



Mi Via
Self-Directed Waiver Program

Service Standards

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

MI VIA WAIVER SERVICE STANDARDS

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1. INTRODUCTION TO MI VIA

A. Purpose

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

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

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

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

B. Guiding principles

All participants:

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

C. Philosophy of Self-Direction

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

D. Participant Rights

A Mi Via participant has the right to:

- Decide where and with whom to live;
- Choose his/her own work or productive activity;
- Choose how to establish community and personal relationships;
- Make decisions regarding his/her own support, based upon informed choice;

- Be respected and supported during the decision-making process and in the decisions made;
- Access natural supports as needed;
- Hire, train, schedule, supervise and dismiss service providers;
- Receive training, resources and information related to Mi Via and self-direction in a format that meets the American with Disabilities Act (ADA) requirements;
- Appeal denials or decisions through the reconsideration and fair hearing processes;
- Access additional supports in order to be successful in self-direction;
- Transfer to programs that are not self-directed;
- Receive culturally competent services; and
- Be free from restraint, restrictive interventions, seclusion and coercion

E. Participant Responsibilities

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

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

On-going participant responsibilities include:

- Comply with the rules and regulations that govern the program;
- Maintain an open and collaborative relationship with the consultant, and work together with the consultant to determine support needs related to the activities of self-direction, develop an appropriate Service and Support Plan (SSP)/budget request, receive necessary assistance with carrying out the approved SSP/budget and with documenting service delivery;
- If a participant is utilizing employees, they must designate an Employer of Record (EOR). An eligible recipient may be his or her own EOR unless the eligible recipient is a minor, or has a plenary or limited guardianship or conservatorship over financial matters in place. An eligible recipient may also designate an individual of his or her choice to serve as the EOR, subject to the EOR meeting the qualifications specified in 8.314.6 NMAC. If a participant is utilizing vendor services only, an EOR is not necessary, however, an employee, contractor or sub-contractor of the vendor may not sign off on the invoice/Payment Request Form for the participant. In some instances, an EOR may be required by the state. The form must be signed by the participant or their authorized representative or EOR if one is designated to assist. A participant who does not have an authorized representative providing oversight of their financial matters may sign off on the Payment Request Form.

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

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

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

F. Conflicts of Interest:

Mi Via Consultant agencies may not provide any other direct services for participants that have an approved SSP/budget and are actively receiving services in the Mi Via program. A Consultant Agency may not provide any direct support services through any other type of 1915 (c) Home and Community Based Waiver Program or through any affiliated agency. A Consultant agency may not employ, as a Consultant, any immediate family member or guardian of a participant in

the Mi Via program that is served by the consultant agency. Mi Via Consultant agencies may not provide guardianship services to any participant receiving Consultant services from that same agency.

A Mi Via Consultant may not serve as the EOR, personal representative or authorized representative for an eligible participant for whom he or she is the consultant. A Mi Via Consultant may not be paid for any other services utilized by the participant for whom he or she is the consultant whether as an employee of the participant, vendor, or an employee or a sub-contractor of a vendor. Additionally, a Mi Via Consultant may not provide any other paid Mi Via services to a participant unless the participant is receiving Consultant services from another Consultant agency.

G. Solicitation

Employees/Vendors/Providers 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 provider agencies, service agreements, medication, supplies, goods or services.

H. Coordination with MCO Services

“Centennial Care” is New Mexico’s comprehensive managed care delivery system that offers the full array of current Medicaid services, including acute, behavioral health, and home and community based services/long term care (for those programs that require a nursing facility level of care) through a person-centered care coordination system for which those at the highest level of acuity and risk for poor health outcomes will be guided through the system and assisted in developing personalized plans to assure that all necessary services are provided.

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

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

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

- a. Coordination of the member’s health care needs through the development of the care plan;

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

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

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

2. GENERAL AUTHORITY AND REQUIREMENTS

The Centers for Medicare and Medicaid Services (CMS) approved the Mi Via Self-Directed Waiver effective October 1, 2015.

Mi Via provides self-directed home and community based services (HCBS) to individuals who are both financially eligible and medically eligible under the ICF/IID Level of Care (LOC) guidelines (8.314.6.13 NMAC). Eligible waiver participants include people who are eligible to receive services through the Home and Community Based Services Waivers for those that are Developmentally Disabled (DD) or Medically Fragile (MF).

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

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

3. DEFINITIONS AND ACRONYMS

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

Authorized Representative – The individual designated to represent and act on the participant’s behalf. The participant or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, conservator, or any other individual or individuals designated in writing by the participant to make decisions on their behalf. The participant’s authorized representative may be a service provider (depending on what the participant or court order allows) for the participant. An authorized representative cannot approve his or her own timesheet. The authorized representative cannot serve as the participant’s consultant.

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

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

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

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

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

Developmental Disabilities Waiver (DDW) – Medicaid HCBS waiver program for individuals who meet the definition of intellectual/developmental disability (I/DD) or a specific related condition as determined by Department of Health (DOH) in accordance with approved DDW

criteria and the LOC provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities.

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

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

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

FOCoSonline – The Mi Via Plan of Care on-line system used by the Mi Via FMA for receiving and processing payments. FOCOsonline is also used by participants and consultants to develop and submit SSP/budget requests for TPA review and to monitor spending throughout the SSP/budget year.

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

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

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

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

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

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

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

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

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

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

NMAC-New Mexico Administrative Code

NMSA-New Mexico Statutes Annotated 1978 compilation

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

Personal Representative (PR) – The participant may choose to appoint a personal representative designated to have access to information for the purpose of offering support and assisting the participant in understanding Mi Via waiver services. The participant can designate a person to act as a personal representative by signing a release of information form indicating the

participant's consent to the release of confidential information specific to Mi Via services. The participant does not need a legal relationship with his or her personal representative. The personal representative will not have the authority to direct Mi Via waiver services or make decisions on behalf of the eligible recipient. Directing services remains the sole responsibility of the participant or his/her authorized representative. While the participant's personal representative can be a service provider for the participant, the personal representative cannot serve as the participant's consultant. If the personal representative is an employee, he/she cannot approve his/her own timesheet.

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

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

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

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

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

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

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

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

Support Guide – Non-professional staff hired by the consultant provider that directly assists the participant in implementing the SSP/budget to ensure access to Mi Via services and supports and to enhance success with self-direction. Support guide services provide additional assistance to the participant with employer/vendor functions or with other aspects of implementing his/her SSP/budget. This service may also be provided by a consultant at the discretion of the Consultant Agency.

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

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

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

4. MI VIA CONTRACTORS AND SUPPORTS

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

A. Third Party Assessor

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

- Determine initial medical eligibility for individuals who choose Mi Via including conducting in-home assessments and reviewing and determining LOC;
- Notify the participant and CA at least ninety (90) days in advance of the need for annual LOC determination, and provide the participant with the appropriate assessment forms to take to their physician;
- Conduct the in-home LOC assessment in person with the participant in his/her current living environment, or in a location approved by the state;
- Review the information from the LOC documents that include a current History and Physical and Long Term Care Assessment Abstract (LTCAA) completed by the Primary Care Physician and the in-home assessment to make an LOC determination and assign the IBA for the participant. The TPA may re-evaluate the LOC more often than annually if there is an indication that the participant's medical condition or LOC has changed; and
- Review each Mi Via participant's individual SSP/budget, and using the SSP/budget and other submitted documentation, review and make a determination regarding each Mi Via participant's SSP/budget request and any SSP/budget revision requests. The TPA uses the Mi Via Program Regulations and Standards to determine approval and denial of services and goods.

B. Financial Management Agent

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

- Assure program compliance with State and Federal employment and Internal Revenue Service (IRS) requirements;
- Assist each participant to set up a unique Employer Identification Number (EIN) if they intend to hire employees;
- Answer participant inquiries, solve related problems, and offer periodic trainings for participants and their representatives on how to handle the Mi Via billing and invoicing processes. The FMA will provide all participants with necessary documents, instructions and guidelines;
- Collect all documentation necessary to verify that providers and vendors have the qualifications and credentials required by Mi Via regulations;

- Collect all documentation necessary to support the participant's specific arrangements with each employee and vendor, including employment agreement forms and vendor agreement forms;
- Complete criminal history and/or background investigations for service providers, pursuant to 7.1.9 NMAC and in accordance with 1978 Section 29-17-1 NMAC of the Caregivers Criminal History Screening Act;
- Check the Department of Health Employee Abuse Registry, pursuant to 7.1.12 NMAC Consolidated Online Registry (COR), to determine whether service providers or employees of participants are included in the registry. If a provider or employee is listed in the Abuse Registry, that person may not be employed by a Mi Via participant;
- Process and pay invoices for services and goods that are approved in the participant's SSP and AAB, when supported by required documentation;
- Handle all payroll functions on behalf of the participants who hire direct service employees and other support personnel, including collecting and processing timesheets of support workers, processing payroll and withholding, filing and payment of applicable Federal, State and local employment-related taxes and insurances;
- 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; and
- Report any concerns related to the health and safety of a participant or that the participant is not following the approved SSP and AAB to the consultant provider, HSD/MAD and DOH/DDSD, as appropriate.

FOCoSonline: The Mi Via Plan of Care on-line system

In addition to the above functions, the FMA operates the *FOCoSonline* system through which the Mi Via program is operated. *FOCoSonline* 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/budget expenditures.

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

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

C. Consultant Agencies, Consultants and Support Guides

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

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 CA in their region.

Pre-Eligibility and Enrollment Services

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

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

On-going Consultant Functions

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

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

Consultants shall make contact with the participant in person or by telephone at least monthly for routine follow up. Consultants shall meet face to face with the participant with the participant at least quarterly; one visit per year must be conducted in the participant's residence with the participant.

Monthly contact and Quarterly visits will be conducted to include but not be limited to the following:

- Review spending patterns;
- Document the purchase of goods;
- Review and document the progress of the SSP/budget implementation; and

- Document the usage and effectiveness of the twenty four 24 hour emergency backup plan.

Support Guide Functions

Support guide services provide more intensive supports that help participants more effectively self-direct services based upon their needs. For example, support guide services may include (but are not limited to):

- Education related to how to use the Mi Via program and provide information on program changes or updates as part of overall information sharing;
- Assistance with employer/vendor functions such as recruiting, hiring and supervising workers; establishing and documenting job descriptions for direct supports; completing forms related to employees or vendors, approving/processing timesheets and purchase orders or invoices for goods; obtaining quotes for services and goods as well as identifying and negotiating with vendors;
- Assistance with problem solving employee and vendor payment issues with the FMA and or other relevant parties; and
- Assistance with managing the SSP/budget to include reviewing and monitoring the SSP/budget expenditures; preparing and submitting SSP/budget and revisions.

5. DETERMINING LEVEL OF CARE

A. Initial Medical Eligibility Process

- The Level of Care (LOC) eligibility process begins with the individual taking the Long Term Care Assessment Abstract (LTCAA) and instructions to his/her health care practitioner for completion, signature and date. The applicant will also obtain a History and Physical (H&P) from his/her health care practitioner. These forms and instructions are enclosed in the allocation packet sent to the participant by the Department of Health and it is the responsibility of the participant to ensure that the LTCAA is submitted upon completion to the TPA.
- The TPA is notified of the need for an in-home assessment (IHA) via a copy of the allocation letter/completed Primary Freedom of Choice (PFOC) from the Department of Health. The TPA will arrange for an IHA in the applicant's current living environment or in a location agreed upon by the participant and the TPA and approved by the State, or in an inpatient setting, utilizing the assessment tools prescribed by the waiver through which the individual is applying. The TPA provides copies of the assessment(s) to the CA for use in developing the participant's SSP/budget.
- The TPA reviews the LTCAA, the IHA(s), the current history and physical; and other relevant medical information submitted. The TPA reviewer applies the ICF/IID LOC criteria to determine the participant's medical eligibility. The TPA notifies the applicant, the CA, and ISD whether the applicant meets the medical eligibility criteria. Additionally, the TPA determines the participant's IBA based on the LOC and age.

B. Expedited Medical Eligibility Process

When necessary for the health and safety of the participant, the TPA will conduct an expedited LOC determination to establish Mi Via medical eligibility as requested by the consultant and authorized by HSD.

C. Annual Medical Eligibility Process

Medical eligibility recertification occurs every twelve (12) months, and follows essentially the same process as the initial LOC evaluation. The participant will receive a letter from the TPA ninety (90) days prior to the expiration of his/her LOC, informing him/her of how to proceed with the process and to provide the appropriate forms and instructions. The participant is responsible for the timely submission of the required forms and medical documents to the TPA to ensure eligibility re-evaluation.

D. Reevaluation of LOC Determination

- A Mi Via participant may be reassessed during the LOC term if there is evidence that the participant's LOC may have changed substantially due to illness, injury, disease process or progression or successful rehabilitative intervention or that the assessments conducted were not inclusive of additional information from a competent informant.

- The consultant or participant may request a reevaluation from the DOH Mi Via Waiver Program Manager, who will work with HSD to review the request and if appropriate, authorize the TPA to conduct another IHA and review a new LTCAA completed for LOC reevaluation. The completed IHA and LTCAA are submitted to the TPA for review.
- A post hospitalization LTCAA must be provided for all Mi Via participants in coordination with the discharge planner and Primary Care Physician (PCP) within designated timeframes to the TPA. This change in condition process will occur if the participant has been hospitalized more than three (3) midnights. This process will be facilitated by the TPA through education of hospital personnel and by the consultants through education of participants to contact the consultant or the TPA should an extended hospitalization occur. The participant must notify consultant/TPA for hospitalization upon discharge.
 - The hospital is expected to complete the LTCAA document and discharge summary and fax to the TPA by the hospital on the day of discharge. If the participant is discharged after working hours or on a weekend, then the hospital can fax in the document the next working day;
 - If the hospital does not submit the information according to the timelines outlined above, the TPA will contact the hospital for a discharge summary and a LTCAA signed by the attending physician within 14 days of discharge. If unable to obtain a discharge summary on time, this will be obtained as soon as available; and
 - Results of the post-hospitalization LOC review determination will be provided to the participant and consultant.

E. LOC Denial

- In the event of any LOC denial, the participant has the right to request reconsideration and/or a Fair Hearing to appeal the denial.

6. PLANNING AND BUDGETING FOR SERVICES AND GOODS

A. Service and Support Plan Development Processes

The Service and Support Plan (SSP) development process starts with person-centered planning. This process obtains information about the participant's strengths, capacities, preferences desired outcomes and risk factors. In person-centered planning, the SSP must revolve around the individual participant and reflect his or her chosen lifestyle, cultural, functional, and social needs for successful community living. The goal of the planning process is for the participant to achieve a meaningful life in the community, as defined by the participant. Upon eligibility for the Mi Via Waiver and choosing his/her consultant, each participant shall receive an IBA and information and training from the consultant about covered/non-covered Mi Via services and the requirements for the content of the SSP.

The participant is the leader in the development of the SSP. The participant will take the lead or be encouraged and supported to take the lead to the best of their abilities to direct development of the SSP. The participant may involve, if he/she so desires, family members or other individuals, including service workers or providers, in the planning process.

Mi Via program covered services include personal plan facilitation, which supports planning activities that may be used by the participant to develop his/her SSP as well as identify other sources of support outside the SSP process. This service is available to participants one (1) time per SSP/budget year.

B. Service and Support Plan (SSP) Components

The Mi Via SSP template is available on the Mi Via web site and is included in the Service Standards (Appendix B). A paper document can be obtained from the consultant. It is organized by the four (4) categories of services, and includes questions in each section that help identify the participant's strengths, goals, natural and informal supports, concerns and challenges, and how the participant will know whether the plan he/she has developed is working well.

Each section of the SSP must be completed by the participant, even if he/she does not plan to request services or goods from that section. This is because the SSP is a comprehensive planning tool and all areas need to be considered carefully.

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

Living Supports

The first section of the SSP covers Living Supports, which are individually determined supports that help the participant stay in his/her own home and community. These supports can provide needed assistance with activities of daily living, home management, supports for health and safety as well as independent living skills. Supports can be provided using three (3) different

models: Homemaker/Direct Support Services; Home Health Aide; and In-Home Living Supports.

Community Membership Supports

The second section of the SSP covers Community Membership Supports, which help the participant participate in community life in order to enhance relationships with others, work or participate in meaningful activities. These supports include: Community Direct Support, Employment Supports and Customized Community Group Supports.

Health and Wellness Supports

The third section of the SSP covers Health and Wellness Supports. These supports are available in Mi Via to assist participants with medically related or behavioral health needs that are not covered by their health plan and will enhance the participant's ability to remain in his/her 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.

Other Supports

The fourth section of the SSP addresses other supports that are available to enhance or enable the participant to receive other services on his/her plan, or to decrease the need for more direct services, thereby increasing his/her independence. In Mi Via these supports include: Transportation; Emergency Response Services; Respite; and Related Goods.

Other Sections of the SSP

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

The 24-Hour Emergency Back-up Plan

This section lists who the participant will contact in an emergency or if regularly scheduled employees or service providers are unable to report to work. The Emergency Back-Up Plan is mandatory and must be completed in the SSP.

Consultant/Support Guide Services

The last section of the SSP addresses how much help the participant or his/her employer of record may need from their Consultant/Support Guide or others to be successful with self-direction and with being a successful employer.

Completing and Submitting the SSP

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

C. Budget Development Process

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

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

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

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

D. Participant's Budget-Related Authority

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

1. Budget-Spending Authority

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

2. Employer Authority

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

3. Decision-Making Authority

Participants shall have authority to do the following:

- Identify service providers (employees/vendors) and refer them to the FMA for enrollment;
- Complete the employer paperwork to be submitted to the FMA if utilizing employees. All participants who plan to hire employees are required to designate an Employer of Record following the process established by the FMA to do so.

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

7. NON-COVERED SERVICES

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

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

- a. Services covered by the Medicaid State plan (including EPSDT), Medicaid school-based services, Medicare and other third-parties. This includes services that are covered under Centennial Care and/or EPSDT. The Mi Via Program is the payer of last resort;
- b. Any service or good, the provision of which would violate Federal or State statutes, regulations or guidance.
- c. Any goods or services that are considered primarily recreational or diversional in nature;
- 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, fire wood, wood pellets, water, sewer, and waste management;
- f. Experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC;
- g. Home schooling materials and/or related supplemental materials and activities;
- h. Any goods or services that a household that does not include a person with a disability would be expected to pay for as a routine household or personal expense;
- i. Personal goods or items not related to the participant's condition or disability;
- j. Purchase of animals and the costs of maintaining animals, including the purchase of food, veterinary visits, grooming and boarding but with the exception of training and certification for service dogs;
- k. Gas cards and gift cards. Items that are purchased with Mi Via program funds may not be returned for gift cards;
- l. Purchase of insurance, such as cell phone, car, health, life, burial, renters, home-owners, service 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, including airfare, lodging or meals;
- x. Consumer electronics such as computers (including laptops or any electronic tablets), printers and fax machines, or other electronic equipment that does not meet the criteria specified in Section 15 Subsection A of 8.314.6.15 NMAC. No more than one (1) of each type of item may be purchased at one (1) time, and consumer electronics may not be replaced more frequently than once every three (3) years, including those consumer electronics previously purchased through any other MAD program;
- y. Cell phone services that include more than one (1) cell phone line per participant. Cell phone service, including cell phone service that includes data, is limited to the cost of one hundred dollars per month.
- z. Dental services utilizing the Mi Via IBA

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

8. SERVICE AND SUPPORT PLAN AND BUDGET APPROVAL PROCESSES

A. Initial SSP/Budget Approval Processes

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

The TPA may request additional information, through the Request For Information process (RFI), from the participant and/or the consultant during the process of reviewing the SSP/budget request. The consultant may assist the participant in obtaining requested documents and responding to the RFI, but providing a timely and complete response to the TPA is primarily the participant's responsibility. If information is not received within fifteen (15) days from the date of the RFI letter, the service or good will be technically denied.

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

SSP Review Criteria

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

- the services or goods must be responsive and directly related to the participant's qualifying condition or disability; and
- the services or goods must address the participant's clinical, functional, medical or habilitative needs; and
- the services or goods must accommodate the participant in managing his/her household; or
- the services or goods must facilitate activities of daily living; or
- the services or goods must promote the participant's personal health and safety; and
- the services or goods must afford the participant an accommodation for greater independence; and
- the services or goods must support the participant to remain in the community and reduce his/her risk for institutionalization; and
- the services or goods must be documented in the SSP and facilitate the desired outcomes in the participant's SSP; and
- the SSP contains the quality assurance criteria to be used to determine if the service or goods meet the participant's need as related to the qualifying condition or disability; and
- the services or goods must decrease the need for other Medicaid services; and
- the participant receiving the services or goods does not have the funds to purchase the services or goods; or

- the services or goods are not available through another source. The participant must submit documentation that the services or goods are not available through another source, such as the Medicaid State plan or Medicare; and
- the service or good is not prohibited by Federal and State statutes, regulations and any other guidance; and
- each service or good must be listed as an individual line item whenever possible; when services or goods are ‘bundled’ the SSP must document why bundling is necessary and appropriate.

Budget Review Criteria

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

- the proposed annual budget request is within the participant’s IBA; and
- the proposed rate for each service is within the Mi Via range of rates for that chosen service; and
- the proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and
- the estimated cost of the service or good is specifically documented in the participant’s SSP/budget; and
- no employee of any type may be paid in excess of 40 hours in a consecutive seven day work week for any one participant or EOR.

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

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

B. Approval of the SSP/Budget

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

The TPA shall indicate which goal(s) of the SSP/budget have been approved or denied in

FOCo*Online*. This action will send an auto-alert to the consultant; this is a secondary form of notification of determination.

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

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

C. Requests for Additional Funding over the IBA

The amount of the AAB cannot exceed the participant's annual IBA. The rare exception would be a participant whose assessed or documented needs for services, based on his/her 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:

1. Chronic physical condition

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

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

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

- a. A life-threatening condition with frequent or constant periods of acute exacerbation that:
 - places the participant at risk for institutionalization;
 - could result in the participant's inability to remember to self-administer medications accurately even with the use of assistive technology devices; or

- requires a frequency and intensity of assistance, or consultation to ensure the participant's health and safety in the home or in the community; or,
 - in the absence of such skilled intervention, assistance, medical supervision or consultation, would require hospitalization or admission to a Nursing Facility (NF) or an ICF/IID.
- b. The need for administration of specialized medications, enteral feeding or treatments that:
- are ordered by a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant; which
 - require frequent and ongoing management or monitoring or oversight of medical technology.

2. Change in physical health status

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

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

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

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

- the participant now requires the administration of medications via intravenous or injections on a daily or weekly basis;
- the participant has experienced recent onset or increase in aspiration of saliva, foods or liquids;
- the participant now requires external feedings, e.g. naso-gastric, percutaneous endoscopic gastrostomy, gastric-tube or jejunostomy-tube;
- the participant is newly dependent on a ventilator;

- the participant now requires suctioning every two (2) hours, or more frequently, as needed;
- the participant now has seizure activity that requires continuous monitoring for injury and aspiration, despite anti-convulsant therapy; or
- the participant now requires increased assistance with activities of daily living as a result of a deterioration or permanent changes in his or her physical health status.

3. Chronic or intermittent behavioral conditions or cognitive difficulties

The participant has chronic or intermittent behavioral conditions or cognitive difficulties, which are identified during the initial or reevaluation LOC assessment, or the participant has experienced a change in 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 in order to keep the participant safe. These behaviors or cognitive difficulties are so severe and intense that they:

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

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

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

The participant may submit additional supportive documentation including a current Individual Service Plan (ISP) if the participant is transferring from another waiver, a positive behavioral support plan or assessment, recent notes, a summary or letter from a

behavioral health practitioner or professional with expertise in intellectual and/or developmental disabilities, recent discharge plan, recent recommendations from a rehabilitation facility, any other relevant documentation or recent statements from family members, friends or other support individuals involved with the participant.

4. Change in natural supports

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

This absence of natural supports or other resources is expected to continue throughout the period for which supplemental funds are requested. The type, intensity or amount of care or services previously provided by natural supports or other resources cannot be acquired within the IBA and are not available through the Medicaid State plan services, Medicare, other programs or sources in order for the participant to live in a home and community-based setting.

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

A. Amending the SSP/Budget

Modification of the SSP

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

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

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

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

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

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

Modifications to the Authorized Annual Budget

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

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

Only one (1) SSP/budget revision may be submitted at a time, for example; a 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) days of the expiration date of the current SSP/budget year. Revision requests for review within sixty (60) days of the expiration date of the current SSP/budget year must be submitted to the DOH Mi Via Program Manager or their designate for approval. A SSP/budget revision that is requested by a participant due to health and safety reasons may also be processed expeditiously. Expedited review requests must be submitted to the DOH Mi Via Program Manager or their designate for approval.

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

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

B. SSP/Budget Denials

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

Reconsideration

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

Fair Hearing

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

A Fair Hearing may be requested when:

- a Mi Via applicant's LOC has been denied;
- a Mi Via applicant has not been given the choice of HCBS as an alternative to institutional care;

- a Mi Via applicant is denied the services of his/her choice or the provider of his/her choice;
- a Mi Via participant services are denied, suspended, reduced or terminated;
- a Mi Via participant has been involuntarily terminated from the program; or
- a Mi Via participant request for a budget adjustment has been denied; and
- when any other adverse action is taken by MAD against the participant.

Continuation of Benefits

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

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

10. IMPLEMENTATION OF THE SERVICE AND SUPPORT PLAN AND BUDGET

A. Enrolling Employees and Vendors

Pre Hire Packet

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

Credentialing Requirements

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

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

Other Required Documents

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

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

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

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

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

B. Purchasing Services and Goods

Timesheets

If a participant is utilizing employees, they must designate an Employer of Record (EOR). With access to *FOCoSonline*, an employee (or EOR) may enter the employee(s)'s timesheet(s) into *FOCoSonline*. The EOR may then review and approve the timesheet through their online access. Having access to *FOCoSonline* and submitting timesheets online means that the EOR or employees do not need to send the timesheet to the FMA for processing. Upon completing *FOCoSonline* training, a new user will receive a *FOCoSonline* Account Authorization form (via e-mail). Once the new user completes the *FOCoSonline* Account Authorization form and faxes it to the FMA, the user will receive an e-mail with their password and login instructions. Timesheets may also be mailed, faxed or delivered directly to the FMA.

Timesheets are submitted and processed on a two-week pay schedule according to the Mi Via Payroll Payment Schedule. The payroll workweek starts on Saturday and ends the following Friday. The payment schedule is included in the January Mi Via newsletter that is mailed to all participants by the FMA and is also available online at www.mivianm.org/mivia_newsletter.htm. Timesheets are due at the end of the two-week pay period and must be received at the FMA no later than Saturday at 11:59 pm. Timesheets must be completed per instructions on the form, which includes the description of services provided. Incomplete timesheets could delay processing and payment timelines.

A Personal Representative (PR) may also complete the training and gain access to *FOCoSonline*. If a PR has access, they will be able to view payments and monitor budget spending, however, they will not have authorization to perform the functions of the EOR and approve timesheets. To designate a PR, a participant must complete the PR Form, which may be requested through the FMA or the consultant.

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

Vendor Invoices

Vendor Payment Request Forms (PRF) and invoices may be submitted to the FMA on any day of the week. PRFs may not be signed prior to the delivery of services. If a participant is only utilizing vendor services, an EOR is not necessary, however, an EOR can be identified by a participant to assist with the use of vendors. In some instances, an EOR for vendor services may be required by the State. Those signing a PRF for vendor services rendered to a participant may not serve as an employee, contractor or sub-contractor of that vendor for that participant. The Form must be signed by the participant (unless there is an authorized representative over

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

PRFs and invoices must be faxed to the FMA for processing. However, if the participant, authorized representative or EOR has access to *FOCoSonline*, they may review their payments and monitor them as they are being processed. In addition, the participant, authorized representative, EOR, or PR may run reports through *FOCoSonline* to monitor spending activity.

Vendors of direct services are required to complete service documentation as required in the Mi Via Regulations.

Return to Participant Process

Return-to-Participant (RTP) phone calls and emails are an effective means used by the FMA to assist in communicating with the participant, authorized representative or EOR when there are problems in processing payment. For example, if a timesheet or invoice is submitted to the FMA and it does not contain the appropriate signatures, The FMA uses the RTP process as a means to inform the participant, authorized representative or EOR that payment could not be made. The FMA attempts contact with the participant, authorized representative or EOR by phone. If one (1) unsuccessful phone call attempt to the participant, authorized representative or EOR has been made, the FMA will send an e-mail to the participant, authorized representative or EOR (provided the participant, authorized representative or EOR has an e-mail address in *FOCoSonline*) with a copy to the consultant. If the participant, authorized representative or EOR does not have an e-mail address in *FOCoSonline*, the FMA will send an e-mail to the consultant regarding the details. Since contact is attempted by the FMA to the participant, authorized representative or EOR, it is extremely important that *FOCoSonline* contain the correct contact information for the participant, authorized party or EOR. If the participant, authorized representative or EOR contact information needs to be updated, please contact the FMA for assistance. Updates to phone or e-mail contact information may also be sent to the FMA.

Employee and Vendor Pay Rates

Employee and vendor pay rates must be approved in the participant's SSP/budget. Once the rate is approved, Employee Agreements and Vendor Agreements must be submitted to the FMA in order to indicate their rate of pay. If an employee or vendor does not submit an Agreement, the FMA will not know the correct rate of pay for the service the employee or vendor is providing.

In order for the FMA to pay an employee or vendor, an Employee Agreement or Vendor Agreement needs to be submitted to the FMA. If the pay rate for an employee or vendor needs to be changed, the new rate must be approved in the SSP/budget and a new Employee Agreement or Vendor Agreement must be submitted to the FMA at least fifteen 15 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.

Timely-Filing Requirements

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

C. Budget Expenditure Safeguards

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

The participant should review his/her monthly spending report which is mailed out by the FMA on a monthly basis. The participant may also obtain “real-time” information on service usage and spending through direct access to *FOCoSonline*. It is highly recommended that participants obtain access to *FOCoSonline* so that they can effectively monitor their budget and track spending. In addition, the EOR and employees may obtain access to *FOCoSonline*. With *FOCoSonline* access, the EOR will have the capability to approve timesheets that an employee has entered online. Training for *FOCoSonline* is offered for employees, participants and EOR. If interested in training, the employee, participant or EOR may contact the FMA for assistance.

The consultant is required to review the participant’s SSP/budget expenditures during each monthly and quarterly contact with the participant. The consultant will provide the participant with expenditure information and discuss any concerns. If the participant needs to revise his/her 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 particular 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 regards to internet and phone services (landline or cell), the FMA will pay up to the approved monthly amount. This helps to ensure that this category of service is not overspent which could put the participant at-risk of losing these services due to possible non-payment later in the SSP/budget year. If the FMA is unable to make payment as requested due to lack of funds remaining in the SSP/budget, the FMA will contact the participant, authorized representative or EOR once with instruction for them to contact the Consultant for assistance.

11. WAIVER CHANGE

After initial allocation, waiver participants may choose to switch to another waiver that they are eligible for after they have made an initial choice to receive services from the Mi Via Waiver Program. If a participant wants to switch waivers within the first 30 days of allocation, *and* no medical or financial eligibility has begun, the transfer is permitted. The participant must contact the DOH, Developmental Disabilities Supports Division (DDSD) Intake and Eligibility Unit 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 their local DOH, DDSD Regional Office or the DDSD Medically Fragile Waiver Manager to request a Waiver Change Form (WCF). Transitions between waivers should occur within ninety (90) calendar days from receipt of the WCF unless there are circumstances related to the participant's services that require more time. The participant must always end existing waiver services on the last day of a month and start new waiver services on the first day of a month. There must not be a break in waiver services.

A. Participants Transferring from another Waiver to Mi Via

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

B. Participants Transferring from Mi Via to Another Waiver

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

12. CONSULTANT AGENCY CHANGE REQUESTS

Mi Via participants may choose to switch to another Consultant Agency (CA) after they have met medical and financial eligibility. Participants must contact DOH to request the Consultant Agency Change (CAC) form.

When the CAC is returned to DOH, the form is mailed to the current and new Mi Via CA. The two (2) agencies will have a transition meeting with the participant to decide upon a transition date and to exchange documents. The new CA will always start on the first of the month. There must be no break in waiver services.

13. TERMINATION FROM THE MI VIA PROGRAM

A. Voluntary Termination

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

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

B. Involuntary Termination

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

1. The participant refuses to follow Mi Via rules and regulations after receiving focused technical assistance on multiple occasions, support from the program staff, consultant, or FMA, which is supported by documentation of the efforts to assist the participant;
2. The participant is in immediate risk to his/her health or safety by continued self-direction of services, e.g., the participant is in imminent risk of death or serious bodily injury related to participation in the waiver. Examples include but are not limited to the following:
 - a. The participant refuses to include and maintain services in his/her SSP and AAB that would address health and safety issues identified in his/her medical assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, consultant, or FMA;
 - b. The participant is experiencing significant health or safety needs, and, after having been referred to the State (which includes the appropriate State agencies and additional parties as deemed necessary by the State) for level of risk determination and assistance, refuses to incorporate the team's recommendations into his/her SSP and AAB;
 - c. The participant exhibits behaviors which endanger him/her or others.
3. The participant misuses Mi Via funds following repeated and focused technical assistance and support from program staff, the consultant or FMA, which is supported by documentation of efforts to assist the participant. Focused technical assistance is defined as a minimum of three (3) separate occasions where a participant, participant's authorized representative, and/or the Employer of Record (EOR) have received training, education or technical assistance, or a combination of both; and
4. The participant commits Medicaid fraud.
5. DOH notification that the participant continues to utilize an employee and/or vendor who have consistently been substantiated against for abuse, neglect, exploitation while providing Mi Via services after notification of this on multiple occasions by DOH.

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

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

14. Appendices

Appendix A: Service Descriptions in Detail – 2015 Waiver Renewal

Appendix B: Service and Support Plan Template

Appendix C: Range of Rates and Service Codes

Appendix D: Vendor Credentialing Requirements Grid

Appendix E: Toolkit: Employee

Appendix F: Toolkit: Vendor