide information on the Service and Support Plan including Mi Via covered and non-covered goods and services, planning tools and available community resources;

B. For those participants transitioning from other waivers, a transition meeting including the transfer of program information must occur prior to the SSP meeting; and
C. Schedule the date for the SSP meeting within ten (10) working days of the enrollment meeting.
D. Assist the participant in utilizing all program assessments, such as the in-home assessment, comprehensive individual assessment, and the level of care abstract, to develop the SSP.
E. Educate the participant regarding Mi Via covered and non-covered supports, services, and goods.
F. Review the Mi Via Service Standards with the participant and either provide a copy of the Standards or assist the participant to access the Mi

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Via Service Standards online.

G. Assist the participant to identify resources outside the Mi Via Program that may assist in meeting their needs.
H. Ensure that the SSP for each participant includes the following:
    i. The services and supports, covered by the Mi Via program, to address the needs of the participant as determined through an assessment and person-centered planning process;
    ii. The purposes for the requested services, expected outcomes, and methods for monitoring progress must be specifically identified and addressed;
    iii. The twenty-four (24) hour emergency backup plan for services that affect health and safety of participants; and
    iv. The quality indicators, identified by the participant, for the services and supports provided through the Mi Via Program.
I. Ensure that the SSP is submitted in the appropriate format as prescribed by the state which includes the use *of FMA online system.*
J. Complete and submit revisions, requests for additional funding and justification for payment above the range of rates as needed, in the format as prescribed by the state, which includes the use of *the FMA online system.* No more than one revision is allowed to be submitted at any given time.
K. Ensure the completion and submission of the annual SSP to the Third-Party Assessor (TPA) at least thirty (30) days prior to the expiration of the plan so that sufficient time is afforded for TPA review.
L. Provide a copy of the final approved SSP and budget documents to participants.
M. Provide a copy of TPA Assessments to the participant upon their request.
N. Assist the participant with the application for LRI as employee process; submit the application to the Mi Via Program Manager or designated staff.
O. Assist with the environmental modification (EMOD) process including submission of required forms to the TPA for their review.
P. Assist the participant to identify and resolve issues related to the implementation of the SSP.
Q. Serve as an advocate for the participant, as needed, to enhance their opportunity to be successful with self-direction.
R. Assist the participant with reconsiderations of goods or services denied by the Third-party Assessor (TPA), submit documentation as required, and participate in Fair Hearings as requested by the participant or state.

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S. Assist the participant with required quality assurance activities to ensure implementation of the participant's SSP and utilization of the authorized budget.

T. Assist participants to identify measures to help them assess the quality of their services/supports/goods and self-direct their quality improvement process.

U. Assist the participant to assure their chosen service providers are adhering to the Mi Via Service Standards as applicable.

V. Assist participants to transition to another consultant provider when requested. Transitions should occur within thirty (30) days of request on the Consultant Agency Change (CAC) form but may occur sooner based on the needs of the participant. Transition from one consultant provider to another can only occur at the first of the month.

W. Assist participants to transition from and to other waiver programs. Transition from one waiver to another can only occur at the first of the month. The Developmental Disabilities Supports Division (DDSD) will review the Level of Care (LOC) expiration date prior to or upon receipt of the Waiver Change Form (WCF). If a participant is within ninety (90) days of the expiration of the LOC, the DDSD Regional Office (RO) or appropriate program manager will advise the participant they must wait until the LOC is approved before initiating the transfer. (Please refer to Mi Via Waiver Transition procedures for further details).

X. It is the State's expectation that consultants will work with participants transferring from another waiver to ensure that an approved services and supports plan (SSP) is in effect within ninety (90) days of the waiver change. Any exceptions to this timeframe must be approved by the State. Approval must be obtained in writing from the Mi Via Program Manager or their designate for any plan not in effect within ninety (90) days of the waiver change. The consultant request must contain an explanation of why the ninety (90) day timeline could not be met.

Y. The consultant provider shall participate in required trainings at the frequency determined by DDSD.

Contact Requirements

Consultant providers shall contact the participant at least monthly for a routine follow up. This contact is required to be face to face. The monthly contacts are for

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the following purposes:

i.

A. Monitoring of Services, Supports, and SSP Implementation:

i. Ensure the participant has access to all services and supports identified in the Service and Support Plan (SSP), including non-waiver services.
ii. Verify that services are furnished as outlined in the SSP and are meeting the participant's needs.
iii. Monitor progress on all time-sensitive SSP activities.
iv. Review and monitor SSP and budget implementation, including spending patterns, over- or under-utilization, and access to related goods.
v. Assess the use and effectiveness of the 24-hour Emergency Backup Plan.
vi. Monitor the quality of services, supports, and functionality of goods in accordance with Mi Via Service Standards and quality assurance requirements.

B. Participant Choice, Self-Direction, and Community Access:

i. Review the participant's choice of provider and ensure informed choice and decision-making.
ii. Support the participant's self-direction of services.
iii. Monitor access to the community, non-disability-specific settings, and competitive employment.
iv. Verify the participant has a lease or legal housing agreement, when applicable.

C. Health, Safety, and Welfare:

i. Monitor health and safety, including current health status, recommended appointments, and needed medical follow-up.
ii. Assess the home environment and service settings for compliance with CMS Final Rule HCBS settings requirements.
iii. Identify and address any health and safety issues.
iv. Review any incidents, challenging events, or circumstances affecting the participant's health, welfare, or ability to access supports.

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v. Assess for suspected abuse, neglect, or exploitation (ANE); ensure proper reporting and take remedial action if needed.
vi. Confirm completion of ANE training and review any ANE-related concerns.

D. Coordination, Problem Resolution, and Follow-Up:

i. Follow up on complaints regarding service providers, vendors, or employees.
ii. Coordinate with MCOs regarding durable medical equipment and other needs.
iii. Address issues related to vendors, employees, or service delivery.
iv. Provide resources and assistance to the participant as needed.

Reimbursement Ongoing Consultant Services

A. Consultant services shall be reimbursed based upon a per-member/per-month unit. There is a maximum of twelve (12) billing units per participant per Service and Support Plan (SSP) year. A maximum of one unit per month can be billed per each participant receiving consultant services.

B. Consultant records must be sufficiently detailed to substantiate the nature, quality, and amount of consultant services provided. Months for which no documentation is found to support the billing submitted shall be subject to non-payment or recoupment by the state. Documentation supporting service delivery must be completed no later than two (2) business days after the service is provided.
C. The consultant provider/agency shall provide the level of support required by the participant and a minimum of twelve (12) monthly face-to-face visits per SSP year. One of the monthly visits must include the development of the annual SSP and assistance with the LOC assessment.
D. It is the State's expectation that consultants will work with participants transferring from another waiver to ensure that an approved services and supports plan (SSP) is in effect within ninety (90) days of a waiver change. Consultants must obtain approval in writing from the DOH Mi Via Program Manager or their designate for any transfers occurring over the ninety (90) day timeframe.
E. Consultant providers shall submit all billing through the Mi Via FMA as

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determined by the State.

F. Non-Billable services Include:
    i. Services furnished to an individual who does not reside in New Mexico.
    ii. Services furnished to an individual who is not eligible for the Mi Via Program.
    iii. Outreach activities, including contacts with persons potentially eligible for the Mi Via Program.
    iv. Consultant services furnished to an individual who is in an institution (e.g., ICF/IID, nursing facility, hospital) or is incarcerated, except for discharge planning services in accordance with MAD Supplement No. 01-22

Critical Incident Management Responsibilities and Reporting Requirements

A. The consultant provider shall report incidents of abuse, neglect, exploitation, suspicious injuries, any participant death as well as any environmentally hazardous conditions which creates an immediate threat to health or safety as directed by the state.

B. The consultant provider will maintain a critical incident management system to identify, report, and address critical incidents. The consultant provider is responsible for follow-up and assisting the participant to help facilitate health and safety when the health and safety of a participant is determined to be at risk.

C. Critical incident reporting requirements:
    i. For individuals on the Mi Via Waiver, critical incidents should be immediately reported to:
        a. The Health Care Authority (HCA), Division of Health Improvement (DHI) for persons 18 years or older for critical incidents involving abuse, neglect and/or exploitation, suspicious injuries, participant death as well as any environmentally hazardous condition which creates an immediate any threat to health or safety.
        b. The HCA/DHI and/or Children, Youth and Families Department (CYFD)Child Protective Services (CPS) for persons under 18 years of age for critical incidents involving abuse, neglect and/or exploitation, suspicious injuries, participant death as well as any environmentally hazardous condition which creates

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an immediate any threat to health or safety;

ii. Critical incidents shall be called into the HCA/DHI hotline, and the Consultant shall also collaboratively work with the HCA/DHI Intake to create and help implement an Immediate Action and Safety Plan for the consumer as appropriate.

D. A copy of the Division's abuse, neglect, exploitation or report of death form must be submitted to HCA/DHI within 24 hours of the verbal report.
E. Anyone may report an incident; however, the person with the most direct knowledge of the incident is the individual who is required to report the incident.
F. Use the Regional Office Request for Assistance (RORA) as indicated and outlined as per these Mi Via Service Standards.

Administrative Requirements

A. Consultant agencies and their individual consultants shall comply with all applicable federal, state and waiver regulations, all policies and procedures governing consultant services, all terms of their provider agreement and shall meet all of the following requirements, as applicable:

i. Have a current business license issued by the state, county, or city government as required;
ii. Maintain financial solvency;
iii. Ensure all employees or sub-contractors providing consultant services under this standard attend all state-required trainings and demonstrate knowledge of and competence with the Mi Via policies and procedures, philosophy of self-direction, financial management processes and responsibilities, needs assessments, person-centered planning and service plan development, the CMS HCBS Settings Requirements and other federal regulations, and adhere to all other training requirements as specified by the state;
iv. Ensure that all Consultants are trained and competent in the use of the fiscal management an*d FMA online system;*
v. Ensure all employees providing services under this scope of service and all other staff paid with Mi Via funds, are trained on how to identify and where to report abuse, neglect and exploitation, as well as how to report suspicious injuries, environmental hazards as well

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as death; and

vi. Ensure compliance with the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) for all employees.

B. The consultant provider shall develop a quality management plan to ensure compliance with regulatory and program requirements and to identify opportunities for continuous quality improvement.

C. The consultant provider will conduct an annual participant satisfaction survey. A copy of a report summarizing the results of this survey must be submitted to the New Mexico Department of Health, Developmental Disabilities Supports Division upon provider renewal or as requested by the state.

D. The consultant provider shall ensure that participants have access to their consultant. This requirement includes, but is not limited to the following:

i. The consultant provider must maintain a presence in each region for which they are providing services;

ii. The consultant must maintain a consistent way (for example, phone, email, and fax) for the participant to contact the consultant during typical business hours which are 8:00 a.m. to 5:00 p.m. Monday through Friday;

iii. The consultant must maintain a consistent way (for example phone, email, and fax) for the participant to leave messages with the consultant during non-business hours: prior to 8:00 a.m. and after 5:00 p.m. MST on weekdays and on weekends and for emergency purposes;

iv. The consultant provider must assure that consultants and other staff will respond to participant and/or participant representative communications within three (3) working days except in emergency situations where a response is needed within twenty-four (24) hours during the work week.

v. The consultant provider must provide a location to conduct confidential meetings with participants when it is not possible to do so in the participant's home. This location must be convenient for the participant and compliant with the Americans with Disabilities Act (ADA);

vi. The consultant provider must maintain an operational fax machine at all times; and

vii. The consultant must maintain an operational email address, internet

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access, and the necessary technology to access Mi Via related systems.

E. The consultant provider shall maintain a current local/state community resource manual that is accessible to a participant.
F. The consultant provider shall adhere to Medicaid General Provider Policies NMAC 8.302.1.
G. The consultant provider shall maintain HIPAA compliant primary records for each participant including, but not limited to:
    i. Current and historical SSPs and budgets;
    ii. Contact log that documents all communication with the participant;
    iii. Completed/signed monthly (12) face to face visit form(s)
    iv. TPA documentation of approvals/denials, including budgets and requests for additional funding;
    v. TPA correspondence; (requests for additional information; requests for additional funding, etc.);
    vi. Assessor's individual specific health and safety recommendations;
    vii. Notifications of medical and Financial eligibility;
    viii. Approved Long Term Care Assessment Abstract with level of care determination and Individual Budgetary Allotment from the TPA;
    ix. Budget utilization reports from the FMA;
    x. Environmental modification approvals/denials;
    xi. Legally Responsible Individual (LRI) forms
    xii. Certificate of completion on employee training on reporting abuse, neglect, and exploitation awareness. New Mexico Waiver training hub agency compliance reports;
    xiii. Consultant will need to register with New Mexico Waiver training Hub to track trainings and compliance
    xiv. Copy of legal guardianship or representative papers and other pertinent legal designations; and
    xv. Primary Freedom of Choice form (PFOC) and/or, Waiver Change Form (WCF) and/or Consultant Agency Change Form (CAC) as applicable.

H. The consultant provider shall ensure the development and implementation of a written grievance procedure in compliance with 7.26.4 NMAC.
I. The consultant provider shall meet all of the qualifications set forth in 8.314.6.11 NMAC.

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Conflict 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 Service and Support Plan (SSP) and as such must also adhere to the following:

A. Consultant Agency owners and their employed or contracted Consultants may not:
    i. Be related by blood or affinity to the person supported, or to any paid caregiver of the individual supported.
    ii. 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.
    iii. Be empowered to make financial or health related decisions for people on their caseload.
    iv. 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, Behavioral Support Consultants (BSC) and therapists.

B. A Mi Via Consultant may not serve as the Support Broker, personal representative (PR) or authorized representative (AR), or authorized signer for an eligible participant for whom he or she is the consultant.
C. A Consultant Agency may not be a Provider Agency for any other Mi Via Waiver service.
D. A Consultant Provider Agency must disclose to both DDSD 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.
E. A Consultant or Director of a Consultant Agency may not serve on the Board of Directors of any Mi Via Waiver support services.
F. Consultant Agency staff and subcontractors must maintain independence and avoid all activity which could be perceived as a potential conflict of interest.

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G. A Consultant Agency may not provide guardianship services to an individual receiving Consultant services from that same agency.
H. A Consultant may not provide training to staff of Mi Via Waiver employees or vendors.

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

i. 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;
ii. Mi Via Waiver Consultant Agencies may not employ or subcontract with a spouse or domestic partner to support the person in services; and
iii. 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 DDSD expectations and professional standards.

Staff Ratio Requirements

The Consultant Provider Agency must assign manageable caseloads, averaging about 30 Mi Via Waiver cases per consultant and never exceeding 50 individuals across all waiver programs. Child cases may be weighted based on months of service received. The agency must ensure coverage during a consultant's absence and provide ongoing supervision, mentoring, and regular evaluations to ensure caseloads are appropriate and service requirements are met.

The consultant/agency must ensure that all required consultant functions (and support guide functions as applicable) are met and that there is adequate time to provide the necessary supports unique to each participant.

Provider Qualifications

Consultants must be employed by an enrolled Mi Via Consultant agency. Agency

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requirements are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;
iii. Meet Financial solvency;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
v. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
vi. Must have proof of records being maintained in accordance with waiver standards.
vii. Develop and adhere to Quality Improvement (QI) strategies as required per the waiver Service Standards and DDSD Waiver Provider Agreement;
viii. Ensure that all individuals providing the services meet the criteria specified in this section:
    a. Be at least 21 years of age;
    b. Possess a minimum of a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field;
    c. Have one (1) year of supervised experience working with people living with disabilities;
    d. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;;
    e. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

Or

    a. Be at least 21 years of age;
    b. Have a high school diploma or GED and a minimum of six (6) years of direct experience related to the delivery of social services to people living with disabilities;
    c. Complete initial and annual training requirements set

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forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;

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

B. SUPPORT BROKER AS A SERVICE *[PENDING CMS APPROVAL]*

Support Broker as a waiver Service is a service intended for participants who otherwise do not have a natural supports who can fill the role of the traditional unpaid Support Broker (Support Broker).

Support Broker is the individual responsible for directing the work of Mi Via Waiver participant. The Support Broker:

i. Helps identify and hire employees and vendors to provide services in the participants' SSP.
ii. Is the common law employer of workers who provide Mi Via Waiver Participant-Directed services.
iii. Provide a level of support to participants that is unique to their individual needs to maximize their ability to self- direct in the Mi Via Waiver.
iv. Must adhere to the scope of work, qualifications and requirements as outlined in the Mi Via regulations, 8.316.4 NMAC, and these Service Standards.

Support Broker are provided through a vendor agency and must be approved as a service on the participants' Service and Support Plan (SSP) and budget. Support Broker agencies are selected via the Developmental Disabilities Supports Division Secondary Freedom of Choice (SFOC) form. Mi Via Waiver Participant recipients have the freedom of choice to work with any Mi Via Waiver approved Support Broker agency in their region. Agencies who provide Support Broker services are prohibited to provide any other waiver service.

Scope of Service

Support Broker as a Paid Service are responsible for, but are not limited to:

A. Service and Support Budget Monitoring

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i. The Support Broker (Support Broker) will schedule a meet and greet with the Participant within five (5) working days of receipt of notification of agency selection via the Secondary Freedom of Choice (SFOC).
ii. The Support Broker will review the Service and Support Plan (SSP) with the participant to understand their goals and desired outcome for each service listed on the SSP Based on the participant's identified needs
iii. The Support Broker will work with the participant and their consultant to keep expenditures within the Approved Annual Budget (AAB) so the participant will not experience gap in services at end of SSP term.
iv. When a service has a state-approved range of rates, the Support Broker has the authority to negotiate rates within an approved range on behalf of the participant. The Support Broker and participant are the only ones who can determine the rates. The Support Broker must employ individuals using state issued service rates or state approved range of rates.
v. The Support Broker will provide and review with the participant in a way that they can understand monthly reports of expenditures and the status of the Mi Via Waiver service and support plan spending.
vi. The Support Broker will monitor the access to services for the participants as documented in the SSP by reviewing timesheets, invoices, and other service documentation to ensure services are being delivered in the scope, duration, and frequency as outlined in the SSP.

B. Hiring Employees and Vendors
    i. The Support Broker must include the participant in the interview and final decisions when hiring an employee. The participant's comfort level and choice must be considered when making final hiring decisions. A participant or Support Broker can choose to hire employees or vendors to provide services.
    ii. When a potential employee or vendor has been chosen, the Support Broker will assist the potential employee with completing the mandatory paperwork that is required before the employee, or vendor can start working for the participant. Paperwork must be completed and submitted to the Fiscal Management Agency (FMA).
    iii. The Support Broker will review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees, as applicable. The Support Broker will assist the participant they serve with submitting documentation to the Consultant to support review of LRI request.

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iv. The Support Broker must consult and include the participant routinely about satisfaction with employee performance and decisions to fire an employee.
v. The Support Broker will review any adverse findings found on any employee or vendor through the required background check. If an employee or vendor is found ineligible, the Support Broker will work to find a new employee or vendor to provide the service.
vi. The FMA will notify the Support Broker and will unlink the employee from the budget.
vii. Support Broker will assure employee compliance with the state's requirements for Electronic Visit Verification for all direct hire employees of services requiring EVV.

C. Training Employees

The Support Broker will work with the participant and the employee to ensure that the employee is providing services in a way that supports the participant's preferences and choices. The Support Broker:

i. Provides detailed directions in a manner that can be easily understood;
ii. Explain the types of tasks that need to be performed;
iii. Develops helpful tools like a checklist and provides a copy to the employee;
iv. Make sure the employees understand the tasks by asking them to demonstrate the task. If the task is not completed correctly, take a moment to provide clarification;
v. Ensure that all employees and vendors complete Developmental Disabilities Supports Division (DDSD) required training for Mi Via Waiver;
vi. Ensure that all employees are trained and able to comply with the state's Electronic Visit Verification (EVV) requirements when applicable;
vii. Always sets clear expectations during initial and ongoing training. The Support Broker should not ask employees to do work outside of the approved SSP or outside the qualifications of the employee;
viii. Familiarizes employees with the participant's SSP Back-Up Plan and trains the employee to call 911 in case of an emergency and provides instructions on what they should do while help arrives;
    a. The backup plan is part of the SSP and should include paid and unpaid supports that will be available to provide services when a regularly scheduled employee cannot work, a list of family

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members, neighbors, friends, or any other paid provider. It should contain the name of the individual and their contact number;

b. The backup plan is an alternate plan to cover unforeseen circumstances as well as planned events when the employee cannot work their regular schedule for:
    1. Unforeseen events can be illness or emergencies.
    2. Planned events can be holidays, planned vacations.
    3. Dates/times they are available to assist.

ix. Let employees know of any health and safety concerns in the event of emergency. This is best reinforced by keeping a list of:
    a. Medical conditions
    b. Allergies
    c. Emergency contacts, such as doctors, specialists, and preferred hospital
    d. Keep the list updated and readily available.

x. Works with the Consultant to enter themselves and employees in the DDSD training database. The database provides access to the online trainings, creates a transcript for employees and provides for the ability for Support Broker to track completion. Ongoing training will assist with setting and maintaining a routine as well as introducing changes to processes.

xi. Support Broker will monitor training compliance for all direct hire employees

D. Scheduling Employees

The Support Broker will establish a mutually agreeable schedule with employees and participant. The Support Broker will ensure the backup plan is followed, and coverage is provided in the event of an employee calling in due to illness, emergencies or any other instance that prevents them from coming to work or arriving on time.

E. Authorizing Timesheets and Payments

The Support Broker also has the responsibility to manage employees and service records. This includes approving timesheets in the FMA system, signing vendor

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payment request forms (VPR), safeguarding protected health information, tracking expenses, keeping employee and vendor files, etc. The Support Broker must:

i. Communicating with the Fiscal Management Agency (FMA) and correcting issues in a timely manner will ensure employees and vendors are paid correctly and on time.
ii. Follow due dates and deadlines for when timesheets must be entered and approved, when vendor Payment Request Forms (PRFs) are due and approved, filing system for PRFs and invoices and other Support Broker duties.
iii. Comply with policy regarding the use of electronic payment methods
iv. Comply with all billing and documentation requirements.
v. Comply with timely filing requirements. All payment requests forms must be submitted within 90 days of the date the service was provided. If timesheets or invoices are submitted more than 90 days after the service has been provided, payment will not be processed, and the Support Broker will be notified. The Support Broker may be responsible for payment.
vi. Must assist an injured employee with reporting and filing Workers Compensation claims which is available for injured employees through coverage provided by the FMA..
vii. Keep records that show that services have been provided as outlined in the Service and Support Plan (SSP) and Budget. Documents to keep include but are not limited to:
    a. Approved SSP and Budget;
    b. Copies of signed Employee and Vendor Agreements;
    c. Copies of invoices, VPRs, mileage sheets, or time sheets;
    d. Receipts for goods purchased;
    e. Daily progress notes; and
    f. Attendance logs.
viii. Seek assistance and guidance from the FMA as needed

F. Billing & Documentation Requirements

Prior to approval of timesheets and Vendor Payment Request Forms (VPR), the Support Broker (Support Broker) is responsible for ensuring that all documentation related to employees, vendors, services, and expenditures is complete, accurate, and compliant with program rules. This includes daily progress notes as they relate to services received and maintaining receipts for

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goods or services purchased with the Money Network Card.

Mi Via Waiver Support Brokers are subject to audits conducted by the Health Care Authority (HCA) and the Centers for Medicare and Medicaid Services (CMS). Support Brokers and the employees must adhere to the program rules and requirements to avoid suspicion of fraud, waste and abuse.

Examples of what can be considered Medicaid Fraud, Waste and Abuse:

i. Approving time sheets or PRFs for time or services not rendered.
ii. Utilizing FMA checks to purchase goods that are not approved in the budget.
iii. Altering employee/vendor payment checks.
iv. Paying for services or goods that violate Federal or State statues, rules or guidance.
v. Paying for services or goods for someone else other than the eligible participant.
vi. Forging signatures in timesheets or PRFs.
vii. Claiming services while the eligible participant is in the hospital, nursing home, rehabilitation facility, etc.

The Developmental Disabilities Supports Division (DDSD) will refer cases related to Medicaid fraud to the OIG for investigation. False claims have federal and civil penalties and fines.

Conflict of Interest

Support Broker 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. Support Broker Agencies are required to mitigate real or perceived conflict of interest issues. Support Broker are agents responsible for the administrative duties and as such must also adhere to the following:

Support Broker Agency owners and their employed or contracted Support Broker's may not:

i. Have material financial interest in any entity that is paid to provide 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.

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ii. Be empowered to make financial or health related decisions for people on their caseload.
iii. Be related by blood or affinity to any Mi Via providers, vendors or employees for individuals on their caseload. Provider Agencies are identified as Mi Via vendors, Mi Via Consultants, Community Supports Coordinators, BSC's and therapists.
iv. Support Broker Agency may not be an employee for any other Mi Via service
v. Support Broker Agency must disclose to both DDSD and to people supported by their agency, any familial relationships between the agency's employees/subcontracting Support Broker's and employees or subcontractors of Provider Agencies, vendors, or employees of other Mi Via Waiver services.
vi. Support Broker or Director of a Support Broker Agency may not serve on the Board of Directors of any Mi Via Waiver Provider Agency or vendor agency.
vii. Support Broker Agency staff and subcontractors must maintain independence and avoid all activity which could be perceived as a potential conflict of interest.
viii. Support Broker Agency may not provide guardianship services to an individual receiving Mi Via Waiver Services.
ix. Support Broker Agencies must mitigate any conflict-of-interest issues by ensuring that 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 who stems solely from the caregiver relationship is not sufficient to satisfy this requirement.
x. The participant's Support Broker may not also be their employee or vendor.
xi. A Support Broker whose performance compromises the health, safety or welfare of the participant, may have his or her status as a Support Broker terminated.
xii. A Support Broker makes important determinations about what is in the best interest of the participant and should not have any conflict of interest.
xiii. A Support Broker assists in the management of the participant's budget and should have no personal benefit connected to the services requested or approved on the budget.

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Staff Ratio Requirements

The Support Broker Provider Agency must assign manageable caseloads, averaging about 30 Mi Via Waiver cases per Support Broker. The agency must ensure coverage during a Support Broker's absence and provide ongoing supervision, mentoring, and regular evaluations to ensure caseloads are appropriate and service requirements are met.

The Support Broker Provider Agency shall hire and retain sufficient SBs to adequately provide service to the agency's client population. Caseload assignments by the agency must adhere to the following requirements:

1. The Support Broker Provider Agency shall assign caseloads in such a way as to assure adequate coverage for each person in services, using an average of 30 cases per SB across the agency.

2. The Support Broker Provider Agency must ensure a colleague or supervisor performs essential duties during the SB's absence.

5. The Support Broker Agency must provide ongoing supervision and mentoring, which includes regular evaluations of caseload levels and of each SB's ability to meet service requirements within the assigned caseload level.

Provider Qualifications

Vendor agency qualifications are as follows:

i. Support Brokers as Paid Service must be employed by an enrolled Mi Via Employer Record agency. Vendor agency qualifications are as follows: Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;
iii. Meet financial solvency;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation.
v. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
vi. Must have proof of records being maintained in accordance with waiver standards;

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vii. Develop and adhere to Quality Improvement (QI) strategies as required per the waiver Service Standards and DDSD Waiver Provider Agreement;

viii. Ensure that all individuals providing services meet the criteria specified in this section:

a. Be at least 21 years of age;
b. Possess a minimum of a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field; Mi Via Waiver Service Descriptions and Provider Qualification page 23 of 75 July 1, 2022
c. Have one (1) year of supervised experience working with people living with disabilities
d. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
e. Pass a nationwide Caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1973, Section 27-71-1 et seq. and 8.11.6 NMAC
f. In extraordinary circumstances, a Support Broker agency may need to request an exception to the standards. An exception may be based on individual circumstances or extenuating circumstances at the agency. Any exception to the standards needs

LIVING SUPPORT SERVICES

A. Homemaker/Direct Support

Homemaker/Direct Support Services are provided on an episodic or continuing basis to assist the participant with activities of daily living, performance of general household tasks, provide companionship to acquire, maintain, or improve social interaction skills in the community and enable the participant to accomplish tasks they would normally do for themself if they did not have a disability. Homemaker/Direct Support services are provided in the participant's own private home and in the community, depending on the participant's needs and choice. The participant identifies the Homemaker/Direct Support worker's training needs. If the participant is unable to do the training for him or herself, the participant arranges for the needed training

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This service is not to be provided in homes or apartments owned/leased by provider agencies, unless the participant has a lease or other type of legal protection in place for that residence.. Waiver participants in all living arrangements are assessed individually, and service plan development is individualized, however; two or more eligible recipients living in the same residence, who are receiving services and supports from the Mi Via Waiver will be assessed both independently and jointly to determine coverage of services and supports that are shared. 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 cognitive, clinical, and habilitative needs are met. Services and supports will be approved based on common needs and not individual needs unless the TPA has assessed that the eligible recipient has an individual need for the services. Providers will bill for services in shared households within state guidelines.

Participants who access this service may not access In-home Living Support Services.

Services are not intended to replace supports available from a primary caregiver or other natural, or unpaid supports.

This service is not available for participants under age 21, because personal care services are covered under the Medicaid state plan as expanded EPSDT benefits for waiver participants under age 21.

Scope of Services

Homemaker/Direct Support Services include but are not limited to the following:

i. Assist the participant with activities of daily living such as grooming, bathing, dressing, oral care, eating, transferring, mobility, and toileting;
ii. Perform general household tasks;
iii. Provide companionship to acquire, maintain or improve social interaction skills in the community; and

Provider Qualifications – Individual Provider

Individual Provider qualifications are as follows:

i. Be at least 18 years of age;
ii. Be qualified to perform the service and demonstrate capacity to perform required tasks, including to advocate for the person's Americans with Disabilities Act (ADA) rights, as desired by the person ;

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iii. Be able to communicate successfully with the participant;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including but not limited to critical incidents, abuse, neglect and exploitation;
v. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC prior to initial hire and every three years after initial hire.
vi. Complete participant specific training: the evaluation of training needs is determined by the participant or their legal representative; participant is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Mi Via participant's AAB; and
vii. Meet any other service qualifications, as specified in the Mi Via regulations.
viii. Utilize the state approved EVV system to meet EVV requirements

Provider Qualifications – Vendor Agency

Vendor Agency Provider qualifications are as follows:

i. Must be a home health agency must hold a New Mexico home health agency license; or
ii. Must be a homemaker agency certified by the HCA/Medical Assistance Division (MAD); and
iii. Have a current business license issued by the state, county or city government;
iv. Provide a tax identification number;
v. Meet solvency;
vi. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD but not limited to, critical incidents, abuse, neglect and exploitation;
vii. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
viii. Must have proof of records being maintained in accordance with waiver standards;

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ix. Ensure that all individuals providing the services meet the criteria specified in this section:

a. Be at least 18 years of age;
b. Be qualified to perform the service and demonstrate capacity to perform required tasks, including to advocate for the person's Americans with Disabilities Act (ADA) rights, as desired by the person ;
c. Be able to communicate successfully with the participant;
d. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
e. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.
f. Complete participant specific training: the evaluation of training needs is determined by the participant or their legal representative; participant is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the Mi Via participant's AAB; and
g. Meet any other service qualifications, as specified in the Mi Via regulations.
h. Utilize the state approved EVV system to meet EVV requirements.

B. In-Home Living Supports

** *IHLS services may not be provided in a home or apartment owned or leased by a provider agency unless the participant has a lease or other legal protection in place for that residence.*

***IHLS is a vendor-delivered service and may not be provided by a participant-hired employee. IHLS providers must be employed or contracted by an approved IHLS provider agency.* In-home Living Supports (IHLS) are individually designed services and supports that are related to the participant's qualifying condition or disability that enable the participant to live in their apartment, house, or family home that is owned or leased, in the community of their choice, for the purpose of preventing institutionalization. This service is not to be provided in homes or apartments owned/leased by provider agencies unless the participant has a lease or other legal protection in place for that residence. Services are individually designed to instruct or enhance home living skills as well as address health and safety.

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More than one (1) participant may reside in the home or apartment. 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 cognitive, clinical, and habilitative needs are met.

In-home Living Supports must be indicated in the participants' SSP and will be based on assessed needs. This service is provided on a regular basis; at least four (4) or more hours per day one or more days per week. The numbers of hours of support are based on the needs of participant(s) and may be up to twenty-four (24) hours per day. The hours and days must be specified in the service plan. In-home Living providers must assure twenty-four (24) hour response capability to address scheduled or unpredictable needs for health, safety, or security concerns.

IHLS vendor is not responsible for finding or providing a physical residence for the participant. This service does NOT provide:

i. Service coordination
ii. Residential placements (a home)
iii. Nursing (separate line item in budget if needed)

Participants receiving IHLS must be 18 years of age and may not use Homemaker/Direct Support, Home Health Aide or Respite services because they duplicate In-home Living Supports. In-Home Living Supports providers, whether hired directly by the participant or operating as part of an approved provider agency, must comply with the requirements for approval and oversight outlined in this section.

All In-Home Living Supports providers are required to meet applicable Direct Support Professional (DSP) qualifications as specified in these standards.

When services are furnished through a provider agency, the agency must maintain an internal approval process for each employee delivering In-Home Living Supports. This process must include verification of DSP qualifications, completion of required training, and documentation of a current Home Study consistent with Section V of this standard.

Homes or residences that are privately owned or rented by the participant or their family are presumed to comply with the Centers for Medicare and Medicaid Services (CMS) Home and Community-Based Services (HCBS) Settings Requirements. However, the participant or legal representative, with support from the Mi Via Consultant, is responsible for maintaining

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awareness of and adherence to these requirements. The Consultant educates and assists the participant and their household on the settings requirements and ensures that the home environment continues to support privacy, autonomy, and community inclusion.

Developmental Disabilities Supports Division (DDSD) and the Division of Health Improvement (DHI) Quality Management Bureau (QMB) will conduct compliance surveys to ensure Mi Via IHLS vendors are:

1. Meeting qualifications to provide in Home Living Supports
2. Compliance with the Mi Via Service Standards and waiver requirements
3. Meeting all applicable program expectations

In-Home Living Support providers must be employed or contracted by an In-Home Living Supports Agency.

Scope of Services

In-home Living Supports services include but not limited to:

i. Assist/instruct the participant with activities of daily living including grooming, bathing, dressing, oral care, eating, transferring, mobility, and toileting;
ii. Assist the participant with the acquisition, restoration, and/or retention of independent living skills such as shopping, banking, money management, health care and medication management;
iii. Assist/instruct the participant in the performance of general household tasks including housekeeping and meal preparation; and
iv. Provide assistance in the acquisition or maintenance of social interaction skills, community involvement and transportation.

Vendor Responsibilities and Billing Accountability

The In-Home Living Supports (IHLS) vendor provider shall maintain responsibility for the delivery, oversight, supervision, and quality of In-Home Living Support services provided to the participant. The provider shall not function solely as an administrative, billing, or pass-through entity. In order to bill Medicaid, the provider shall:

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1. Ensure service delivery is consistent with the participant's Service and Support Plan (SSP), approved services, applicable Service Standards, and the participant's identified needs and preferences.
2. Employ or contract with qualified staff to provide authorized services and maintain documentation demonstrating staff qualifications and competency.
3. Ensure a process that provides appropriate supervision and oversight of individuals providing In-Home Living Supports, including monitoring the quality and consistency of services, ensuring all required DDSD trainings are completed, and ensuring documentation is completed.
4. Ensure a process that service delivery documentation is completed daily, or no later than two (2) business days after the service for all billable time. Documentation must align with applicable waiver service standards, person-centered plans, plans of care, and authorized individual budgets.
5. Ensure a process to maintain accountability for service documentation, including reviewing documentation for accuracy, completeness, and consistency with the services authorized and provided. All records must be retained for six (6) years and must be made available to DDSD upon request. Vendors must verify services that are documented prior to submitting claims for payment.
6. Ensure a process to respond to service concerns, missed services, incidents, and complaints and take appropriate corrective action when services are not provided as required per the SSP.
7. Ensure a process to maintain ongoing communication with the participant and, as applicable, the participant's guardian or authorized representative regarding service delivery and concerns.
8. Ensure continuity of IHLS service staffing when assigned staff are unavailable or changes in staffing occur.
    i. The IHLS provider shall be identified in the participant's Emergency Back-Up Plan and shall be responsible for providing or arranging qualified backup staff, as needed, to meet the participant's authorized IHLS needs.
    ii. When IHLS is authorized 24 hours per day, the provider shall maintain sufficient staff availability and a backup staffing process to meet the participant's scheduled and unpredictable health, safety, or security needs identified in the SSP.

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iii. The IHLS provider's responsibility for backup staffing does not include providing, locating, arranging, or securing a physical residence for the participant.

iv. Retain responsibility for the services billed under the vendor provider, regardless of any staffing, contractual, or other arrangements used to support service delivery.

Provider Qualifications - Vendor Agency

Vendor agency qualifications are as follows::

i. Have a current business license issued by the state, county or city government.
ii. Be Financially solvent.
iii. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
iv. Must have proof of records being maintained in accordance with waiver standards.
v. Provide a tax identification number;
vi. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
vii. Must comply with Division of Health Improvement (DHI) provider surveys. When delinquencies are identified IHLS provider agencies must implement corrective action to remediate delinquencies. Failure to remediate delinquencies will result in disqualification of the vendor.
viii. Ensure all individuals providing the services meet the criteria specified in this section:
    a. Meets the requirements to serve as an Independent Contractor to provide this service as determined by the Internal Revenue Service (IRS);
    b. Be at least 18 years of age;
    c. Have at least one (1) year of experience working with people with disabilities;

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d. Be qualified to perform the service and demonstrate capacity to perform required tasks;
e. Be able to communicate successfully with the participant;
f. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation; Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.
g. Complete participant specific training: the evaluation of training needs is determined by the participant or their legal representative; participant is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Mi Via participant's AAB; and;
h. Additionally, the participant or his/her representative evaluates training needs, provides or arranges for training, as needed, and supervises the worker
i. Meet any other service qualifications, as specified in the Mi Via regulations.

COMMUNITY SUPPORT SERVICES

Community Support (CS) services provide supports through different models of care. CS services help people with intellectual and developmental disabilities (IDD) access and participate in activities and functions of community life. CS services are provided to adults and children. CS services can complement but not replace or be billed at the same time as supports provided or funded by services authorized under the Rehabilitation Act of 1973 as amended and the Individuals with Disabilities Education Act (IDEA). All CS services are expected to use the four guideposts of Community Life Engagement. They are:

1. Provide individualized supports through choice. Everyone should have choice in what they do. People should be given choice in where they receive supports. What people do during the day for CS services should match their interests and abilities. What a person chooses may change over time. CS services should allow for individual choice to change.

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2. Promote community inclusion and cultivating meaningful roles in the community. CS services offer targeted supports that increase social participation. CS services help people make decisions about whether to work and what their interests are. CS services support age-appropriate community roles (people over 17 might have a summer job). Services should occur in a community setting to the greatest extent possible.
3. Fade supports over time. This requires CS services to promote the use of natural supports such as friends and family.
4. Document the outcome of supports. Documentation of supports should match the SSP and Medicaid rules.

A. Community Direct Supports

Community Direct Support (CDS) services deliver supports that assist the person to identify, develop, expand, and maintain community connections. Community Direct Support also assists the person to access social, educational, recreational and leisure activities in the community. Community Direct Support Services promote the development of valued social relationships and build connections within a person's community. Community Direct Support services aid the participant outside of the participant's residence. CDS services ensure individuals have a choice of and access to non-disability specific settings. This service is not formal education (including home schooling and tutoring related activities) or vocational services related to traditional academic subjects or vocational training. CDS services do not include the purchase of memberships, event tickets, or course fees (such a zoo membership or the cost of a college class).

The CDS Provider may be a vendor, skilled independent contractor or a hired employee.

Scope of Services

Community Direct Supports service includes:

a) Gathering information about the person's interest, skills and abilities for the ongoing process of making an informed choice about employment;
b) Instructing and model self-advocacy, communication, and other skills necessary to interact with community members or in groups;
c) Promoting the development of social relationships and build connections within communities;

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d) Promoting self-determination, enhance the participant's ability to interact with and contribute to their community;
e) Providing assistance with tasks related to community membership;
f) Making sure people get the accommodations they need to take part in community activities, as required by the Americans with Disabilities Act (ADA);
g) Providing help with everyday tasks needed to be in the community setting of their choice;
h) Assisting the participant to schedule, organize and meet expectations related to chosen community activities;
i) Promoting choice of and access to non-disability specific settings;
j) Provide information about transportation options;
k) Providing, arranging for, and training on the use of transportation (including public transportation or ride share) to chosen community activities;
l) Supporting the participant in having frequent opportunities to expand meaningful roles in the community;
m) Supporting increased use of natural supports, networks, local resources, and friendships to increase independence;
n) Assisting in the development of peer relationships with others based on shared interests. The individual will be supported to create such connections individually, not as a part of a group of people with disabilities; and
o) Supporting exploration and informed decisions about education, employment, and volunteering opportunities. This means helping a person with information about choices related to classes, working, and contributing to the community.
p) Maintaining documentation for how service provision and outcomes align with the SSP. All documentation of services must be accurate, timely, and accessible to the person responsible for monitoring the services.

Provider Qualifications - Individual Provider

Individual provider qualifications are as follows:

i. Be at least 18 years of age;
ii. Be qualified to perform the service and demonstrate capacity to perform required tasks;
iii. Be able to communicate successfully with the participant;
iv. Complete initial and annual training requirements set forth in DDSD Policy,

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and periodic training updates and supplemental requirements as issued by DDSD;

v. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC prior to initial hire and every three years after initial hire.

vi. Complete participant specific training: the evaluation of training needs is determined by the participant or their legal representative; participant is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Mi Via participant's Authorized Annual Budget (AAB); and

vii. Meet any other service qualifications, as specified in the Mi Via regulations

Provider Qualifications -Vendor Agency

Vendor Agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;
iii. Meet financial solvency;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incident, abuse, neglect, and exploitation;
v. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
vi. Must have proof of records being maintained in accordance with waiver standards;
vii. Ensure that all individuals providing the services meet the criteria specified in this section:

viii. Be at least 18 years of age;
ix. Have knowledge of the local community and resources identified by the participant on the SSP
x. Be qualified to perform the service and demonstrate capacity to perform required tasks, including to advocate for the person's ADA rights, as desired by the person;

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xi. Be able to communicate successfully with the participant. Be aware of the participant's barriers to communicating and maintaining health and safety while in the community setting;

xii. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;

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

xiv. Complete participant specific training: the evaluation of training needs is determined by the participant or their legal representative; participant is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Mi Via participant's AAB; and

xv. Meet any other service qualifications, as specified in the Mi Via regulations.

B. CUSTOMIZED COMMUNITY GROUP SUPPORTS

Customized Community Group Supports (CCGS) include supports that offer functional age-appropriate activities that assist with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. This service is to be provided in an integrated community-based setting that supports opportunities for participants to access, as well as actively engage with, their preferred community resources and activities that include others in their community. CCGS are expected to be provided in integrated community settings such as community-based adult day programs and community centers and takes place in non-institutional and non-residential settings including typical integrated community settings as specified in the participant's service and support plan (SSP). CCGS supports ensure each individual has a choice of and access to non-disability specific settings and peers. CCGS services are only available to adults age 18 or older..

Services are available at least four (4) or more hours per day one (1) or more days per week as specified in the participant's SSP. CCGS include adult day habilitation and other day support models and do not duplicate community direct support services, employment support services or any other waiver service. Customized Community Group Support services are only provided through a provider agency. Provider agencies are required to adhere to the Home and Community Based Services (HCBS) Setting Rule.

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Customized Community Group Supports services must be provided through a Vendor Agency.

Remote-Based Supports

Remote-based supports may be implemented to assist the person to explore the community, online community activities, groups, and resources. Remote based supports must comply with the CCGS Scope of Work. In the event of remote based supports:

i. The staff must be trained to support individuals using remote-based supports.
ii. Remote-based supports may only be billed from the start time of the remote
iii. based class/session to the end of the remote-based class/session.
iv. Agencies can only bill for one location at a time – remote-based or agency-operated.
v. Agencies may not bill for time used to develop remote based supports or supplies associated with the sessions.
vi. If technical issues occur resulting in the interruption of services (i.e., internet outage, power, or connectivity issues) only the hours that the service was provided can be billed.
vii. Remote-based supports must meet accessibility requirements related to both
viii. the ADA and the individual's technology availability.
ix. Providers are responsible for providing remote services on a platform that all individuals can access. An inability for an individual to access remote services is the same as choosing not to provide the service.
x. Remote-base supports must be person-centered and presented described in the SSP.
xi. Remote-based supports are intended to supplement not supplant community-based services and must not lead to social isolation. Individuals are encouraged to participate in the community to the fullest extent possible in conjunction with the use of remote-based support.

Settings Requirements for Non-Residential Settings

All individuals have the right to choose where they receive services.

All settings must facilitate individual choice, including the choice to pursue employment. Any service provided in an agency-operated facility should be chosen by the person and be integrated in and support full access to the community and non-disability specific activities and peers.

Settings must be free of any abuse, neglect, or exploitation.

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CCGS service provider responsibilities in agency-operated settings include but are not limited to:

i. Encouraging and allowing visitors or others from the greater community (aside from paid staff) to be present and visit at times that are convenient for the individuals. It is the responsibility of the Agency to ensure visitors understand and follow HIPPA privacy requirements.
ii. Allow individuals to access the building freely and fully, while maintaining safety. Physical barriers such as gates, Velcro strips, locked doors, or fences should not restrict individuals from entering or leaving specific areas unless required for safety and supported by documentation
iii. Ensure the building is fully accessible and meets all requirements of the Americans with Disabilities Act (ADA).
iv. Provide personal support (including assistance with dining, if needed) in private settings whenever possible to protect individual dignity and privacy.
v. Staff must not discuss individuals in their presence as if the person is not there. Conversations about the person must include them directly and respectfully.
vi. Provide a secure location for individuals to store personal items.
vii. Ensure individuals have unrestricted access to a dining area with comfortable seating, and opportunities to socialize with others during meals and breaks.
viii. Individuals shall be treated in a manner appropriate to their age and not required to wear bibs or engage in practices that undermine their dignity.
ix. Upon request, the Provider Agency shall provide reasonable assistance in arranging alternative meals or private dining space.

Scope of Services

Customized Community Group Supports services include, but are not limited to the following:

i. Provide supports within the community which can include day programs and community centers that assist with the acquisition, retention or improvement in self-help, self-advocacy, socialization and adaptive skills.
ii. Supports and provides opportunities for participants to access and engage with community resources and activities with others in their community, including opportunities for the individual to have knowledge of and access to information regarding age-appropriate activities outside of the setting.

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iii. Promote choice of and access to non-disability specific settings, including education, volunteering, and employment options.
iv. Provide information about transportation options and sufficient training to maximize independent scheduling and coordination for transportation to chosen community activities.

Provider Qualifications - Vendor Agency

Vendor agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;
iii. Meet financial solvency;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD incl including, but not limited to, critical incidents, abuse, neglect and exploitation;
v. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
vi. Must have proof of records being maintained in accordance with waiver standards;
vii. Ensure that all individuals providing the services meet the criteria specified in this section:
    a. Be at least 18 years of age;
    b. Have at least one (1) year of experience working with people with disabilities;
    c. Be qualified to perform the service and demonstrate capacity to perform required tasks;
    d. Be able to communicate successfully with the participant;
    e. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
    f. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

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g. Complete participant specific training: the evaluation of training needs is determined by the participant or their legal representative; participant is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Mi Via participant's AAB; and
h. Meet any other service qualifications, as specified in the Mi Via regulations.

C. EMPLOYMENT SUPPORTS SERVICES

Employment Support (ES) services provide support to the participant in achieving and maintaining jobs of their choice in their community, including self- employment. ES services result in competitive integrated employment outcomes. Competitive integrated employment (CIE) means work performed by a person on a part- or full-time basis. To be CIE, the person should earn the same amount as other people doing the same or similar work and have access to opportunities for advancement and benefits. CIE work is performed in an integrated community setting. ES services are designed to increase economic independence, self-reliance, social connections, and the ability to grow within a career.

ES services are geared to place and support individuals of working age (14+) with disabilities in CIE with non-disabled co-workers within the general workforce; or assist the individual in business ownership. ES include job development and job coaching supports. All ES services are required to be in support of jobs that meet federal and state labor laws. ES services through the Mi Via Waiver complement but do not replace or duplicate services authorized and funded by the Individuals with Disabilities Education Act (20 U.S.C. § 1401(34)) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. § 730) as amended with the Workforce Innovation and Opportunity Act (29 U.S.C § 3101).

The Developmental Disabilities Supports Division (DDSD) is committed to Employment First principles and practices. Consultants have requirements to document strategies to support informed choice about employment in the SSP. Consultants use the SSP to document the outcome of a participant's informed choice about employment. All services support a person in making and informed choice about employment. Informed choice means making a decision based on a solid understanding of all available options and the consequences of how each decision may impact their life. It is an individualized process that starts with:

1. Assessment: Annual assessments for employment planning means getting to know the person's likes, dislikes, interests, hobbies, strengths and potential barriers to

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employment. CDS and CCGS service providers offer support for assessing and documenting interests, skills, abilities, and strengths, based on individual scope of the services outlined in the SSP.

2. Experience: Providing experiences that build volunteer or work history to determine interests, skills, abilities, and accommodation needs. Work-related experiences must be clearly documented in the SSP annually.
3. Opportunity for Trial Work or Volunteering: Provide the person with access to job exploration activities including volunteering and/or trial work opportunities, if the participant and guardian are interested. Plan for support needs according to the individual being supported. This may include support with ADLs during the trial work, assistance with accessing transportation, or planning to use technology as a source of support or accommodation during the trail work experience. Consider the use of all available resources to establish a trial work opportunity, such as the Division of Vocational Rehabilitation. These opportunities must be documented in the SSP.
4. If employment is to be pursued, then the Consultant should follow the Employment Supports Process. This will include identifying who will complete the referral to the Division of Vocational Rehabilitation (DVR). Sufficient documentation should be shared at the time the referral to expedite eligibility for DVR services, as authorized by the person. The necessary documents for expedited eligibility are
    a. Current years' Benefits Award Letter issued by the Social Security Administration and/or
    b. Current approved SSP.
5. Information about how working may impact a person's benefits should be explored and understood by the person. Individualized benefits counseling for benefits managed by the Social Security Administration should be completed by the Division of Vocational Rehabilitation (DVR), when available. Information about income and asset limitations and financial planning for Medicaid should be reviewed using the Medical Assistance Division's online resources and by working with Income Support Division. In all cases the Consultant should provide access to resources through SSA.gov and HCA.nm.gov. Details of the method for benefits advisement must be documented in the SSP.
6. If a person is retired, then the SSP must clearly state the person's retired status, the reasons for the choice to retire, the retirement date and other pertinent information.

ES services are to be individualized to meet the needs of the participant and not the needs of a group.

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Waiver funding is not available for the provision of vocational services where individuals are supervised in producing goods or performing services under contract to third parties, for example sheltered workshops.

ES services cannot pay for the following:

i. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
ii. The wages of the person receiving ES services;
iii. Payments that are passed through to users of supported employment programs;
iv. Payments that are used to start a small business; or
v. Supports which violate DDSD's Employment First Authorization and Implementation Policy.

Services are driven by the participant's Service and Support Plan (SSP) and job schedule.

Scope of Service

Job Development

Job Development (JD) is a service provided to participants to identify career development opportunities and secure employment based on individualized career planning. JD is a service provided to participants by qualified individuals or Provider agency staff. The service can include but not be limited to job identification and carving activities; employer negotiations; job restructuring; job sampling; and job placement.

The service requires specialized skills and cannot be performed by the general public. The service has several components:

i. Conducting Situational and Vocational Assessments that are individually appropriate for assessing skills, interests, abilities, capabilities, and workplace accommodation and support needs;
ii. Developing and/or identifying community-based job opportunities that match the personal skills and interests or will support development of essential workplace skills for improved career prospects, including self- employment;
iii. Supporting independence in workplace advocacy;
iv. Promoting career exploration, including self-employment if desired, based on interests within various careers through job sampling, job trials or other assessments as needed;

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v. Arranging for or providing benefits counseling by a qualified and skilled benefits counselor or work-incentives counselor;
vi. Facilitating or negotiating job accommodations to ensure a person have equal access to employment;
vii. Promoting the use of assistive technology such as communication devices for increased independence and for any applicable job accommodations;
viii. Providing job site analysis (matching workplace accommodation and support needs with those of the individual to maximize independence);
ix. Providing, arranging for, and training on the use of transportation (including public transportation or ride share) to work, job samples, interviews, or for other career exploration or application;
x. Assisting the individual in gaining and/or increasing job seeking skills (interview skills, resume writing, work ethics, etc.); and
xi. Supporting a person as needed and established by the SSP to find individualized competitive integrated employment.

If JD cannot be accessed through special education or vocational rehabilitation services, requests from participants job development employment services must include verification from DDSD. The following must be provided to the Community Inclusion and Employment Lead or designee:

i. Written documentation from the vocational rehabilitation or school district on their letter head that specifies why services are not otherwise available.
ii. A letter of justification from the Consultant outlining:
    a. The number of job development hours to be requested (not to exceed 30 hours/month);
    b. Anticipated duration of the service (not to exceed 6 months);
    c. Exact scope for the job development supports;
    d. Anticipated employment outcome/goal based on the participant's interests, skills and desired outcome as defined in the SSP; and
    e. The qualifications of the person or Agency who has been chosen to provide job development services.
iii. Failure to follow partner agency requirements does not constitute justification for services being otherwise unavailable (i.e., they do not want to use these services, missing appointments, etc.)

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Job Coaching

Job Coaching (JC) services provide individualized support services as necessary to increase independence and mastery for an existing job. Job coaches are a paid service. The presence of a job coach is a reasonable accommodation under the ADA. JC services begin once a job has been secured. JC is a one-on-one support service provided to employed persons to the extent that ongoing support services are necessary to maintain their job and increase independence at work. Job coaches will adhere to the specific supports and expectations negotiated with the participant and employer throughout service delivery.

The provision of services must be driven by the identified supports necessary and documented in the SSP. They may include the following:

i. Implementation of accommodations to perform specific work tasks and support training provided by the employer;
ii. Employer consultation specific to the participant and with the participant's knowledge and permission;
iii. Co-worker training to increase natural supports at the job site as appropriate and desired by the person;
iv. Job site and task analysis to be used for developing a plan to maximize independence and potentially fade paid supports;
v. Education of the participant and co-workers on rights and responsibilities as relates to specific accommodation or support services;
vi. Assistance with self-employment after the business has already been started, including support to access other community resources.
vii. Maintaining the infrastructure to support a business in the event of self-employment;
viii. Provide, arrange for, and train on the use of transportation (including public transportation or ride share) to work; and
ix. Increase the participants' skills for engaging in meaningful and productive interpersonal interactions co-workers, supervisors and customers.

Provider Qualifications – Individual Provider: Job Developer

Provider qualifications are as follows:

i. Be at least 21 years of age;

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ii. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
iii. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
iv. Must have proof of records being maintained in accordance with waiver standards;
v. Experience developing and using job task analyses for skill development and instruction;
vi. Knowledge of and/or experience working with the Division of Vocational Rehabilitation, a DD waiver employment provider, an independent living center or organization that provides employment supports or services for people with disabilities;
vii. Knowledge of and/or experience with the purposes, functions and general practices of entities such as:
    a. Division of Vocational Rehabilitation (DVR)
    b. Department of Workforce Solutions (DWS)
    c. America's Job Centers
    d. Chamber of Commerce
    e. Job Accommodation Network
    f. Small Business Development Centers including SCORE – Service Corps of Retired Executives
    g. Local Businesses
    h. Community Agencies
    i. Developmental Disabilities Supports Division (DDSD) Resources
viii. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC prior to initial hire and every three years after initial hire.
ix. Knowledge of Americans with Disabilities Act (ADA) and the interactive process;
x. Complete participant specific training: the evaluation of training needs is determined by the participant or their legal representative; participant is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Mi Via participant's AAB; and

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xi. Meet any other service qualifications, as specified in the Mi Via regulations.

Provider Qualifications – Individual Provider: Job Coach

Provider qualifications are as follows:

i. Be at least 18 years of age;
ii. Have a high school diploma or GED;
iii. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
iv. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
v. Must have proof of records being maintained in accordance with waiver standards;
vi. Be qualified to perform the service and demonstrate capacity to perform required tasks, experience with providing employment supports and training methods;
vii. Be able to communicate successfully with the participant and with the employer and the participant's coworkers to develop/ encourage natural supports on the job.
viii. Knowledgeable about business and employment resources;
ix. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC prior to initial hire and every three years after initial hire;
x. Complete participant specific training: the evaluation of training needs is determined by the participant or their legal representative; participant is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Mi Via participant's AAB; and
xi. Meet any other service qualifications, as specified in the Mi Via regulations.

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Provider Qualifications – Vendor Agency: Job Coach and/or Job Developer

Vendor Agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;
iii. Meet financial solvency;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
v. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
vi. Must have proof of records being maintained in accordance with waiver standards;
vii. Ensure that all individuals providing the Job Developer services meet the criteria specified in this section:
    a. Be at least 21 years of age;
    b. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.
    c. Experience developing and using job task and analyses;
    d. Knowledge of Americans with Disabilities Act (ADA) and the interactive process;
    e. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
    f. Knowledge of and/or experience with the purposes, functions and general practices of entities such as:
        1) Division of Vocational Rehabilitation (DVR)
        2) Department of Workforce Solutions (DWS)
        3) America's Job Centers
        4) Chamber of Commerce
        5) Job Accommodation Network
        6) Small Business Development Centers including SCORE – Service Corps of Retired Executives

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7) Local Businesses
8) Community Agencies
9) Developmental Disabilities Supports Division (DDSD) Resources

viii. Ensure that all individuals providing the Job Coaching services have the following qualifications:

a. Be at least 18 years of age;
b. Be qualified to perform the service and demonstrate capacity to perform required tasks, experience with providing employment supports and training methods;
c. Be able to communicate successfully with the participant and with the employer and the participant's coworkers to develop/ encourage natural supports on the job.
d. Have a high school diploma or GED;
e. Knowledgeable about business and employment resources;
f. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
g. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
h. Complete participant specific training; the evaluation of training needs is determined by the participant or their legal representative: participant is also responsible for providing and arranging for provider training and supervising provider performance: training expenses for paid providers cannot be paid for with the Mi Via participant's AAB; and
i. Meet any other service qualifications, as specified in the Mi Via regulations.

HEALTH AND WELLNESS SERVICES

A. BEHAVIOR SUPPORT CONSULTATION

Behavioral Support Consultation (BSC) services are intended to enhance a wavier participant's quality of life by providing Positive Behavior Support (PBS) as the person works on functional

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and relational skills. The focus of PBS is primarily on assisting and guiding the person toward opportunities to pursue the goals that genuinely represent what is most important to the person. BSC services occur in different environmental settings in the community and within the participant's home.

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 modify behavior. Mi Via participants have the right to be free from restraint, restrictive interventions, seclusion and coercion.

Scope of Service

Behavioral Support Consultation Services include but are not limited to:

i. Inform and guide the participant, family, employees and/or vendors toward
ii. understanding the contributing factors to the participant's behavior;
iii. Identify support strategies to enhance functional capacities, adding to the
iv. provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behaviors;
v. Support effective implementation based on a functional assessment and subsequent service and support plans;
vi. Monitor and adapt support strategies based on the response of the participant and their family, employees and/or vendors for services to be provided in the least restrictive manner.

Provider Qualifications – Individual Provider

Individual Provider qualifications are as follows:

i. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
ii. Must maintain training roosters;
iii. Licensure:
    a) A mental health professional that wants to provide BSC services must possess one of the following licenses approved by the New Mexico Regulation and Licensing Department and/or applicable New Mexico Licensing/Practice Board:

1. Licensed Independent Social Worker (LISW);
2. Licensed Professional Clinical Counselor (LPCC);
3. Licensed Professional Art Therapist (LPAT);
4. Licensed Marriage and Family Therapist (LMFT).

Provider Qualifications – Vendor Agency

Vendor Agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;
iii. Meet financial solvency;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
v. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
vi. Must have proof of records being maintained in accordance with waiver standards;
vii. Ensure therapists have and maintain a current New Mexico license with the appropriate professional field licensing body; current licensure may be any of the following:
    a) Psychiatrist licensed by the New Mexico practice board;
    b) Licensed Clinical Psychologist;
    c) Licensed Independent Social Worker (LISW);
    d) Licensed Professional Clinical Counselor (LPCC)
    e) Licensed Clinical Nurse Specialist (CNS) or Certified Nurse Practitioner (CNP) who is certified in psychiatric nursing by a national nursing organization who can provide services to adults or children as certification permits
    f) Licensed Marriage and Family Therapist (LMFT)
    g) A supervisory-level practice license: Ensure professionals licensed at this level are approved in one-year increments and require direct clinical supervision by an independently licensed mental health professional:
    1. Licensed Master Social Worker (LMSW); or
    2. Licensed Psychologist Associate (PA-master's or Ph.D. Level).

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B. HEALTHY RELATIONSHIPS AND PERSONAL SAFETY EDUCATION

The Healthy Relationships and Personal Safety Education is a comprehensive lifelong adult education program that teaches students knowledge and skills to increase social networks with healthy, meaningful relationships and to increase personal safety including decreasing interpersonal and intimate violence in relationships, sexual victimization, exploitation and abuse.

In order to access HRPSE, participants must add and request the course on their budget for review and approval by the Third-Party Assessor (TPA).

To access HRPSE, participants must request the classes through their Mi Via Service and Support Plan. *Scope of Service*

The course enhances participant's ability to develop close friendships and romantic relationships. The HRPSE involves the person's network of support (natural supports, paid supports, teachers, nurses, family members, guardians, friends, advocates, or other professionals) teaching them to support the social and sexual lives of persons with IDD, through participation in classes, and by using trained and paid self-advocates as role models and peer mentors in classes. HRPSE services must comply with 8.314.5 NMAC.

Provider Qualifications - Vendor Agency

Healthy Relationships and Personal Safety Education vendor agency qualifications are as follows:

i. A provider agency must be approved by the HCA, bureau of behavioral support (BBS) as a healthy relationships and personal safety education provider and must meet training requirements as specified by HCA.
ii. Have a current business license issued by the state, county or city government;
iii. Provide a tax identification number;
iv. Meet financial solvency;
v. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD;
vi. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to

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documentation of activities, progress and scope of work outlined in the participant's service and support plan;

vii. Must have proof of records being maintained in accordance with waiver standards;

viii. In addition, a socialization and sexuality education provider agency must employ or contract with provider who has one of the following qualifications for the service:

a. A master's degree or higher in psychology
b. A master's degree or higher in counseling

C. HOME HEALTH AIDE

Home Health Aide (HHA) services provide total care or assist a participant 21 years and older in all activities of daily living (ADLs). Home Health Aide services assist the participant in a manner that will promote and improve the participant's quality of life and provide a safe environment for the participant. HHA services can be provided outside the participant's home. HHA services are only provided through an agency provider. This service is not to be provided in homes or apartments owned/leased by provider agencies. Waiver participants in all living arrangements are assessed individually, and service plan development is individualized.

Medicaid State Plan home health aide services are intermittent and are provided primarily on a short-term basis; whereas, in Mi Via, HHA services are hourly services for participants who need this service on a more long-term basis. Waiver participants in all living arrangements are assessed individually, and service plan development is individualized. Two or more eligible recipients living in the same residence, who are receiving services and supports from the Mi Via program will be assessed both independently and jointly to determine coverage of services and supports that are shared. The Third-Party Assessor (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 cognitive, clinical, and habilitative needs are met. Services and supports will be approved based on common needs and not individual needs unless the TPA has assessed that the eligible recipient has an individual need for the services.

Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Homemakers do not have the ability to perform such tasks.

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Home Health Aides do not administer medication(s), adjust oxygen levels, perform any intravenous procedures or perform sterile procedures. Home health aide services are not duplicative of homemaker/direct support services.

Scope of Services

Services and/or supports provided under Home Health Aide services include but are not limited to:

i. Provide personal hygiene (e.g., sponge bathing, showering, shaving, oral hygiene, dressing) and associated supports (e.g., linen change, laundry, bed shampooing, cleaning);
ii. While under the supervision of a licensed physical therapist or licensed nurse (RN or LPN), assist with ambulation, transfer, and range of motion exercises;
iii. Assist with menu planning, meal/snack preparation and assist participant with eating as necessary;
iv. As ordered by a physician and under supervision of a licensed nurse (RN or LPN), they will assist with bowel and bladder elimination with activities such as catheter care, colostomy care, enemas, insertion of non-prescribed suppository, prosthesis care and vital signs.
v. Pick up medication(s);
vi. Assist or prompt participant in self-administration of medication(s);
vii. Observe general condition of participant and report changes to supervisor;
viii. Document participant's status and services furnished, infection control procedures; and
ix. Recognize emergencies and adhere to emergency procedures.

Provider Qualifications – Vendor Agency

Vendor Agency qualifications are as follows:

i. Licensed as a Home Health Agency, Rural Health Clinic or Federally Qualified Health Center
ii. Have a current business license issued by the state, county or city government;
iii. Provide a tax identification number;
iv. Meet financial solvency;
v. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD;
vi. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to

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documentation of activities, progress and scope of work outlined in the participant's service and support plan;

vii. Must have proof of records being maintained in accordance with waiver standards;

viii. Licensed in New Mexico as a home health agency, rural health clinic or federally qualified health center license;

ix. Supervision must be performed by a Registered Nurse (RN) licensed in New Mexico. Such supervision must occur at least once every sixty (60) calendar days in the participant's home and shall be in accordance with the New Mexico Nurse;

x. Practice Act NMSA 1978 Section 61-3-4 et. seq and be specific to the participant's SSP. Contact must be made with family members during supervision as applicable.

xi. Ensure all assigned staff meet the following qualifications:

   a. Be at least 18 years of age;
   b. Be qualified to perform the service and demonstrate capacity to perform required tasks;
   c. Have successfully completed a home health aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a home health aide training program pursuant to 7.28.2.30 NMAC. Copies of Certified Nurse Aide (CNA) certificates must be maintained in the personnel file of the home health aide;
   d. Be able to communicate successfully with the participant;
   e. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.
   f. Meet any other service qualifications, as specified in the Mi Via NMAC 8.314.6.

D. NUTRITIONAL COUNSELING

Nutritional Counseling services are designed to meet the unique food and nutritional needs of Mi Via participants. This does not include oral- motor skill development services, such as those provided by a speech pathologist.

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Scope of Services

Services and/or supports provided under Nutritional Counseling services include but are not limited to:

i. Assessment of nutritional needs;
ii. Development and/or revision of the participant's nutritional plan; and
iii. Counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan.

Provider Qualifications - Individual Provider

Individual provider qualifications are as follows:

i. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
ii. Be licensed per the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A-7 et. seq.; current registration as a dietician by the Commission on Dietetic Registration of the American Dietetic Association.

Provider Qualifications – Vendor Agency

A Nutritional Counseling Provider Agency may be a group of nutritional counseling group practice or a group practice that employs nutritional counselors. The agency must meet requirements as outlined in a nutritional counseling provider agency application approved by HSD or its designee, including a business license, financial solvency training requirements, records management, quality assurance policy and processes.

Vendor Agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;
iii. Meet financial solvency;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
v. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;

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vi. Must have proof of records being maintained in accordance with waiver standards;
vii. Ensure that all individuals providing the services are licensed per the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A-7 et. seq.; current registration as dieticians by the Commission on Dietetic Registration of the American Dietetic Association.

E. PRIVATE DUTY NURSING FOR ADULTS

Private Duty Nursing for Adults is for participants 21 years and older. Services include activities, procedures, and treatment for a participant's physical condition, physical illness or chronic disability.

Scope of Services

Private duty nursing services for adults may include performance, assistance, and education with the following tasks:

i. Medication management, administration and teaching;
ii. Aspiration precautions;
iii. Feeding tube management, gastrostomy and jejunostomy care;
iv. Skin care;
v. Weight management;
vi. Urinary catheter management;
vii. Bowel and bladder care;
viii. Wound care;
ix. Health education and screening;
x. Infection control;
xi. Environmental management for safety;
xii. Nutrition management;
xiii. Oxygen management;
xiv. Seizure management and precautions;
xv. Anxiety reduction;
xvi. Staff supervision; and
xvii. Behavior and self-care assistance.

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Provider Qualifications - Individual Provider

Individual Provider qualifications are as follows:

i. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
ii. Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN;
iii. Demonstrate capacity to perform required tasks;
iv. Be able to communicate successfully with the participant;
v. Meet any other service qualifications, as specified in the Mi Via regulations.

Provider Qualifications – Vendor Agency

Vendor agency qualifications are as follows:

i. Licensed in New Mexico as a Home Health Agency, Rural Health Clinic or Federally Qualified Health Center (FQHC Agency);
ii. Have a current business license issued by the state, county or city government;
iii. Provide a tax identification number;
iv. Meet financial solvency;
v. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
vi. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
vii. Must have proof of records being maintained in accordance with waiver standards;
viii. Develop and adhere to Quality Improvement (QI) strategies as required per the waiver Service Standards and DDSD Waiver Provider Agreement;
ix. Ensure that all individuals providing the services meet the criteria specified in this section:
    a. Licensed by the New Mexico State Board of Nursing as a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
    b. Demonstrate capacity to perform required tasks;
    c. Be able to communicate successfully with the participant;

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d. Meet any other service qualifications, as specified in the Mi Via regulations.

F. RESPITE

Respite is a flexible family support service that provides intermittent support to the participant and gives the primary, unpaid caregiver time away from their duties. Respite services are furnished on a short-term basis and can be provided in the participant's home, the provider's home, in community setting of the family's choice (e.g., community center, swimming pool and park), or at a center in which other individuals are provided care.

If there is a paid primary caregiver residing with the participant providing living supports and/or community membership supports, respite services cannot be utilized.

Respite services may be provided by eligible individual respite providers; licensed registered (RN) or practical nurses (LPN); or respite provider agencies.

Scope of Services

Respite services include, but are not limited to the following:

i. Assist with routine activities of daily living (e.g. bathing, toileting, preparing or assisting with meal preparation and eating);
ii. Enhance self-help skills, leisure time skills and community and social awareness;
iii. Provide opportunities for leisure, play and other recreational activities;
iv. Provide opportunities for community and neighborhood integration and involvement;
v. Ensure each individual has a choice of and access to non-disability specific settings;
vi. Provide opportunities for the participant to make their own choices with regards to daily activities.
vii. Respite services do not include the cost of room and board;
viii. Cannot be used for purposes of day-care; and
ix. Cannot be provided to school age children during school (including home school) hours.
x. Utilize the state approved EVV system to meet EVV requirements.

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Provider Qualifications – Individual Provider

Individual Provider qualifications are as follows:

i. Be at least 18 years of age;
ii. Be qualified to perform the service and demonstrate capacity to perform required tasks;
iii. Be able to communicate successfully with the participant;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
v. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC prior to initial hire and every three years after initial hire.
vi. Complete participant specific training: the evaluation of training needs is determined by the participant or their legal representative; participant is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Mi Via participant's AAB;
vii. Meet any other service qualifications, as specified in the Mi Via regulations; and
viii. Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN.

Provider Qualifications – Vendor Agency

Vendor agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;
iii. Meet financial solvency;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
v. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;

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vi. Must have proof of records being maintained in accordance with waiver standards;

vii. Ensure all assigned staff meet the following qualifications:

a. Be at least 18 years of age;
b. Be qualified to perform the service and demonstrate capacity to perform required tasks;
c. Be able to communicate successfully with the participant;
d. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
e. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.
f. Complete participant specific training: the evaluation of training needs is determined by the participant or their legal representative; participant is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the Mi Via participant's AAB;
g. Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN; and
h. Meet any other service qualifications, as specified in the Mi Via regulations.

G. SKILLED THERAPIES FOR ADULTS

Extended Skilled Therapy for Adults may include physical therapy, occupational therapy, or speech language therapy when skilled therapy services under the Medicaid State Plan are exhausted or are not a benefit. Adult participants, 21 years and older, in Mi Via with rehabilitation needs related to illness or injury may access therapy services under the Medicaid State Plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to adults in Mi Via are intended to focus on long-term habilitative/health maintenance not covered under the Medicaid State Plan to focus on health maintenance, improving functional independence,

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community integration, socialization, exercise or to enhance supports and normalization of family relationships.

Therapy Practitioners may also include Physical Therapy Assistants (PTA) or Certified Occupational Therapy Assistants (COTA) providing services in collaboration with their supervisor.

Physical Therapy

Physical therapy is the diagnosis, assessment, treatment, and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance, and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy prevents the onset, symptoms and progression of impairments, functional limitations, and disability that may result from diseases, disorders, conditions, or injuries.

Occupational Therapy

Occupational therapy is the diagnosis, assessment, treatment, and management of functional limitations intended to assist adults to regain, maintain, develop and build skills that are important for independence, functioning and health. Occupational Therapy addresses physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

Speech Language and Pathology

Speech and language pathology is the diagnosis, counseling and instruction related to the development and disorders of communication including speech fluency, voice, verbal language, written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal and sensorimotor competencies. Speech language pathology is also used when a participant requires the use of an augmentative communication device.

Scope of Services

Physical Therapy

i. Addresses the diagnosis, restoration, maintenance, and promotion of optimal physical function, wellness, and quality of life related to movement and health including;
ii. Diagnostic activities to diagnose physical abnormalities and determine the dysfunction of physical and functional activities;
iii. Prevention of a loss of mobility before it occurs by developing fitness and wellness-oriented programs for healthier and more active lifestyles,
iv. Develop, maintain, and restore maximum movement and functional ability throughout the lifespan,

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v. Provide treatment in circumstances where movement and function are threatened by aging, chronic conditions, or environmental factors.
vi. Activities to increase, maintain or reduce the loss of functional skills;
vii. Treat specific condition(s) clinically related to an individual's qualifying condition or disability;
viii. Activities to support the participant's health and safety needs;
ix. Write treatment program and written strategies to provide guidance to the participant, family, and/or staff in the home related to implementation of non-skilled therapy interventions (e.g., Range of Motion Protocols, AT Maintenance Protocols, Fitness and Wellness Protocols);
x. Identify, implement, and train on therapeutic strategies to support the participant, family and/or staff in the home setting or other environments as addressed in the SSP;
xi. Make assistive technology recommendations and provide usage training for participants, family, and staff
xii. Procure or Fabricate Assistive Technology (AT) as identified as needed and documented in the SSP.
xiii. Consultation and Collaboration with physicians, DME providers, and other medical specialists and clinical professionals regarding the individual's health and AT needs.
xiv. Provide Consultation and input into Assessments for environmental modification requests.
xv. Monitor the progress of the person toward the achievement of therapeutic goals and objectives

Occupational Therapy

i. Diagnostic activities related to skills assessment and treatment;
ii. Addresses physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of context to support engagement in everyday life activities that affect health, wellbeing, and quality of life;
iii. Treat specific conditions clinically related to the individual's
iv. developmental disability;
v. Write treatment program and written strategies to improve one's ability to perform daily tasks;
vi. Comprehensive home, employment and/or volunteer sites evaluations with adaptation recommendations;
vii. Provide guidance to family members and caregivers;

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viii. Support the participant's health and safety needs;
ix. Provide support to increase or maintain functional skills or reduce the loss of functional skills;
x. Make assistive technology recommendations and provide usage training for participants, family and staff;
xi. Procure or Fabricate Assistive Technology (AT) as identified as needed and documented in the SSP.
xii. Consultation and Collaboration with physicians, DME providers, and other medical specialists and clinical professionals regarding the individual's health and AT needs.
xiii. Identify, implement, and train on therapeutic strategies to support the participant, family and/or staff in the home setting or other environments as addressed in the SSP;
xiv. Provide Consultation and input into Assessments for environmental modification requests; and
xv. Monitor the progress of the person toward the achievement of therapeutic goals and objectives.

Speech and Language Pathology

i. Improve or maintain the participant's capacity for successful communication or to lessen the effects of the participant's loss of communication skills;
ii. Treat specific conditions clinically related to the individual's
iii. developmental disability
iv. Write treatment program to improve one's functional communication
v. Identification and fabrication or procurement of augmentative communication devices/systems.
vi. Consultation on usage and training on augmentative communication devices/systems;
vii. Activities to improve or maintain the individual's ability to eat food, drink liquid and manage oral secretions with minimal risk of aspiration or other injuries or illness related to swallowing disorders; and
viii. Activities to identify, implement and train on therapeutic strategies to support the participant, their family and/or staff consistent with the
ix. participant's SSP.
x. Diagnostic activities to diagnose physical abnormalities and determine the dysfunction of physical and functional activities; and
xi. Monitor the progress of the person toward the achievement of therapeutic goals and objectives

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Delivery of Therapy Services/Service Setting

Therapy services must be delivered in mutually agreed upon settings with the participant. Services may be provided in the home, community, or other modality (pool, horsemanship program, etc.) that meet the participant's needs. Although it is anticipated the majority of therapy services will be provided face-to-face with the individual, it is recognized some services may be provided when the individual is not present. Services that may be provided when a participant is not present include the following:

1. Development of Written Treatment Programs
2. Development of Written Strategies/Guidelines for therapeutic interventions
3. Fabrication/Procurement of Assistive Technology (AT)
4. Fabrication or Procurement of Augmentative Communication Systems.
5. Development of Written Justification Letters or Requests for Assistive Technology, Equipment or Environmental Modifications.
6. Consultation and Collaboration with physicians, DME providers, and other medical specialists and clinical professionals regarding the individual's health and AT needs.

Provider Qualifications – Individual Therapist Provider

Individual Therapist Provider qualifications are as follows:

i. Provide a tax identification number.

ii. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan; Participant's service and support plan; Reports as requested in the service and support plan; Contact notes; Training roster(s); and Assessments for environmental modification requests.

iii. Licensures:

a. Physical Therapist, Physical Therapy Assistant and Student

1. Physical therapists or a Physical Therapy Assistant will be licensed as per the New Mexico Regulation and Licensing Department; Physical Therapy Act NMSA 1978, Section 61-12-1.1 et.seq. Physical Therapy Assistants must possess a Therapy license in their respective field from the New Mexico Regulation and Licensing Department;

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2. A licensed Physical Therapy Assistant (PTA) may perform physical therapy procedures and related tasks pursuant to a plan of care/therapy intervention plan written by the supervising physical therapist in accordance with the PT Licensing Act.
3. A student physical therapist or a student physical therapist assistant may provide billable physical therapy services if a formal academic intern agreement is signed by the therapy Provider Agency and the university, and 100% direct on-site supervision is provided for evaluation and treatment services by a licensed physical therapist or physical therapy assistant who is an approved Mi Via Waiver therapist.

b. Occupational Therapists, Certified Occupational Therapy Assistants and Level II Student Interns

1. Occupational therapists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-12A-1et.seq.; Occupational Therapy Assistants must possess a Therapy license in their respective field from the New Mexico Regulation and Licensing Department and
2. An Occupational Therapy Practitioner (OT) or Certified Occupational Therapy Assistant (COTA) with a current and active license issued by the New Mexico Regulation and Licensing Department may provide billable occupational therapy services in accordance with the current NM OT Licensing Board/OT Practice Act and applicable American Occupational Therapy Association (AOTA) guidance documents.
3. A Level II Student Intern from an AOTA accredited university may provide billable services on behalf of an occupational therapy Provider Agency if a formal academic intern agreement is signed by the Therapy Provider Agency and the student's university. An OT Student must receive 100% direct on-site supervision during client evaluation and treatment by a Mi Via Waiver OT (for OT students) or a Mi Via Waiver OT and OTA as applicable (for OTA students). The supervising OT shall review and approve all support services such as non-direct

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Assistive Technology services. The supervising OT shall review and sign all therapy related reports/documentation completed by the Level II Student Intern.

4. An Occupational Therapy Aide/Technician or a Level I Student Intern is not permitted to provide billable occupational therapy services to DD Waiver participant.
5. Occupational Therapy Assistants (COTAs) may perform occupational therapy procedures and related tasks pursuant to a therapy intervention plan written by the supervising OT and in accordance with the current NM OT Licensing Act.

c. Speech and Language Pathologists will be licensed as per the New

1. Mexico Regulation and Licensing Department; Speech and Language Therapy Act NMSA 1978, Section 61-14B-1et.seq.; Speech Clinical Fellows must possess a Clinical Fellow License from the New Mexico Regulation and Licensing Department.

Provider Qualifications – Vendor Agency

Vendor agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;
iii. Meet financial solvency;
iv. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan; Participant's service and support plan; Reports as requested in the service and support plan; Contact notes; Training roster(s); and Assessments for environmental modification requests.
v. Develop and adhere to quality assurance rules and requirements;
vi. Ensure therapists have appropriate license for service:
    a. Physical therapists, or Physical Therapy Assistant will be licensed as per the New Mexico Regulation and Licensing Department; Physical Therapy Act NMSA 1978, Section 61-12-1.1 et.seq. Physical Therapy Assistants must possess a Therapy license in their respective field from the New Mexico Regulation and Licensing Department;
    b. A licensed Physical Therapy Assistant (PTA) may perform physical therapy procedures and related tasks pursuant to a plan of care/therapy

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intervention plan written by the supervising physical therapist in accordance with the PT Licensing Act.

c. A student physical therapist or a student physical therapist assistant may provide billable physical therapy services if a formal academic intern agreement is signed by the therapy Provider Agency and the university, and 100% direct on-site supervision is provided for evaluation and treatment services by a licensed
d. physical therapist or physical therapy assistant who is an approved Mi Via Waiver therapist.
e. Occupational therapists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-12A-1et.seq.; Occupational Therapy Assistants must possess a Therapy license in their respective field from the New Mexico Regulation and Licensing Department and
f. Occupational therapists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-12A-1et.seq.; Occupational Therapy Assistants must possess a Therapy license in their respective field from the New Mexico Regulation and Licensing Department
g. An Occupational Therapy Practitioner (OT) or Certified Occupational Therapy Assistant (COTA) with a current and active license issued by the New Mexico Regulation and Licensing Department may provide billable occupational therapy services in accordance with the current NM OT Licensing Board/OT Practice Act and applicable American Occupational Therapy Association (AOTA) guidance documents.
h. A Level II Student Intern from an AOTA accredited university may provide billable services on behalf of an occupational therapy Provider Agency if a formal academic intern agreement is signed by the Therapy Provider Agency and the student's university. An OT Student must receive 100% direct on-site supervision during client evaluation and treatment by a Mi Via Waiver OT (for OT students) or a Mi Via Waiver OT and OTA as applicable (for OTA students). The supervising OT shall review and approve all support services such as non-direct Assistive Technology services. The supervising OT shall review and sign all therapy related reports/documentation completed by the Level II Student Intern.
i. An Occupational Therapy Aide/Technician or a Level I Student Intern is not permitted to provide billable occupational therapy services to DD Waiver participant.

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j. Occupational Therapy Assistants (COTAs) may perform occupational therapy procedures and related tasks pursuant to a therapy intervention plan written by the supervising OT and in accordance with the current NM OT Licensing Act.
k. Speech and Language Pathologists will be licensed as per the New Mexico Regulation and Licensing Department; Speech and Language Therapy Act NMSA 1978, Section 61-14B-1et.seq.; Speech Clinical Fellows must possess a Clinical Fellow License from the New Mexico Regulation and Licensing Department.

H. SPECIALIZED THERAPIES

Specialized therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. Services must be related to the participant's disability or condition, ensure the participant's health and welfare in the community. The service will supplement (not replace) the participant's natural supports and other community services for which the participant may be eligible.

Experimental or investigational procedures, technologies or therapies and those services covered in Medicaid state plans are excluded. Only the specific specialized therapy services outlined below are covered in the Mi Via program.

Scope of Services

Acupuncture

Acupuncture is a distinct system of primary health care. The goal of acupuncture is to prevent, cure or correct any disease, illness, injury, pain or other physical or behavioral health condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increase mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits. See Acupuncture and Oriental Medicine Practitioners 16.2.1 NMAC.

Biofeedback

Biofeedback uses visual, auditory or other monitors to provide a participant with physiological information of which they are normally unaware. This technique enables a participant to learn how to change physiological, psychological and

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behavioral responses for the purposes of improving emotional, behavioral and cognitive health performance. Biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm or weakness.

Chiropractic

Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis. Chiropractic care restores and maintains health for treatment of human disease primarily by, but not limited to, adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, increase range of motion and lead to improved general health. See Chiropractic Practitioners 16.4.1 NMAC.

Cognitive Rehabilitation Therapy

Cognitive rehabilitation therapy is designed to improve cognitive functioning by reinforcing, strengthening, or re-establishing previously learned patterns of behavior or establishing new patterns of cognitive activity or compensatory mechanisms of impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory, language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome a participant's specific cognitive problems.

Collaborative Consultative Model

The Collaborative-Consultative therapy service delivery model is encouraged to be followed by therapists providing therapy under the Mi Via Waiver. The role of the therapist is to design and train supportive/adaptive strategies through direct collaboration with the person, DSP and other supports. Purposes for collaboration and consultation include the following:

a. to ensure that therapy provided under the Mi Via Waiver is of the highest quality and professionally appropriate;
b. to coordinate therapy interventions and ensure consistent approaches;

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c. to share information as it pertains to the person receiving services;

d. to perform specialty evaluations, as needed and

e. to provide cross-over training and to respond to special requests for assistance.

Hippotherapy

Hippotherapy is provided by a licensed physical, or occupational therapist or speech language pathologist as a physical, occupational and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for a participant with movement dysfunction and may increase mobility and rage of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the participant use cognitive functioning especially for sequencing and memory. Participants with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities and individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production. Hippotherapy must be performed by a physical therapist, occupational therapist or speech therapist licensed by the New Mexico Regulation and Licensing Department.

Massage Therapy

Massage therapy is the assessment and treatment of soft tissues and their dysfunction for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising range of motion and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a participant's ability to be more independent in the performance of activities of daily living; thereby, decreasing dependency upon others to perform or assist with basic daily

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activities. See Massage Therapists 16.7.1 NMAC.

Naprapathy

Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and joints and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interferes with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function. See Naprapathic Practitioners 16.6.1 NMAC.

Play Therapy

Play therapy is a variety of play and creative arts techniques (e.g., Play Therapy Tool Kit) utilized to alleviate chronic, mild, and moderate psychological and emotional conditions for a participant that are causing behavioral problems and/or are preventing the participant from realizing his or her potential. The play therapist works interactively using a wide range of play and creative arts techniques, mostly responding to the participant's wishes.

Provider Qualifications – Individual Provider

Individual Provider qualifications are as follows:

i. Current New Mexico state licensure from the New Mexico Regulation and Licensing Department or New Mexico certification as applicable:
    a. Acupuncture and Oriental Medicine license
    b. Biofeedback – license or certification with appropriate specialized training, clinical experience, and supervision whose scope of practice includes biofeedback.
    c. Licensed in Chiropractic Medicine
    d. Cognitive Rehabilitation Therapy – license or certification for which he or she has appropriate specialized training, clinical experience, and supervision whose scope of practice includes cognitive rehabilitation therapy.
    e. Hippotherapy – licensed as a physical therapist, occupational therapist or speech therapist through the New Mexico Regulation and Licensing Department whose scope of practice includes

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hippotherapy with the appropriate specialized training and experience.

f. Licensed in Massage Therapy
g. Licensed in Naprapathic Medicine
h. Play therapy – a master's degree or a higher-level behavioral health degree with specialized play therapy training, clinical experience and supervision whose licensed scope of practice includes play therapy.

Provider Qualifications – Vendor Agency

Vendor agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;
iii. Meet financial solvency;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
v. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
vi. Must have proof of records being maintained in accordance with waiver standards;
vii. Group practice/vendor staff must hold current New Mexico state licensure from the New Mexico Regulation and Licensing Department or New Mexico certification as applicable:
    a. Acupuncture and Oriental Medicine license
    b. Biofeedback – license or certification with appropriate specialized training, clinical experience, and supervision whose scope of practice includes biofeedback.
    c. Licensed in Chiropractic Medicine
    d. Cognitive rehabilitation therapy – license or certification for which he or she has appropriate specialized training, clinical experience and supervision whose scope of practice includes cognitive rehabilitation therapy.
    e. Hippotherapy – licensed as a physical therapy or occupational therapist or speech therapy and whose scope of practice includes

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hippotherapy with the appropriate specialized training and experience.

f. Licensed in Massage Therapy
g. Licensed in Naprapathic Medicine
h. Play therapy – a master's degree or a higher-level behavioral health degree with specialized play therapy training, clinical experience and supervision whose licensed scope of practice includes play therapy.

OTHER SERVICES

A. EMERGENCY RESPONSE SERVICES

Emergency Response Services (ERS) provide an electronic device that enables a participant to secure help in an emergency at home and thereby avoids institutionalization. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center when a "help" button is activated. The response center is staffed by trained professionals.

Scope of Services

Emergency Response Services include, but is not limited to:

i. Testing and maintaining equipment;
ii. Training participants, caregivers and first responders on the use of the equipment;
iii. Twenty-four (24) hour monitoring for alarms;
iv. Checking systems monthly or more frequently if warranted (e.g., electrical outages, severe weather, etc.);
v. Reporting emergencies and changes in the participant's condition that may affect service delivery; and
vi. Initial set-up and installation of ERS devices is not a covered service.

Provider Qualifications – Vendor Agency

Vendor agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;

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iii. Meet financial solvency;
iv. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
v. Comply with all laws, rules and regulations of the state of New Mexico; and
vi. Comply with all laws, rules and regulations from the Federal Trade Communication Commission (FCC) for telecommunications.

B. ENVIRONMENTAL MODIFICATION SERVICES

Environmental modification services include the purchase and/or installation of equipment and/or making physical adaptations to a participant's residence that are necessary to ensure the health, welfare, and safety of the participant or enhance the participant's level of independence. All services shall be provided in accordance with applicable federal, state, and local building codes. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant, such as fences, storage sheds or other outbuildings. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

The environmental modification provider must ensure proper design criteria is addressed in the planning and design of the adaptation, be a licensed and insured contractor(s) or approved vendor(s) to provide construction/re-modeling services, provide administrative and technical oversight of construction projects, provide consultation to family members, waiver providers and contractors concerning environmental modification projects to the participant's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

Environmental modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects.

Environmental modification services are limited to five thousand dollars ($5,000.00) every five (5) years including those previously accessed through any other Medical Assistance Division (MAD) program. Requests for environmental modification services require verification by Mi Via Waiver program coordinator of funds available through the Developmental Disabilities Supports Division (DDSD) Verification of Benefit Availability Form, which can be obtained from the Regional Office.

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For any requests exceeding five thousand dollars ($5,000), the participant is responsible for paying the amount above $5,000 or any portion not covered by their remaining available balance within the five-year period.

Environmental modifications will not be paid for under related goods.

Scope of Services

Environmental modifications include, but not limited to:

i. Installation of ramps and grab-bars;
ii. Widening of doorways/hallways;
iii. Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;
iv. Installation of lifts/elevators;
v. Modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing);
vi. Turnaround space adaptations;
vii. Installation of specialized accessibility/safety adaptations/additions;
viii. Installation of trapeze and mobility tracks for home ceilings;
ix. Installation of automatic door openers/doorbells;
x. Installation of voice-activated, light-activated, motion-activated, and electronic devices;
xi. Installation of fire safety adaptations;
xii. Installation of air filtering devices;
xiii. Installation of heating/cooling adaptations;
xiv. Installation of glass substitute for windows and doors;
xv. Installation of modified switches, outlets or environmental controls for home devices; and
xvi. Installation of alarm and alert systems and/or signaling devices.

Provider Qualifications – Individual Contractor and Agency Contractor

Vendor agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;

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ii. Provide a tax identification number;
iii. Appropriate New Mexico plumbing, electrician, contractor license; and/or
iv. Appropriate technical certification or other New Mexico licensure/certification to perform the modification.

C. INDIVIDUAL DIRECTED GOODS AND SERVICES

Individual Directed Goods and Services (IDGS) are equipment, supplies or fees (such as for conferences or classes) and memberships, not otherwise provided through Mi Via, the Medicaid state plan or through Medicare. Related goods do not include services such as housecleaning, yard maintenance, etc.

IDGS must be documented in the SSP and approved by the TPA. The cost and type of related good is subject to approval by the TPA. Participants are not guaranteed the exact type and model of related good that is requested. The consultant, TPA and the state can work with the participant to find other (including less costly) alternatives.

The goods and services must not be available through another source, and the participant must not have the personal funds needed to purchase the goods. Experimental or prohibited treatments and goods are excluded.

Scope of Services

Individual Goods and Services must:

i. Address a need identified in the participant's service and support plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements:
ii. Be directly related to the participant's qualifying condition or disability; and
iii. Explicitly address a clinical, functional, medical or habilitative need; and
iv. Address a need identified in the participant's SSP; and
v. Support the participant to remain in the community and reduce the risk for institutionalization; and
vi. Promote personal safety and health; and afford the participant an accommodation for greater independence; and
vii. Decrease the need for other Medicaid services; and
viii. Accommodate the participant in managing their household; or
ix. Facilitate activities of daily living; and
x. Advance the outcomes in the participant's SSP.

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Provider Qualifications - Vendor Agency

Vendor agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;

D. TRANSPORTATION

Transportation services are offered in order to enable participants to gain access to waiver and other community services, activities and resources, as specified by the SSP. Transportation services under Mi Via are non-medical in nature, whereas transportation services provided under the Medicaid state plan are to transport participants to medically necessary physical and behavioral health services. Transportation for the purpose of vacation is not covered through the Mi Via program.

Transportation is reimbursed in several different ways to the driver: by the mile, by the trip or at an hourly rate. It may also be paid through the purchase of a bus pass, money network card or Uber gift card. Payments are made to the participant's individual transportation employee or vendor or to a public or private transportation service vendor. Payments cannot be made to the participant. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge shall be identified in the SSP and utilized. Transportation services for minors are not a covered service as these are services that a LRI would ordinarily provide for household members of the same age who do not have a disability or chronic illness. Payments are limited to transportation costs required to access approved SSP activities. Mi Via transportation is non-medical, designed to help participants connect with their community and access waiver-related activities. Ride share under Mi Via cannot be used for medical transportation.

Scope of Services

Transportation services must:

i. The service will be provided as specified in the participant's service and support plan and budget.
ii. Cannot be used instead of or to replace transportation services available under the Medicaid state plan.

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Provider Qualifications - Individual Provider

Individual Provider qualifications are as follows:

i. Be at least 18 years of age;
ii. Possess a valid New Mexico driver's license with the appropriate classification; and
iii. Possess and maintain current insurance policy and registration.
iv. Must pass a criminal history and background check and the nationwide caregiver criminal history screening and employee abuse registry prior to providing services; and
v. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation.

Provider Qualifications – Vendor Agency

Vendor agency qualifications are as follows:

i. Have a current business license issued by the state, county or city government;
ii. Provide a tax identification number;
iii. Meet Financial solvency;
iv. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation;
v. Develop and adhere to a records management policy and maintain individual records for each participant within HIPAA compliance. The agency will maintain a confidential case file for each individual that includes but is not limited to documentation of activities, progress and scope of work outlined in the participant's service and support plan;
vi. Have a current basic First Aid kit in the vehicle;
vii. Ensure drivers meet individual qualifications:
    a. Be at least 18 years of age;
    b. Possess a valid New Mexico driver's license with the appropriate classification;
    c. Possess current insurance policy and registration;
    d. Must pass a criminal history and background check and the nationwide caregiver criminal history screening and employee abuse registry prior to providing services; and
    e. Complete initial and annual training requirements set forth in DDSD Policy, and periodic training updates and supplemental requirements as issued by DDSD including, but not limited to, critical incidents, abuse, neglect and exploitation.

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Appendix A: SERVICE AND SUPPORT PLAN

The Service and Support Plan, instructions and training can be found:

Mi Via Services & Supports – New Mexico Health Care Authority

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Appendix B: RANGE OF RATES

See the updated fee schedule for details, found at the Health Care Authority website:

Fee Schedules – New Mexico Health Care Authority

https://www.hca.nm.gov/providers/fee-schedules/

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Appendix C: DEFINITIONS AND ACRONYMS

1915c Waiver Programs - Programs in which the federal government (Centers for Medicare and Medicaid Services (CMS)) has waived certain statutory requirements of the Social Security Act to allow states to provide an array of home and community-based services (HCBS) options through the Health Care Authority's (HCA) Developmental Disabilities Supports Division (DDSD) as an alternative to providing long-term care services in an institutional setting.

Abuse - Includes: (1) knowingly, intentionally, and without justifiable cause inflicting physical pain, injury or mental anguish; (2) the intentional deprivation by a caretaker or other person of services necessary to maintain the mental and physical health of a person; or (3) sexual abuse, including criminal sexual contact, incest and criminal sexual penetration.

Access Rule - A federal rule governing home and community-based services (HCBS) programs. The rule focuses on improving access to and the quality of HCBS by focusing on the home maker, home health aide, or personal care services. General areas of relevance to HCBS waivers are person-centered planning, HCBS grievance system, incident management systems, HCBS Quality Measure Set, access reporting, payment adequacy and transparency, and standardization of HCBS reporting requirements and transparency.

Activities of Daily Living (ADLs) - Basic personal everyday activities that include bathing, dressing, transferring (e.g., from bed to chair), toileting, mobility and eating.

Adult - An individual who is eighteen (18) years of age or older.

Advisory Council on Quality (ACQ) - A council that advises DDSD on the systems guiding the provision of services and supports that assist people with intellectual and developmental disabilities (IDD) of all ages and their families to be fully included in their communities.

Affiliated Agency - A direct service agency providing waiver services that has a marital, domestic partner, blood, business interest or holds financial interest in providing direct care for individuals receiving waiver services.

Annual - A twelve (12) month period.

Authorized Annual Budget (AAB) - The total annual amount of Mi Via Waiver (Mi Via) services and goods approved by the Third-Party Assessor (TPA), based on the budget request developed by the eligible recipient and their consultant, which specifies the

frequency, amount, duration, and cost of the services and goods included.

Authorized Representative – The individual designated, by the eligible recipient or their guardian, as applicable, to represent and act on the recipient's behalf.

Category of Eligibility (COE) - The Medicaid eligibility category assigned to an individual based on the program through which they qualify

Centers for Medicare and Medicaid Services (CMS) – The federal agency within the United States Department of Health and Human Services (HHS) that works in partnership with New Mexico (NM) to administer Medicaid and Medical Assistance Program (MAP) services under the NM Health Care Authority (HCA).

Centers for Medicare and Medicaid Services (CMS) Final Rule: Settings Requirements A federal rule that requires all home and community-based services (HCBS) 1915(c) waiver settings to be integrated in the community and to ensure full access, meaningful choice, autonomy, privacy, dignity, freedom from coercion, opportunities for competitive employment, and choice of services and providers for people receiving HCBS.

Change in Condition or Health Status - When a person experiences one or more of the following: a decline in physical, cognitive, or functional ability; a life change; or a new diagnosis or event that requires the creation or revision of a healthcare plan.

Chemical Restraint-The administration of medication at a dose and/or frequency 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.

Code of Federal Regulations (CFR) - A compilation of mandatory laws that have been created by several federal regulatory agencies.

Community Inclusion - The opportunity for people with intellectual and developmental disabilities (IDD) to access and participate in activities and functions of community life, including community integrated employment.

Community Inclusion and Supported Employment (CI/SE) Unit - A DDSD unit consisting of Statewide Community Inclusion and Employment staff and Regional Office Community Inclusion Coordinators, functioning as a group of Subject Matter Experts (SME's) responsible for systemically implementing Employment First and Community Life Engagement statewide.

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Competitive Integrated Employment (CIE) - Work performed by an individual on a part-time or full-time basis, including self-employment, in an integrated community setting where the person earns competitive wages and has access to the same benefits, workplace interactions, and opportunities for advancement as workers without disabilities performing similar tasks

Consultant Provider Agency (CA) – An agency that delivers case management services to Mi Via Waiver (Mi Via) recipients; these services assist recipients with arranging, coordinating, and monitoring Mi Via Waiver (Mi Via) supports.

Corporate Guardian - A private non-profit corporation or unincorporated association that is established to provide guardianship services for individuals age 17 years and 9 months or older who have been determined by a court to be incompetent.

Department of Vocational Rehabilitation (DVR) A state and federally funded program designed to help eligible individuals with documented disabilities find suitable employment.

Developmental Disabilities Supports Division (DDSD) - A division of the New Mexico Health Care Authority (HCA) that serves individuals with intellectual and developmental disabilities (IDD) by providing a comprehensive system of person-centered community supports, enabling people to live the lives they prefer in environments where they are respected, empowered, and free from abuse, neglect, and exploitation.

Developmental Disabilities Waiver (DDW) – A Medicaid home and community-based services (HCBS) waiver that offers comprehensive supports to eligible children and adults with intellectual and developmental disabilities (IDD) through an agency-based service delivery model, in which participants select approved provider agencies to deliver the services and supports needed to live in their communities as an alternative to institutional care, in accordance with New Mexico Administrative Code (NMAC) 8.314.5 and all other applicable Medicaid requirements.

Dignity of Risk - The philosophy that everyone has the freedom to make decisions and choices in their lives that may expose them to a level of risk.

Division of Health Improvement (DHI) - The division of the Health Care Authority (HCA) that serves as the regulatory entity responsible for providing compliance oversight for home and community-based services (HCBS) Medicaid waiver providers.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – A set of comprehensive and preventative health care services for children under the age of 21 who are enrolled in Medicaid.

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Electronic Visit Verification (EVV)- A telephone- and computer-based system that electronically verifies the occurrence of selected services by documenting the precise time and location at which each authorized visit begins and ends, as required by the 21st Century CURES Act.

Eligible Recipient - An applicant who meets the financial and medical level-of-care (LOC) criteria and is approved to receive services through the Developmental Disabilities (DD) Waiver, Medically Fragile Waiver (MFW), or Mi Via Waiver (Mi Via).

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.

Environmental Concerns- Accessibility barriers: Obstacles or environmental layouts that limit mobility, excessive clutter preventing navigation or safe exits from the home, use of adaptive equipment, or safe navigation within the home
Utility disruptions: Lack of essential utilities such as water, electricity, heating, or cooling
instability: Conditions that threaten the continuity of residence (e.g., eviction risk, condemnation, or severe overcrowding)
External environmental threats: Immediate neighborhood or surrounding factors that impact safety (e.g., hazardous waste nearby, unsafe access routes), loss of benefits
A condition is considered an environmental concern when it is present, observable, or credibly reported, and has the potential to negatively impact the participant's health, safety, rights, or service delivery in the future. An environmental concern may rise to the level of an environmental hazard (i.e. neglect), when the condition is pervasive, on-going and all attempts at intervention have been unsuccessful.

Enhanced Staffing- The provision of staffing above the standard service ratio, including additional direct support staff, one-to-one staffing, or increased supervision, to address an individual's assessed behavioral, medical, psychiatric, safety, or community participation needs.

Exploitation - An unjust or improper use of a person's money or property for another person's profit or advantage, whether financial or otherwise

Face-to-Face - A mode of service delivery in which support is provided in the physical presence of the person with intellectual and developmental disabilities (IDD) or, when appropriate, the family of a child with IDD.

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Fair Hearing - An evidentiary hearing that is conducted by the Health Care Authority's (HCA) Office of Fair Hearings (OFH) so that evidence may be presented as it relates to an adverse action taken, or intended to be taken, by the HCA Medical Assistance Division (MAD), its utilization review (UR) contractor, or the Managed Care Organization (MCO).

Fiscal Management Agency (FMA) – The Health Care Authority's (HCA) Medical Assistance Division (MAD) contractor that helps self-directed participants implement the Authorized Annual Budget (AAB) by paying the eligible recipient's service providers and tracking expenses

FMA On-line System – The on-line system used by the Fiscal Management Agency (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.

Grievance - An expression of dissatisfaction or complaint submitted by a DDSD constituent or stakeholder to the DDSD Office of Constituent Support (OCS) that may relate to, but is not limited to, the states or a provider's performance of person-centered planning, service plan requirements, or home and community-based services (HCBS) settings requirements, regardless of whether the beneficiary requests remedial action.

Grievance System - The processes the DDSD Office of Constituent Support (OCS) implements to collect, track, and address each constituent grievance.

Guardian - A person appointed by the court to make certain decisions for an individual who has been determined to lack capacity, or the custodial parent(s) if the individual is a minor

Health Care Authority (HCA) - The state government department responsible for ensuring that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services through coordinated coverage, strategic purchasing, partnerships, and data-driven innovation.

Health Insurance Portability and Accountability Act (HIPAA) – A federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the individual's consent or knowledge.

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Home and Community Based Services (HCBS) waiver – Types of person-centered services and supports delivered in the home and community.

Incident Management Bureau (IMB) - The Division of Health Improvement (DHI) bureau responsible for conducting investigations and tracking data related to reported allegations of abuse, neglect, and exploitation (ANE) to improve the quality of services and prevent the abuse, neglect, and exploitation of individuals receiving services from home and community-based services (HCBS) waiver programs

Individual Budgetary Allotment (IBA) – The maximum budget allotment available to an eligible recipient on the Mi Via Waiver (Mi Via), based on age.

In-Home Assessment (IHA)- Assessment conducted in the participant's current living environment (or a location approved by the State) by the Third-Party Assessor (TPA) to help determine initial and ongoing medical eligibility.

Instrumental Activities of Daily Living (IADL) - Activities related to independent living, including meal preparation, money management, grocery or personal shopping, light or heavy housework, and communication.

Intellectual and Developmental Disabilities (IDD) - Disability conditions in which an individual either has an intellectual disability with onset before age 18 or has a related condition such as Cerebral Palsy, Autism Spectrum Disorder, Down Syndrome, or Epilepsy, and has significant limitations in at least three major life activities that began before age 22.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) – Facilities that are licensed and certified by the Health Care Authority (HCA) to provide room and board, continuous active treatment, and other services for eligible recipients with a primary diagnosis of intellectual disabilities or related conditions. They must hold a current license issued by the HCA.

Legally Responsible Individual (LRI) – A person who has a duty under state law to care for another person, including the parent (biological, legal, or adoptive) of a minor child, a guardian responsible for the care of an eligible recipient under 18 years of age, or the spouse of an eligible recipient, as defined in 8.314.6.7 NMAC, but not the parent of an adult even if the parent is the legal guardian.

Managed Care Organizations (MCO) - Health plans that provide health care services to Medicaid members.

Mechanical Restraint-Any device attached or adjacent to an individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

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Medically Fragile (MF) - A chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following: a life threatening condition characterized by reasonable frequent periods of acute exacerbation which require frequent medical supervision, or physician consultation and which in the absence of such supervision or consultation would require hospitalization; a condition requiring frequent, time consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include but are not limited to ventilators, dialysis machines, enteral or parenteral nutrition support and supplemental oxygen

Medically Fragile (MF) Waiver – A Medicaid home and community-based services (HCBS) waiver for individuals whose primary eligibility is based on complex medical needs prior to age of 22 and who may also be at risk of developmental disability, delivered through an agency-based model in which participants select approved provider agencies to deliver the services and supports needed to live in their communities as an alternative to institutional care.

Mi Via Waiver – A Medicaid home and community-based services (HCBS) waiver for individuals with intellectual and developmental disabilities (IDD) that uses a self-directed service delivery model in which the participant or their designated Support Broker hires, trains, and manages their own support staff.

Money Network Card - An optional payroll card used by Mi Via Waiver (Mi Via) participants and employees to receive payments in place of direct deposit, which is also used to pay for approved services added to the participant's budget and processed through a Vendor Payment Request (VPR).

Natural Supports - Unpaid personal associations and relationships typically developed in the community that enhance the quality and security of life for people, including, but not limited to, family relationships; friendships reflecting the diversity of the neighborhood and the community; association with fellow students or employees in regular classrooms and workplaces; and associations developed through participation in clubs, organizations, and other civic activities.

Neglect - The failure of the caretaker to provide basic needs of a person, such as clothing, food, shelter, supervision, and care for the physical and mental health of that person.

New Mexico Administrative Code (NMAC) - The official collection of New Mexico's current rules and regulations written and filed by state agencies to clarify and interpret laws passed by the Legislature.

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New Mexico Consolidated On-Line Registry (NMCOR)- An application that provides a one-stop repository for New Mexico 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.

Participant – An individual who meets program eligibility requirements and is approved to receive services.

Participant-Directed - The provision of opportunities for a waiver participant to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.

Personal Care – A service that provides support for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Personal Emergency Response System - An electronic device that enables a person to secure help in an emergency.

Personal Representative (PR) – An individual selected to act as his or her personal representative for the purpose of offering support and assisting the eligible recipient understand his or her Mi Via Waiver (Mi Via) services.

Person-Centered Plan - A written plan directed by the individual, that outlines their goals, preferences, needs, and the specific supports and services they choose to help them live the life they want in the most integrated community setting.

Person-Centered Planning (PCP) - A planning process that is directed and led by an individual with intellectual and developmental disabilities (IDD) with assistance as needed or desired from a representative or other persons of the individual's choosing designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the individual.

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.

Primary Care Practitioner (PCP) – A person's primary medical care provider, usually a Medical Doctor, Physician's Assistant, or Certified Nurse Practitioner.

Prior Authorization - The process of obtaining authorization prior to the person receiving services.

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Quality Assurance and Quality Improvement (QA/QI) – A process utilized by state and federal governments, programs and providers whereby appropriate oversight and monitoring of home and community-based services (HCBS) waiver programs of waiver assurances and other measures provide information about the health and welfare of participants and the delivery of appropriate services.

Quality Management Bureau (QMB) – A bureau of the Division of Health Improvement (DHI) that conducts compliance surveys of providers holding a provider agreement with DDSD to determine compliance with federal and state standards, ensure the health, safety, and welfare of people receiving services through the Developmental Disabilities (DD) Waiver, Medically Fragile Waiver (MFW), and Mi Via Waiver (Mi Via), and identify opportunities for improvement among these providers.

Reconsideration – A written request submitted on behalf of a participant to request that a review decision made by the Third-Party Assessor be reviewed again.

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 challenging behavior.

Regional Office Request for Assistance (RORA)- A system for internal or external stakeholders to request assistance from DDSD.

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.

Self-Determination - The process by which people with intellectual and developmental disabilities (IDD) have control over the planning and delivery of their long-term services and supports, including choices about who provides their services, how services are delivered, and how their service budget is used.

Self- Direction – A service delivery model in which the individual receiving services (or their representative) have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports

Service and Support Plan (SSP) – A person-centered plan used in the Mi Via Waiver (Mi Via) that includes, but is not limited to, the waiver services chosen by the participant; the projected amount, frequency, and duration of services and goods; the types of supports; who will furnish each service or good; other services and goods the participant will use (regardless of funding source); and the participant's available natural and informal supports that will complement waiver services in meeting their needs

Shared Household - A private residence (not a group home or other facility) in which two (2) or more waiver recipients live.

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Support Broker - The individual responsible for directing the paid supports provided to a Mi Via Waiver (Mi Via) participant, including recruiting, selecting, managing, and ending the working relationship with the people who deliver those supports.

Third Party Assessor (TPA) – The contracted entity within the Health Care Authority (HCA) that reviews Level of Care (LOC) assessments, determines medical eligibility and approves and enters person-centered plans and budgets into the Medicaid Management Information System to ensure waiver requirements are met.

Vendor- A business that is employed by, contracted with, and provides services to a Mi Via Waiver (Mi Via) participant.

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 (HCBS) options through Medicaid as an alternative to providing long-term care services in an institutional setting.

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Appendix D: DEVELOPMENTAL DISABILITIES SUPPORTS 0DIVISION (DDSD) CONTACT INFORMATION

DDSD Community Programs Bureau

Mi Via Unit
5300 Homestead Rd NE; Suite 218
Albuquerque New Mexico 87110

DDSD Regional Offices

REGIONAL OFFICE	COUNTIES SERVED	ADDRESS	CONTACT INFORMTION
Metro Regional Office	Bernalillo Torrance Valencia Sandoval	5300 Homestead Rd NE; Suite 218 Albuquerque New Mexico 87110	505-841-5500 (Phone) 800-283-5548 (Toll-Free) 505-841-5554 (Fax)
Northeast Regional Office	Rio Arriba Taos Colfax Union Mora Santa Fe San Miguel Harding Los Alamos	224 Cruz Alta Suite B Taos, NM 87571	575-758-5934 (Phone) 866-315-7123 (Toll-Free) 575-758-5973 (Fax)
Northwest Regional Office	San Juan McKinley Cibola	2914 E. Historic Route 66, Gallup NM 87301	505-863-9937 (Phone) 866-862-0448 (Toll-Free) 505-863-4978 (Fax)
Southeast Regional Office	Guadalupe Quay De Baca Curry Lincoln Chavez Roosevelt	726 South Sunset Suite B Roswell, NM 88203	575-624-6100 (Phone) 866-895-9138 (Toll-Free) 575-624-6104 (Fax)

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	Lea Eddy		
Southwest Regional Office	Catron Socorro Grant Sierra Otero Doña Ana Luna Hidalgo	1170 North Solano Drive, Suite G Las Cruces, NM 88001	575-528-5180 (Phone) 866-742-5226 (Toll-Free) 575-528-5194 (Fax)

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