State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY
The Human Services Department, Medical Assistance Division (HSD/MAD) is proposing to repeal and replace the Mi Via Waiver Program regulations to conform to the program as approved by the Centers for Medicare and Medicaid Services (CMS).

Definitions are being added to clarify program terms. Service categories are being changed. Language is being added to clarify the individual budget allotment and service and support plan and budget approval and modification processes.

VI. REGULATIONS
These proposed regulation changes refer to 8.314.6 NMAC of the Medical Assistance Program Manual. This register and the proposed changes are available on the Medical Assistance Division web site at www.hsd.state.nm.us/mad/registers/2010 If you do not have Internet access, a copy of the regulations may be requested by contacting the Medical Assistance Division at 827-3156.

VII. EFFECTIVE DATE
The Department proposes to implement these regulations effective February 15, 2011.

VIII. PUBLIC HEARING
A public hearing to receive testimony on these proposed regulations will be held at 9:00 a.m. on Tuesday, January 4, 2011 in the ASD conference room, Plaza San Miguel, 729 St. Michael's Drive, Santa Fe.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the Medical Assistance Division upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Kathryn Falls, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 p.m. on January 4, 2011. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these regulations approved by:

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KATHRYN FALLS, SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 314 LONG TERM CARE SERVICES - WAIVERS
PART 6 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER

8.314.6.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.314.6.1 NMAC - N, 2-15-11]

8.314.6.2 SCOPE: The rule applies to the general public.
[8.314.6.2 NMAC - N, 2-15-11]

8.314.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, Sections 27-2-12 et seq.
[8.314.6.3 NMAC - N, 2-15-11]

8.314.6.4 DURATION: Permanent.
[8.314.6.4 NMAC - N, 12-1-06]

8.314.6.5 EFFECTIVE DATE: February 15, 2011, unless a later date is cited at the end of a section.
[8.314.6.5 NMAC - N, 2-15-11]

8.314.6.6 OBJECTIVE: The objective of this rule is to provide rules for the service portion of the New Mexico medicaid program. This rule describes eligible providers, eligible participants, covered services, non-covered services, utilization review, and provider reimbursement.
[8.314.6.6 NMAC - N, 2-15-11]

8.314.6.7 DEFINITIONS:

A. **AIDS waiver:** A medicaid home and community-based services (HCBS) waiver program for recipients who are diagnosed as having acquired immunodeficiency syndrome (AIDS) or AIDS-related conditions and who meet the level of care provided in a nursing facility (NF).

B. **Authorized agent:** The participant may choose to appoint an authorized agent designated to have access to medical and financial information for the purpose of offering support and assisting the participant in understanding waiver services. The participant will designate a person to act as an authorized agent by signing a release of information form indicating the participant's consent to the release of confidential information. The authorized agent will not have the authority to direct mi via waiver services. Directing services remains the sole responsibility of the participant or his/her legal representative. The participant's authorized agent does not need a legal relationship with the participant. While the participant's authorized agent can be a service provider for the participant, the authorized agent cannot serve as the participant's consultant. If the authorized agent is an employee, he/she cannot sign his/her own timesheet.

C. **Authorized annual budget (AAB):** The actual amount of the annual budget approved for a participant by the 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 authorized annual budget (AAB).

D. **Brain injury (BI):** Individuals (through age 65) with an injury to the brain of traumatic or acquired origin resulting in a total or partial functional disability or psychosocial impairment or both. The BI participant must have a documented BI diagnosis, as included in the international classification of diseases 9th revision clinical modification (ICD 9-CM) codes which are attached to this part of the NMAC as attachment I.

E. **Category of eligibility (COE):** To qualify for medicaid, a person must meet financial criteria AND belong to one of the groups that the state has defined as eligible. All participants in mi via must belong to one of the categories of eligibility (COE) described in 8.314.6.13 NMAC.

F. **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.

G. **Consultant provider:** May be an agency or an individual. Provides consultant and support guide services to mi via participants that assist the participant (or the participant's family or legal representative,

as appropriate) in arranging for, directing and managing mi via services and supports, as well as developing, implementing and monitoring the service and support plan (SSP) and AAB.

H. **Employer of record (EOR):** The employer of record (EOR) is the individual responsible for directing the work of mi via employees, including recruiting, hiring, managing and terminating all employees. The EOR tracks expenditures for employee payroll, goods, and services. EORs authorize the payment of timesheets by the financial management agency (FMA). A participant may be his/her own EOR unless the participant is a minor, or has a plenary or limited guardianship or conservatorship over financial matters in place. Participants may also designate an individual of their choice to serve as their EOR, subject to the EOR meeting the qualifications specified in these regulations.

I. **Financial management agency (FMA):** Contractor that tracks expenditures and helps implement the AAB by paying the participant's service providers and tracking expenses.

J. 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 these waiver programs.

K. **Individual budgetary allotment (IBA):** The maximum budget allotment available to an individual participant, determined by his/her established level of care (LOC) and category of eligibility. Based on this maximum amount, the participant will develop a plan to meet his/her assessed functional, medical and habilitative needs to enable the participant to remain in the community.

L. **Intermediate care facilities for the mentally retarded (ICF/MR):** Facilities that are licensed and certified by the New Mexico department of health (DOH) to provide room and board, continuous active treatment and other services for eligible medicaid recipients with a primary diagnosis of mental retardation.

M. **Legal representative:** A person that is a legal guardian, conservator, power of attorney or otherwise has a court established legal relationship with the participant. The participant must provide certified documentation to the consultant provider and FMA of the legal status of the representative and such documentation will become part of the participant's file. The legal representative will have access to participant medical and financial information to the extent authorized in the official court documents.

N. **Legally responsible individual (LRI):** A legally responsible individual (LRI) is any 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 child; or a spouse.

O. **Level of care (LOC):** The level of care (LOC) required by an individual in an institution. Participants in the mi via program must be determined to need either the LOC required for admittance to a licensed nursing facility (NF) or an ICF/MR.

P. **Mi via:** Mi via is the name of the Section 1915 (c) medicaid self-directed HCBS waiver program through which eligible participants have the option to access services to allow them to remain in the community.

Q. **Participant:** Individuals meeting the financial and medical LOC criteria who are approved to receive services through the mi via program.

R. **Reconsideration:** Participants who disagree with a clinical/medical utilization review decision or action may submit a written request through a consultant to the Third Party Assessor (TPA) for a re-consideration of the decision.

S. **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.

T. **Service and support plan (SSP):** Participant plan that includes waiver services that meet the participant's needs to include the projected amount, frequency and duration of the services; the type of provider who will furnish each service; other services that the participant will access; and the participant's available supports that will complement waiver services in meeting his/her needs.

U. **State or state agency:** The mi via waiver program is managed and administered by three state agencies, the aging and long term services department (ALTSD), the department of health (DOH), and the human services department, medical assistance division (HSD/MAD). References to the "state" or "state agency" means these three agencies or other specifically indicated agency as appropriate.

V. **Support guide:** A function of the consultant provider that directly assists the participant in implementing the SSP to ensure access to mi via services and supports and to enhance success with self-direction. Support guide services provide assistance to the participant with employer/vendor functions or with other aspects of implementing his/her SSP.

W. **Third party assessor (TPA):** The contractor that determines and re-determines LOC and medical eligibility for mi via services. The TPA also reviews each participant's SSP and approves an AAB for each participant. The TPA performs utilization management duties of all waiver services.

X. **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.

[8.314.6.7 NMAC – N, 2-15-11]

8.314.6.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.

[8.314.6.8 NMAC - N, 2-15-11]

8.314.6.9 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER: Mi via, New Mexico's self-directed waiver program (mi via), is intended to provide a community-based alternative to institutional care that allows eligible participants to have control over services and supports. Mi via provides self-directed home and community-based services to eligible recipients, hereafter referred to as participants, who are living with disabilities (CoLTS (c)), conditions associated with aging (CoLTS (c)), certain acquired brain injuries (BI), acquired immunodeficiency syndrome (AIDS), developmental disabilities (DD), or medically fragile conditions (MF). (See 42 CFR 441.300.)

A. Mi via is comprised of two medicaid home and community-based waivers established under Section 1915(c) of the Social Security Act. One waiver is specifically for eligible individuals who meet the LOC otherwise provided in an NF. The second waiver is specifically for eligible individuals who meet the LOC otherwise provided in an ICF-MR. Both waivers are managed as a single self-directed program and are administered collaboratively by the ALTSD, DOH, and HSD/MAD.

(1) The ALTSD is responsible for the daily administration of mi via for eligible individuals living with disabilities, conditions associated with aging, and certain acquired brain injuries who meet the LOC for admittance to an NF. The DOH is responsible for the daily administration of mi via for eligible individuals living with developmental disabilities and medically fragile conditions who meet the LOC for admittance to an ICF/MR The DOH also manages the waiver for individuals living with AIDS who meet the LOC for admittance to an NF.

(2) Enrollment in mi via is limited to the number of federally authorized unduplicated participants and funding appropriated by the New Mexico legislature for this purpose.

[8.314.6.9 NMAC - N, 2-15-11]

8.314.6.10 MI VIA CONTRACTED ENTITIES AND PROVIDERS SUPPORTING SELF-DIRECTED SERVICES: The following resources and services have been established to assist participants to self-direct services. These include:

A. **Consultant services:** Consultant services are direct services intended to educate, guide and assist the participant to make informed planning decisions about services and supports, to develop a service and support plan (SSP) that is based on the participant's assessed needs and to assist the participant with quality assurance related to the SSP and AAB.

B. **Third-party assessor:** The TPA or HSD/MAD's designee is responsible for determining medical eligibility through an LOC assessment, assigning the applicable individual budgetary allotment (IBA), approving the SSP, and authorizing a participant's annual budget in accordance with mi via regulations. The TPA:

(1) determines medical eligibility using the LOC criteria in 8.314.6.13 NMAC; LOC determinations are done initially for individuals who are newly allocated to the waiver and at least annually for currently enrolled mi via participants; the LOC assessment is done in person with the participant in his/her home, an agreed upon location or in an inpatient setting; the TPA may re-evaluate the LOC more often than annually if there is an indication that the participant's condition or LOC has changed;

(2) applies the information from the LOC documentation and the following assessments, long-term care assessment abstract (NF or ICF/MR), the comprehensive individual assessment (CIA), the universal assessment tool (UAT), or other state approved assessment tools, as appropriate for the category of eligibility, to assign the IBA for participants that are medically eligible; and

(3) reviews and approves the SSP and the annual budget request resulting in an AAB, at least annually or more often if there is a change in the participant's circumstances in accordance with mi via regulations.

C. **Financial management agent:** The FMA acts as the intermediary between the participant and the medicaid payment system and assists the participant or the EOR with employer- related responsibilities. The FMA pays employees and vendors based upon an approved SSP and AAB. The FMA assures participant and program compliance with state and federal employment requirements, monitors, and makes available to participants and the state reports related to utilization of services and budget expenditures. Based on the mi via participant's individual approved SSP and AAB, the FMA must:

(1) verify that mi via participants are eligible for medicaid prior to making payment for services;

(2) receive and verify that all required employee and vendor documentation and qualifications are in compliance with the mi via regulations;

(3) establish an accounting for each participant's AAB;

(4) process and pay invoices for goods, services, and supports approved in the SSP and the AAB and supported by required documentation;

(5) process all payroll functions on behalf of participants and EORs including:

(a) collect and process timesheets of employees;

(b) process payroll, withholding, filing, and payment of applicable federal, state and local employment-related taxes and insurance; and

(c) track and report disbursements and balances of the participant's AAB and provide a monthly report of expenditures and budget status to the participant and his/her consultant and quarterly and annual documentation of expenditures to the state;

(6) receive and verify provider agreements, including collecting required provider qualifications;

(7) monitor hours billed for services provided by the an LRI and the total amounts billed for all goods and services during the month;

(8) answer inquiries from participants and solve problems related to the FMA's responsibilities; and

(9) 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 ALTSD or DOH, as appropriate. [8.314.6.10 NMAC - N, 2-15-11]

8.314.6.11 QUALIFICATIONS FOR ELIGIBLE INIDVIDUAL EMPLOYEES, INDEPENDENT PROVIDERS, PROVIDER AGENCIES, AND VENDORS:

A. **Requirements for individual employees, independent providers, provider agencies and vendors:** In order to be approved as an individual employee, an independent provider, including non-licensed homemaker/companion workers, a provider agency (excluding consultant providers which are covered in a different sub-section) or a vendor, including those that provide professional services, each entity must meet the general and service specific qualifications set forth in these regulations and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the FMA. In order to be an authorized provider for mi via and receive payment for delivered services, the provider must complete and sign an employee or vendor provider agreement and all required tax documents. The provider must have credentials verified by the participant/EOR and the FMA. In order to be an authorized consultant provider for the mi via program, the provider must have an approved provider agreement executed by the DOH/developmental disabilities supports division (DDSD) and HSD/MAD.

B. **General qualifications:** Individual employees, independent providers, including non-licensed homemaker/companion workers, and provider agencies (excluding consultant providers) who are employed by a mi via participant to provide direct services shall:

(1) be at least 18 years of age;

(2) be qualified to perform the service and demonstrate capacity to perform required tasks;

(3) be able to communicate successfully with the participant;

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

(5) complete training on critical incident, abuse, neglect, and exploitation reporting;

(6) complete participant specific training. The evaluation of training needs is determined by the participant or his/her legal representative. The participant is also responsible for providing and arranging for employee training and supervising employee performance. Training expenses for paid employees cannot be paid for with the mi via participant's AAB; and

(7) meet any other service specific qualifications, as specified in these regulations.

(8) vendors, including those providing professional services, shall:

(a) be qualified to provide the service;

(b) possess a valid business license, if applicable;

(c) if a professional provider, be required to follow the applicable licensing regulations set forth by the profession; refer to the appropriate New Mexico board of licensure for information regarding applicable licenses;

(d) if a consultant provider, meet all of the qualifications set forth in 8.314.6.11 NMAC;

(e) if a currently approved waiver provider, be in good standing with the appropriate state agency; and

(9) meet any other service specific qualifications, as specified in the mi via regulations.;

(10) relatives/legal representatives except LRIs (e.g., parents of minor children or spouses) may be hired and paid for provision of waiver services (except consultant/support guide, assisted living, and customized community supports services); payment is made to a participant's relative or legal representative for services provided when the relative/legal representative is qualified and approved to provide the service; the services must be identified in the approved SSP and AAB, and the participant or his/her legal representative is responsible for verifying that services have been rendered by completing, signing and submitting documentation, including the timesheet, to the FMA; relatives/legal representatives must provide services within the limits of the approved SSP and AAB and may not be paid in excess of 40 hours in a consecutive seven-day period; LRIs, legal representatives or relatives may not be both a paid employee for a participant and serve as his/her EOR;

(11) LRIs, (e.g., the parent [biological, legal or adoptive] of a minor child [under age 18] or the guardian of a minor child) who must provide care to the child, or a spouse of a mi via participant, may be hired and paid for provision of waiver services (except consultant/support guide, assisted living, and customized community supports services) under extraordinary circumstances in order to assure the health and welfare of the participant, to avoid institutionalization and provided that the state is eligible to receive federal financial participation (FFP).

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

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

(c) Services provided by LRIs must:

(i) meet the definition of a service or support and be specified in the participant's approved SSP and AAB;

(ii) be provided by a parent or spouse who meets the provider qualifications and training standards specified in the waiver for that service; and

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

(d) An LRI who is a service provider must comply with the following:

(i) a parent, parents in combination, or a spouse, may not provide more than 40 hours of services in a consecutive seven-day period; for parents, 40 hours is the total amount of service regardless of the number of children who receive services under the waiver;

(ii) planned work schedules must be identified in the approved SSP and AAB, and variations to the schedule must be reported to the participant's consultant and noted and supplied to the FMA when billing;

(iii) timesheets and other required documentation must be maintained and submitted to the FMA for hours paid; and

(e) Married individuals must be offered a choice of providers. If they choose a spouse as their service provider and it is approved in writing by ALTSD or DOH, it must be documented in the SSP.

(f) Children 16 years of age or older must be offered a choice of provider. If a child chooses his or her parent and it is approved in writing by ALTSD or DOH, it must be documented in the SSP.

(g) The FMA monitors, on a monthly basis, hours billed for services provided by the LRI and the total amounts billed for all goods and services during the month.

(h) Hiring of LRIs must be approved in writing by ALTSD for CoLTS (c) and BI populations, or DOH for the AIDS, DD and MF populations.

(12) Once enrolled, providers, vendors and contractors receive a packet of information from the mi via participant or FMA, including medicaid billing instructions, and other pertinent materials. Mi via participants are responsible for ensuring that providers, vendors and contractors have received these materials and for updating them as new materials are received from the state (ALTSD for CoLTS (c), and BI or DOH for AIDS, DD, and MF).

(a) No provider of any type may be paid in excess of 40 hours within the established work week for any one participant.

(b) No provider agency is permitted to perform both LOC assessments and provide any services for mi via participants.

(c) Mi via providers may market their services, but are prohibited from soliciting participants under any circumstances.

(13) Employer of Record. The EOR is the individual responsible for directing the work of employees. Mi Via encourages the participant to be the EOR. It is also possible to designate someone else to act as the EOR.

(a) If a participant is the subject of a plenary or limited guardianship or conservator regarding financial matters, he/she may not be his or her own EOR.

(b) A peson under the age of 18 years may not be an EOR.

(c) An EOR shall reside within 100 miles of the state border. If the participant wants to have an EOR who resides beyond this radius, he/she must obtain written approval from the appropriate state program manager prior to the EOR performing any duties.

(d) A participant's provider may not also be his/her EOR.

(e) An EOR whose performance compromises the health, safety or welfare of the participant, may have his/her status as an EOR terminated.

(f) An EOR may not be paid for any services provided to the participant for whom they are the EOR, whether as an employee of the participant, a vendor, or an employee or contactor of an agency. An EOR makes important determinations about what is in the best interest of a participant, and should not have any conflict of interest. An EOR assists in the management of the participant's budget and should have no personal benefit connected to the services requested or approved on the budget.

C. **Service Specific Qualifications for consultant services providers:** Consultant providers shall ensure that all individuals providing consultant services meet the criteria specified in this section in addition to the general requirements.

(1) Consultant providers shall:

(a) possess a minimum of a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field; and have one year of supervised experience working with seniors or people living with disabilities; or

(b) have a minimum of six years of direct experience related to the delivery of social services to seniors or people living with disabilities; and be employed by an enrolled mi via consultant provider agency; and

(c) complete all required mi via orientation and training courses.

(2) Consultant providers may also use non-professional staff to carry out support guide functions. Support guides provide more intensive supports, as detailed in the service section of these rules. Support guides help the participant more effectively self-direct services when there is an identified need for this type of assistance. Consultant providers shall ensure that non-professional support staff:

(a) are supervised by a qualified consultant as specified in this regulation;

(b) have experience working with seniors or people living with disabilities;

(c) demonstrate the capacity to meet the participant's assessed needs related to the implementation of the SSP;

(d) possess knowledge of local resources, community events, formal and informal community organizations and networks;

(e) are able to accommodate a varied, flexible and on-call type of work schedule in order to meet the needs of participant; and

(f) complete training on self-direction and incident reporting.

D. **Service specific qualifications for personal plan facilitation providers:** A personal plan facilitator agency must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. Personal plan facilitators must possess the following qualifications in addition to the general qualifications:

(1) have at least one year of experience working with persons with disabilities; and

(2) be trained and certified in the planning tool(s) used; and

(3) have at least one year experience in providing the personal plan facilitation service.

E. **Service specific qualification for LIVING SUPPORTS providers:** In addition to the general qualifications, the following types of providers must meet additional qualifications specific to the type of services provided.

(1) **Qualifications of homemaker/direct support service providers:** Homemaker agencies must be certified by the HSD/MAD or its designee. Home health agencies must hold a home health agency license. Homemaker/home health agencies must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements.

(2) **Qualifications of home health aide service providers:** Home health agency/homemaker agencies must hold a current home health agency, rural health clinic, or federally qualified health center license. Home health aides must have successfully completed a home health aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a home health aide training program pursuant to 7.28.2.30 NMAC. Home health aides must also be supervised by a registered nurse. Such supervision must occur at least once every 60 days in the participant's home, and shall be in accordance with the New Mexico Nurse Practice Act and be specific to the participant's SSP.

(3) **Qualifications of assisted living providers:** Assisted living providers must be licensed as an adult residential care facility by DOH pursuant to 7.8.2 NMAC, and meet all the requirements and regulations set forth by DOH as an adult residential care facility pursuant to 7.8.2 NMAC et seq.

(4) **Qualifications of customized in-home living supports providers:** The individual customized living provider must have at least one year of experience working with people with disabilities. Provider agencies must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. Customized living agency staff must have one year of experience working with people with disabilities.

F. **Service Specific Qualifications for COMMUNITY MEMBERSHIP SUPPORT Providers:** In addition to the general qualifications, the following types of providers must meet additional qualifications specific to the type of services provided. Community access provider agencies providing community direct support services must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements.

(1) **Qualification**s **of supported employment providers:**

(a) Job developers must have experience as a job developer for at least one year; have experience for at least one year developing and using job and task analyses; have experience for at least one year working with the division of vocational rehabilitation (DVR), a traditional DD waiver employment provider, an independent living center or other organization that provides employment supports or services for people with disabilities; and be trained on the purposes, functions and general practices of entities such as the department of workforce solutions navigators, one-stop career centers, business leadership network, chamber of commerce, job accommodation network, small business development centers, retired executives and New Mexico employment institute.

(b) Job coaches must have experience as a job coach for at least one year in the state of New Mexico; have experience for at least one year using job and task analyses; be trained on the Americans with Disabilities Act (ADA); and be trained on the purpose, function and general practices of the DVR office.

(2) **Qualifications of customized community supports providers:** Adult habilitation agency staff must have at least one year of experience working with individuals with disabilities. Adult day health provider agencies must be licensed by DOH as an adult day care facility pursuant to 7.13.2 NMAC. Adult day health agency staff must have at least one year of experience working with individuals with disabilities.

G. **Service specific qualifications for providers of HEALTH AND WELLNESS SUPPORTS:** In addition to the general qualifications, the following types of providers must meet additional qualifications specific to the type of services provided.

(1) **Qualifications of extended state plan skilled therapy providers for adults:** Physical and occupational therapists, speech/language pathologists, and physical therapy assistants must possess a therapy license in their respective field from the New Mexico regulation and licensing department (RLD). Certified occupational therapy assistants must possess an occupational therapy assistant certification from the New Mexico RLD. Speech clinical fellows must possess a clinical fellow license from the New Mexico RLD.

(2) Q**ualifications of behavior support consultation providers:** Behavior consultant provider agencies shall have a current business license issued by the state, county or city government, if required. Behavior consultant provider agencies shall comply with all applicable federal, state, and waiver regulations, policies and procedures regarding behavior consultation. Providers of behavior support consultation services must possess qualifications in at least one of the following areas: licensed psychiatrist, licensed clinical psychologist, licensed psychologist associate, (masters or Ph.D. level), a licensed independent social worker (LISW), licensed master social worker (LMSW), licensed professional clinical counselor (LPCC), licensed professional counselor (LPC), licensed psychiatric nurse (MSN/RNCS), licensed marriage and family therapist (LMFT), or licensed practicing art

therapist (LPAT). Providers of behavior support consultation must maintain a current New Mexico license with the appropriate professional field licensing body.

(3) **Qualifications of nutritional counseling providers:** Nutritional counseling providers must maintain a current registration as dietitians by the commission on dietetic registration of the American dietetic association.

(4) **Qualifications of private duty nursing providers for adults:** Direct nursing services are provided by individuals who are currently licensed as registered or practical nurses by the New Mexico state board of nursing.

(5) Q**ualifications of specialized therapy providers:** Specialized therapy providers must possess a current New Mexico state license, as applicable, in at least one of the following areas:

(a) acupuncture and oriental medicine;

(b) biofeedback or a health care profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision;

(c) chiropractic medicine;

(d) cognitive rehabilitation therapy or a health care profession whose scope of practice includes cognitive rehabilitation therapy, and appropriate specialized training and clinical experience and supervision;

(e) hippotherapy or a health care profession whose scope of practice includes hippotherapy, and appropriate specialized training and experience;

(f) massage therapy;

(g) naprapathic medicine;

(h) play therapy or a mental health profession whose scope of practice includes play therapy, a master's degree or higher mental health degree, and specialized play therapy training and clinical experience and supervision; or

(i) Native American healers, or individuals who are recognized as traditional healers within their communities.

H. **Service specific qualifications for OTHER SUPPORTS providers:** In addition to the general qualifications, the following types of providers must meet additional qualifications specific to the type of services provided.

1. Qualifications of transportation providers: Individual transportation providers must possess a valid New Mexico driver's license with the appropriate classification, be free of physical or mental impairment that would adversely affect driving performance, have no driving while intoxicated (DWI) convictions or chargeable (at fault) accidents within the previous two years, have current CPR/first aid certification; and be trained on DOH/division of health improvement (DHI) critical incident reporting procedures and have a current insurance policy and vehicle registration. Transportation vendors must hold a current business license and tax identification number. Each agency will ensure drivers meet the following qualifications:

(1) possess a valid, appropriate New Mexico driver's license;

(2) be free of physical or mental impairment that would adversely affect driving performance;

(3) have no DWI convictions or chargeable (at fault) accidents within the previous two years;

(4) have current CPR/first aid certification;

(5) be trained on DOH/DHI critical incident reporting procedures;

(6) have a current insurance policy and vehicle registration; and

(7) each agency will ensure vehicles have a current basic first aid kit in the vehicle.

J. Q**ualifications of emergency response providers:** Emergency response providers must comply with all laws, rules and regulations of the New Mexico state corporation commission for telecommunications and security systems.

K. **Qualifications of respite providers:** Respite services may be provided by eligible individual respite providers; licensed registered (RN) or practical nurses (LPN); or respite provider agencies. Individual RN/LPN providers must be licensed by the New Mexico state board of nursing as an RN or LPN. Respite provider agencies must hold a current business license, and meet financial solvency, training, records management and quality assurance rules and requirements.

L. **Qualifications of related goods vendors:** Related goods vendors must hold a current business license for the locale they are in and a tax ID for the state and federal government.

M. **Qualifications of environmental modifications providers:** Environmental modification providers must possess an appropriate plumbing, electrician, contractor or other appropriate license.

[8.314.6.11 NMAC - N, 2-15-11]

8.314.6.12 RECORDKEEPING AND DOCUMENTATION RESPONSIBILITIES: Service providers and vendors who furnish goods and services to mi via participants are reimbursed by the FMA and must comply with all mi via regulations. The FMA, consultants and service providers must maintain records, which are sufficient to fully disclose the extent and nature of the goods and services provided to participants, pursuant to 8.302.1.17 NMAC, *record keeping and documentation requirements*, and comply with random and targeted audits conducted by HSD/MAD, ALTSD, and DOH or their audit agents. HSD/MAD or its designee will seek recoupment of funds from service providers when audits show inappropriate billing for services. Mi via vendors who furnish goods and services to mi via participants and bill the FMA must comply with all medicaid participation requirements, including but not limited to 8.302.1 NMAC, *General Provider Policies.*
[8.314.6.12 NMAC - N, 2-15-11]

8.314.6.13 ELIGIBILITY REQUIREMENTS FOR PARTICIPANT ENROLLMENT IN MI VIA: Enrollment in mi via is contingent upon the applicant meeting the eligibility requirements as described in the mi via regulations, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated participants. When sufficient funding as well as waiver positions are available, the appropriate state administering agency will offer the opportunity to individuals to apply for mi via.

A. Once an allocation has been offered to the applicant he/she must meet certain medical and financial criteria in order to qualify for enrollment. Applicants must meet the following eligibility criteria:

(1) Financial eligibility criteria determined in accordance with 8.290.500 NMAC, and

(2) The participant must meet the LOC required for admittance to an NF or an ICF-MR and additional specific criteria as specified in the categories below:

(a) **Developmental disability:** Individuals who have a severe chronic disability, other than mental illness, that:

(i) is attributable to a mental or physical impairment, including the result of trauma to the brain, or a combination of mental and physical impairments;

(ii) is manifested before the person reaches the age of 22 years;

(iii) is expected to continue indefinitely;

(iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency;

(v) reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other supports and services that are of life-long or extended duration and are individually planned and coordinated;

(vi) the individual must have a developmental disability and mental retardation or a specific related condition; related conditions are limited to cerebral palsy, autism (including asperger syndrome), seizure disorder, chromosomal disorders (e.g. down), syndrome disorders, inborn errors of metabolism, and developmental disorders of brain formation; and

(vii) the individual must require an ICF/MR LOC.

(b) **Medically fragile:** Individuals who have been diagnosed with a medically fragile condition before reaching age 22, and who:

(i) have a developmental disability or developmental delay, or who are at risk for developmental delay;

(ii) have a chronic physical condition which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following;

(iii) have a life-threatening condition, characterized by reasonably frequent periods of acute exacerbation, which requires frequent medical supervision or physician consultation, and which, in the absence of such supervision or consultation, would require hospitalization; or have frequent, time-consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include, but are not limited to, ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen; and

(iv) require ICF/MR LOC.

(c) **Disabled and elderly:** Individuals who are elderly (age 65 or older), blind or disabled, as determined by the disability determination unit utilizing social security disability guidelines, who require NF LOC and either reside in the community, are institutionalized, or are at risk of institutionalization.

(d) **AIDS:** Individuals who have been diagnosed as having AIDS or AIDS-related condition (ARC) and who require NF LOC.

(e) **Brain-Injury (BI):** Individuals (through age 64) with an injury to the brain of traumatic or acquired origin resulting in total or partial functional disability or psychosocial impairment or both. Additional criteria include:

(i) the term applies to open and closed head injuries caused by an insult to the brain from an outside physical force, anoxia, electrical shock, shaken baby syndrome, toxic and chemical substances, near-drowning, infections, tumors, or vascular lesions;

(ii) BI may result in either temporary or permanent, partial or total impairments in one or more areas including, but not limited to: cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem solving, sensory perceptual and motor abilities, psychosocial behavior, physical functions, information processing, and speech;

(iii) the term ***"brain injury"*** does not apply to brain injuries that are congenital, degenerative, induced by birth trauma or neurological disorders related to the aging process, or chemically caused brain injuries that are a result of habitual substance abuse; the BI participant must have a documented BI diagnosis contained in the ICD-9-CM document (see Attachment I to these regulations); and

(iv) the individual must require NF LOC.

B. After initial eligibility has been established, on-going eligibility must be re-determined on an annual basis.

[8.314.5.13 NMAC - N, 2-15-11]

8.314.6.14 PARTICIPANT RESPONSIBILITIES: Mi via participants have certain responsibilities to participate in the waiver. Failure to comply with these responsibilities or other program rules and regulations can result in termination from the program. The participant and EOR have the following responsibilities:

A. To maintain eligibility a participant must complete required documentation demonstrating medical and financial eligibility both upon application and annually at recertification, meet in person with the TPA for a comprehensive LOC assessment in the applicant/participant's home, an agreed upon location or an inpatient setting, and seek assistance with the application and the recertification process as needed from a mi via consultant.

B. To participate in mi via a participant must:

(1) comply with the rules and regulations that govern the program;

(2) collaborate with the consultant to determine support needs related to the activities of self-direction;

(3) collaborate with the consultant to develop an SSP using the IAB in accordance with mi via program regulations;

(4) use state funds appropriately by only requesting and purchasing goods and services covered by the mi via program in accordance with program regulations and which are identified on the approved SSP;

(5) comply with the approved SSP and not exceed the AAB;

(a) If a participant does not adequately allocate the resources contained in the AAB resulting in a premature depletion of the AAB amount during an SSP year due to mismanagement or failure to properly track expenditures, the failure to properly allocate does not substantiate a claim for a budget increase (i.e., if all of the AAB is expended within the first three months of the SSP year, it is not justification for an increase in the budget for the SSP year).

(b) Revisions to the AAB may occur within the SSP year, and the participant is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. The SSP must be amended first to reflect a change in the participant's needs or circumstances before any revisions to the AAB can be requested. Major budget revisions may not be submitted to the TPA for review during the first 90 days of the participant's budget year, or within the last 60 days of the budget year.

(c) No mi via program funds can be used to purchase goods or services prior to TPA approval of the SSP and annual budget request.

(d) Any funds not utilized within the SSP and AAB year cannot be carried over into the following year.

(6) access consultant services based upon identified need(s) in order to carry out the approved SSP;

(7) collaborate with the consultant to appropriately document service delivery and maintain those documents for evidence of services received;

(8) report concerns or problems with any part of mi via to the consultant;

(9) work with the TPA agent by attending scheduled meetings, in the participant's home if necessary and providing documentation as requested;

(10) respond to requests for additional documentation and information from the consultant provider, FMA, and the TPA within the required deadlines;

(11) report to the local income support division office within 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;

(12) report to the TPA and consultant provider if hospitalized for more than three nights so that an appropriate LOC can be obtained; and

(13) keep track of all budget expenditures and assure that all expenditures are within the AAB; and

(14) meet monthly and quarterly with the consultant.

C. Additional responsibilities of the participant or EOR:

(1) Submit all required documents to the FMA to meet employer-related responsibilities. This includes, but is not limited to documents for payment to employees and vendors and payment of taxes and other financial obligations within required timelines.

(2) Report any incidents of abuse, neglect or exploitation to the appropriate state entity.

(3) Arrange for the delivery of services, supports and goods.

(4) Hire, manage, and terminate employees.

(5) Maintain records and documentation in accordance with 8.302.1.17 NMAC, related to personnel, payroll and service delivery.

D. **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 current traditional waivers (CoLTS (c), DD, MF, or AIDS) and decide to discontinue self-directing their services, may return to the traditional waiver in accordance with the mi via rules and service standards. Mi via participants who are eligible under the BI category of eligibility and choose to discontinue self-direction may be transitioned to CoLTS services.

E. **Involuntary termination:** A mi via participant may be terminated involuntarily and offered services through another 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:

(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 contractor team 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/herself or others.

(3) The participant misuses mi via funds following repeated and focused technical assistance and support from the consultant or FMA, which is supported by documentation.

(4) The participant commits medicaid fraud.

(5) Participant who is involuntarily terminated from mi via may be offered a non self-directed waiver alternative. If transfer to another waiver is authorized by the state and accepted by the participant, 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 no break in service occurs. The mi via consultant and the service coordinator in the new waiver will work closely together with the participant to ensure that the participant's health and safety is maintained. Fair hearing notice and rights apply to the participant.

[8.314.6.14 NMAC - N, 2-11-11]

8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA: The services covered by mi via are intended to provide a community-based alternative to institutional care that allows greater choice, direction and control over services and supports in a self-directed environment. Mi via services must specifically address a therapeutic, rehabilitative, habilitative, health and/or safety need that results from the participant's qualifying

condition. The mi via program is the payor of last resort. The coverage of mi via services must be in accordance with the mi via program regulations.

A. **General requirements regarding mi via covered services.** For a service to be considered a covered service under the mi via program, the following criteria must be met. Services, supports and goods must:

(1) directly address the participant's qualifying condition or disability;

(2) meet the participant's clinical, functional, medical or habilitative needs;

(3) be designed and delivered to advance the desired outcomes in the participant's service and support plan; and

(4) support the participant to remain in the community and reduce the risk of institutionalization.

B. **Consultant pre-eligibility/enrollment services:** Consultant pre-eligibility/enrollment services are intended to provide information, support, guidance, and assistance to individuals during the medicaid financial and medical eligibility process. The level of support provided is based upon the unique needs of the individual. When an opportunity to be considered for mi via waiver services is offered to an individual, he/she must complete a primary freedom of choice form. The purpose of this form is for the individual to select a consultant provider. The chosen consultant provider provides pre-eligibility/enrollment services as well as on-going consultant services. Once the individual is determined to be eligible for mi via waiver services, the consultant service provider will continue to provide consultant services to the newly enrolled participant as set forth in the consultant service standards.

C. **Consultant services:** Consultant services are required for all mi via participants to educate, guide, and assist the participant to make informed planning decisions about services and supports. The consultant helps the participant develop the SSP based on his/her assessed needs. The consultant assists the participant with implementation and quality assurance related to the SSP and AAB. Consultant services help the participant identify supports, services and goods that meet his/her needs, meet the mi via requirements and are covered mi via services. Consultant services provide support to participants to maximize their ability to self-direct in mi via.

(1) **Contact requirements:** Consultant providers shall make contact with the participant in person or by telephone at least monthly for a routine follow-up. Consultant providers shall meet in person with the participant at least quarterly for the following purposes:

(a) review and document progress on implementation of the SSP;

(b) document usage and effectiveness of the 24-hour emergency backup plan;

(c) review SSP/budget spending patterns (over and under-utilization);

(d) assess quality of services, supports and functionality of goods in accordance with the quality assurance section of the SSP and any applicable mi via regulations and service standards;

(e) document the participant's access to related goods identified in the SSP;

(f) review any incidents or events that have impacted the participants' health, welfare or ability to fully access and utilize support as identified in the SSP; and

(g) other concerns or challenges raised by the participant, legal representative, or authorized representative.

(2) **Change of consultants:** Consultants are responsible for assisting participants to transition to another consultant provider when requested. Transition from one consultant provider to another can only occur at the first of the month.

(3) **Critical incident management responsibilities and reporting requirements:** The consultant provider shall provide training to participants regarding recognizing and reporting critical incidents. Critical incidents include abuse, neglect, exploitation, emergency services, law enforcement involvement, environmental hazards and participant deaths. This participant training shall also include reporting procedures for participants, employees, participant representatives or other designated individuals. The consultant provider shall report incidents of abuse, neglect and exploitation as directed by the state. The consultant provider shall maintain a critical incident management system to identify, report, and address critical incidents. The consultant provider is responsible for follow-up and assisting the individual to help ensure health and safety when a critical incident has occurred. Critical incident reporting requirements:

(a) For mi via participants who have been designated with an ICF/MR level of care, critical incidents should be directed in the following manner.

(i) The DOH/DHI/ Incident Management Bureau (IMB) receives, triages, and investigates all reports of alleged abuse, neglect, exploitation, and other incidents for mi via services provided by community-based waiver service agencies, to include expected and unexpected deaths. The reporting of incidents is mandated pursuant to 7.1.13 NMAC. Any suspected abuse, neglect, or exploitation must be reported to the children youth and families department (CYFD)/child protective services (CPS) for individuals under the age of 18 or to the

ALTSD/adult protective services (APS) for individuals age 18 or older by reporting or faxing an incident report (IR). Additionally, the IR form must be faxed to DOH/DHI within 24 hours of knowledge of an incident or the following business day when an event occurs on a weekend or holiday. Anyone may report an incident; however, the person with the most direct knowledge of the incident is the individual who is required to report the incident.

(ii) When an incident is reported late, and the mi via service is provided by a community-based waiver service agency, a letter is sent to the provider stating that an incident report was received beyond the required 24-hour timeline for reporting. The letter further reiterates the requirement to report incidents within 24 hours. The consequences of non-compliance may result in sanctions, as set forth in 7.1.13.12 NMAC.

(iii) With respect to waiver services provided by any employee, contractor or vendor other than a community-based waiver service agency, any suspected abuse, neglect, or exploitation must be reported to the CYFD/CPS for individuals under the age of 18 or to the ALTSD/APS for individuals age 18 or older by reporting or faxing an incident report. See NMSA 1978, Sections 27-7-14 through 27-7-31 (Adult Protective Services Act) and in NMSA 1978, Sections 32A-4-1 through 32A-4-34 (Child Abuse and Neglect Act).

(b) For individuals in mi via that have been designated with an NF LOC, critical incidents should be directed to:

(i) ALTSD/APS for individuals age 18 or older or CYFD/CPS for individual under the age of 18 for critical incidents involving abuse, neglect and/or exploitation; and

(ii) ALTSD, elderly and disability services division (EDSD) as well as the managed care organization, if applicable. The consultant provider shall fax all critical incidents in the standardized format provided by the state.

D. **Personal plan facilitation:** Personal plan facilitation 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 time per budget year.

(1) In the scope of personal planning facilitation, the personal plan facilitator will:

(a) meet with the participant and his/her family (or legal representative, as appropriate) prior to the personal planning session to discuss the process, to determine who the participant wishes to invite, and determine the most convenient date, time and location. This meeting preparation shall include an explanation of the techniques the facilitator is proposing to use or options if the facilitator is trained in multiple techniques. The preparation shall also include a discussion of the role the participant prefers to play at the planning session, which may include co-facilitation of all or part of the session.

(b) arrange for participation of invitees and location;

(c) conduct the personal planning session;

(d) document the results of the personal planning session and provide a copy to the participant, the consultant and any other parties the participant would like to receive a copy.

(2) Elements of this report shall include:

(a) recommended services to be included in the SSP;

(b) services from sources other than medicaid to aid the participant;

(c) long-term goals the participant wishes to pursue;

(d) potential resources, especially natural supports within the participant's community that can help the participant to pursue his or her desired outcomes(s)/goal(s); and

(e) a list of any follow-up actions to take, including time lines.

(3) Provide session attendees, including the participant, with an opportunity to provide feedback regarding the effectiveness of the session.

E. **Living supports:**

(1) **Homemaker/direct support services:** Homemaker/direct support services are provided on an episodic or continuing basis to assist the participant with activities of daily living, performance of general household tasks, and enable the participant to accomplish tasks he/she would normally do for him/herself if he/she did not have a disability. Homemaker/direct support services are provided in the participant's home and in the community, depending on the participant's needs. The participant identifies the homemaker/direct support worker's training needs, and, if the participant is unable to do the training him/herself, the participant arranges for the needed training. Services are not intended to replace supports available from a primary caregiver.

(a) Two or more participants living in the same residence, who are receiving services and supports from mi via will be assessed both independently and jointly to determine coverage of services and supports that are shared. Services and supports will be approved based on common needs and not individual needs, unless the TPA has assessed that there is an individual need for the services.

(b) Personal care services are covered under the medicaid state plan as expanded EPSDT benefits for waiver participants under age 21.

(2) **Home health aide services:** Home health aide services provide total care or assist an adult participant in all activities of daily living. Home health aide services assist the participant in a manner that will promote an improved quality of life and a safe environment for the participant. Home health aide services can be provided outside the participant's home. State plan home health aide services are intermittent and provided primarily on a short-term basis. Mi via home health aide services are hourly services for participants who need this service on a more long-term basis. Home health aide services are not duplicative of homemaker services. Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Homemakers do not have this ability to perform such tasks.

(3) **Assisted living:** A residential service that includes personal care and supportive services (homemaker, chore, attendant services, meal preparation); medication oversight (to the extent permitted under state law); and 24-hour, on-site response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety, and security.

(a) Services also include social and recreational programming. Coverage does not include 24-hour skilled care or supervision or the cost of room or board.

(b) Nursing and skilled therapy services are incidental, rather than integral, to the provision of assisted living services.

(c) Services (other than those included in the bundle of "assisted living" services) provided by third parties must be coordinated with the assisted living provider.

(d) Participants who access this service cannot utilize mi via homemaker/direct support, environmental modifications, emergency response, customized community supports and customized in-home living supports services because they are provided by assisted living services.

(4) **Customized in-home living supports:** Customized in-home living supports are related to the participant's qualifying condition or disability and enable him/her to live in his /her apartment or house. This is for homes/apartments owned or leased by the participant. This is not available for a provider's home.

(a) These services and supports are provided in the participant's home and are individually designed to instruct or enhance home living skills as well as address health and safety.

(b) Customized in-home living supports include assistance with activities of daily living and assistance with the acquisition, restoration, or retention of independent living skills. This service is provided on a regular basis at least four or more hours per day one or more days per week as specified in the service plan.

(c) Participants receiving customized in-home living supports may not use homemaker/direct support or home health aide services because they are provided by customized in-home living supports.

F. **Community membership supports:**

(1) **Community direct support:** Community direct support providers deliver support to the participant to identify, develop and maintain community connections and access social, educational, recreational and leisure options.

(a) The community direct support provider may be a skilled independent contractor or a hired employee depending on the level of support needed by the participant to access the community.

(b) The community direct support provider may instruct and model social behavior necessary for the participant to interact with community members or in groups, provide assistance in ancillary tasks related to community membership, provide attendant care and help the participant schedule, organize and meet expectations related to chosen community activities.

(c) Community direct support services include:

(i) provide assistance to the participant outside of his/her residence and segregated facilities;

(ii) promote the development of social relationships and build connections within local communities;

(iii) support the participant in having frequent opportunities to expand roles in the community to increase and enhance natural supports, networks, friendships and build a sense of belonging; and

(iv) assist in the development of skills and behaviors that strengthen the participant's connection with his or her community.

(d) The skills to assist someone in a community setting may be different than those for assisting a person at home. The provider will:

(i) demonstrate knowledge of the local community and resources within that community that are identified by the participant on the SSP; and

(ii) be aware of the participant's barriers to communicating and maintaining health and safety while in the community setting.

(2) **Employment supports:** Employment supports include job development, support to find a job, and job coaching after available vocational rehabilitation supports have been exhausted. The job coach provides training, skill development, and employer consultation that a participant may require while learning to perform specific work tasks on the job; co-worker training; job site analysis; situational or vocational assessments and profiles; education of the participant and co-workers on rights and responsibilities; and benefits counseling.

(a) Job development is a service provided to participants by skilled staff. The service has five components:

(i) job identification and development activities;
(ii) employer negotiations;
(iii) job restructuring;
(iv) job sampling; and
(v) job placement.

(b) Employment supports will be provided by staff at current or potential work sites. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting.

(c) Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or IDEA.

(d) FFP is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

(i) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
(ii) payments that are passed through to users of supported employment programs; or
(iii) payments for training that is not directly related to an individual's supported employment program;
(iv) FFP cannot be claimed to defray expenses associated with starting up or operating a business.

(3) **Customized community supports:** Customized community supports can include participation in congregate community day programs and centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Customized community supports may include adult day habilitation, adult day health and other day support models. Customized community supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings. These services are provided at least four or more hours per day one or more days per week as specified in the participant's SSP.

G. Health and wellness:

(1) **Extended state plan skilled therapy for adults:** Extended state plan skilled therapy for adults includes physical therapy, occupational therapy or speech language therapy. Services are provided when state plan skilled therapy services are exhausted. Adults on mi via access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to adults in mi via focus on improving functional independence, health maintenance, community integration, socialization, and exercise, or enhance support and normalization of family relationships.

(a) **Physical therapy:** Diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance and promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy activities do the following:

(i) increase, maintain or reduce the loss of functional skills;
(ii) treat a specific condition clinically related to a participant's disability;
(iii) support the participant's health and safety needs; or
(v) identify, implement, and train on therapeutic strategies to support the participant and his/her family or support staff consistent with the participant's SSP desired outcomes and goals.

(b) **Occupational therapy:** Diagnosis, assessment, and management of functional limitations intended to assist adults to regain, maintain, develop, and build skills that are important for independence, functioning, and health. Occupational therapy services typically include:

(i) customized treatment programs to improve the participant's ability to perform daily activities;

(ii) comprehensive home and job site evaluations with adaptation recommendations;

(iii) skills assessments and treatment;

(iv) assistive technology recommendations and usage training;

(v) guidance to family members and caregivers;

(vi) increasing or maintaining functional skills or reducing the loss of functional skills;

(vii) treating specific conditions clinically related to a participant's developmental disability;

(viii) support for the participant's health and safety needs, and

(ix) identifying, implementing, and training therapeutic strategies to support the participant and his/her family or support staff consistent with the participant's SSP desired outcomes and goals.

(c) **Speech and language pathology:** Diagnosis, counseling and instruction related to the development and disorders of communication including speech fluency, voice, verbal and written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal, and sensor motor competencies. Speech language pathology is also used when a participant requires the use of an augmentative communication device. Based upon therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group. Services are intended to:

(i) improve or maintain the participant's capacity for successful communication or to lessen the effects of the participant's loss of communication skills; or

(ii) improve or maintain the participant's ability to eat foods, drink liquids, and manage oral secretions with minimal risk of aspiration or other potential injuries or illness related to swallowing disorders;

(iii) identify, implement and train therapeutic strategies to support the participant and his/her family or support staff consistent with the participant's SSP desired outcomes and goals.

(d) **Behavior support consultation:** Behavior support consultation services consist of functional support assessments, treatment plan development, and training and support coordination for a participant related to behaviors that compromise a participant's quality of life. Based on the participant's SSP, services are delivered in an integrated, natural setting, or in a clinical setting. Behavior support consultation:

(i) informs and guides the participant's service and support employees/vendors toward understanding the contributing factors to the participant's behavior;

(ii) identifies support strategies to ameliorate contributing factors with the intention of enhancing functional capacities, adding to the provider's competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behavior(s);

(iii) supports effective implementation based on a functional assessment and SSP;

(iv) collaborates with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues, and to limit the need for psychotherapeutic medications; and

(v) monitors and adapts support strategies based on the response of the participant and his/her service and support providers.

(e) **Nutritional counseling:** Nutritional counseling services include assessment of the participant's nutritional needs, development or revision of the participant's nutritional plan, counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan.

(f) **Private duty nursing for adults:** Private duty nursing for adults includes activities, procedures, and treatment for a participant's physical condition, physical illness or chronic disability. Services include medication management, administration and teaching, aspiration precautions, feeding tube management, gastrostomy and jejunostomy, skin care, weight management, urinary catheter management, bowel and bladder care, wound care, health education, health screening, infection control, environmental management for safety, nutrition management, oxygen management, seizure management and precautions, anxiety reduction, staff supervision, behavior and self-care assistance.

(2) **Specialized therapies:** Specialized therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. Experimental or investigational procedures, technologies or therapies and those services covered as a medicaid state plan benefit are excluded. Services in this category include the following therapies:

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

(b) **Biofeedback:** Biofeedback uses visual, auditory or other monitors to feed back to patients physiological information of which they are normally unaware. This technique enables an individual to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral, and cognitive health and performance. The use of biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback therapy is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

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

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

(e) H**ippotherapy:** Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for individuals with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the individual use cognitive functioning, especially for sequencing and memory. Individuals with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production.

(f) **Massage therapy:** Massage therapy is the assessment and treatment of soft tissues and their dysfunctions for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising the range of motion, and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, an individual's ability to be more independent in the performance of activities of daily living; thereby, decreasing dependency upon others to perform or assist with basic daily activities. See Massage Therapists 16.7.1 NMAC.

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

(h) **Native American healers:** Native American healing therapies encompass a wide variety of culturally-appropriate therapies that support participants in their communities by addressing their physical, emotional and spiritual health. Treatments may include prayer, dance, ceremony, song, plant medicines, foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel or other sacred objects.

(i) **Play therapy:** Play therapy is a variety of play and creative arts techniques ("the play therapy tool-kit") utilized to alleviate chronic, mild and moderate psychological and emotional conditions in

children that are causing behavioral problems and/or are preventing children from realizing their potential. The play therapist works integratively using a wide range of play and creative arts techniques, mostly responding to the child's wishes.

H. **Other supports:**

(1) T**ransportation:** Transportation services are offered to enable participants to gain access to services, activities, and resources, as specified by the SSP. Transportation services under the waiver are offered in accordance with the participant's SSP. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the medicaid state plan are to transport participants to medically necessary physical and behavioral health services. Payment for mi via transportation services is made to the participant's individual transportation employee or to a public or private transportation service vendor. Payment cannot be made to the participant. Whenever possible, family, neighbors, friends, or community agencies, who can provide this service without charge shall be identified in the SSP and utilized.

(2) **Emergency response services:** Emergency response services provide an electronic device that enables a participant to secure help in an emergency at home and avoid institutionalization. The participant may also wear a portable help button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center when a help button is activated. The response center is staffed by trained professionals. Emergency response services include:

(a) testing and maintaining equipment;

(b) training participants, caregivers and first responders on use of the equipment;

(c) 24-hour monitoring for alarms;

(d) checking systems monthly or more frequently, if warranted by electrical outages, severe weather, etc.;

(e) reporting emergencies and changes in the participant's condition that may affect service delivery; and

(f) ongoing emergency response service is covered, but initial set up and installation is not.

(3) **Respite:** Respite is a family support service, the primary purpose of which is to give the primary caregiver time away from his/her duties. Respite services include assisting the participant with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation and eating), enhancing self-help skills, and providing opportunities for leisure, play and other recreational activities; assisting the participant to enhance self-help skills, leisure time skills and community and social awareness; providing opportunities for community and neighborhood integration and involvement; and providing opportunities for the participant to make his/her own choices with regard to daily activities. Respite services are furnished on a short-term basis and can be provided in the participant's home, the provider's home, in a community setting of the family's choice (e.g., community center, swimming pool, and park) or at a center in which other individuals are provided care. FFP is not claimed for the cost of room and board as part of respite services.

(4) **Related goods:** Related goods are equipment, supplies or fees and memberships, not otherwise provided through mi via, the medicaid state plan, or medicare.

(a) Related goods must address a need identified in the participant's SSP and meet the following requirements:

(i) be responsive to the participant's qualifying condition or disability; and

(ii) meet the participant's clinical, functional, medical or habilitative needs; and

(iii) supports the participant to remain in the community and reduces the risk for institutionalization; and

(iv) promote personal safety and health; and afford the participant an accommodation for greater independence; and

(v) decrease the need for other medicaid services; and

(vi) accommodate the participant in managing his/her household; or

(vii) facilitate activities of daily living.

(b) Related goods must be documented in the SSP, comply with Paragraph (3) of Subsection D of 8.314.6.17 NMAC, and be approved by the TPA. The cost and type of related good is subject to approval by the TPA. Participants are not guaranteed the exact type and model of related good that is requested. The consultant, TPA or the state can work with the participant to find other (including less costly) alternatives.

(c) The related goods must not be available through another source and the participant must not have the personal funds needed to purchase the goods.

(d) These items are purchased from the participant's AAB.

(e) Experimental or prohibited treatments and goods are excluded.

(4) **Environmental modifications**: Environmental modification services include the purchase and installation of equipment or making physical adaptations to a participant's residence that are necessary to ensure the health, safety, and welfare of the participant or enhance the participant's level of independence.

(a) Adaptations include the installation of ramps and grab-bars; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities such as roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing; turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light-activated, motion-activated and electronic devices; fire safety adaptations; air filtering devices; heating/cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems or signaling devices.

(b) All services shall be provided in accordance with applicable federal, state, and local building codes.

(c) Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant, such as fences, storage sheds or other outbuildings. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

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

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

(f) Environmental modification services are limited to $7,000 every five years. Environmental modifications must be approved by the TPA.

(g) Environmental modifications are paid from a funding source separate from the AAB.

[8.314.6.15 NMAC - N, 2-15-11]

8.314.6.16 NON-COVERED SERVICES: Non-covered services include, but are not limited to the following:

A. services covered by the medicaid state plan (including EPSTD), medicaid school-based services, medicare and other third-parties;

B. any service or good, the provision of which would violate federal or state statutes, regulations or guidance;

C. formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by DVR;

D. room and board, meaning shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing, maintenance, utilities and utility deposits, and related administrative expenses. Utilities include gas, electricity, propane, fire wood, wood pellets, water, sewer, and waste management;

E. experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC,

F. 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 expense;

G. any goods or services that are to be used primarily for recreational or diversional purposes;

H. personal goods or items not related to the disability;

I. service animals and the costs of maintaining service animals, with the exception of training and certification;

J. gas cards and gift cards;

K. purchase of insurance, such as car, health, life, burial, renters, home-owners, service warrantees or other such policies;

L. purchase of a vehicle, and long-term lease or rental of a vehicle;

M. purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items;

N. firearms, ammunition or other weapons;

O. gambling, games of chance (such as bingo or lottery), alcohol, tobacco, or similar items;

P. vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses;

Q. 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;

R. purchase of food, maintenance, routine veterinary visits, medication, grooming and boarding for any therapeutic service or assistance animal;

S. purchase of any pet animal, food, maintenance, routine veterinary visits, medication, grooming and boarding costs associated with maintaining any pet;

T. 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;

V. 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;

W. clothing and accessories, *excluding* specialized clothing based on the participant's disability or condition;

X. training expenses for paid employees;

Y. conference or class fees may be covered for participants or unpaid caregivers, but costs associated with such conferences or class cannot be covered, including airfare, lodging or meals;

Z. consumer electronics such as computers, printers and fax machines, or other electronic equipment that does not meet the criteria specified in Subsection A of 8.314.6.15 NMAC; and

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

[8.314.6.16 NMAC - N, 2-15-2011]

8.314.6.17 SERVICE AND SUPPORT PLAN (SSP) AND AUTHORIZED ANNUAL BUDGET(AAB): An SSP and an annual budget request are developed at least annually by the mi via participant in collaboration with the participant's consultant and others that the participant invites to be part of the process. The consultant serves in a supporting role to the mi via participant, assisting the participant to understand mi via, and with developing and implementing the SSP the AAB. The SSP and annual budget request are developed and implemented in accordance with the mi via program rules and service standards and submitted to the TPA for final approval. Upon final approval the annual budget request becomes and AAB.

A. **SSP Development Process:** For development of the participant-centered service plan, the planning meetings are scheduled at times and locations convenient to the participant. The state obtains information about participant strengths, capacities, preferences, desired outcomes and risk factors through the LOC assessment and the planning process that is undertaken between the consultant and participant to develop the participant's SSP. If the participant chooses to purchase personal plan facilitation services, that assessment information would also be used in developing the SSP.

(1) **Assessments:**

(a) Assessment activities that occur prior to the SSP meeting assist in the development of an accurate and functional plan. The functional assessments conducted during the LOC determination process address the following needs of a person: medical, adaptive behavior skills, nutritional, functional, community/social and employment. LOC assessments are conducted in person and take place in the applicant/participant's home, an agreed upon location or an inpatient setting.

(b) Assessments occur on an annual basis or during significant changes in circumstance or at the time of the LOC determination. After the assessments are completed, the results are made available to the participant and his/her consultant for use in planning.

(c) The participant and the consultant will assure that the SSP addresses the information and concerns, if any, identified through the assessment process.

(d) Participant/employer self assessments are completed prior to SSP meetings (participant/employer self assessments may be revised during the year to address any life changes). The SSP must address areas of need, as recognized in the participant/employer self assessment.

(2) **Pre-Planning:**

(a) The consultant contacts the participant upon his/her choosing mi via to provide information regarding mi via, including the range and scope of choices and options, as well as the rights, risks, and responsibilities associated with self-direction.

(b) The consultant discusses areas of need to address on the participant's SSP. The consultant provides support during the annual recertification process to assist with completing medical and financial eligibility in a timely manner.

(c) Personal plan facilitators are optional supports. To assist in pre-planning, the participant is also able to access an approved provider to develop a personal plan.

(3) **SSP components:** The SSP contains:

(a) the waiver services that are furnished to the mi via recipient, the projected amount, frequency and duration, and the type of provider who furnishes each service;

(i) the SSP must describe in detail how the services or goods relate to the participant's qualifying condition or disability;

(ii) the SSP must describe how the services and goods support the participant to remain in the community and reduce his/her risk of institutionalization; and

(iii) the SSP must specify the hours of services to be provided and payment arrangements;

(b) other services needed by the mi via recipient regardless of funding source, including state plan services;

(c) informal supports that complement waiver services in meeting the needs of the recipient;

(d) methods for coordination with state plan services and other public programs;

(e) methods for addressing the recipient's health care needs when relevant;

(f) quality assurance criteria to be used to determine if the services and goods meet the participants needs as related to his/her qualifying condition or disability;

(g) information, resources or training needed by the mi via recipient and service providers;

(h) methods to address the recipient's health and safety, such as 24-hour emergency and back-up services; and

(i) the IAB.

(4) **Service and support plan meeting:**

(a) The participant receives an LOC assessment and local resource manual prior to the SSP meeting.

(b) The participant may begin planning and drafting the SSP utilizing those tools prior to the SSP meeting.

(c) During the SSP meeting, the consultant assists the participant to ensure that the SSP addresses the participant's goals, health, safety and risks. The participant and the consultant will assure that the SSP addresses the information and concerns identified through the assessment process. The SSP must address the participant's health and safety needs before addressing other issues. The consultant ensures that:

(i) the planning process addresses the participant's needs and goals in the following areas: health and wellness and accommodations or supports needed at home and in the community;

(ii) services selected address the participant's needs as identified during the assessment process. Needs not addressed in the SSP will be addressed outside the mi via program;

(iii) the outcome of the assessment process for assuring health and safety is considered in the plan;

(iv) services do not duplicate or supplant those available to the participant through the medicaid state plan or other programs;

(v) services are not duplicated in more than one service code;

(vi) job descriptions are complete for each provider and employee in the plan; job descriptions will include frequency, intensity and expected outcomes for the service;

(vii) the quality assurance section of the SSP is complete and specifies the roles of the participant, consultant and any others listed in this section;

(viii) the responsibilities are assigned for implementing the plan;

(ix) the back-up plans are complete; and

(x) the SSP is submitted to the TPA after the SSP meeting, in compliance with mi via waiver rules.

B. **Individual budgetary allotment (IBA):** Each mi via participant's annual IBA is determined by the state as follows:

(1) budgetary allotments are based on calculations developed by the state for each mi via population group, including AIDS, former Disabled & Elderly (D&E) now CoLTS (c), DD or MF waiver, and BI category of eligibility, utilizing historical traditional waiver care plan authorized budgets within the population, minus the case management costs, and minus a 10 percent discount. The budget metholodogy is attached to this section of the NMAC as Attachment II;

(2) the determination of each mi via participant's sub-group is based on a comprehensive assessment. The participant then receives the IBA available to that sub-group, according to the participant's age, the IBA for each sub-group is attached to this section as Attachment III;

(3) a mi via participant has the authority to expend the IBA through an AAB that is to be expended on a monthly basis and in accordance with the mi via rules and program service standards.

(a) The current mi via rate schedule, which is attached to this section as Attachment IV shall be used as a guide in evaluating proposed payment rates for services that are currently covered or similar to currently covered services. The participant must justify in writing the rate that he/she wishes to pay when that rate exceeds the rate schedule. The participant must include this justification with the SSP and annual budget request when it is submitted for approval.

(b) The AAB shall contain goods and services necessary for health and safety (i.e. direct care services and medically related goods) which will be given priority over goods and services that are non-medical or not directly related to health and safety. This prioritization applies to the IBA, AAB, and any subsequent modifications.

C. **SSP review criteria: S**ervices and related goods identified in the participant's requested SSP may be considered for approval if the following requirements are met:

(1) The services or goods must be responsive to the participant's qualifying condition or disability; and

(2) The services or goods must address the participant's clinical, functional, medical or habilitative needs; and

(3) The services or goods must accommodate the participant in managing his/her household; or

(4) The services or goods must facilitate activities of daily living; or

(5) The services or goods must promote the participant's personal health and safety; and

(6) The services or goods must afford the participant an accommodation for greater independence; and

(7) The services or goods must support the participant to remain in the community and reduce his/her risk for institutionalization; and

(8) The services or goods must be documented in the SSP and advance the desired outcomes in the participant's SSP; and

(9) 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

(10) The services or goods must decrease the need for other medicaid services; and

(11) The participant receiving the services or goods does not have the funds to purchase the services or goods; or

(12) 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

(13) The service or good is not prohibited by federal and state statutes, regulations and guidance; and

(14) 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.

D. **Budget review criteria:** The participant's proposed annual budget request may be considered for approval, if all of the following requirements are met:

(1) The proposed annual budget request is within the participant's IBA; and

(2) The proposed rate for each service is within the mi via range of rates for that chosen service; and

(3) The proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and

(4) The estimated cost of the service or good is specifically documented in the participant's budget worksheets; and

(5) No employee exceeds 40 hours paid work in a consecutive seven-day period.

E. **Modification of the SSP:**

(1) 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.

(2) If the modification is to provide new or additional services than originally included in the SSP, these services must not be able to be acquired through other programs or sources. The participant must document the fact that the services are not available through another source.

(3) 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 by forwarding the request for modification to the TPA for review.

(4) The SSP must be modified before there is any change in the AAB.

(5) The SSP may be modified once the original SSP has been submitted and approved. Only one SSP revision may be submitted at a time, e.g., an SSP revision may not be submitted if an initial SSP request or prior SSP revision request is under initial review by the TPA. This requirement also applies to any re-review or re-consideration of the same revision request. Other than for critical health and safety reasons, neither the SSP nor the AAB may be modified within 90 days of initial approval or within 60 days of expiration of the current SSP.

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

(1) 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. Other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review during the first 90 days of the participant's budget year, or within the last 60 days of the budget year;

(2) The amount of the AAB cannot exceed the participant's annual IBA. The rare exception would be a participant whose assessed or documented needs, 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.

(3) If the participant requests an increase in his/her budget above his/her annual IBA, the participant must show one of the following circumstances:

(a) Chronic physical condition: The participant has one 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; the participant's needs cannot be met within the assigned IBA or other current resources, including natural supports, medicaid state plan services, medicare or other sources; and which are characterized by at least one of the following:

(i) a life-threatening condition with frequent or constant periods of acute exacerbation that places the participant at risk for institutionalization;

(ii) that could result in the participant's inability to remember to self-administer medications accurately even with the use of assistive technology devices;

(iii) that requires a frequency and intensity of assistance, supervision, or consultation to ensure the participant's health and safety in the home and/or in the community; or

(iv) which, in the absence of such skilled intervention, assistance, medical supervision or consultation, would require hospitalization or admission to an NF or ICF/MR.

(b) The need for administration of specialized medications, enteral feeding or treatments that:

(i) are ordered by a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant; and

(ii) require frequent and ongoing management or monitoring or oversight of medical technology.

(c) 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 IAB or other current resources, including natural supports, are not covered under the medicaid state plan, medicare or other sources. These are the types of changes that may necessitate an increase in the IAB. 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 hours, or more frequently, as needed. The participant now has seizure activity that requires continuous

monitoring for injury and aspiration, despite anti-convulsant therapy. The participant now requires increased assistance with activities of daily living.

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

(ii) The participant may submit additional supportive documentation by others involved in the participant's care, such as a current individual service plan 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.

(d) 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 and cognitive difficulties are so severe and intense that they result in considerable risk to the participant, caregivers or the community; require a frequency and intensity of assistance, supervision or consultation to ensure the participant's health and safety in the home or the community; are likely to lead to incarceration or admission to a hospital, NF or ICF-MR; require intensive intervention or medication management by a doctor or mental health practitioner or care practitioner; and cannot be effectively addressed within the IAB or other resources, including natural supports, the medicaid state plan, medicare or other sources.

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

(ii) The participant must submit a written dated and signed evaluation or letter from a medical doctor, doctor of osteopathy, certified nurse practitioner, physician's assistant, psychiatrist or psychologist with a doctorate of psychologist that documents the participant's mental health or behavioral status relevant to the criteria. If the need for additional budgetary allotment is identified during the LOC assessment, it must be reflected in the assessment. If there has been a change in the participant's behaviors or cognitive difficulties, additional documentation is required. With a change in the participant's behavior or cognitive difficulties, the evaluation or letter must have been completed since the last LOC assessment or less than one year from the date the request is submitted, whichever is more recent.

(iii) The participant may submit additional supportive documentation including a current individual service plan if the participant is transferring from another waiver, a positive behavioral support plan or assessment, recent notes, a summary or letter from a mental health practitioner or professional with expertise in developmental disabilities, brain injury or geriatrics, 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.

(e) 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 IAB and are not available through the medicaid state plan, medicare, other programs or sources in order for the participant to live in a home and community-based setting.

(4) A mi via participant is responsible for tracking all budget expenditures and assuring that all expenditures are within the AAB. The participant must not exceed the AAB within any SSP year. A participant's failure to properly allocate the expenditures within the SSP year resulting in the depletion of the AAB, due to mismanagement of or failure to track the funds, prior to the calendared expiration date does not substantiate a claim for a budget increase (i.e, if all of the AAB is expended within the first three months of the SSP year, it is not justification for an increase in the annual budget for that SSP year). Amendments to the AAB may occur within the SSP year and the participant is responsible for assuring that all expenditures are in compliance with the most current AAB in effect. Amendments to the AAB must be preceded by an amendment to the SSP.

(5) The AAB may be revised once the original annual budget request has been submitted and approved. Only one annual budget revision request may be submitted at a time, e.g., an annual budget revision request may not be submitted if a prior annual budget revision request is under initial review by the TPA. The same requirement also applies to any re-review or reconsideration of the same revision request.

G. **SSP and annual budget supports:** As specified in the mi via program regulations and service standards, the mi via participant is assisted by the consultant in development and implementation of the SSP and AAB. The FMA assists the participant with implementation of the AAB,

H. **Submission for approval:** The TPA must approve the SSP and associated annual budget request (resulting in an AAB). The TPA must approve certain changes in the SSP and annual budget request, as specified in the mi via program rules and service standards and in accordance with 8.302.5 NMAC, *Prior Authorization and Utilization Review.*

(1) At any point during the SSP and associated annual budget utilization review process, the TPA may request additional documentation from the participant. This request must be in writing and submitted to both the participant and the consultant provider. The participant has 15-working days from the date of the request to submit the additional documentation. Failure by the participant to submit the requested information may subject the SSP and annual budget request to denial.

(2) Services cannot begin and goods may not be purchased before the start date of the approved SSP and AAB or approved revised SSP and revised AAB.

(3) Any revisions requested within the first 90 days of approval of the SSP and AAB or within 60 days of expiration of the SSP and AAB are subject to denial.

[8.314.6.17 NMAC - N, 2-15-11]

8.314.6.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services, including services covered under this waiver, are subject to utilization review for medical necessity and program requirements. Reviews by HSD/MAD or its designees may be performed before services are furnished, after services are furnished, before payment is made, or after payment is made in accordance with 8.302.5 NMAC, *Prior Authorization and Utilization Review.*

A. **Prior authorization:** Services, supports, and goods specified in the SSP and AAB require prior authorization from HSD/MAD or its designee. The SSP must specify the type, amount and duration of services. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** To be eligible for mi via program services, participants must require the LOC of services provided in an ICF-MR for recipients identified as DD and MF, or in an NF for recipients identified as Colts (c), diagnosed with AIDS, or BI. Prior authorization of services does not guarantee that applicants/participants are eligible for medicaid.

C. **Reconsideration:** If there is a disagreement with a prior authorization denial or other review decision, the consultant provider on behalf of the participant, can request a reconsideration from the TPA that performed the initial review and issued the initial decision. A reconsideration must be requested within 30-calendar days of the date on the denial notice. Reconsideration requests must be in writing and provide additional documentation or clarifying information regarding the participant's request for the denied services or goods.

D. **Denial of Payment:** If a service, support, or good is not covered under the mi via program, the claim for payment may be denied by HSD/MAD or its designee. If it is determined that a service is not covered before the claim is paid, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

[8.314.6.18 NMAC - N, 2-15-10]

8.314.6.19 REIMBURSEMENT:

A. Mi via participants must follow all billing instructions provided by the FMA to ensure payment of service providers and vendors.

B. Claims must be billed to the FMA per the billing instructions. Reimbursement to service providers and vendors in the mi via program is made, as follows:

(1) mi via service providers and vendors must enroll with the FMA;

(2) mi via participants receive instructions and documentation forms necessary for service providers' and vendors' claims processing;

(3) mi via participants must submit claims for payment of mi via service providers and vendors to the FMA for processing; claims must be filed per the billing instructions provided by the FMA;

(4) mi via participants and mi via service providers and vendors must follow all FMA billing instructions and those contained in 8.302 NMAC; and

(5) reimbursement of mi via service providers and vendors is made at a predetermined reimbursement rate negotiated by the participant with the service provider or vendor, approved by the TPA contractor, and documented in the SSP and in the provider/vendor agreement; at no time can the total expenditure for services exceed the participant's AAB.

C. The FMA must submit claims that have been paid by the FMA on behalf of mi via participant to the HSD/MAD fiscal contractor for processing.

D. Reimbursement may not be made directly to the participant, either to reimburse him/her for expenses incurred or enable the participant to pay a service provider directly.

[8.314.6.19 NMAC - N, 2-15-11]

8.314.6.20 RIGHT TO A HEARING: The HSD/MAD must grant an opportunity for an administrative hearing as described in this section in the following circumstances pursuant to 42 CFR Section 431.220(a)(1) and (2), NMSA 1978, Section 27-3-3 and 8.352.2 NMAC:

A. when a mi via applicant has been determined not to meet the LOC requirement for waiver services;

B. when a mi via applicant has not been given the choice of HCBS as an alternative to institutional care;

C. when a mi via applicant is denied the services of his/her choice or the provider of his/her choice;

D. when a mi via participant's services are denied, suspended, reduced or terminated;

E. when a mi via participant has been involuntarily terminated from the program;

F. when a mi via participant's request for a budget adjustment has been denied.

G. ALTSD and its counsel, if necessary, shall participate in any fair hearing involving a disabled or elderly participant, or a participant diagnosed with BI. DOH and its counsel, if necessary, shall participate in any fair hearing involving a DD or MF participant, or a participant diagnosed with AIDS. HSD/MAD, and its counsel, if necessary, may participant in fair hearings.

[8.314.6.20 NMAC – N, 2-15-11]

8.314.6.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL

A. Continuation of benefits may be provided to participants who request a hearing within 13 days of the 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.

B. Once a participant requests a continuation of benefits, his/her AAB that is in place at the time of the request is termed a continuation budget. The continuation budget may not be revised until the conclusion of the fair hearing process unless one of the criteria to modify the budget in Paragraph (3) of Subsection F of 8.314.6.17 NMAC is met.

8.314.6.22 GRIEVANCE/COMPLAINT SYSTEM: The HSD/MAD, DOH and ALTSD operate a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under the mi via program. Any mi via participant may file a grievance with HSD/MAD.

A. ALTSD/EDSD administers the grievance/complaint process. Participants may register complaints with ALTSD/EDSD via e-mail, mail or phone. Participants can also register a complaint with HSD/MAD or DOH/DDSD, which is then referred to ALTSD/EDSD. The participant is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing.

(1) A grievance or complaint is required to be resolved within 30 days from the date it was received.

(2) Upon receipt of the grievance or complaint, ALTSD enters it into the complaint tracker and informs the contractor or provider of the grievance or complaint. ALTSD/EDSD notifies the participant within one day of receipt of the grievance or complaint who will be responsible for resolution of the grievance or complaint.

(3) ALTSD/EDSD gives the contractor or provider 14 days to resolve the grievance or complaint. If the grievance or complaint contains an issue that may compromise the health or safety of the participant, ALTSD/EDSD remains involved with the parties until the grievance or complaint is resolved.

(4) The contractor or provider shall notify ALTSD/EDSD of their progress toward resolution of the grievance or complaint. If the grievance or complaint has not been resolved in 14 days, ALTSD/EDSD becomes involved to ensure that resolution occurs within 30 days of receipt of the grievance or complaint.

B. Participants in the ICF/ MR Waiver may register a complaint or grievance about any program issue with which they are dissatisfied. Participants may register complaints with DOH/DDSD via e-mail, mail, or by phone. The DOH/DDSD utilizes a standardized complaint form and has established a dedicated e-mail address to register complaints. Participants can also register complaints with the ALTSD/EDSD, and HSD/MAD, which is then referred to DOH/DDSD. The participant is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing.

(1) The complaint/grievance is required to be resolved within 14 days from the date the complaint/grievance was filed by the participant.

(2) Upon receipt of the complaint/grievance, the complaint is entered into the complaint tracker by DOH/DDSD and the appropriate contractor/provider is e-mailed the nature of the complaint/grievance to begin the resolution process.

(3) The participant is contacted within one business day from the date the complaint/grievance is received by DOH/DDSD to acknowledge receipt of the complaint/grievance.

(4) On either the fifth or tenth day after the filing of the complaint, the DOH/DDSD follows up with the contractor/provider on the status of the complaint/grievance. The DOH/DDSD enters the status information into the complaint tracker.

(5) No later than the 14th day after the complaint was filed, the contractor/provider is required to e-mail the resolution to the DOH/DDSD. The date the e-mail is sent to DOH/DDSD is the date the complaint/grievance is resolved. Once received, the DOH/DDSD enters the resolution into the complaint tracker and calls the participant to verify that resolution occurred. The conversation with the participant is documented into the complaint tracker.

(6) Contractor/providers may request extensions to resolve issues at least three days prior to the 14-day deadline. Extensions to resolve complaints must occur via e-mail to DOH/DDSD. DOH/DDSD will grant or deny extensions within one business day. If approved by DOH/DDSD, extensions will be granted for an additional 14 days.

[8.314.6.22 NMAC – N, 2-15-11]

HISTORY OF 8.314.6 NMAC: [RESERVED]

To be completed by the individual's physician, psychiatrist, certified nurse practitioner, or physician's assistant as proof of eligibility for Mi Via, Self-Directed Medicaid Waiver services for individuals with brain injury.

Confirmation of ICD 9 Code
New Mexico Mi Via Brain Injury Services

Mi Via
MY WAY
NEW MEXICO'S SELF-DIRECTED WAIVER PROGRAM

I confirm that my patient has a brain injury diagnosis as indicated by the ICD 9 code(s) entered below.

Patient with Brain Injury _____

SS # of Patient _____--_____--_____

ICD 9 Code _____

ICD 9 Code _____

ICD 9 Code _____

Name _____
Physician/Psychiatrist—Please print

Signature _____
Physician/Psychiatrist

Date ____/____/____

On the reverse side of this form you will find a list of ICD 9 codes that may be related to your patient's brain injury. **Confirmation of at least one of these ICD 9 codes is a requirement for an individual with brain injury to be found medically eligible for Mi Via Waiver services.**

ATTACHMENT I

New Mexico Medicaid Mi Via Brain Injury ICD 9 Codes

ICD 9 Code	Diagnosis
191.0 – 191.8	Malignant neoplasms of brain
192.1	Malignant neoplasms of brain, meninges
192	Malignant neoplasms of brain, cranial nerves
198.3	Secondary malignant neoplasm of brain
198.4	Secondary malignant neoplasm of other parts of nervous system
225	Benign neoplasm of brain & other parts of nervous system, brain
225.1	Benign neoplasm of brain & other parts of nervous system, cranial nerves
225.2	Benign neoplasm of brain & other parts of nervous system, cerebral meninges
310.2	Post Concussion Syndrome
320.0 – 320.9	Bacterial Meningitis
321.0 – 320.8	Meningitis due to other organisms
322.0 – 322.9	Meningitis of unspecified
323.0 – 323.9	Encephalitis, myelitis, encephalomyelitis
324.0	Intracranial and Intraspinal abscess
325	Phlebitis and thromophlebitis of intracranial venous sinuses
326	Intracranial and intraspinal abscess
348.1	Anoxic brain damage
348.3	Encephalopathy, unspecified
430	Subarachnoid hemorrhage
852.0 – 852.9	Subarachnoid hemorrhage following injury
431	Intracerebral hemorrhage
432	Other and unspecified intracranial hemorrhage
433.0 – 433.91	Occlusion and stenosis of precerebral arteries
434.0 – 434.91	Occlusion of cerebral arteries
435.0 – 435.9	Transient cerebral ischemia
436	Acute, but ill-defined cerebrovascular disease
437.0 – 437.9	Other and ill-defined cerebrovascular disease
438.0 – 438.9	Late effects of cerebrovascular disease
800.0 – 800.95	Fracture of vault of skull
801.0 – 801.99	Fracture of base of skull
803.0 – 803.99	Other and unqualified skull fractures
804.0 – 804.99	Multiple fractures involving skull or face with other bones
850.0 – 850.9	Concussion
851.0 – 851.99	Cerebral laceration and contusion
852.0 – 852.59	Subarachnoid, subdural, and extradural hemorrhage following injury
853.0 – 853.19	Other and unspecified intracranial hemorrhage following injury
854.0 – 854.19	Intracranial injury of other and unspecified nature
905	Late effect of fracture of skull and face bones
907	Late effect of intracranial injury without mention of skull fracture
994.1	Drowning and non-fatal submersion
994.7	Asphyxiation and strangulation
995.5	Child maltreatment syndrome
995.8	Adult maltreatment syndrome

Attachment II

INDIVIDUAL BUDGETARY ALLOTMENT The state determines an individual budgetary allotment (IBA) for each Mi Via participant. The Mi Via IBA is the annual budget amount available to each participant, which can be utilized to purchase flexible combinations of services, supports and goods. The amount in an IBA is based upon the individual's assessed needs which are documented in a service and support plan (SSP). Services contained in the SSP must be within the scope of services covered within the Mi Via regulations and meet all applicable criteria. For the ICF/MR waiver populations, each participant's annual individual budget is based on the traditional Developmental Disabilities Waiver (DDW) Annual Resource Allotments (ARA) method. The DDW ARAs are determined by an analysis of expenditure and utilization data over a five-year period based on level of care and age of the individuals. The ARAs allow the individual to utilize a flexible combination of services that are identified in the traditional DDW Individual Service Plan (ISP) up to the maximum available amount.

A. Adult Budget Methodology

The adult (21 and over) Mi Via non-residential budgets are developed using the ARAs for non-residential services, deducting the cost for case management services and the State applied a 10 percent (10%) discount to the net remaining amount. The ten percent (10%) discount, which reflects administrative/overhead agency costs that are not provided by and included in the reimbursement to self-directed providers, is used to fund the fiscal management role under the self-directed waiver. The State performed this calculation for the remaining adult level of care ARAs. The State then calculated a weighted budget using the new amounts multiplied by the number of participants at the time of calculation in each corresponding level of care category to get a total cost divided by the total number of participants.

For adults that need to receive a Community Living service or enhanced supports similar to those residential options, the State then applied the same methodology to adult residential ARAs. The weighted residential ARA developed is added to the annual cost of the most flexible and community oriented Community Living Service in the traditional DDW, Family Living, to derive the Adult Enhanced Supports Budget allotment for Mi Via. b. Children's (0 – 20 years) Budget Methodology

The same methodology utilizing the DDW ARAs for children was applied. Generally, in New Mexico, children under 18 have residential options available through the Children, Youth and Families Department rather than through Waiver services. However, under the DDW, young adults ages 18-20 are eligible for Community Living Services. Should a young adult require residential or similar supports, a budgetary amount equal to Intensive Independent Living (IIL) under the DDW would be made available. The Intensive Independent Living rate was chosen as it provides assistance to an individual living at home or in his/her own home for 100 to 300 hours per month. This is equivalent to 8-10 hours per day and should provide sufficient support as these individuals are still receiving school services during the day.

The assigned budgets change as the person ages, at the time of the change or at recertification.

B. Medically Fragile

The State applies the same methodology to persons on the Medically Fragile Waiver (MFW) that transition to Mi Via, as they also would benefit from services available to other persons with developmental disabilities. The annual Mi Via budget for medically fragile children is calculated by removing case management and the ten percent (10%) discount (as with other Mi Via budget methodologies). The resulting budget, when included in the weighted calculations, is consistent with the weighted average of budgets for other children with developmental disabilities. For medically fragile individuals 21 years and over, the rates developed for Adults with Developmental Disabilities will apply including the opportunity to access community living services or enhanced supports.

Participants in Mi Via have authority to expend waiver funds for services through an authorized annual budget that is to be expended on a monthly basis. Mi Via budget calculations are customized according to three (3) distinct populations served by this waiver: Acquired Immunodeficiency Syndrome (AIDS), Coordination of Long-Term Services (CoLTS), and Brain Injury Category of Eligibility. The budget calculation process is derived either from the AIDS traditional waiver, the former Disabled and Elderly (D&E) traditional waiver, or State General Fund Traumatic Brain Injury (TBI) program. While the budget calculation process is similar, calculations and resulting budget amounts are separated according to the three (3) Mi Via populations served.

For the NF Waiver populations, budget amounts are based on a sampling in February 2007 of average costs of prior authorized units for either the AIDS or former D&E traditional waiver service budgets, minus case management service costs, minus environmental modification costs (for former D&E budgets only), and minus a discount of ten percent (10%). The ten percent (10%) discount, which reflects administrative/overhead agency costs that are not provided by and included in the reimbursement to self-directed providers, is used to fund the fiscal management role under the self-directed waiver. Environmental modification costs are excluded from the budget calculations since the ad hoc nature of this service misrepresents the typical budget cost of the majority of the population (approximately six percent (6%) of the former D&E traditional waiver population used this service). Full traditional waiver case management service costs for AIDS and the former D&E populations are transferred to administration and are used to fund the consultant function in the self-directed waiver. In addition, participants can manage their budgets with the ability to negotiate fees for different providers and rates in accordance with the Mi Via regulations (e.g., hiring individuals directly to provide services), as well as the option to choose a different array of services that better meet their individual need for homemaker/companion services. The State anticipates that individual participants are able to negotiate for more supports and services both in type and volume when they are in control of their purchasing decisions even with 10 percent (10%) less in their individual budget than the State previously experienced through the traditional waivers for the same or similar services. In essence, participants are better able to get the most from their budget dollars when they are empowered to negotiate the best possible rate.

a. Participants eligible for the Mi Via Brain Injury Category of Eligibility

For the Mi Via Brain Injury Category of Eligibility, budget amounts are based on the calculated Mi Via former D&E budgets (described above) as the starting point and are supplemented with supports and services unique to this population identified through the State General Fund TBI program and individual supported employment for adults.

b. Participants eligible for Mi Via through the AIDS Waiver

For the AIDS Mi Via budgets, AIDS Waiver Individual Service Plans (ISPs) were sampled as of the end of February 2007. ISPs for all traditional AIDS participants are identified and the aggregate group cost is determined. As described above, case management costs are removed from the aggregate group cost and the remainder is further discounted by ten percent (10%). The discounted amount is then divided by the number of ISPs to determine the AIDS Mi Via budget that is allocated to each applicable individual.

c. Participants eligible for Mi Via through the former D&E Waiver, now the CoLTS Waiver

To derive the schedule of budgets for former D&E participants, the costs of prior authorized units are separated by age band: children/young adults aged 0-20, and adults aged 21 and older. The former D&E Waiver average costs of prior authorized units are further broken down into a schedule of compatible case-mix groupings by utilizing a comprehensive individual assessment that determines the participants' level of homemaker need according to a four-tier rating scale.

Within each age band, the costs are sorted according to each participant's assessed need for authorization of homemaker hours: 1) none or mild; 2) moderate; 3) extensive; and 4) not applicable due to an assisted living arrangement. By using the appropriate age band grouping and each individual Mi Via participant's assessment of homemaker level of need (i.e., case mix grouping), an annual individual budget is established, as follows:

- CoLTS Adults (Age 21 and over) For the CoLTS adult (21 and over) Mi Via budgets, last available former D&E waiver ISPs were sampled as of the end of February 2007.

As one example, there were 950 adults assessed as moderate in their need for homemaker hours. The aggregate ISP cost of all former D&E waiver services for this group was $23,704,013. After removing case management and environmental modification costs, the aggregate cost was $21,208,053, at an average cost of $22,324 per person. Discounting this by 10 percent resulted in an average cost of $20,092 per person.

Based on the comprehensive individual assessment rating for homemaker need, each of the case-mix budgets for adults (Mild or None, Moderate, Extensive and Assisted Living) were calculated using the same methodology as the example above. A single budget amount was determined for each of the case-mix levels and allocated to each applicable Mi Via participant within the case-mix.

- CoLTS Children and Young Adults (Ages 0 - 20) For children and young adults aged 0 - 20, existing prior authorized former D&E Waiver service plans include service types or portions of units now covered by Early Periodic Screening, Diagnosis and Treatment (EPSDT) services. For this age group, an alternative cost basis for Mi Via participant budgets has been established by constructing a reasonable composite of services that are conducive to sustaining a child with special needs through Mi Via, including skilled therapies that support community integration, community access, and respite.

Services delivered by a licensed physical therapist, occupational therapist or speech language pathologist fulfill therapy needs not covered by the State plan under EPSDT requirements or by an Individual Education Plan (IEP) through the public schools. Community access activities are also not covered by the State plan under EPSDT or by the IEP through the public schools. Respite care is available in the CoLTS Waiver, but requests for prior authorization of this service have been omitted in many of the sampled 2007 care plans due to similar former waiver services previously available to this age group. When calculating the Mi Via children's budgets, pricing per unit for these services is based on similar former traditional waiver services discounted by ten percent (10%).

Three tiers of service need are identified according to the former D&E waiver comprehensive individual assessment rating for homemaker need: Mild or None; Moderate; and Extensive. Although the homemaker service is not part of the typical cost basis for this age group, the assessment rating method is used as an indicator to determine case-mix grouping bias.

A single budget allocation is determined for each of the three service tiers (Mild/None, Moderate, Extensive) that is allocated to each applicable child. The single budget for each tier includes the following:

- Discounted cost of Respite services of 14 days per year for Mild/None, 21 days per year for Moderate and 28 days per year for Extensive;
- Discounted cost of Non-EPSDT Skilled Therapy services single amount of $4,050 for each tier; and
- Discounted cost of Community Access services single amount of $3,978 for each tier.

d. Participants Eligible for Mi Via through the Brain Injury Category of Eligibility

Mi Via budgets for individuals with Brain Injury start with the base cost calculations used for Mi Via former D&E budgets with the same case-mix groupings by age band and assessed rating for homemaker need: Mild or None; Moderate; Extensive; and Assisted Living. Specific to this population, the costs are supplemented based on services authorized and utilized in New Mexico's State General Fund TBI program and individual supported employment for adults. The TBI program in State Fiscal Year 2006 was sampled, identifying the costs of TBI services that are not in the Medicaid State plan including alternative therapies and activities of daily living (ADL) skills coaching. (Alternative therapies and ADL skills coaching can be accessed under Mi Via through Participant Delegated Goods and Services.)

An average annualized cost per person of $1,550 is calculated for alternative therapies, $2,295 for ADL skills coaching and $9,600 for supported employment. The supplemental cost for alternative therapies discounted by 10 percent (10%) is applied to all case-mix groups, and the supplemental cost for ADL skills coaching and supported employment, discounted by 10 percent (10%), are applied to adults over 20.

Using this methodology 11 specific budget allocations are determined for the age groups listed. The age below are further broken down by the assessed rating for homemaker need: Mild/None, Moderate, Extensive, and Assisted Living

- Aged 0-18 years (Mild/None, Moderate and Extensive);
- Aged 19-20 years (Mild/None, Moderate, Extensive, and Assisted Living); and
- Aged Adults 21-64 (Mild/None, Moderate, Extensive, and Assisted Living).

State of New Mexico

Mi Via Schedule of Participant Budgets

Updated March 2009

Waiver group	AGE BAND	Further Breakout By Assessed Category of Need	**Mi Via Annual Budget**
AIDS	Any age	No further breakout for AIDS	**$36,249**
D&E	0-20	**Rated need for homemaker care hours**	
		Mild	**$13,522**
		Moderate	**$16,148**
		Extensive	**$18,775**
	21 and older	Participant in Assisted Living	**$18,276**
		Otherwise...	
		Mild	**$12,179**
		Moderate	**$20,695**
		Extensive	**$33,065**
Brain Injury	0-18	**Rated need for homemaker care hours**	
		Mild	**$14,959**
		Moderate	**$17,585**
		Extensive	**$20,212**
	19-20	Mild	**$25,986**
		Moderate	**$28,612**
		Extensive	**$31,239**
	21 and older	Participant in Assisted Living	**$30,740**
		Otherwise...	
		Mild	**$24,643**
		Moderate	**$33,159**
		Extensive	**$45,529**
DD and Medically Fragile	0-20	**Need for Enhanced Support**	
		Without Enhanced Support	**$23,443**
	18-20 as needed	With Enhanced support included	**$54589***
	21 and older	Without Enhanced Support	**$34,553**
		With Enhanced support included	**$72,710**

*$68,589 only if using trad. Family Living model

ATTACHMENT III

MEDICAID MI VIA WAIVER
RANGE OF RATES AND CODES

MI VIA WAIVER SERVICE	Code	UNIT	PAYMENT RATES*
Homemaker/Companion*	99509	Hour	$13.51 - $14.60
Physical Therapy*	G0151	15 min.	$13.51 - $24.22
Occupational Therapy*	G0152	15 min.	$12.74 - $23.71
Speech/Language Pathology*	G0153	15 min.	$16.06 - $24.22
Intensive Case Management *	G9002	Hour	$49.97 - $51.49 Please note that this service will no longer be available for new Mi Via participant SSP's or for revisions to SSP's effective 12/1/10.
Respite- Standard*	T1005RS	15 min.	$1.88-$3.38
Respite RN*	T1005RN	15 min.	$.01-$10.90
Respite- LPN*	T1005LPN	15 min.	$.01-$6.79
Respite- Home Health Aide*	T1005HHA	15 min.	$.01-$4.08
Community Access*	H2021	15 min.	$0.99 - $15.48**
Behavior Support Consultation*	H2019	15 min.	$12.24 - $20.65
Emergency Response, Testing and Maintenance	S5160	Each	Negotiated Rate***
Emergency Response, Monthly Service Fee *	S5161	Month	$36.71 - $40.79
Environmental Modifications	S5165	Each	Based on approved estimate (maximum of $7,000 every 5 years)
Nutritional Counseling – Adults *	S9470	Hour	$.01-$42.83
Private Duty Nursing – Adults- RN*	T1002	15 min.	$.01-$10.90
Private Duty Nursing – Adults- LPN*	T1003	15 min	$.01-$6.79
Supported Employment*	T2019	15 min.	$2.15 - $6.93
Supported Employment*	T2018	Day	$24.26 Please note that this service will no longer be available for new Mi Via

			participant SSP's or for revisions to SSP's effective 10/1/10.
Adult Day Habilitation*	T2021	15 min.	$2.27 - $3.90
Adult Day Health*	S5100	15 min.	$1.36 - $2.04
Family Living *	T2033FL	Day.	$100.25
Substitute Care*	T1005SC	15 min	$3.50
Supported Living *	T2033SL	Day	$ 42.57- $316.69
Assisted Living *	T2031	Day	$51.49
Independent Living*	T2030	Month	$1,866 - $2,668.60
Transportation/Driver	T1999TD-H	Hour	Negotiated***
Transportation/Driver	T1999TD-I	Each	Negotiated***
Transportation	T1999MILE	Per Mile	$0.34
Community Participation	T1999CP-H	Hour	Negotiated***
Community Participation Item/Invoice	T1999CP-I	Item	Negotiated***
Household Related Goods and Services (ie. lawn mowing)	T1999HG-H	Hour	Negotiated***
Household Related Goods and Services	T1999HG-I	Each	Negotiated***
Coaching/education for parents, spouse or others	T1999CE-H	Hour	Negotiated*** Please note that this service will no longer be available for new Mi Via participant SSP's or for revisions to SSP's effective 12/1/10.
Coaching/education for parents, spouse or others	T1999CE-I	Each	Negotiated*** Not available for paid caregivers effective12/1/10.
Resource Facilitation	T1999RF-H	Hour	Negotiated*** Please note that this service will no longer be available for new Mi Via participant SSP's or for revisions to SSP's effective 12/1/10.
Resource Facilitation	T1999RF-I	Each	Negotiated*** Please note that this service will no longer be

			available for new Mi Via participant SSP's or for revisions to SSP's effective 12/1/10.
Technology for Safety and Independence	**T1999TS**	**Each**	**Negotiated*** **
Alternative Medicine and Therapies	**T1999AMT**	**Each**	**Negotiated*** **
Health-Related services, equipment and supplies	**T1999HR-I**	**Each**	**Negotiated*** **

*Range of rates that are paid by the New Mexico Medicaid program to provider agencies for services provided to participants in the Traditional Home and Community-Based Services Waivers (Disabled and Elderly, Developmental Disabilities, Medically Fragile and AIDS Waivers). **These rates are inclusive of taxes with the exception of those services marked with an*. These rates may include additional gross receipts tax if the services are provided by an approved traditional waiver provider subject to gross receipts taxes. (for -profit provider). The consultant must indicate the inclusion of gross receipts tax as a note on the goal to alert the TPA. Additional costs of workers compensation insurance costs, where applicable, are attached in a separate table.** Actual amount to be paid for these services in Mi Via is based on these suggested ranges of rates and negotiated and established by the participant with the service provider. Mi Via participants can decide to pay less or, with justification, more than these rates. Justification for paying more than these rates more must be submitted for consideration and approval in writing along with the Service and Support Plan and budget.

**Substitute Care can only be utilized in conjunction with the traditional waiver Family Living Service and is limited to 4000 units (1000 hours) per year. Charges for this service code would be submitted on a Payment Request Form (PRF) with an attached invoice from the provider detailing the charge. This service will be paid only at the per unit rate of $3.50. PRF/Invoices reflecting a different rate will be retuned for correction.

*** Paid according to the amount negotiated between the participant and the service provider or vendor.

Request for payment is made by the Mi Via participant to the Financial Management Agent (FMA) for traditional waiver services and participant-delegated goods and services, according to the Mi Via participant's approved Service and Support Plan and budget. When the service is to be provided by an employee, payment is rendered upon submission of an employee's timesheets to the FMA; or, when the service provider is an independent contractor or when an item is purchased from a vendor, upon submission of an invoice to the FMA. Please refer to FMA payment instructions.

Justification for paying more than these rates must be submitted for consideration and approval in writing along with the Service and Support Plan and budget.

New Mexico Minimum Wage

Each participant (or Employer of Record) is responsible for researching and ensuring payment of minimum wage, both state, federal, or in some instances, "living wage." Please refer to state website for further information: http://www.workforceconnection.state.nm.us

Minimum wage is the lowest hourly wage that businesses may legally pay to employees or workers. Recent legislation (SB 324) changed the state minimum wage law effective January 1, 2008. The federal government has also passed a higher federal minimum wage. Both the federal and state minimum wage increases are phased in on different dates.

Most New Mexico businesses will see the state minimum wage increase and will be required to pay a minimum wage of:

· $7.50 per hour effective January 1, 2009

Federal minimum wage increases:

· $7.25 per hour effective July 24, 2009

For questions on minimum wage, please contact Wage and Hour Bureau at:
· 301 West DeVargas Street, Santa Fe, NM 87501 [Phone: 827-7441 | Fax: 827-7474]
· 501 Mountain Road, Albuquerque, NM 87102 [Phone:222-4667 | Fax:222-4666]
· 500 South Main, Suite 10200, Las Cruces, NM 88001 [Phone: 524-6195 | Fax: 524-6194]

For more information on Federal Law on minimum wage visit the US DOL website at http://www.dol.gov/dol/topic/wages/minimumwage.htm

MI VIA EMPLOYEE WORKERS COMPENSATION RATE GUIDE*

Hourly Wage	Workers Compensation	Cost to You
$7.50	$0.24	$7.74
$8.00	$0.25	$8.25
$8.50	$0.27	$8.77
$9.00	$0.29	$9.29
$9.50	$0.30	$9.80
$10.00	$0.32	$10.32

Hourly Wage	Workers Compensation	Cost to You
$12.50	$0.40	$12.90
$13.00	$0.41	$13.41
$13.50	$0.43	$13.93
$14.00	$0.44	$14.44
$14.50	$0.46	$14.96
$15.00	$0.48	$15.48

This table shows the approximate cost to you for workers compensation insurance when you hire a worker. You can figure out rough workers compensation insurance cost by multiplying the wage you want to pay by 3.17 percent. Then, by adding the wage and workers compensation insurance costs together, you'll get the total "cost to you". This "cost to you" does not include health insurance benefits or other benefits that you, as the employer, may want to cover for your employees.

***When you decide how much you want to pay your worker, you must stay within the payment rates for services, as outlined on the preceding page, Mi Via Waiver Range of Rates and Codes. These ranges include taxes.**

*** Workers compensation insurance is required for all employees providing all of the services listed in the tables of this document.**