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Susana Martinez, Governor
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January 4, 2011

Nicole Nicholson
Grants Management Officer
Center for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Mail Stop: C2-21-15, Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Money Follows the Person Demonstration Project Application

Dear Ms. Nicholson:

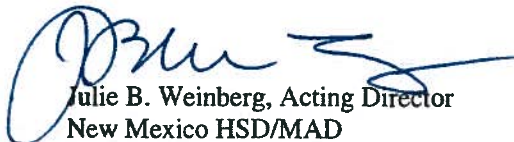
New Mexico is pleased to submit an application in response to the United States Department of Health and Human Services Funding Opportunity; *Money Follows the Person Rebalancing Demonstration.* The application has been submitted electronically using the web-based application process.

The New Mexico Human Services Department, Medical Assistance Division (HSD/MAD), as New Mexico's single state Medicaid administering agency, is the lead agency for New Mexico's program; *Money Follows the Person Rebalancing Demonstration Project.* The New Mexico Aging and Long Term Services Department (ALTSD) will be the operating agency. The Department of Health will serve as an additional partner for this project. New Mexico projects total costs of $28,707,048 for this project, with a request of $23,724,360 in Federal funding over a five (5) year period.

Enclosed with this letter are signed copies of the Application for Federal Assistance Standard Form 424 and the Certification Regarding Maintenance of Effort form, as required in the Program Announcement.

I am the primary contact for this application and may be contacted at (505) 827-6253 or the email address, julie.weinberg@state.nm.us. Thank you for the opportunity to submit this application.

Sincerely,



Julie B. Weinberg, Acting Director
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Access • Quality • Accountability

State of New Mexico January 7, 2011

New Mexico Money Follows the Person Demonstration Project Abstract and Profile

Even though New Mexico leads the nation on commonly cited rebalancing measures, about 5,700 Medicaid participants continue to reside in institutions in the State and many of them—with adequate services and supports—could be safely transitioned to the community. New Mexico's accomplishments in rebalancing reflect a long-standing commitment at the highest levels of State government to build and maintain a system of long-term services and supports (LTSS) that provides accessible home and community-based options, offers easy access to choice of culturally responsive, appropriate, and quality LTSS, and empowers people with disabilities to live independently, productively, and with dignity.

The Coordination of Long-Term Services (CoLTS) program is the centerpiece of New Mexico's current efforts to rebalance its LTSS system. CoLTS, implemented in August 2008, is a mandatory, statewide integrated care program for Medicaid participants assessed at nursing facility level of care as well as "healthy" dual eligibles. The program operates under concurrent 1915(b)(c) waivers. The State contracts with two managed care organizations (MCOs) to coordinate primary and acute care and institutional and community-based LTSS for CoLTS participants under a capitated payment structure. Current enrollment in CoLTS is just over 38,300. Behavioral health services are provided to CoLTS participants through a single Statewide Entity under a capitated payment structure. New Mexico provides a unique opportunity to integrate the "money follows the person" concept into a managed care structure.

New Mexico's MFP Demonstration will target two populations: 1) nursing home residents aged 65 and older; and 2) institutionalized adults aged 65 and older with a mental illness. Because the State's behavioral health system is in a period of transition and key services are still being developed, the second population will be phased in after approximately one year. The State's Aging and Disability Resource Center (ADRC) will have primary responsibility for recruiting and enrolling MFP participants. An Integrated Service Plan Coordinator will be assigned to each transitioning individual to provide case management and to coordinate all the other service coordinators (e.g., those affiliated with the MCOs, Mi Via, nursing homes, Ombudsman, behavioral health Statewide Entity, etc.).

New Mexico's total budget for MFP demonstration services, administrative expenses, and federal evaluation supports for the six-year demonstration (CY 2011-CY 2016) is $28,707,048 ($23,724,360 Federal; $4,982,688 State). The State projects 75 transitions in SFY 2012, 110 in SFY 2013, 145 in SFY 2014, 170 in SFY 2015, and 170 in SFY 2016, for a total of 670 transitions.

The proposed MFP Demonstration will promote further rebalancing in New Mexico through case management focused specifically on community transitions and the development of specialized services that will enable persons with mental health conditions to live successfully in the community. The State will pursue procedural and regulatory alignment to support rebalancing, such as improving care coordination across Medicare and Medicaid for dual eligibles in nursing facilities and strategies for addressing the future of institutional care. The State will also explore development of a universal assessment tool appropriate for a managed care environment.

New Mexico Money Follows the Person Demonstration Application Narrative: Draft Operational Protocol

A. Project Introduction

Enacted by Section 6071(h) of the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), the Money Follows the Person Rebalancing Demonstration (MFP) is a Medicaid program offered through the Centers for Medicare and Medicaid Services (CMS). The MFP Demonstration is part of a comprehensive, coordinated strategy to assist states with rebalancing their long-term care systems. The purpose of the Demonstration is to promote and support a series of initiatives that aim to reduce or eliminate barriers to receiving LTC services in home and community-based settings. Under the Demonstration, Medicaid-eligible individuals transition from long-term care institutions to qualified community settings and states receive an enhanced Federal Medical Assistance Percentage (FMAP) for qualified services provided to MFP participants for the first year (365 days) after transition. Each state must ensure continued provision of home and community-based services after the 12-month participation period for as long as the state continues to operate the program into which the individual was enrolled at the time of transition and the individual remains Medicaid-eligible and requires community-based services. In collaboration with stakeholders, states must ensure that quality assurance and quality improvement procedures are in place for MFP participants as well as other individuals receiving Medicaid home and community-based services (HCBS). Under the DRA, the MFP Demonstration was set to expire on September 30, 2011. The Patient Protection and Affordable Care Act (ACA) of 2009 extends the MFP Demonstration through September 30, 2016.

The New Mexico Human Services Department (HSD) and Aging and Long-Term Services Department (ALTSD) propose implementing an MFP Demonstration in New Mexico. Below is the State's proposed Operational Protocol.

1. *Organization and Administration*

Part #1: Systems and Gap Analysis

Demographics

Like other states, New Mexico's population is aging and the demand for long-term services and supports (LTSS) is expected to increase dramatically. As shown in Table 1, the population aged 65 and older is projected to almost double from 2010 to 2030, from 278,967 to 555,184. By 2030, more than a quarter of the State's residents will be aged 65 and older. As shown in Table 2, 14 percent of the 1,975,830 residents of New Mexico have some type of disability. Disability rates among older New Mexicans are especially high. Thirty percent of New Mexicans aged 65-74 have a disability and 57 percent of those aged 75 and older have a disability. The number of New Mexicans with disabilities is expected to increase as the population ages.

Table 1. New Mexico's Projected Population Age 65+

New Mexico	2010	2020		2030	
		Number	% Change from 2010	Number	% Change from 2000
Population 65+	278,967	419,690	50%	555,184	99%
% of Total Population	14.1%	20.1%		26.4%	

Source: ProximityOne. Retrieved December 7, 2010, at http://www.proximityone.com/st003065.htm.

Table 2. Disability Rates by Age in New Mexico, 2009

Age	Population	Number with Any Disability*	Disability Rate (%)
0-5	149,790	1,971	1%
5-17	364,308	16,042	4%
18-34	461,914	29,607	6%
35-64	741,460	114,675	15%
65-74	142,493	43,434	30%
75 and over	115,865	65,731	57%
Total	1,975,830	271,460	14%

*Includes persons with a sensory disability, a physical disability, a mental disability, a self-care disability, and a go-outside-the-home disability.
Source: U.S. Census, 2009 American Community Survey

A recent analysis by the State examined the mean and median number of days a sample of 175 nursing home residents spent in the facility prior to transitioning under the State's Community Reintegration Program. Findings are shown in Table 3. Due to budget constraints, Community Reintegration is currently the only path for an institutionalized individual to receive an allocation for the Coordination of Long-Term Services (CoLTS) 1915(c) waiver.[1] A facility resident is registered under the Community Reintegration category if he or she has been a resident of a licensed nursing facility for 30 consecutive days and wishes to reintegrate to the community. With implementation of the proposed MFP Demonstration, the State hopes not only to increase transitions from institutions but also to reduce lengths of stay in facilities.

[1] The CoLTS program and its role in the State's proposed MFP Demonstration is discussed in greater detail below.

Table 3. Number of Days from Nursing Home Admission to Allocation to a Waiver for Community Reintegration Participants Enrolled from July 1, 2010, to October 31, 2010

Nursing Home Stay	Number of Days	
	Mean	Median
Admission to Registration Date	141	33
Admission to LOI Date	167	43
Admission to Waiver Allocation Date	242	76

Source: New Mexico ALTSD

Progress in Rebalancing

Using the leading rebalancing indicator—percentage of Medicaid expenditures for institutional versus community-based care—New Mexico ranks first in the nation in rebalancing. In FY 2008, 74.8 percent of total Medicaid spending for LTSS community-based care. New Mexico ranked first in the proportion of community versus institutional spending for the aged and disabled population (63.9 percent for community versus 36.1 percent for institutional) and seventh in the nation for the population with developmental disabilities (92.3 percent for community versus 7.7 percent for institutional).[2] Even though the State leads the nation in rebalancing, about 5,700 Medicaid participants continue to reside in institutions in the State and many of them—with adequate services and supports—could be safely transitioned to the community.

New Mexico's accomplishments in rebalancing reflect a long-standing commitment at the highest levels of State government to build and maintain a LTSS system that provides accessible home and community-based options, offers easy access to choice of culturally responsive, appropriate, and quality LTSS, and empowers people with disabilities to live independently, productively, and with dignity.

[2] Thomas Reuters. (2009, December 1). Distribution of Medicaid Long-Term Care Expenditures, FY 2008.

The CoLTS program is the centerpiece of New Mexico's current efforts to rebalance its LTSS system. CoLTS, implemented in August 2008, is a mandatory, statewide integrated care program for Medicaid participants assessed at nursing facility level of care as well as "healthy" dual eligibles. The State contracts with two managed care organizations (MCOs) to coordinate the care of CoLTS participants under a capitated payment structure. Current enrollment in CoLTS is just over 38,300.

New Mexico's accomplishments to date in rebalancing include the following:

- **Legislative Mandate**: The *Money Follows the Person in New Mexico Act* (2006 House Bill 353) ensures that "money follows the person" as an individual navigates the LTSS system. The legislation states that "An individual … shall be allowed to choose … the type of service that best meets that individual's needs. The individual's medical assistance funds shall be made available for the individual for the service option the individual selects, not to exceed the cost of the service." This legislation also requires that information be given to Medicaid participants in nursing homes on options for community-based services and mandates implementation of a quality improvement system to measure the effectiveness of MFP efforts.
- **No-Wrong Door, One-Stop System**. New Mexico's Aging and Disability Resource Center (ADRC), established in 2004, hosts a resource directory website and offers walk-in and call-in assistance, including information on LTSS, screening, options counseling, and referrals. The ADRC manages the registration and allocation process for the CoLTS 1915(c) waiver. Development of the State's ADRC has been funded through grants from U.S. Administration on Aging.

- **Standardized Assessment**: Level of care assessments for CoLTS participants are conducted by a Third Party Assessor (TPA) using standardized forms and procedures. The State is in the early phases of developing a universal assessment tool for level of care determinations that would be used for CoLTS participants and possibly other Medicaid populations. Development of the universal assessment tool would be an integral component of the State's federally-funded MFP Demonstration.
- **Comprehensive Array of Services**: The CoLTS program provides comprehensive State Plan primary and preventive physical health services, as well as CoLTS 1915(c) waiver LTSS to eligible program participants. Consumer-directed HCBS is available to CoLTS 1915(c) waiver participants through the Mi Via waiver. In addition to the CoLTS 1915(c) waiver, the State operates three other HCBS waivers (AIDS, Medically Fragile, and Developmental Disabilities), all of which also include consumer-direction through Mi Via. The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive acute, home and community-based, and institutional services to eligible participants who live in a PACE designated service area. Personal care is available under the Medicaid State Plan. Behavioral health services are provided to all Medicaid participants through a single statewide entity. There is also a wide variety of LTSS available through the State's Aging Network, which includes senior centers, congregate meal sites, adult day care program, volunteer programs, employment programs, and other service and support programs. The State has a network of public and private institutional services for those who need institutional care.
- **Integrated Physical Health and LTSS**: The CoLTS program provides both physical health services and LTSS under a capitated rate structure. Medicare Advantage Special

Needs Plans (SNPs) operated by the CoLTS MCOs provide an opportunity to integrate Medicare and Medicaid benefits for CoLTS participants. Under the proposed federal MFP Demonstration, the State will explore ways to better coordinate behavioral health services with physical health services and LTSS through its Behavioral Health Collaborative and single statewide entity for behavioral health services.

- **Individual Choice and Control**. Self-direction opportunities are available through the Mi Via waivers and the State Plan Personal Care Option. Mi Via, which is the State's self-directed waiver, has choice and control at its core and gives participants both budget and employer authority. Participants design their service and support plans, based on their individual needs, choose from among a wide range of LTSS, and, using their individual authorized annual budget, hire workers and purchase goods, within the parameters of the program. The CoLTS 1915(c) waiver promotes person-centered care planning. Consumers (and/or family or legal representatives, as indicated,) are involved in every step of the planning process. The CoLTS MCOs' Service Coordinators work with consumers to develop transition plans that reflect the consumers' needs and choices.
- **Direct Care Workforce and Informal Caregivers**: In the Mi Via waivers and the Personal Care Option under the Medicaid State Plan, participants can opt to hire their own personal attendant who can be a friend or family member. This has helped to increase the pool of available direct care workers in the State. The State's Personal Care Option program offers training for both paid attendants and unpaid caregivers.
- **Stage Agency Responsibility**: ALTSD, the State's agency on aging, is the operating agency for CoLTS, PACE, Mi Via-NF, the ADRC, and the Aging Network. ALTSD works in close partnership with HSD, the Medicaid agency, in developing and managing

these programs. The respective roles and responsibilities of HSD and ALTSD are delineated in a Joint Powers Agreement. The Interagency Quality Review Committee (IQRC)—with representatives from HSD and ALTSD—is responsible for overall program quality.

MFP Demonstration: New Opportunities

The CoLTS program provides a unique opportunity to integrate the "money follows the person" concept into a managed care structure. Through the proposed MFP Demonstration, HSD and ALTSD will continue to work together and with providers and stakeholders across the State to strengthen the LTSS infrastructure, develop specialized services and supports, and align rules and regulations to support further rebalancing. Specific objectives include:

1. **Case Management**: Currently, participants in the State's Long-Term Services programs may have multiple service coordinators. This is especially true for individuals choosing self-direction in the Mi Via program and those who may have significant behavioral health needs (e.g., MCO Service Coordinator, Mi Via Consultant, nursing home discharge planner, statewide entity care coordinator, Ombudsman representative, Core Service Agency). For individuals expressing interest in transitioning from a nursing home or other institution as an MFP participant, the State will work with the CoLTS MCOs to assign a single case manager who will be responsible for coordinating all of the other service coordinators so that the individual has one person to call and there is one professional accountable for making the transition happen. Case management will be an MFP Demonstration service and case managers will receive special training on how to

work with the various agencies, institutions, and providers to efficiently accomplish transitions.

2. **Special Populations**: The State will determine the number and characteristics of CoLTS participants and potential CoLTS participants (i.e., individuals in nursing facilities potentially eligible for Medicaid) aged 65+ in nursing homes and other institutions with mental health conditions who could safely transition to the community. Then the State will develop a package of specialized transition services for this population working with the Behavioral Health Collaborative and the single statewide entity. Few states have developed programs targeting such a population, so this will require careful research and development work. The authority for providing specialized services must also be researched and developed, including exploring whether the 1915(i) might be appropriate. The State anticipates phasing in this population into the MFP Demonstration by the end of FY 2012.
3. **Procedural/Regulatory Alignment to Support Rebalancing:** Under the MFP Demonstration, the State will work towards the following:
    a. **Facilitating Better Care Coordination for Duals Admitted to Nursing Homes**: Currently when a Medicare primary/CoLTS secondary participant enters a nursing home, the CoLTS MCO may not be alerted. The State will explore new rules that mandate that nursing homes notify the MCOs immediately so that the MCOs can immediately begin planning transitions to the community. Otherwise transitions can be delayed.
    b. **Assisted Living Facilities as MFP Qualified Residences**: The State will investigate how assisted living facilities might be reconfigured to meet the requirements for an

MFP qualified residence and how room and board charges might be structured so that assisted living facilities could be more affordable for Medicaid participants.

c. **Addressing the Future of Institutional Care**: The State will investigate strategies for working with providers and stakeholders to transform the nursing home industry in the State to better reflect the LTSS needs of the population, such as providing incentives for nursing homes to become home health agencies and offer other LTSS.

4. **Universal Assessment Tool:** The State will explore developing and implementing a universal assessment tool for CoLTS and potentially other programs that builds on the best tools in existence and can be used in a managed care environment. Included will be development of the required Information Technology (IT) infrastructure and linkages with other systems. This will be particularly important in order for the State to take advantage of many of the opportunities under the ACA.
5. **Involving Stakeholders**: Stakeholder involvement will be key to all of these efforts. The State convened meetings with stakeholders as part of the Demonstration planning process and stakeholders made recommendations on specific components of the Operational Protocol, i.e., the target populations; eligibility processes; benefits and services that should be available to individuals who are transitioning; how to recruit Demonstration participants; and identification of barriers to a successful transition and methods for addressing those barriers. If New Mexico is approved for an MFP Demonstration, the State will convene a formal stakeholder advisory work group, appointed by the HSD Secretary, that will include representatives from the following areas: institutional providers, including nursing facilities, psychiatric hospitals and psychiatric residential treatment facilities; HCBS providers; centers for independent living; area agencies on

aging; public housing authorities; public safety/adult protective services; New Mexico Indian Council on Aging; and, most importantly, individuals with disabilities, individuals who have transitioned, and families of individuals with disabilities. The MFP Work Group will meet, at a minimum, on a bi-monthly basis over the course of the Demonstration to provide guidance during implementation and to monitor progress on all aspects of the Operational Protocol.

Projected MFP Transitions: Table 4 shows the estimated number of potential MFP participants in institutions in New Mexico and projected transitions in SFY 2012 through SFY 2016.

Table 4. Potential MFP Participants and Projected Transitions, SFY 2012-SFY 2016

Population	Potential MFP Participants SFY 2011	Projected MFP Transitions				
		2012	2013	2014	2015	2016
Target Population 1						
Nursing Homes	200	75	100	125	150	150
Other Institutions	0	0	0	0	0	0
Target Population 2						
Nursing Homes	20	0	7	15	15	15
Other Institutions	5	0	3	5	5	5
Total	**225**	**75**	**110**	**145**	**170**	**170**

Part #2: Description of the Demonstration's Administrative Structure

ALTSD will be responsible for the day-to-day administration of the New Mexico MFP Demonstration. The Human Services Department/Medical Assistance Division (HSD/MAD) will remain the single state Medicaid authority and provide oversight of the program. The two agencies have a history of strong on-going collaboration, with HSD/MAD providing program oversight and ALTSD responsible for program administration (e.g., the CoLTS program, PACE, and Mi Via-NF waiver).

The MFP project will be administered jointly through a partnership between the New Mexico Aging and Long-Term Services Department (ALTSD) and the New Mexico Human Services Department (HSD). The two agencies have a history of strong on-going collaboration, with HSD/MAD providing regulatory and fiscal oversight and ALTSD providing the program administration components (e.g., the CoLTS program, PACE, and Mi Via-NF waiver). The two Departments have a Joint Powers Agreement (JPA) already in place that outlines each agency's responsibilities related to the administration and management of the various programs that are jointly managed by the two agencies. This JPA will be revised to incorporate oversight and administration of the MFP Demonstration.

ALTSD, as the administering agency, will be responsible for overall program operations, oversight and monitoring activities, as well as quality management. The MFP program office will be housed at ALTSD. The full-time MFP Demonstration Program Director and the two full-time transition specialists will be on the staff of ALTSD. ALTSD will work in collaboration with HSD/MAD to develop all policies, processes, procedures, program issues, and quality assurance and quality improvement procedures developed for the MFP Demonstration. HSD/MAD will provide support to ALTSD on financial reporting and monitoring.

HSD/MAD, as the federally recognized single state Medicaid agency (SSMA), will provide regulatory and fiscal oversight. HSD/MAD will oversee ALTSD's administrative responsibilities through the Interagency Quality Review Committee (IQRC). The IQRC meets quarterly to review aggregated and trended financial data, operations data, and performance measures collected by ALTSD for the various waivers and programs administered by that agency. The

IQRC identifies areas for program improvement and key action steps for the development and implementation of Action Plans to address areas requiring improvement. Additionally, HSD/MAD monitors ALTSD for compliance with the JPA, to ensure they have fulfilled their administrative and operational responsibilities and performed the functions listed therein.

In addition to formal oversight activities, HSD/MAD and ALTSD will convene regular meetings between program level and management staff to review MFP implementation and encourage cross-agency communication and collaboration related to individual staff roles and responsibilities, department roles and responsibilities, program issues, client concerns, provider questions, complaints, and other issues.

2. *Benchmarks*

Benchmark 1: Number of MFP-eligible individuals in each target group transitioned from an inpatient facility to a qualified residence.

Table 5. Benchmark 1: Number of Transitions from Institutions to Qualified Residences

Number of Transitions	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Target Group 1	75	100	125	150	150
Target Group 2	0	10	20	20	20
Total	75	110	145	170	170

Benchmark 2: Medicaid expenditures for community-based long-term services and supports versus institutional long-term services and supports.

Table 6. Benchmark 2: Medicaid Expenditures for Community Versus Institutional LTSS

Expenditures	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Community: Medicaid Expenditures	$458,443,374	$473,151,305	$489,112,000	$506,204,342	$523,925,348
Institutions: Medicaid Expenditures	$181,971,004	$184,319,482	$185,737,481	$186,349,878	$186,729,085

Benchmark 3: Percent of Medicaid long-term services and supports expenditures for services provided in the community versus in institutional settings.

Table 7. Benchmark 3: Percentage of Medicaid LTSS Expenditures for Services in the Community Versus Institutional Settings

Percent of Expenditures	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Community: Percent Expenditures	71.6%	72.0%	72.5%	73.1%	73.7%
Institutions: Percent Expenditures	28.4%	28.0%	27.5%	26.9%	26.3%

Benchmark 4: Number of individuals with mental health conditions who are identified, screened, and assessed for transitioning to the community as MFP participants.

Table 8. Benchmark 4: Number of Individuals with Mental Health Conditions Who Are Identified, Screened, and Assessed

Number of People	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Nursing Homes	10	25	35	45	45
Other Institutions	5	10	10	10	5
Total	15	35	45	55	50

Benchmark 5: Percent of MFP participants in Target Population 2 who are transitioned and successfully live in the community for one year without reinstitutionalization.

Table 9. Benchmark 5: Target Population 2 MFP Participants Who Successfully Live in the Community for One Year Without Reinstitutionalization

	SFY 2012	SFY 2013	SY 2014	SFY 2015	SFY 2016
Percent Successful Transitioners in Target Population 2	40%	50%	70%	75%	80%

B. Demonstration Implementation Policies and Procedures

1. *Participant Recruitment and Enrollment*

Target Populations: New Mexico's MFP Demonstration will target two populations.

Target Population 1: Medicaid-eligible nursing home residents aged 65 and older who express a wish to transition to a non-institutional care setting. The State will target individuals in CMS-certified and State licensed nursing homes. The non-institutional care setting can be the individual's home, the home of a family member, an apartment, or an MFP-qualifying assisted living facility[3] that is also certified under the CoLTS 1915(c) waiver. It is the resident's expressed desire to transition that begins the process of building a person-specific HCBS support system.

Target Population 2: Institutionalized Medicaid-eligible adults aged 65 and older with a mental illness who express a wish to transition to a non-institutional care setting. Individuals in this population who are residing in nursing homes are a subset of Target Population 1, but will have more significant behavioral health needs. In addition, Target Population 2 includes individuals in other institutional

[3] No more than four unrelated individuals may reside in the facility.

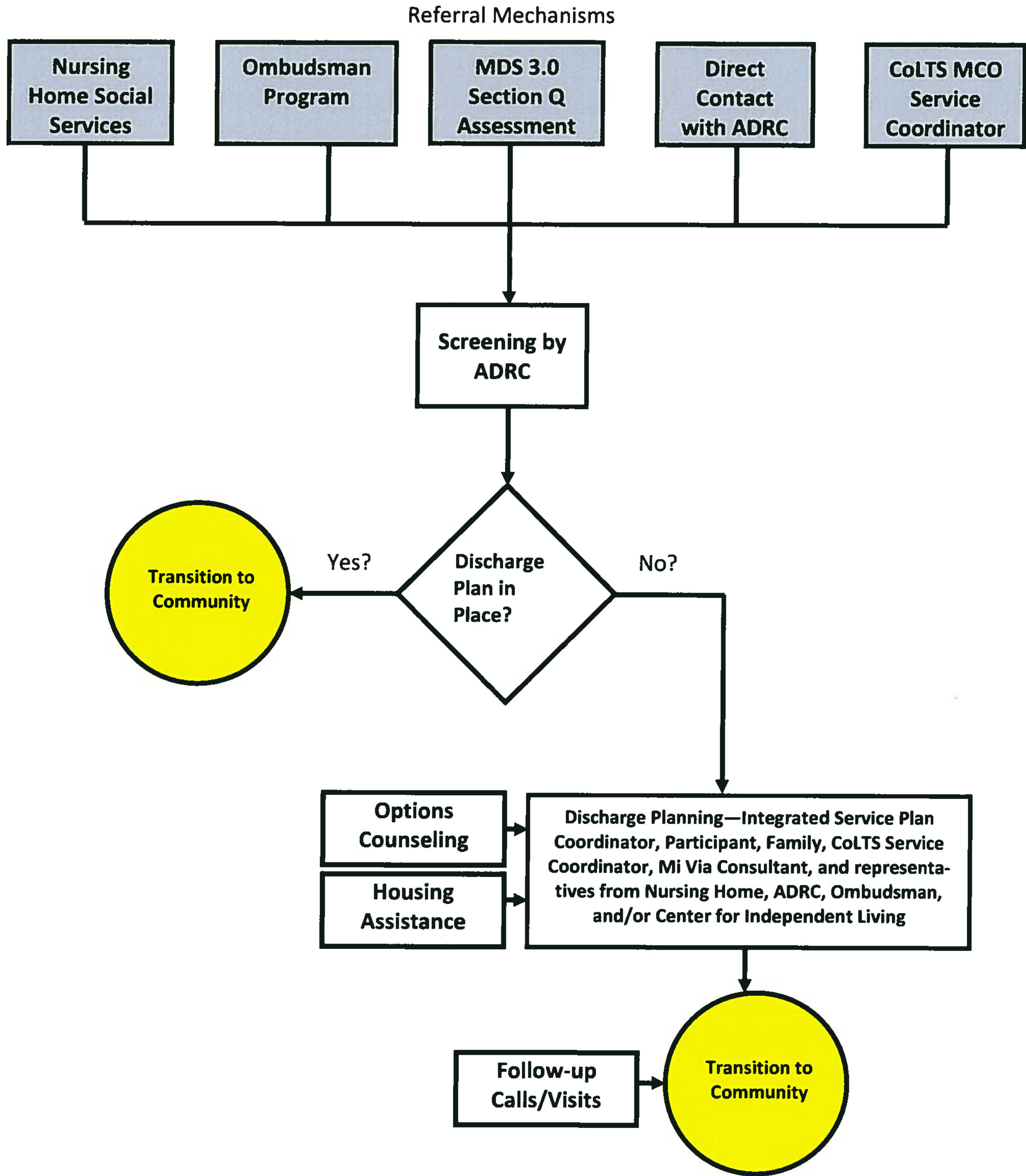
settings such as the New Mexico Behavioral Health Institute, the Fort Bayard Medical Center, and possibly New Mexico State Veterans' Home.

Because the State's behavioral health service system is in transition and some key services are still developing, Target Population 2 will be phased in beginning approximately one year after the initial start-up of the MFP Demonstration program. Individuals in Target Population 2 can still be considered for MFP during the phase-in period if there are adequate behavioral health services available in their community. Work under the phase-in period will include more precisely defining the mental health conditions and criteria that would qualify individuals for Target Population 2. Behavioral health services for this population will then be tailored to the needs of the defined population.

Eligibility for MFP: To qualify as MFP participants, individuals in each target population must meet MFP eligibility requirements at the time of transition as defined in Section 6071(b)(2) of the Deficit Reduction Act (DRA), as amended by Section 2403 of the Affordable Care Act. That is, the individual a) must have resided in a qualifying inpatient facility for not less than 90 consecutive days; b) is receiving Medicaid benefits for inpatient services furnished by that inpatient facility; and c) will continue to require nursing home level of care post-transition. In addition, individuals must also transition to qualified residence as defined by Section 6071(b)(6) of the DRA in order to be a MFP participant. Individuals not meeting these requirements but still seeking assistance in transitioning from an institutional setting may still seek assistance through New Mexico's MFP Demonstration, but the State will not designate them as MFP participants.

Identifying and Enrolling MFP Participants: Figure 1 illustrates New Mexico's proposed process for identifying MFP participants in Target Population 1 and transitioning them to the community. This process involves referrals, screening, eligibility determination, options counseling, discharge planning, and post-transition follow-up.

Figure 1
Target Population 1: Recruitment and Enrollment



As shown in Figure 1, potential MFP participants will be identified in a variety of ways and referred to the ADRC for screening, options counseling, and registration, as appropriate. The most likely paths to identification and participation are:

- **Section Q Referrals**. The goal of this process is to make the return-to-the-community referral as easy as possible, to honor the resident's rights, and to assure that residents are discharged from facilities with a safe place to live, appropriate medical equipment, and services that will both meet the individual's needs and enhance quality of life. In New Mexico, the ADRC is the designated local contact agency for Section Q referrals from the MDS 3.0 admission and quarterly assessments. The ADRC is responsible for working with the nursing facility providers to insure that residents find appropriate and least restrictive placement in the community if that is the resident's wish. The ADRC has established the following protocol for managing Section Q referrals and has sent information on this process to all nursing facilities:
    - **Nursing home calls the ADRC**: Within 10 days of the assessment in which the nursing home resident indicates a desire to move to the community, the facility's social worker, discharge planner, MDS coordinator, or other designated person telephones the ADRC to report that the individual wishes to be transitioned. The ADRC coordinator who answers the call either assists at the time of the call or contacts a specialist at the ADRC based on the individual's needs.
    - **Nursing home resident needing specialized assistance**: If a resident lacks a discharge plan, which can occur when there are complex transition needs, the ADRC contacts the resident directly and, if Medicaid-eligible, the facility, the ADRC, and a CoLTS representative work together with the resident to plan the

transition to the community. Other entities or representatives that may be involved at this point include the resident's family, the State Ombudsman, a Mi Via consultant, and the Independent Living Center.

- **Active discharge plan is in place**: If the nursing home staff has marked Q0400A as "1" yes—meaning that an active discharge plan is in place—and the nursing home staff has already developed a complete discharge plan, the level of planning and intervention outlined above would not be necessary. However, all transitions under MFP will still require a contact with the ADRC as the ADRC is responsible for registration in all Medicaid cases.

- **Interaction with volunteer ombudsmen**. The advocacy efforts of the ombudsman program will be coordinated with the MFP Demonstration (see Appendix 1 for a description of this program).
- **Social services units in nursing homes**. The ombudsman program schedules in-service sessions with the nursing homes throughout the year to ensure that the social services units are responsive to residents' wishes to transition.
- **Telephone call to the ADRC**. Calls from nursing home residents, their families, or other advocates can initiate a referral to MFP.
- **Contact from a CoLTS MCO Service Coordinator.** The initial contact to the ADRC may come from a CoLTS service coordinator.

Upon receiving a referral from any of the sources listed above, the ADRC will initiate and oversee the screening, eligibility determination, options counseling, and transition process for all

potential MFP participants. This process will be similar to the existing process for Community Reintegration participants but will benefit from some modifications and enhancements.

Upon receipt of a referral, the ADRC staff will complete a registration process and send out a letter of interest (LOI) asking if the potential participant is still interested in transitioning to the community. ADRC staff will determine if the client has met (or will meet) the eligibility requirements for the MFP Demonstration described above. In consultation with the Ombudsman Transition Specialist (if involved in the case), The ADRC will ensure that the resident meets the minimum residency period in the nursing home. In consultation with the appropriate CoLTS MCO, the ADRC will also ensure that the individual is eligible for Medicaid for at least one day prior to transition.

If the individual has met, or is likely to meet, MFP requirements, he or she will be allocated a transition slot.[4] The Resource Center Allocation staff will call the nursing facility to confirm that the client is a resident in the facility.

The ADRC sends a Letter of Interest (LOI) to the potential MFP participant. The LOI informs the individual that an allocation is available. The individual has 45 days to accept the HCBS/MFP allocation, choose to stay in the nursing facility, or refuse services altogether. An extension can be requested if the individual is unable to respond within 45 days. If there is no response, the allocation is closed.

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[4] Residents who do not or will not meet MFP requirements may still transition under the existing Community Reintegration policy, but will not be counted as an MFP program transition. In such cases, the ADRC will assist the individual with Medicaid eligibility determination, options counseling, and the transition to the community.

When the ADRC receives the response from the individual (called a PFOC) with a request for HCBS, the allocation is complete and the involvement of the ADRC is typically concluded. There are additional medical and financial determinations that need to be made before the individual receives the final determination of eligibility. The individual may be denied waiver eligibility at either of these determinations.

The CoLTS MCO service coordinator or the Third Party Assessor (TPA) works with the individual to verify their medical and financial eligibility requirements. In both cases, a face-to-face assessment is conducted and paperwork is sent to the primary care physician for completion. Both the assessment and the paperwork the physician completes are then submitted to the state utilization review contractor.

At the same time the medical eligibility is in process, the individual is sent a letter from the HSD Income Support Division (HSD/(ISD). The individual or their representative is responsible for submitting the application and required documents to HSD/ISD. The case worker at HSD/ISD works with the individual or his or her representative to determine financial eligibility. The medical eligibility determination is sent to HSD/ISD and if both medical and financial eligibility are approved, the HSD/ISD case worker approves the Medicaid category of eligibility and enters it into the state Medicaid system. The TPA enters the medical eligibility approval.

Assignment of Integrated Service Plan Coordinator: Once eligibility for both Medicaid and MFP have been determined, the MFP participant is assigned an Integrated Service Plan

Coordinator who will be responsible for coordinating all of the other service coordinators (e.g., MCO Service Coordinator, Mi Via Consultant, nursing home discharge planner, Ombudsman representative, Community Service Agency). This way the individual will have one person to call and there will be one professional accountable for ensuring that the transition to the community occurs. Individuals in Target Population 1 will be assigned an Integrated Service Plan Coordinator from the CoLTS MCO staff (if the individual chooses to participate in the CoLTS 1915(c) waiver or Medicaid State Plan services only) or from the Mi Via consultant agency. Individuals in Target Population 2 will be assigned an Integrated Service Plan Coordinator from the staff of the Statewide Entity.

Discharge Planning: During the discharge planning process, the Integrated Service Plan Coordinator convenes Team Care Plan meetings involving the resident and family, MCO, facility social service unit, and Ombudsman (if involved). Participants and family members will be given information on making informed choices about community living options and services, including information packets with contact numbers for the Integrated Service Plan Coordinator, the ADRC, the Ombudsman Program, the MCO service coordinator, and Adult Protective Services (APS). The information packet will include the CMS brochure (CMS Product No.1147) which has been revised to include information on the ADRC and Ombudsman Program.

In special cases, facility social service workers will contact the Ombudsman and/or the MCO service coordinator to assist a resident with special needs—e.g., an unbefriended /orphan elder, individuals with unique physical requirements, residents/families who are confused about the level of care assessment, waiver allocation, or financial eligibility, and the like.

Transition Services: With oversight by the Integrated Service Plan Coordinator, the CoLTS MCO (AMERIGROUP or Evercare) will be responsible for planning and providing transition services in collaboration with the State's statewide entity for behavioral health (OptumHealth New Mexico), with one exception. For those individuals choosing the Mi Via waiver program and self-direction, the responsibility of the CoLTS MCO will be limited to planning the individual's transition and community-based services.

Depending on the needs of the MFP participant, other providers may be involved in planning the transition and providing services, including the Core Service Agencies (for individuals with significant behavioral health needs), the Mi Via consultant agencies (for those choosing Mi Via), and local Centers for Independent Living (for those who need assistance with housing and other specific transition issues).

Ombudsmen Transition Specialists are available to advocate for the transition, serve as a contact for the resident, provide technical assistance to nursing facility staff, and teach self-advocacy to the resident and the relatives and friends who make up the resident's support system. Ombudsmen secure permission from the resident and home/lease owners to visit the resident post-transition in the new home. This is an extra layer of protection for the resident to ensure that services are being provided and the transitioned resident is safe.

Post-Transition Follow-up: The Integrated Service Plan Coordinator will be required to make telephone contact within 24 hours of the transition and a home visit within five days of

transition. Thereafter the Integrated Service Plan Coordinator will visit on a regular basis. The frequency of home visits and/or telephone contact by ombudsmen will be determined on a case-by-case basis in accordance with resident needs and wishes. Individual self advocacy is routinely taught by ombudsmen to all transitioning individuals. If during an ombudsman home visit an incident occurs that may be unsafe, the ombudsman will initiate contact with the Integrated Service Plan Coordinator or the MCO service coordinator to ensure resolution and safety.

Staff Training: The Integrated Service Plan Coordinators will receive special training on how to work with the various agencies, institutions, and providers to efficiently accomplish MFP transitions.

Training for nursing facility staff and MCO staff is a cooperative effort in New Mexico. The New Mexico Health Care Association (NMHCA) and the Ombudsman program host in-service trainings for nursing facility staff. NMHCA convenes training conferences twice a year offering CEUs for licensed individuals. Ombudsmen, clinical care specialists, and HCBS service specialists are frequent presenters. The Ombudsmen program offers free in-service resident rights training to all nursing homes in the State. This training fulfills one of the facilities' annual staff training requirements, so the sessions are well attended and supported by facility upper management.

Specialized trainings will be offered to nursing home discharge planners and social services staff to increase their knowledge about supportive community services offered in New Mexico. Additionally, nursing home staff will be offered in-service trainings about the ADRC and how to

access the range of information available electronically. ADRC staff will also work with the Ombudsman Transition Specialists to provide residents and family members with ADRC contact information as a segment of the self advocacy taught to all residents seeking a different care setting.

MFP Participant Safeguards: If a MFP participant who has transitioned to the community requires re-admission to a long-term care facility or admission to an acute care facility during the one-year MFP participation period, the resident will be eligible for HCBS again after discharge from the institution, even if the service plan requires adjustment to meet new clinical challenges or MFP eligibility timeframes.

Recruiting and Enrolling Target Population 2: The process for recruiting and enrolling MFP participants in Target Population 2 is anticipated to follow the process described above with the additional steps described below. This process will be refined as the State plans for the phase-in of this population.

- The nursing facility's social services unit, in consultation with the volunteer ombudsmen and the ADRC, will screen residents identified through the MDS 3.0 Section Q admission and quarterly assessments to identify those who meet the criteria for Target Population 2.
- For those residents who meet the criteria for Target Population 2, the MCO Service Coordinator and the facility social services unit will complete a transition assessment form and identify available and appropriate services.
- A Peer Support Specialist will provide prospective participants with information on their Core Service Agency and available behavioral health services. Peer Support Specialists

are employed by the Statewide Entity (currently OptumHealth New Mexico). Each regional office has two Peer Support Specialists.

- An Integrated Service Plan (ISP) Coordinator, employed by the Statewide Entity, will work with transition service providers to develop, design, and implement the participant's ISP.
- The MCO Service Coordinator and the Ombudsman Transition Specialist make post-transition home visits as necessary and the ombudsman teaches self-advocacy to promote and enhance self-care and well-being.

2. *Informed Consent and Guardianship*

Informed Consent: As part of the nursing home discharge planning and MFP enrollment process, prospective MFP participants will be given information on the MFP Demonstration and what they are applying for, the full range of HCBS options available to them, how the transition process will work, what constitutes "qualified housing," and their rights and responsibilities as a MFP participant. Individuals will also be informed that they may at any time choose to return to an institutional setting and that they will be afforded choice among and between services and providers. Individuals will be counseled on what abuse, neglect, and exploitation is and how to report it, as well as the process for reporting critical incidents. This process will be similar to processes used for the CoLTS 1915(c) waiver in order to meet waiver assurances. MFP participants enrolling in the CoLTS 1915(c) waiver or the Mi Via waiver will go through the waiver consent process as well. The MFP consent form is provided in Figure 2.

Figure 2. New Mexico MFP Information Consent Form

New Mexico Money Follows the Person Demonstration
Informed Consent Form

I freely choose to participate in the New Mexico Money Follows the Person program. I understand that this program allows me to receive services that will help me to transition from the institution in which I live to a home, apartment, or other community setting. I understand that my MCO service coordinator will help me access these services. I understand these services are available only after I am determined eligible for the Money Follows the Person program and up to 12-months after I transition to the community.

I understand that I will receive no additional benefits or services under the Money Follows the Person program. I understand that agreeing to participate in the Money Follows the Person program has no impact on my eligibility for any other program, meaning that I will continue to receive other services for which I am eligible regardless of my Money Follows the Person program eligibility. I understand that there are no additional risks anticipated based on my participation in the Money Follows the Person program beyond the risks related to receiving services in a community setting, for which I have already provided my consent.

In order to participate in the Money Follows the Person program, I have been informed that I must meet all of the eligibility requirements specific to the Money Follows the Person program, which include three (3) months living in a qualified institution, such as a nursing facility, hospital, or state residential center, Medicaid eligibility prior to my date of transition to the community, and finally that I must choose to live in a qualified residence, defined as:

1. A home owned or leased by myself or a family member;
2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which myself or my family has domain and control.
3. A residence, in a community-based residential setting, in which no more than 3 other unrelated individuals reside.

As a MFP participant, I will be asked to complete three short surveys about my quality of life. I will still be eligible to receive Money Follows the Person services even if I do not complete the surveys.

My signature below indicates that I agree to participate in the Money Follows the Person program if I am determined eligible and that any questions that I may have about the program have been answered.

Signature:
Printed Name:
Social Security #:
Medical Assistance #:
Signature:
Date:

Ombudsman and APS staffs are trained to provide oversight of guardians and health care powers of attorney to ensure they are meeting their fiduciary responsibilities to act on behalf of the resident. A difference of opinion between the wishes of the resident and the actions of the guardian is viewed as cause for a care plan meeting and mediation among the parties.

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 program 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 Mi Via consultant. If the authorized agent is an employee, he/she cannot sign his/her own timesheet.

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 CoLTS MCO and, if the participant is enrolled in Mi Via, the Mi Via consultant provider and Financial Management Agency (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.

Legally Responsible Individual: A legally responsible individual 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.

3. *Outreach and Marketing*

The State will develop and implement an outreach and marketing program targeted at institutional residents; hospital and nursing facility directors, social services units, and discharge planners; community providers; Mi Via consultant agencies; Centers for Independent Living; guardians and families; Native American tribes, pueblos; Indian Health Service and tribal providers; advocacy groups; and other stakeholders. Messages will be tailored for each targeted audience to communicate the goals of the MFP Demonstration, the services provided, how to obtain additional information, and how to apply. The websites and print materials will include detailed information on program eligibility and any cost sharing responsibilities. The MFP Program Director will have responsibility for developing and implementing the marketing effort. The ADRC and the Ombudsman's office will provide support to these efforts.

Marketing will be statewide; there will be no geographical targeting or facility- or population-specific targeting. Anyone in an institution who meets the MFP criteria and is interested in transitioning will be eligible to participate. Media to be used include the ADRC website and

resource directory, ALTSD website, MCO websites, press announcements, mailings to CoLTS participants, and dissemination of printed materials (including CMS Product No. 11477) by MCO service coordinators, hospital and nursing facility social services units and discharge planners, ADRC staff, and Ombudsman office staff and volunteers. In addition, the more than 100 volunteers from the Ombudsman's office will reach out to institutional residents in person and inform them about MFP during their routine visits to nursing homes.

The ADRC, ALTSD, and MCO websites will provide information on MFP in both English and Spanish. The MFP consent form will be available in English, Spanish, and Navajo. The Ombudsman's office already prints materials on nursing home residents' right in English, Spanish, and Navajo. The ADRC has English- and Spanish-speaking staff and has access to Language Line for interpretation services.

Staff from HSD/MAD, ALTSD, Behavioral Health Collaborative, the Ombudsman's office, the CoLTS MCOs and the Behavioral Health Statewide Entity, nursing facilities, Mi Via consultant agencies, home and community-based services providers, Centers for Independent Living, and Core Service Agencies will receive formal training on MFP. Information sessions for stakeholders will be an opportunity to communicate MFP goals, target populations, and recruitment strategies to the various stakeholders and enlist their support in recruiting participants.

4. Stakeholder Involvement

The State, recognizing that meaningful involvement of stakeholders is absolutely critical to the success of the MFP Demonstration, convened meetings with MFP stakeholders as part of the Demonstration planning process. During these deliberations, stakeholders made recommendations on specific components of the Operational Protocol, i.e., the target populations; eligibility processes; benefits and services that should be available to individuals who are transitioning; how to recruit Demonstration participants; and identification of barriers to a successful transition and methods for addressing those barriers. Stakeholders also emphasized the importance of their continued involvement throughout the Demonstration program. In this regard, the State announced that it planned to appoint a formal work group, and stakeholders strongly recommended that it should include individuals with disabilities, individuals who have transitioned from an institution to the community, and families and other supporters with experience; and they emphasized that the work group should be kept small.

Appointment of MFP Work Group

The State will convene a formal stakeholder advisory work group, appointed by HSD Secretary. The MFP Work Group will include representatives from the following areas: institutional providers, including nursing facilities, psychiatric hospitals and psychiatric residential treatment facilities; HCBS providers; centers for independent living; area agencies on aging; public housing authorities; public safety/adult protective services; New Mexico Indian Council on Aging; and, most importantly, individuals with disabilities, individuals who have transitioned, and families of individuals with disabilities. Special consideration will be given to those

individuals with disabilities and their families who have had experience with transitioning and/or supporting an individual with a disability at home and in the community.

State representatives from the HSD, ALTSD, and the Behavioral Health Collaborative will be expected to attend meetings of the MFP Work Group to listen, participate in the discussion, as appropriate, and receive input. In addition, the State works in partnership with the CoLTS MCOs and the Behavioral Health Statewide Entity (SE); both the MCOs and the SE will also attend the MFP Work Group meetings to listen and, as appropriate, participate.

The MFP Work Group will meet, at a minimum, on a bi-monthly basis over the course of the Demonstration program to provide guidance during implementation and to monitor progress. A call-in number will be arranged for those members who are unable to attend in person. The Work Group will focus on specific areas associated with the Operational Protocol, including:

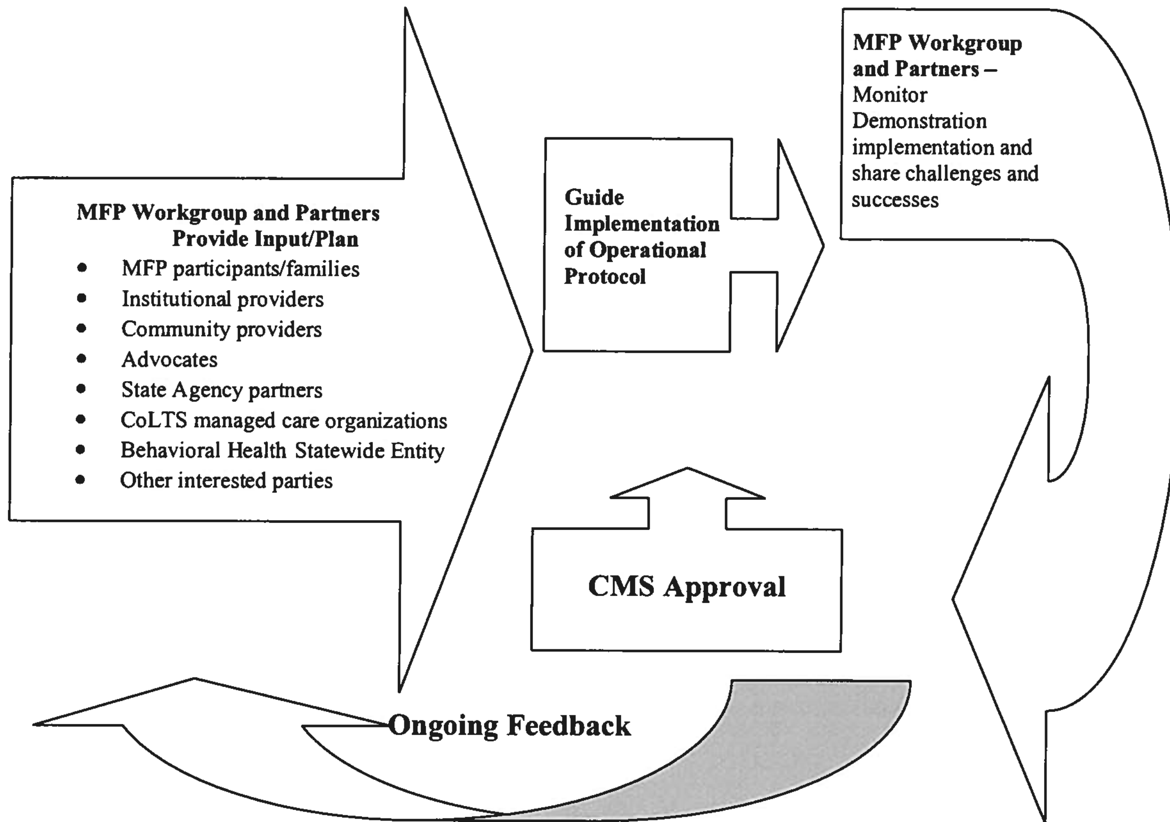
- Processes for identification of eligible participants;
- Numbers and needs of individuals transitioned;
- Availability of and access to covered services and supports;
- Responsiveness, capacity and capability of the State's HCBS network to provide needed services and supports to individuals transitioned to the community;
- Effectiveness of housing partnerships and the methods for identifying and monitoring accessible and appropriate housing;
- Training needs, and numbers, types and locations of training sessions held;
- Adequacy and effectiveness of training;
- Initiatives to expand the needed community workforce;

- Processes for and outcomes of transitioning and supporting individuals who want to self-direct (interface with Mi Via and CoLTS Personal Care Option Consumer-Directed) and experiences of individuals who are self-directing;
- Processes for and outcomes of ensuring cultural competence;
- Performance of the CoLTS MCOs and Behavioral Health Statewide Entity Statewide Entity, including coordination of services where individuals have both physical and behavioral health needs; and
- Methods for identifying and addressing barriers to a successful transition.

The MFP Work Group will also review and provide input on the MFP quality data and reports.

As the MFP Demonstration proceeds, individual Work Group members will be expected to reach out to and consult with their respective constituencies on MFP issues and concerns, and bring feedback to the larger Work Group for discussion and possible resolution. This approach will broaden the scope of stakeholders' participation throughout the MFP Grant Demonstration program. Work Group members will also assist with distributing information about the MFP Demonstration using their respective modes of communicating with their constituencies. Figure 3 depicts stakeholder involvement during the MFP Demonstration.

Figure 3. Diagram of MFP Stakeholder Influence during the MFP Demonstration



Consumers' Roles in the Demonstration

There are a number of ways through which the State listens to and receives input from consumers. Consumers will have representation on the appointed MFP Work Group and consumers and family members who are not on the Work Group will be encouraged to communicate and share their experiences with their respective Work Group representatives.

In addition, the CoLTS MCOs, through which the target populations receive their primary and preventive physical health services, and their long-term services and supports, and the

Behavioral Health Statewide Entity, through which individuals with mental health conditions receive behavioral health services, are required to establish their respective consumer advisory board that include regional representation of consumers and family members. The MCO and Statewide Entity consumer advisory boards, which meet quarterly in a central location every year, advise their respective MCOs and the Statewide Entity on multiple issues, including those concerning service delivery and quality of service. The MCO/Statewide Entity must notify the Human Services Department 10 days in advance of the meeting so that HSD representatives can attend and observe the meetings. The MCO and Statewide Entity, respectively, must each also attend at least two statewide consumer-driven or hosted meetings per year that focus on consumer issues and needs, to help ensure that consumer issues and concerns are heard and addressed.

The State also has other extensive methods for receiving consumers' input on issues related to the MFP Demonstration, including: the Medicaid Advisory Committee; Medicaid Advisory Committee Subcommittee on CoLTS; the ALTSD Long-Term Services Subcommittee and Policy Advisory Committee, which provides input and recommendations to the State on long-term care issues; Brain Injury Advisory Council, which advocates and makes policy recommendations on behalf of persons with brain injuries; New Mexico State and Tribal Consultations; Indian Council on Aging; and the Behavioral Health Collaborative (BHC) and the BHC Office of Consumer Affairs (OCA).

The Draft FY 2011-2014 Behavioral Health Collaborative Strategic Plan devotes an entire chapter to consumer, youth, and family engagement and describes actionable activities to

facilitate and ensure engagement. The BHC Office of Consumer Affairs advances consumer and family driven services through training and education that support and empower individuals in the recovery process. The OCA assures that the voices of New Mexico consumers and family members are heard and included in all major decisions pertaining to mental health and substance abuse issues.

In addition, the Mi Via Task Force, which is an appointed advisory committee that includes individuals with disabilities who are self-directing and their families, monitors and provides input to the State on the Mi Via program, which is the State's self-directed waiver program. There is always a call-in number for those Task Force members who are unable to come in person. It is anticipated that the Task Force will add the MFP Demonstration to its oversight activities.

Institutional Providers' Roles, Responsibilities and Involvement throughout the Demonstration

Institutional providers are represented on the appointed MFP Work Group, and providers that are not on the Work Group are encouraged to communicate and share their experiences with their respective Work Group representatives.

Since the State incorporated MFP into its initial CoLTS program, the CoLTS MCOs are contractually required to identify nursing facility residents who want to move from the institutional setting to home and community-based programs and assist them with making the transition. This includes working closely with their network nursing facility providers to help an eligible resident understand and consider his/her options to receive care in the community and to

assist the individual to prepare for and make the transition to the community. The CoLTS MCOs are also responsible for facilitating the transition of their MFP eligible institutionalized members, including assisting each eligible individual with relocation specialist services, assessing the individual's needs, and assisting the individual to arrange for and procure needed resources for the move from the institution to the community. The nursing facility Family Council meetings also can include discussions on the MFP option and planning, where appropriate, for a resident's transition to the community. In addition, volunteer ombudsmen who work in nursing facilities are available to help facilitate an individual's transition from the nursing facility to reintegration into the community.

As described earlier, the State will phase-in individuals aged 65+ with mental health conditions. At that time, the Statewide Entity will work with the CoLTS MCOs to help to identify nursing facility residents with mental health conditions who want to move to home and community-based programs and assist them with making the transition. The Statewide Entity will also work with its network psychiatric facilities, in particular, the facility social workers to identify institutionalized residents who may be eligible for participation in the MFP Demonstration to help the residents understand and consider their options to receive care in the community. The Statewide Entity will also work with its network Core Service Agencies (CSAs), which will provide the MFP behavioral health service package, on the individual's eligibility assessment, discharge planning, and service planning and coordination.

When the MFP participant has both physical and behavioral health needs, the CoLTS MCO and Statewide Entity coordinate the individual's transition to home and community-based services.

The CoLTS MCO and Statewide Entity must ensure that the individual's physical and behavioral health services are provided through a clinically coordinated and collaborative system between the MCO and Statewide Entity.

Community Providers' Roles, Responsibilities and Involvement throughout the Demonstration

Community providers are represented on the appointed MFP Work Group, and those providers that are not on the Work Group are encouraged to communicate and share their experiences with their respective Work Group representatives.

The CoLTS MCOs are contractually required to assist eligible members who want to move to the community with transition planning. The CoLTS MCO facilitates the institutionalized member's transition, in collaboration with the member and their family and the home and community-based service (HCBS) providers. This includes assisting the individual with relocation specialist services, assessing the individual's needs, and assisting the individual to arrange for and procure needed resources for the move from the institution to the community. The MCO oversees its HCBS network providers and will follow MFP participants who have transitioned to the community throughout the MFP Demonstration and beyond to ensure a successful reintegration.

The Statewide Entity will work with its network CSAs, which will provide the MFP Demonstration behavioral health service package for individuals with mental health conditions who are a transitioning from the institution to the community. CSAs provide multiple services, i.e., eligibility and assessment of an individual's ability to manage living in the community;

discharge planning; service planning and service coordination; and comprehensive community support services, which include community support workers, peer support specialists, 24/7 crisis services, and RN services. It is anticipated that MFP Demonstration participants with behavioral health needs will likely require a high level of assistance, necessitating continued and close monitoring by the Statewide Entity and its network providers throughout the Demonstration program to ensure a successful transition and reintegration into the community.

When the MFP participant has both physical and behavioral health needs, the CoLTS MCO and Statewide Entity coordinate the individual's transition to home and community-based services. The CoLTS MCO and Statewide Entity must ensure that the individual's physical and behavioral health services are provided through a clinically coordinated and collaborative system between the MCO and Statewide Entity.

5. *Benefits and Services*

Service Delivery System

The service delivery system for Target Populations 1 and 2 is organized around the CoLTS program and includes the Medicaid State Plan Personal Care Option (PCO), the Mi Via waiver program, PACE, and the behavioral health single statewide entity. These are described below.

Coordination of Long-Term Services (CoLTS): The primary service delivery mechanism for MFP participants will be CoLTS, which operates statewide under a combination 1915(b)(c) waiver as a coordinated long-term managed care program. CoLTS, implemented in 2008, has four goals:

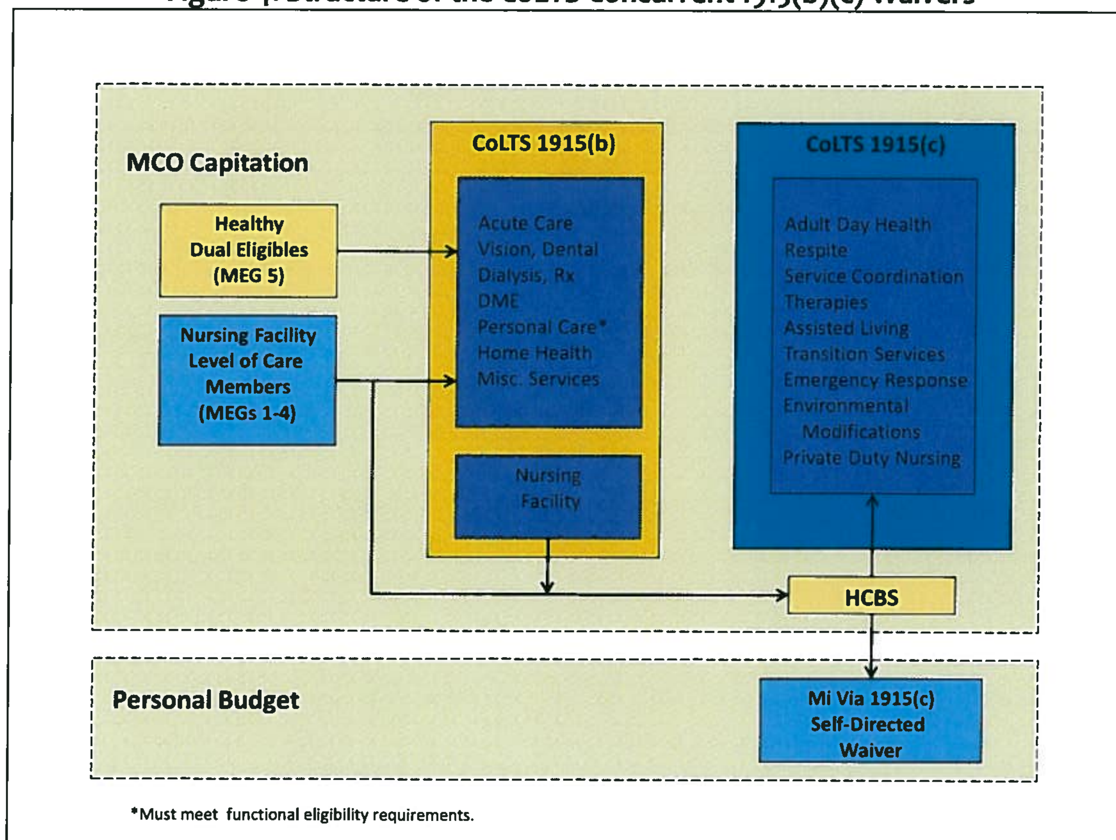
- Further rebalance the Medicaid system of long-term services and supports (LTSS);
- Increase the coordination of Medicaid and Medicare services;
- Improve and expand coordination of acute care and community-based services and supports through service coordination; and
- Establish a participant-focused and directed "continuum of services" approach across each participant's lifespan to improve both health status and quality of life.

Enrollment in CoLTS is mandatory for older adults, individuals with physical disabilities, and certain persons with brain injury. Enrollment in CoLTS now totals approximately 38,300. About 85 percent of CoLTS participants are enrolled in both Medicare and Medicaid ("dual eligibles").

The 1915(b) allows CoLTS to operate as a managed care delivery system. CoLTS participants receive Medicaid State Plan benefits under the 1915(b) waiver: acute care services, institutional services, and in-home personal care services under the Personal Care Option (PCO). CoLTS participants receive home and community-based services under the 1915(c) waiver. CoLTS participants may choose from two MCOs—AMERIGROUP and Evercare—to manage their care. The MCOs are also responsible for assessment administration, service plan development, service coordination, and quality management. CoLTS participants who are eligible for both Medicare and Medicaid ("dual eligibles") can benefit from improved coordination of their Medicare and Medicaid benefits by enrolling in a Medicare Advantage Special Needs Plan (SNP) operated by the MCO from which they receive their Medicaid benefits.

Figure 4 illustrates how CoLTS is structured. Individuals who are not assessed at nursing facility level of care (i.e., "healthy" dual eligibles) are eligible to receive Medicaid State Plan services only under the 1915(b) waiver. Individuals assessed at nursing facility level of care have access to Medicaid State Plan services as well as home and community-based services under the 1915(c) waiver.[5] However, these individuals may choose between CoLTS (c) home and community-based services and the Mi Via waiver, which provides individuals with a personal budget and allows them to self-direct their home and community-based services. Because Mi Via operates separately from CoLTS, funds for Mi Via personal budgets are not included in the MCOs' CoLTS capitation payments.

Figure 4. Structure of the CoLTS Concurrent 1915(b)(c) Waivers



Source: The Hilltop Institute, UMBC.

[5] Availability of home and community-based services is subject to openings in the 1915(c) waiver and legislative appropriations. In FY 2010, approximately 2,700 CoLTS participants were enrolled in the 1915(c) waiver.

State Plan Personal Care Option (PCO): PCO is available under the Medicaid State Plan to CoLTS participants who meet certain financial and medical eligibility criteria. The goal of the PCO program is to prevent institutionalization, maintain or increase the individual's functional level, and maintain or increase the individual's independence. Services are delivered pursuant to an individual plan of care based on the participant's assessment. Participants may choose to receive services under either of two models: consumer-directed or consumer-delegated. Under the consumer-directed model, participants hire and supervise their attendant and a fiscal intermediary assists the participant with the business-related "employer" responsibilities. Under the consumer-delegated model, the participant delegates responsibility to an agency.

Once determined eligible for PCO, the CoLTS participant's MCO service coordinator approves the type and amount of PCO services for the participant based on an in-home assessment and issues a service authorization to the PCO provider agency selected by the consumer. PCO provider agencies contract with the MCOs as part of the community-based provider network.

In FY 2010, 15,567 CoLTS participants who were not enrolled in the 1915(c) waiver received PCO services. CoLTS 1915(c) waiver participants receive State Plan personal care but not as PCO enrollees.

Mi Via: The Mi Via 1915(c) waiver is an option for CoLTS participants who desire to self-direct their home and community-based services. Participants receive acute care services through the CoLTS 1915(b) waiver and Medicaid State Plan and home and community-based services

exclusively through Mi Via. The Mi Via program operates under a co-employment model facilitated by a financial management agent. The participant acts as the employer of record and is responsible for managing an authorized annual individual budget. Additionally, a consultant is available to support the participant in self-directing his/her services and managing the individual authorized annual budget. A third party assessor is responsible for determining eligibility and approving service plans and related budgets.

Program of All-Inclusive Care for the Elderly (PACE): MFP participants may opt out of CoLTS and enroll in PACE if they are returning home to a PACE designated service area. Participants who select PACE must agree to receive all of their acute, home and community-based, and institutional care through the program. MFP services may be obtained through the program or outside of the program depending upon the services. Behavioral health services will be provided outside of the program.

Behavioral Health Service Delivery System: New Mexico's Behavioral Health Collaborative was created by Governor Bill Richardson and the New Mexico State Legislature during the 2004 Legislative Session (link: State Statute). The Legislation calls for the various state agencies involved in behavioral health prevention, treatment, and recovery to combine their resources and work as one entity to improve mental health and substance abuse services in New Mexico. The cabinet-level Collaborative represents 15 state agencies and the Governor's Office.

New Mexico is in its fifth year of a ten-year process to transform behavioral health services for adults, children, youth, and families driven by a focus on recovery and resiliency. The vision of

the Collaborative is to be a single statewide behavioral health delivery system in which funds are pooled and managed effectively and efficiently to create an environment in which the support of recovery and development of resiliency is expected, mental health is promoted, the adverse affects of substance abuse and mental illness are prevented or reduced, and behavioral health consumers are assisted in participating fully in the lives of their communities.

The Collaborative is charged with a number of responsibilities including, but not limited to, contracting with a single, Statewide Entity to manage the behavioral health delivery system. The current Statewide Entity is OptumHealth New Mexico, which is now in the second year of its contract with the Collaborative.

The Core Service Agency (CSA) system is part of the system transformation process. The CSA system exists with 20 CSAs established throughout the State, but it is still in the early stages of development. For this reason, the State anticipates phasing in Target Population 2 (institutionalized adults aged 65+ with mental health conditions) into the MFP Demonstration following a period of research and developmental work in SFY 2012.

A CSA serves as the participant's clinical home, coordinates care, and provides essential services to adults who have serious mental illness (SMI). For those eligible to receive services (see Appendix 2 for eligibility criteria), the CSAs provide or coordinate psychiatric services, medication management, everyday crisis services, comprehensive community support services (CCSS) that support an individual's self-identified recovery goals, and other clinical services.

The CSAs and the system of services that they provide will be integral to the State's inclusion of Target Population 2 in the MFP Demonstration. CSAs will help participants and family members find providers as well as directly provide or coordinate essential services and ensure that a comprehensive array of services that meet the particular needs of the participant are available and accessible. The CSA will be accountable for working with the participant (and/or their representative) on the development, implementation, and monitoring of an integrated service plan that maximizes choice and control for the participant in meeting individual needs for successful community-based living.

Many of the essential services already exist within the behavioral health system and within the State's Medicaid HCBS waivers. However, additional developmental work with the CSA implementation team, the CSA Learning Group (a group of clinical directors of newly appointed CSAs learning from each other during the implementation phase), the Statewide Entity, and the CoLTS MCOs will be required to enhance as well as to weave together these two systems of care to deliver an integrated service plan that meets the needs of MFP participants in Target Population 2.

Including Target Population 2 in New Mexico's MFP Demonstration will provide the State with an unparalleled opportunity to integrate care across two service systems. It is not unusual for CoLTS participants to have several professionals assigned to them with service coordination responsibilities—often with limited communication among service coordinators. The CoLTS MCOs and the behavioral health system (i.e., the Statewide Entity) each have their own service coordinators. In addition, an individual having his/her behavioral health needs addressed through

the CSA system will likely have a community support worker with service coordination responsibilities. Individuals choosing to self-direct their waiver services through Mi Via work with a consultant, yet another professional with service coordination responsibilities.

Under MFP, the State hopes to transform this fragmented system by testing different models for simplifying service coordination. For those individuals with significant behavioral health needs (Target Population 2), the State proposes intensive case management as an MFP Demonstration service, with these professionals functioning as integrated service plan coordinators. The State also plans to conduct monthly MFP participant-specific co-managed rounds involving MFP participants and their coordinators from the CoLTS MCOs, Mi Via, the SE, and the CSAs. The State hopes to learn how best to accomplish service integration and coordination in order to implement best practices for all Medicaid participants with complex physical and behavioral health needs.

For Target Population 2, the State proposes to increase the number of allowable hours of Comprehensive Community Support Services delivered by community support workers and peer support specialists based at the CSAs. Currently individuals are allowed 17 units in 90 days (i.e., 1 ½ hours per week with 40 percent indirect service and 60 percent face-to-face contact). Enhanced Comprehensive Community Support Services will be provided as an MFP supplemental demonstration service during the transition period and throughout the one-year MFP Demonstration period. Community support workers and peer support specialists will engage with MFP participants and family members early in the transition process by becoming part of the transition team along with the Ombudsmen volunteers and the MCO service

coordinators to provide transition assistance and guidance in accessing the behavioral health services system. Regionally-based peer support specialists will provide outreach, peer support, and modeling to MFP participants, as well as teach participants self-advocacy and recovery-oriented skills. Peer support specialists will also share information about choices and opportunities based on their own experiences in utilizing community resources. The increased number of allowable units of service available to MFP participants will not only provide needed assistance to transitioning MFP participants with mental health conditions, but also provide an opportunity to better understand the kinds of supports that are needed not only for a successful transition, but for ongoing successful community living for individuals in Target Population 2. The State will also explore using a "Pay for Performance" incentive system already in place for CSAs to increase payment rates for CSAs providing services to MFP Target Population 2 during the one-year Demonstration period. This would enable the CSAs to conduct in-home assessments and is expected to positively impact staff productivity.

The developmental phase for Target Population 2 will include working with OptumHealth, the State's current Statewide Entity for behavioral health, to develop web-based trainings on promising practices in the treatment of older adults. The State will explore existing web-based trainings (e.g., the Impact Model) and also work with the OHNM Medical Director, who is a geriatric psychiatrist, to develop a Web-Ex training on the assessment and treatment of older adults. A Web-Ex training would be an easily accessible mechanism for increasing the competency of CSA staff in working with the behavioral health needs of the Target Population 2. The State will also explore creative ways for primary care clinics and CSAs to work together to build more integrated models of care. Several CSAs are co-located with primary care clinics, which will help facilitate this process.

In addition to the MFP Demonstration services, the following behavioral health services available to all Medicaid participants will be available to MFP participants in Target Population 2:

- Discharge Planning
- Eligibility Determination and Assessment
- Service Planning and Service Coordination
- Comprehensive Community Support Services:
    - Community Support Worker
    - Peer Support Specialist
    - Family Peer Support Specialist
    - Everyday crisis services
    - Psychiatric and medication management services

In addition, several CSAs currently provide Assertive Community Treatment Teams (ACT) that include nursing services and 24/7 mobile crisis response teams.

Other behavioral health services needed by MFP participants can be accessed through any other provider that offers behavioral health services (e.g., psychosocial rehabilitation; group, individual, and family therapy). Comprehensive Community Support Services are only provided by the CSAs. All behavioral health services that an individual needs to assure successful community living and assist in achieving recovery or treatment goals are part of the CSA treatment plan that the CSA develops and monitors with the participant and the involvement of the participant's family and support network.

Transportation to medical services is provided through Safe-Ride, which is a Medicaid-funded benefit. Local transportation options to enable participants to attend non-medical appointments vary (e.g., transportation provided by local senior services).

Over the past five years, extensive outreach was conducted and education made available to providers of direct service caregivers throughout the State of New Mexico with funding provided to the ALTSD Behavioral Health Unit from the Behavioral Health System Transformation Grant, a five-year grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) that ended September 30, 2010. Trainings were provided to homemakers, home health aides, and nurses. Training topics included, for example, behavioral health needs of older adults, depression and suicide in older adults, working with clients who have difficult behaviors, and support for the caregiver. Staff from the ALTSD Behavioral Health Unit continue to offer this kind of training and consultation upon request from community-based direct care service providers.

MFP Demonstration Benefit Package

Based on assessed needs, eligible MFP participants will receive community-based services and supports under one of the following options after transitioning from the institutional setting. Behavioral health services will be provided to all MFP participants through the CSAs and Statewide Entity.

- CoLTS participants:

  --PCO and Medicaid State Plan acute care

  --CoLTS 1915(c) waiver services and Medicaid State Plan acute care

  --Mi Via 1915(c) waiver services and Medicaid State Plan acute care

- PACE (all inclusive Medicare and Medicaid benefits)

MFP participants will be eligible to receive MFP Demonstration services during the first 365 days post-transition in addition to the services provided under the Medicaid programs in which they are enrolled. MFP Demonstration services are intended to enhance participants' ability to successfully transition to the homes and communities of their choice. After the initial 365-day post-transition period, MFP Demonstration services will no longer be available, but participants will continue to receive the services offered under the program in which they are enrolled.

MFP Demonstration services by target population will be:

Target Population 1:

- Community Transition Services
- Case Management

Target Population 2:

- Community Transition Services
- Case Management
- Intensive Case Management
- Enhanced Comprehensive Community Support Services

Case Management will be key for both target populations. For individuals expressing interest in transitioning from a nursing home or other institution as an MFP participant, the State will assign a case manager called an Integrated Service Plan Coordinator who will be responsible for coordinating all of the other service coordinators (e.g., MCO Service Coordinator, Mi Via

Consultant, nursing home discharge planner, Ombudsman representative, Community Service Agency) so that the individual has one person to call and there is one professional accountable for making the transition happen. Too often there are a multitude of "service coordinators" but not a single individual in charge of overseeing the transition. Case managers will receive special training on how to work with the various agencies, institutions, and providers to efficiently accomplish transitions. The organizational location of the Integrated Service Plan Coordinator, or case manager, will depend on the individual's needs and program choices. For those individuals in Target Population 1—i.e., those for whom behavioral health care needs are not the dominant issue—the Integrated Service Plan Coordinator will be assigned from the CoLTS MCO staff (for those choosing the CoLTS 1915(c) waiver or Medicaid State Plan services only) or from the Mi Via consultant agency (for those choosing Mi Via). For Target Population 2 participants—i.e., those for whom behavioral health care needs are a dominant issue—the Integrated Service Plan Coordinator will be from the staff at the Statewide Entity.

Table 10 lists existing Qualified Home and Community-Based Services offered by New Mexico as well as proposed MFP Demonstration Services and MFP Supplemental Services. Table 11 provides specifications for the services offered as part of the MFP Demonstration.

Table 10. Waiver, State Plan, and MFP Home and Community-Based Services

Service	CoLTS	Mi Via	State Plan	PACE
Qualified Home and Community-Based Services				
Adult Day Health	X			*
Assisted Living	X	X		*
Behavior Support Consultation		X		*
Community Direct Support		X		*
Community Transition Relocation Specialist	X			*
Community Transition Services	X			*
Consultant/Support Guide		X		*
Customized Community Supports		X		*

Service	CoLTS	Mi Via	State Plan	PACE
Customized In-Home Living Supports		X		*
Emergency Response	X	X		*
Employment Supports		X		*
Environmental Modifications	X	X		*
Home Health Aide Service		X		*
Homemaker/Direct Support Services		X		*
Nutritional Counseling		X		*
Personal Care			X	*
Personal Plan Facilitation		X		*
Private Duty Nursing for Adults	X	X		*
Related Goods		X		*
Respite	X	X		*
Service Coordination	X			*
Skilled Maintenance Therapy	X	X		*
Specialized Therapies		X		*
Transportation		X		*
MFP Demonstration Services				
Case Management	X	X	X	X
Intensive Case Management**	X	X	X	X
Community Transition Services			X	X
MFP Supplemental Demonstration Services				
Enhanced Comprehensive Community Support Services**	X	X	X	X

*PACE offers similar services when medically necessary.

** Available only to Target Population 2.

Table 11. Specifications for MFP Demonstration Services and Supplemental Services

Service	Unit	Rate/Unit	Medical Criteria
Case Management	**Month**	**$249.91**	**Nursing facility level of care**
Service Definition	Case Management Services assist participants to gain access to needed waiver and State Plan services, link the individual to needed medical, social, educational and other services from a variety of funding sources as well as to natural supports. Case Management services are intended to enhance, not replace existing natural supports and other available community resources. Services will emphasize and promote the use of natural and generic supports to address the individuals assessed needs in addition to paid services. Case Managers facilitate and assist in assessment and service planning activities. Case Management services are person-centered and intended to support individuals in pursuing their desired life outcomes while gaining independence, and facilitating access to services and supports. Case Management is a set of interrelated activities that are implemented in a collaborative manner involving the active participation of the individual, and /or their designated representative/guardian, and the entire Interdisciplinary Team. The case manager is an advocate for the person they serve, and are responsible for		

Service	Unit	Rate/Unit	Medical Criteria
	developing the ISP and for the ongoing monitoring of the provision of services included in the ISP.		
Provider Qualifications	**A. Agency qualification:** Agencies must be certified by the developmental disabilities division of the New Mexico department of health and meet the HSD/MAD approved standards for agencies providing case management. (1) Agencies must demonstrate knowledge of the community to be served, its populations and its resources, including methods for accessing those resources. (2) Agencies must demonstrate direct experience in case management services and success in serving the target population. (3) Agencies must have personnel management skills, including written policies and procedures that include recruitment, selection, retention and termination of case managers, job descriptions for case managers, grievance procedures, hours of work, holidays, vacations, leaves of absence, wage scales and benefits, conduct and other general rules. **B. Case manager qualifications:** Case managers employed by case management agencies must possess the education, skills, abilities and experience to perform case management service. At a minimum, case managers must meet one of the following qualifications: (1) bachelor's degree from an accredited institution in a human services field or any related academic discipline associated with the study of human behavior or human skills development, such as psychology, sociology, speech, gerontology, education, counseling, social work, human development or any other study of services related field and one (1) year of experience working with individuals with disabilities; (2) licensed as a registered or licensed practical nurse with one year of experience working with individuals with disabilities; or (3) In the event that there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers: (a) associate's degree and a minimum of three (3) years of experience working with individuals with disabilities; or (b) high school graduation or general educational development (GED) test and a minimum of four (4) years of experience working with individuals with disabilities.		
Intensive Case Management	**Year**	**$5,200**	**Must meet criteria for Target Population 2**
Service Definition	Limited to 2 hours per week per year, Intensive case management is a skilled service that assists participants with care coordination, including services such as access to and coordination among primary, preventive and chronic care providers; crisis intervention and planning; staff training; training related to health maintenance and safety; end of life directives; and family mediation. Mi Via participants may wish to delegate some management of their care to a skilled-level case manager. Intensive case management services may also assist participants with the		

Service	Unit	Rate/Unit	Medical Criteria
	identification of and linkage to community resources and activities that are beyond the scope of Medicaid services including recreational, social, and educational activities.		
Provider Qualifications	**A. Agency qualifications:** Agencies must be certified by the mental health division of the department of health. Agencies must meet the following criteria: (1) Agencies must have demonstrated direct experience in successfully serving the target population; and (2) Agencies must demonstrate knowledge of available community services and methods for accessing them. **B. Case manager qualification:** Case managers employed by the agency must possess the education, skills, abilities, and experience to perform case management services for recipients who are chronically mentally ill. Case managers must meet at least one of the following requirements: (1) bachelor's degree in social work, counseling, psychology or a related field, from an accredited institution and one year of experience in the mental health field; or (2) licensed as a registered nurse with one year of experience in the mental health field. (3) In the event that there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers: (a) associate's degree and a minimum of three (3) years of experience working with individuals with chronic mental illness; (b) high school graduation or general educational development (GED) test and a minimum of four (4) years of experience working with individuals with chronic mental illness.		
Community Transition Services	**Year**	**$4,000**	**Nursing facility level of care**
Service Definition	Community transition goods and services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement (excluding assisted living facilities) to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board.		
Provider Qualifications	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.		
Enhanced Comprehensive Community Support Services	**TBD**	**TBD**	**Must meet criteria for Target Population 2**
Service Definition	**TBD during planning phase**		
Provider Qualifications	**TBD during planning phase**		

6. Consumer Supports

MFP Demonstration participants will be accessing already established support and back-up systems. Ombudsman Transition Support Specialists will be available during the transition to advocate for the transitioning individual's care and service needs. They will facilitate coordination among entities responsible for providing this care and services in the community until an integrated service coordinator is in place. This level of advocacy will enhance oversight and accountability of service coordination provided by the MCOs and other community service providers. Self advocacy may be the most important service provided to the transitioning individual in that the person can initiate the first level of protection for him/herself.

- **Educational Materials on State Policies**: A transition brochure (CMS product #11477) will be available to all transitioning individuals listing the health oversight agencies in New Mexico.
- **24-Hour Backup Systems:** Each MCO is required to build provisions for back-up into care plans. The MCO contracts with providers include the requirement that providers have provisions for emergency back-up at the provider level.
    - **Transportation**: The CoLTS MCOs' transportation numbers are toll free and can take requests 24 hours a day, 7 days a week.
    - **Direct service workers**: Each PCO provider is required through current regulation to maintain an accessible and responsive 24-hour communication system for consumers to use in emergency situations to contact the agency. The state will work with the MCOs to ensure all direct service providers are in compliance with this requirement. Provider audits will also ensure compliance.

- **Repair and replacement for durable medical and other equipment**: The MCO contracts require emergency DME provisions to deliver replacement or repair equipment within 2 hours. Each MCO has a process in place to achieve this.
- **Access to medical care**: Individuals are assisted with initial appointments, how to make appointments and deal with problems and issues with appointments, and how to get care issues resolved. This is a core function of the service coordinator in the discharge process. The MCO arranges for a PCO provider to follow the member after the nursing facility discharge and typically pays for the member to be seen before the nursing facility discharge so that the new physician has a chance to get to know the member and his/her needs, write necessary prescriptions, order applicable services, etc. This ensures that individuals are established with a provider prior to leaving the nursing facility while educating the participant on how to access services once in the community.

Additionally, many participants with serious medical or care needs are provided with personal emergency response systems that can provide immediate emergency response. In addition to the continuing provider and/or MCO responsibility in these areas, the MFP program will provide an informed consent form with a section in which the service coordinator must insert specific information including emergency and back-up contact numbers and protocols. This will insure that each MFP participant has this information in a readily accessible form and will provide documentation to ALTSD that this information was provided.

- **Complaint and Resolution Process**: Participant complaints will be handled in much the same way that the Departments currently handle complaints from CoLTS members and waiver participants. The State's contracts with the CoLTS MCOs have specific measures about how to address complaints and grievances. Often, the complaint or grievance may come directly to State staff, either at the ADRC or within a program division.

  All complaints are entered into a database. State staff will typically contact the MCO's service coordination specialist and request that the participant's service coordinator contact the participant. Staff will follow up with the participant at the end of the second business day to verify that the MCO has contacted them. State staff also use their access to various systems (e.g., eligibility system, Medicaid Management Information System) to verify information and assist program participants.

7. *Self Direction*

New Mexico provides several opportunities for CoLTS participants to self-direct their services and supports.

- **State Plan Personal Care Option:** Participants may choose to receive services under either of two models: consumer-directed or consumer-delegated. Under the consumer-directed model, participants hire and supervise their attendant and a fiscal intermediary assists the participant with the business-related "employer" responsibilities. Under the consumer-delegated model, the participant delegates responsibility to an agency.
- **Mi Via**: This 1915(c) waiver program operates under a co-employment model assisted by a financial management agent. The participant acts as the employer of record and is

responsible for managing an authorized annual individual budget. Additionally, a consultant is available to support participants in self-directing their services and managing their budgets. Depending on the needs of the participant, consultant services may include: assistance meeting obligations as an employer; help with navigating the employer/employee and vendor relationships; aid with service plan development and managing the individual budget; monitoring expenditures, progress, and outcomes; assistance with coordinating services; facilitating the eligibility determination and re-determination processes; and facilitating communication and coordination between the financial management agent, third party assessor, and the State when necessary.

Mi Via participants may voluntarily terminate from self-direction. When a Mi Via participant decides to discontinue self-directing his/her services, he/she may return to the CoLTS 1915(c) waiver. The participant is assisted with the transition process and access to services through CoLTS 1915(c) by the consultant in Mi Via and the CoLTS MCO service coordinator. Together, the consultant and service coordinator work with the participant to coordinate Mi Via and CoLTS services, plans, and budgets to ensure that 1) there is a timely revision of the service and support plan; 2) there is continuity in delivery of needed services; and 3) the participant's health and safety are maintained.

Mi Via participants may be involuntarily terminated from self-direction through Mi Via and offered services through the CoLTS 1915(c) 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 and support from the program staff, consultant, or financial management agent (FMA).
2. The participant is at 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 Service and Support Plan (SSP) and authorized annual budget that would address health and safety issues identified in his/her medical assessment or challenges assessment, after repeated and focused technical assistance and support from the program staff, consultant, and/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 authorized annual budget.
    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 and/or FMA.
4. The participant commits Medicaid fraud.

A participant who is involuntarily terminated from the Mi Via waiver may be offered a non self-directed alternative through the CoLTS 1915(c) waiver. If the transfer to the

CoLTS 1915(c) waiver is authorized by the State and accepted by the participant, he/she will continue to receive the services and supports from the Mi Via waiver until the day before the new waiver services start. This will ensure that no break in service occurs. The Mi Via consultant and the CoLTS service coordinator will work closely with the participant and each other to ensure that the participant's health and safety are maintained. The Fair Hearing notice and rights apply.

The State's goal for the Demonstration participants who self-direct their services is to provide a home and community-based alternative to institutuional care that facilitates greater participant choice, direction and control over the services and supports that the participants choose to purchase, as specified within their service and support plans and corresponding authorized annual budgets.

8. *Quality*

Quality Assurance/Improvement for MFP Participants: MFP participants enrolled in the CoLTS 1915(c) waiver or the Mi Via 1915(c) waiver will be subject to CoLTS/Mi Via quality assurance and quality improvement policies and procedures as specified under the waivers, both during and after the one-year MFP Demonstration period. MFP participants will therefore be subject to the same level of quality assurance and improvement activities articulated in Appendix H of the CoLTS 1915(c) waiver and/or Appendix H of the Mi Via 1915(c) waiver. Through performance measures, performance monitoring, remediation activities, and continuous quality improvement processes developed for the CoLTS and Mi Via waivers, the State will address the

waiver assurances for 1) level of care determinations; 2) service plans; 3) qualified providers; 4) health and welfare; 5) administrative authority; and 6) financial accountability.

CoLTS MFP participants who receive Medicaid State Plan services only (i.e., CoLTS "healthy duals" and CoLTS members enrolled in PCO) will be subject to the provisions of the State's overarching quality assurance and quality improvement program.

HSD/MAD and ALTSD conduct oversight through many avenues. Both CoLTS MCOs must report at specified and varying intervals on program performance measures and supply extensive financial and programmatic reports including, but not limited to, claims payments, number of participant community re-integrations from institutions, and information from mandatory consumer and provider surveys.

Monthly, HSD/ALTSD/CoLTS MCO meetings are held to discuss program issues and an additional meeting is held monthly to review system requirements. Oversight occurs through external and internal audits by Health and Human Services, Office of Inspector General, and the External Quality Review Organization (EQRO) in addition to focused audits by HSD and ALTSD. Data from these sources is collected, aggregated, and trended by ALTSD/HSD/MAD to form the basis of the discovery and remediation process.

Description of New Mexico's Waiver Quality Assurance/Improvement System: The State's quality assurance/improvement system is designed around the Interagency Quality Review Committee (IQRC). This committee's membership is comprised of key staff from HSD/MAD,

the oversight agency, and ALTSD, which has operational oversight for waiver operations. The IQRC is inter-departmental and responsible for identifying trends, prioritizing, and implementing waiver program improvements that are identified as the result of continuous quality improvement processes. The primary function of this committee is to prioritize systemic improvements based on resource requirements, departmental, and/or legislative mandates. The IQRC may request and/or conduct additional trending and quality improvement activities as indicated. The IQRC directs the appropriate entity to implement system improvements, provides oversight for implementation of system improvements, and evaluates the effectiveness of system changes. The IQRC reports to the senior management of both departments (HSD/MAD and ALTSD).

To monitor and analyze the effectiveness of system design changes, the IQRC convenes quarterly meetings, at a minimum, to review data on waiver performance measures and data from required reports, as well as any other data related to program monitoring and improvement. When data demonstrate an opportunity for improvement, the IQRC takes action and plans for improvement are developed and implemented. Implementation progress is tracked and reviewed at subsequent IQRC meetings to evaluate effectiveness. If the changes that are implemented do not result in the desired improvements, the IQRC will seek additional data and analysis and implement quality improvement activities and/or additional changes to obtain the desired remediation. Quality monitoring is a documented IQRC activity and is reported to appropriate workgroups and senior management. Additional sources of information for system improvements that may be used by the IQRC include feedback from stakeholders, ad hoc data reports, analysis requests, and consultations with subject experts and research.

Quality of Life Survey: The State will administer the Quality of Life survey to each MFP participant at three points in time: 1) after the individual has been accepted into the MFP program but just prior transition to the community; 2) approximately 11 months post-transition to the community; and 3) approximately 24 months post-transition to the community. The survey will be administered in-person using the instrument provided by the national MFP evaluator. Prior to participating in MFP, participants will be asked to sign a consent form (see Figure 2) that advises participants that they will be asked to complete the Quality of Life survey at three points in time. Completion of the survey will be voluntary and participants will be advised in the consent form that they will be eligible to receive MFP services even if they do not complete the surveys. The State will amend its current contract with the New Mexico Medical Review Association (NMMRA) to include conduct of the Quality of Life surveys. NMMRA is the State's quality review organization. The State will submit Quality of Life survey data to Mathematica on a quarterly basis as required by CMS.

National MFP Evaluation: To facilitate the national evaluation and program monitoring, the State will comply with all reporting requirements specified in the July 26, 2010, Invitation to Apply issued by CMS. This includes the semi-annual web-based reports on program structure, process, output, outcomes, and impact as well as MFP program files from MSIS and the financial reporting forms required by CMS.

New Mexico MFP Metrics: The State does not anticipate conducting its own evaluation of its MFP Demonstration. However, the State will develop a set of New Mexico-specific metrics to monitor MFP program management and outcomes. The metrics will be developed in

collaboration with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC). Hilltop is developing a similar set of metrics for the Maryland MFP Demonstration. The metrics will be designed to address the following questions:

- To what extent have transitions to the community increased since implementation of the MFP Demonstration?
- How many transitions have occurred over time?
- How do people transitioning post-MFP implementation compare to those who transitioned pre-MFP implementation?
- What was the average pre-transition institutional length of stay and how has it changed during the MFP Demonstration?
- What Medicaid programs do MFP participants enroll in?
- What is the rate of reinstitutionalization for MFP participants?
- What is the rate of hospitalizations for MFP?
- Do MFP participants report being satisfied and getting the services they need?

9. Housing

Since development of its *Long Term Supportive Housing Plan* in 2007, the New Mexico Behavioral Health Collaborative has been working with a number of organizations—including Public Housing Authorities—to develop supportive housing capacity in the State. While much of the initial work targeted supportive housing for people with behavioral health disorders, the housing plan always addressed strategies to promote and provide supportive housing for people with a broader range of disabilities, or what the U.S. Department of Housing and Urban Development (HUD) calls the non-elderly population with disabilities.

New Mexico's MFP Demonstration will benefit from the accomplishments of the Behavioral Health Collaborative and, going forward, MFP will be an active partner in the Collaborative's efforts to expand the supply of affordable housing for persons with disabilities. The State proposes to have a housing specialist on the MFP Demonstration staff and this individual would be the liaison with the Collaborative on affordable housing development.

The Collaborative's accomplishments include the following:

- From FY 2008 to FY 2010, the Behavioral Health Collaborative invested in the development of 97 supportive housing units through the Collaborative's Supportive Housing Development Funds. The housing units are located in eight different affordable housing projects in Albuquerque, Santa Fe, Carlsbad, Gallup, Las Vegas, and Tularosa.
- The Collaborative partnered with the State Housing Finance Authority, Mortgage Finance Authority, and instituted a program of bonus points to incentivize developers to participate in the Low Income Housing Tax Credit Program for development of supportive housing units for persons with special needs. In 2009, the Mortgage Finance Authority committed to awarding bonus points to developers who agreed to reserve units for special needs households. In 2009 and 2010, the Low Income Housing Tax Credit Program succeeded in leveraging an additional 73 supportive housing units for special needs households in 11 housing developments in Farmington, Hobbs, Belen, Los Lunas, Santa Fe, Albuquerque and Clovis in 2009 and 2010 alone.
- A statewide data base of 23 New Mexico Public Housing Authorities tracks Section 8 Housing Choice Voucher waiting lists and target population preferences to increase

access to subsidized housing for individuals with disabilities (see Appendix 3). MFP Demonstration participants will be included in this database. Currently 9 Public Housing Authorities have preferences for vouchers for individuals with disabilities: Albuquerque, Grants, Tucumcari, Town of Bernalillo/Cuba, County of San Miguel, County of Santa Fe, Bernalillo County, Village of Los Lunas/County of Valencia, and County of Socorro.

- In 2010, the Collaborative, in cooperation with OptumHealth, the SE, selected and trained five Local Lead Agencies in Bernalillo, Santa Fe, Valencia, San Juan and Lea Counties who serve as the tenant screening and coordination liaison between property managers and local support services providers for persons with disabilities.
- The Collaborative's State Supportive Housing Coordinator, working with all 23 Public Housing Authorities, ensures that the Public Housing Authorities are informed about HUD notices of funding opportunities as they become available so that they can apply (e.g.,Veterans Administration Supported Housing vouchers, Non-Elderly Disabled vouchers).
- All projects funded by State Housing Finance Authority, Mortgage Finance Authority, must incorporate "visitability" standards for at least 50 percent of units. The minimum features include:
    - One zero step entrance (can be primary entrance, garage entrance, or other) on a route that has no steps, steep slopes, or abrupt level changes from the driveway, sidewalk or other point of arrival. Zero step means that there is no or a low (3/4 inches maximum, beveled) level change at threshold.
    - All main floor interior passage doors, including bathrooms, should have 32 inches of clear passage space.

- At least a half bath, preferably a full bath, on the main floor of the unit with a minimum area of 30 inches by 48 inches beyond the swing of the door.

- The State, together with the Collaborative, conducted a statewide *Survey of Housing Preferences for Independent Living* of 739 persons with disabilities. The survey examined choice in living situations, satisfaction with current living arrangements, and perceived gaps in current and ideal living situations.

Availability of Qualified Residences and Documentation Process: Table 12 shows the types of qualified housing to which New Mexico MFP participants may transition, the estimated number of each, and how each type is regulated. The ADRC is responsible for ensuring that MFP participants move to qualified housing.

Table 12. New Mexico MFP Demonstration: Qualified Residences

Type of Qualified Residence	Estimated Number Available	Type of Setting	Estimated Number in Each Setting	How Regulated
Home owned or leased by individual or individual's family member	Rate in NM is 70% owned, 30% leased	Home leased by individual or family	Equal to 30% of estimated number of MFP-transitioned individuals	
		Home owned by individual	Equal to 70% of estimated number of MFP-transitioned individuals	
		Home owned by family		
Apartment with an individual lease, lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control		Apartment building		
		Assisted living	4 ALF with 177 units, total	Licensed by DOH and approved as Assisted Living waiver providers by ALTSD
		Public housing units	2,944	Housing Authority Management

Type of Qualified Residence	Estimated Number Available	Type of Setting	Estimated Number in Each Setting	How Regulated
Residence in a community-based residential setting in which no more than four unrelated individuals reside		Adult foster care		
		Group home (2 homes)	5	One Licensed by DOH and approved as Assisted Living waiver provider by ALTSD; and one under threshold for DOH licensing, but approved as Assisted Living waiver provider by ALTSD

10. Continuity of Care Post-Demonstration

Continuity of care for MFP participants will not be disrupted when the participant's one-year MFP Demonstration period expires. After the Demonstration period, the participant will continue to receive services in the programs in which he/she is enrolled (e.g., CoLTS, Mi Via, PACE, PCO, behavioral health programs through SE). MFP Demonstration services will enhance ongoing services by promoting improved coordination and integration of services across the service delivery spectrum and inform the State's efforts to implement best practices in the future.

C. Project Administration

Organization and Oversight: HSD/MAD will be the lead agency and ALTSD will administer the Demonstration Project. By State law, ALTSD is responsible for programs relating to long-term services. ALTSD and HSD will complete an interagency agreement to delineate relationships and responsibilities required to administer the Project. ALTSD is currently responsible for managing the CoLTS 1915(c) waiver program and will be responsible for managing the MFP Demonstration Project once it is operational. HSD oversees ALTSD's management of Medicaid funds relative to the Demonstration Project and long-term services administered by ALTSD. ALTSD and HSD have collaborated closely in development of the

MFP Demonstration Project proposal and will continue the collaboration throughout the implementation of the project.

The MFP Project Director and Transition Specialists will reside in the ALTSD Elderly and Disability Services Division. The Project Director will report to the CoLTS Bureau Chief. These positions will work closely with the Long-term Ombudsman Program and the ADRC, both of which are located in the ALTSD.

The MFP Liaison/Coordinator position will reside in HSD/MAD's Long-Term Services & Support Bureau and will report to the Bureau Chief.

Appendix 4 provides an organizational chart for ALTSD. Appendix 5 provides an organizational chart for HSD/MAD.

Staffing Plan: Proposed MFP Demonstration staff are listed in Table 13, along with their roles and responsibilities and reporting relationships.

Table 13. New Mexico MFP Demonstration Staffing Plan

Position	Role/Responsibility
MFP Project Director (1.0 FTE) To be hired	The Project Director will be a full-time position in ALTSD and will be responsible for the overall functioning of the MFP Demonstration Program including compliance with all State and Federal requirements. For New Mexico State Personnel Office (SPO) purposes, the position will be TERM and at a Staff Manager level. The position will supervise MFP transition specialists and work closely with the State's ADRC, Ombudsman, and Medicaid staff. The position will be subject to the SPO Manager Evaluation process and evaluated on the successful performance and attainment of the goals specific to the MFP program. The position will also oversee any contracts that may be part of the MFP program.
MFP Transition Specialists (2.5 FTE)	The Transition Specialists will be located in ALTSD and dedicated full-time to the MFP program. They will be TERM positions at a program

Position	Role/Responsibility
To be hired	manager range, report to the MFP Project Director, and be subject to the SPO Employee Evaluation process. They will work closely with the ADRC and service coordinators at the nursing home and within the CoLTS MCOs to ensure that the individual wishing to transition is eligible for the MFP program. They will provide residents and family members with ADRC contact information as a segment of the self advocacy taught to all residents seeking a different care setting. They will make post-transition home visits as necessary and teach self-advocacy to promote and enhance self-care and well-being.
MFP Liaison/Coordinator (1.0 FTE) To be hired	This position will reside in HSD/MAD's Long-Term Services and Supports Bureau and will report to the Bureau Chief. This will be a TERM position and subject to the SPO Employee Evaluation process. Position responsibilities include coordinating MFP Demonstration activities across HSD/MAD and ALTSD.
Fiscal/Data Specialist (1.0 FTE) To be hired	This position will reside in ALTSD and report to the MFP Project Director. This will be a TERM position and subject to the SPO Employee Evaluation process. The position will assist the Project Director with: research and analysis necessary to determine whether the Program is meeting its benchmarks and goals; federal and state reporting requirements; and budgeting and other fiscal matters.
TOTAL FTE – 4.5	

Billing and Reimbursement Procedures:

- **Medicaid Billing and Reimbursement Procedures:** Health care for Medicaid eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by HSD/MAD. Upon approval of a New Mexico provider participation agreement by HSD/MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the HSD/MAD claims processing contractors or MCOs. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized

agents, including program rules, billing instruction, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD/MAD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, billing instructions and executive orders. HSD/MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made.

- **MFP Billing and Reimbursement Procedures**: New Mexico's MFP Demonstration will operate within a managed care environment that includes CoLTS (for primary and acute care and institutional and community-based LTSS) and the Statewide Entity (for behavioral health services). The State pays monthly capitation payments to the CoLTS MCOs and the Statewide Entity for each member enrolled in these programs. The State anticipates that Case Management and Community Transition Services will be provided to MFP participants under the CoLTS capitated rate structure, and that Intensive Case Management and Enhanced Comprehensive Community Support Services (available only to Target Population 2) will be provided to MFP participants under the Statewide Entity capitated rate structure. MFP eligibility will be designated in the state's administrative systems. To calculate the enhanced FMAP for MFP participants, the State will develop a method for estimating the percentage of MFP participants' capitation payments that go

towards qualified HCBS. The MCOs, Statewide Entity, and providers will be required to comply with the Medicaid billing and reimbursement procedures described above for all new MFP services offered under the Demonstration.

- **Monitoring:** HSD/MAD and ALTSD conduct oversight through many avenues. Both CoLTS MCOs must report at specified and varying intervals on program performance measures and supply extensive financial and programmatic reports including, but not limited to, claims payments, number of participant community re-integrations from institutions and information from mandatory consumer and provider surveys.

  Monthly, HSD/ALTSD/CoLTS MCO meetings are held to discuss program issues and an additional meeting is held monthly to review system requirements. Oversight occurs through external and internal audits by the Health and Human Services, Office of Inspector General, and the External Quality Review Organization (EQRO) in addition to focused audits by HSD and ALTSD. Data from these sources is collected, aggregated and trended by ALTSD/HSD/MAD to form the basis of the discovery and remediation process.

- **Fraud and Abuse:** HSD is committed to the development and implementation of an aggressive prevention, detection, monitoring and investigation program to reduce provider/member fraud and abuse and member abuse and neglect. If fraud or abuse is discovered, HSD shall seek applicable administrative, civil and criminal penalties, sanctions and other forms of relief. This applies to all individuals participating in or

contracting with HSD for provision or receipt of medicaid services. By contract and regulation, each MCO shall comply with provisions of state and federal fraud and abuse laws and regulations.

The MCOs shall have in place internal controls, policies and procedures for the prevention, detection, investigation and reporting of potential fraud and abuse activities concerning providers and members. The MCO/SE specific internal controls, policies and procedures shall be described in a comprehensive written plan submitted to HSD, or its designee, for approval. Substantive amendments or modifications to the plan shall be approved by HSD. The MCO/SE shall maintain procedures for reporting potential and actual fraud and abuse by clients or providers to HSD.

D. Evaluation

The State does not anticipate conducting its own evaluation of the New Mexico MFP Demonstration. However, the State will develop and monitor metrics on program operations and outcomes as described under "Section 8: Quality" above.

E. Budget

Table 14. New Mexico MFP Demonstration Administrative Budget, CY 2011-2016*

Category	CY 2011**	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Personnel	$170,775	$346,161	$355,507	$365,106	$374,964	$385,088
Travel—Out of State	2,500	5,000	5,135	5,274	5,416	5,562
Travel—In State	10,000	20,000	20,540	21,095	21,664	22,249
Supplies	2,500	5,000	5,135	5,274	5,416	5,562
Copying	500	1,000	1,027	1,055	1,083	1,112
Postage	500	1,000	1,027	1,055	1,083	1,112
Telecommunications and Wireless Internet	3,500	7,000	7,189	7,383	7,582	7,787
Contractual Services	10,500	64,000	101,500	139,000	161,500	175,000
Total	$200,775	$449,161	$497,060	$545,240	$578,709	$603,474

*Budget is presented in calendar years to be consistent with MFP Demonstration Budget Worksheet attached to this proposal.

**CY 2011 Budget is for 6 months only: July 1, 2011, to December 31, 2011.

Administrative Budget Narrative

The following budget narrative is based on the State's proposed budget for SFY 2012 (July 1, 2011, to June 30, 2012). The budget totals $403,050.

Personnel	**$341,550**
Position:	
Project Director (1.0 FTE)	$55,000
MFP Transition Specialists (2.5 FTE)	110,000
MFP Liaison/Coordinator (1.0 FTE)	44,000
Data/Fiscal Specialist (1.0 FTE)	44,000
Total (5.5 FTEs)	$253,000
Fringe Benefits:	
Project Director (1.0 FTE)	19,250
MFP Transition Specialists (2.5 FTE)	38,500
MFP Liaison/Coordinator (1.0 FTE)	15,400
Data/Fiscal Specialist (1.0 FTE)	15,400
Total (5.5 FTEs)	$88,550
Total: Personal Salaries and Fringe Benefits	$341,550

Travel—Out of State	**$5,000**

For Project Director and one additional staff person to attend up to two national meetings and/or conferences.

Travel—In State **$20,000**

For Transition Specialists to travel throughout the state to visit institutional residents and recently transitioned MFP participants. The reimbursement rate for in-state mileage is $0.44 per mile. The in-state per diem reimbursement is $85 per day. Travel is required to conduct in-home visits as well as outreach.

Supplies **$5,000**

Basic office supplies, including computers for the addition 5.5 FTEs.

Copying **$1,000**

Postage **$1,000**

Telecommunications and Wireless Internet Support **$7,000**

For cellular telephone and land line fees for each MFP staff person. Also supports wireless internet access.

Contractual **$22,500**

Includes $300 per survey for administration of the Quality of Life survey to MFP participants at three points in time: prior to transition, 11 months post-transition, and 24 months post-transition. While the State understands that CMS allows $100 per survey, the State anticipates significantly greater costs for survey administration based on the experience of other states and New Mexico's extensive rural and frontier population. The State anticipates administering 75 surveys at $300 each during SFY 2012.

Includes $25,000 in SFYs 2012, 2013, 2014, 2015, and 2016 for a contract with The Hilltop Institute at the University of Maryland, Baltimore County, for development and production of MFP metrics as described above under "Section 8, Quality."

Total Budget—SFY 2012 **$403,050**

Federal Reimbursement: The State requests Federal reimbursement at 50 percent for the administrative costs listed above with the two exceptions noted below. These budget items are crucial to achieving the State's benchmarks and participating in Federal evaluation efforts:

1. **Data/Fiscal Specialist:** Because this position will be devoted largely to research and data analysis related to MFP benchmarks and complying with Federal reporting requirements, the State requests Federal reimbursement at 100 percent for 85 percent of the salary and

fringe benefits for this position. The remaining 15 percent of the salary and fringe benefits for the Data/Fiscal Specialist would be at 50 percent Federal reimbursement. The State's budget forms reflect this.

2. **Quality of Life Survey Administration:** The State requests 100 percent Federal reimbursement for administration of these surveys at $300 per survey. While New Mexico's estimated cost per survey is significantly higher than the $100 per survey the federal government proposes to reimburse, the State believes $300 per survey is realistic given the experience of other MFP states, New Mexico's highly dispersed Medicaid population throughout rural and frontier areas, and preliminary discussions with the proposed contractor, New Mexico Medical Review Association (NMMRA).

Appendix 1
New Mexico Ombudsman Program

The Long-Term Care Ombudsman Program is mandated by state and federal law to advocate for the respect, recognition and enforcement of the civil and human rights of individuals living in long-term care facilities. In New Mexico, eleven staff and more than 100 state-certified volunteers strive to fulfill this mission by ensuring prompt resolution of residents' care complaints, advocacy for their wishes, and a voice for vulnerable adults who would otherwise go unheard. Established through the Older American's Act of 1965, Chapter 2, and NMSA 1978, Section 9.2.19.18, Ombudsmen have been providing resident-centered advocacy services in New Mexico's long-term care facilities since 1975.

Since 2008, this advocacy role has expanded to include advocacy services for individuals wishing to transition to less restrictive care settings in order to fulfill the State's responsibilities under the Olmstead Decision. Ombudsman Transition Specialists (OTS) advocate for residents during and after a transition to HCBS in a care setting of the residents' choice.

One responsibility assumed by the OTS on behalf of the resident is to ensure coordination between the nursing home discharge planning staff, MCO service coordinator, and the support system (e.g., family, home health agencies) on which the resident will rely in the community to facilitate a seamless transition. Ombudsmen Transition Specialists teach self-advocacy skills to transitioned individuals, provide personal and telephonic contact throughout the transition process and for a six-month period thereafter as needed, and remain a resource to individuals.

Appendix 2
Eligibility Criteria for Individuals Served by New Mexico's Core Service Agencies

To receive full services from a Core Service Agency, including Comprehensive Community Support Services, an individual:

Must meet Serious Mental Illness (SMI) criteria and one of the following:

Significant current danger to self or others or presence of active symptoms of an SMI.

Three or more emergency room visits or psychiatric hospitalizations within the last year.

Person is experiencing trauma symptoms related to sexual assault, domestic violence or other traumatic event.

Severe impairment in at least one Axis IV functional domain or moderate functional impairment in multiple domains.

Person has an SMI and potentially life-threatening medical condition (e.g. diabetes, HIV/AIDS).

— OR —

Must meet Chronic Substance Dependence (CSD) and one of the following:

Person has CSD and a potentially life-threatening medical condition.

Individual meets the ASAM placement criteria for level III or IV services and has a high score on the following dimensions: intoxicated/ withdrawal potential, bio-medical condition, emotional/behavioral/cognitive conditions.

— OR —

Must meet SMI or CSD and one of the following co-occurring disorders:

If SMI, a substance use disorder.

If SMI or CSD, a developmental disability.

If CSD, a mental health disorder.

Appendix 3
Section 8 Waiting Lists and Preferences for New Mexico Public Housing Authorities

Section 8 Waiting Lists and Preferences for New Mexico Public Housing Authorities
Updated: July, 2010

HA Code	Housing Authority (HA)	Public Housing Units Under HA Mgmt	No. of Section 8 Housing Choice Vouchers	Sec 8 Wait List-Avg Months Length of Time	Section 8 Waiting List-Number HH on Wait List March 2010 Census	Does Your PHA have Sec 8 Waiting List Preferences? Yes-Y/No-N	Average Waiting Time for Preferences Only	Types of Preferences	Counties/City Served	Housing Authority County Location	Other Programs and Services
NM001	City of Albuquerque Housing Division	952	4,020	24 mos	2,930	YES	18 months	Domestic violence, Working, Seniors, Elderly, Disabled	ABQ city limits	Bernalillo	Family Self-Sufficiency; Veterans Affairs Supportive Hsg (VASH)
NM002/85	Clovis Housing And Redevelopment Agency, Inc.	132	608	18 mos	128	NO	CLOSED		Curry	Curry	Family Self-Sufficiency
NM003	City of Las Cruces	250	917	35 mos	693	NO	CLOSED		LC city limits	Dona Ana	Homeownership; Veterans Affairs Supportive Hsg (VASH); Homelessness Prevention & Rapid Rehousing; Shelter Plus Care
NM006	City of Gallup	287	38	24 - 30 mos	147	NO	CLOSED		McKinley	McKinley	Homelessness Prevention & Rapid Rehousing
NM009	Santa Fe Civic Housing Authority	463	774	24 - 30 mos	400	NO	CLOSED		City of Santa Fe, City of Espanola, Counties of Los Alamos, Catron & Mora	Santa Fe	Family Self-Sufficiency; Elderly/Disabled Service Coordinator; Tenant Based Rental Assistance [illegible]
NM020	City of Truth Or Consequences	100	150	10 - 14 mos	71	NO			Sierra	Sierra	Family Self-Sufficiency; Elderly/Disabled Service Coordinator
NM030	City of Grants	20	56	2 months	17	YES	2 months	Elderly, Disabled, Government relocated, [illegible] DV	Cibola	Cibola	Tenant Based Rental Assistance -- [illegible] & Disabled
NM031	City of Tucumcari	60	140	5 months	71	YES	3 - 6 months	Elderly, Disabled Working, Seniors	Quay	Quay	
NM033	Town of Bernalillo and Cuba	73	75	27 mos	8	YES	CLOSED	Elderly, Disabled, Working/Education, Residents of County, Residents of Bernalillo or Cuba	Sandoval and Town of Cuba	Sandoval	
NM038	County of Taos	160	449	18 mos	349	NO			Taos	Taos	
NM039	County of Rio Arriba	53	25	35 mos	171	NO			Rio Arriba	Rio Arriba	Homelessness Prevention & Rapid Rehousing Program
NM051	County of San Miguel	(City LV)	177	15 mos	165	YES	8 - 12 months	Elderly > 62 yrs & Disabled, Displaced, [illegible]	San Miguel	San Miguel	
NM050	County of Santa Fe	200	241	60 mos	632	YES	36 months	Working Family, [illegible], Elderly & Disabled	Santa Fe	Santa Fe	Family Self-Sufficiency; Veterans Affairs Supportive Hsg (VASH), Linkages
NM057	Bernalillo County Housing Department	21	2,023	24 - 36 mos	1,220	YES	36 - 60 months	Disabled, Elderly, FT Employment, Veterans, CYFD Transitional Youth	Bernalillo	Bernalillo	Family Self-Sufficiency
NM062	County of Dona Ana	6	605	18 - 36 mos	537	NO	CLOSED		Dona Ana	Dona Ana	Homeownership
NM063	Eastern Regional Housing Authority (formerly Region VI and IV)	83	1,259	12 - 18 mos	400	NO			Chaves, Eddy, Lea, Lincoln & Otero	Chaves	Tenant Based Rental Assistance -- deposit assistance only; Family Self-Sufficiency
NM066	County of San Juan	0	320	6 - 12 mos	332	NO			San Juan	San Juan County	Tenant Based Rental Assistance (Note: no San Juan County Hsg Partnership); Homelessness Prevention & Rapid Rehousing Program
NM067	Western Regional Housing Authority	54	911	6 - 8 mos	293	NO			Grant, Luna, Hidalgo, Catron	Grant & Luna	Homeownership; Tenant Based Rental Assistance; Homelessness Prevention & Rapid Rehousing Program; Linkages
NM069	Town of Mountainair	0	120	13 mos	93	NO			Torrance	Torrance	Homeless Prevention & Rapid Rehousing Program
NM070	Village of Los Lunas/Valencia	0	122	18 - 24 mos	192	YES	2 months	Elderly, Disabled	Valencia	Valencia	Homeless Prevention & Rapid Rehousing Program; Family Self-Sufficiency; Shelter Plus Care
NM077	County of Socorro	0	318	6 - 12 mos	32	YES	1 month	Elderly, Disabled, DV, Employ, Education, Job Training, County Res.	Socorro	Socorro	Family Self-Sufficiency; Homelessness Prevention and Rapid Rehousing Program; Shelter Plus Care
	Total	2,944	13,453								

Appendix 4
New Mexico Aging and Long-Term Services Department
Organizational Chart

Aging and Long-Term Services Department
Organizational Chart

Michael Spanier
Cabinet Secretary

Executive Administrator
Kate Dauber

Office of General Counsel
Vacant

Office of Indian Elder Affairs
Ray Espinoza (Acting)

Indian AAA Director
Ray Espinoza

Information Technology
Patricia Barton

Policy and Planning
Emily Kaltenbach

Performance Management
Fred Schaum

Communications
Vacant

Constituent Services
Jack Mack

Long-Term Care Ombudsman
Sondra Everhart

Facility Advocacy

Education and Outreach

Transition Advocacy

Elderly and Disability Services Division
Kim Austin-Oser

- Coordination of Long-Term Services Community-based Waiver
- Coordination of Long-Term Services Personal Care Option
- PACE Program of All-Inclusive Care for the Elderly
- Mi Via Self-Directed Waiver
- Brain Injury Program
- Gap Program
- Quality Assurance and System Integrity

Adult Protective Services Division
Kathleen Hart

NW Region
NE Region
Metro Region
SE Region
SW Region

- Investigations of Abuse, Neglect, Exploitation
- Guardianship Petitions
- Emergency Services
- Attendant Care
- Adult Day Care
- Home Care

Matt Onstott
Deputy Secretary

Geriatric Behavioral Health
Bette Betts

Administrative Services Division
Jason Sanchez

- Human Resources Bureau
- Fiscal Bureau
- Capital Projects Bureau

Aging Network Division
Lynne Anker-Unnever

- Senior Services Bureau
  - Area Agencies on Aging (AAA) Liaison
  - Volunteer Programs
  - Nutrition
  - Senior Olympics
  - Alzheimer's
- Training and Conferences
- Prescription Drug Assistance Program
- HIV/AIDS Consumer Advocate
- Employment Programs Bureau
  - Older Worker Programs
  - GOLD Mentor Program

Consumer and Elder Rights Division
Carlos Moya (Acting)

- Aging and Disability Resource Center
  - Adult Protective Services Intake
  - Information and Referral Coordination
  - Resource Option Coordination
  - Senior Medicare Patrol
  - State Health Insurance Program Benefits Counseling Money Management Bill Payer

Updated: 10.29.2010

Appendix 5
New Mexico Human Services Department
Organizational Chart

Human Services Department

Organizational Chart

FY11-12

Cabinet Secretary

Executive Assistant

Office Clerk

Admin

Public Information Officer

Legislative Liaison Special Projects

Healthcare Reform

Deputy Cabinet Secretary Programs

Constituent Services

General Manager

Staff Attorneys

Gen Mngr CSED

CSED Attorneys

Deputy Director

Deputy Director

Benefit Delivery Bureau

Quality Assessment Bureau

Food & Nutrition Bureau

3 Regional Operation Managers

Policy & Program Bureau

Statewide County Offices

Research & Reporting Bureau

Work & Family Support Bureau

Deputy Director

Deputy Director

Program Bureau

Program Administration Bureau

3 Regional Operation Managers

Statewide County Offices

Office of Fair Hearings

Deputy Director

Deputy Director

Deputy Director

Accounting Bureau

Accounts Receivable Cash Mgmt Bureau

Budget Bureau

Accounts Payable & Payroll Bureau

Grants Mgmt Bureau

General Services Bureau

State Disbursement Bureau

Compliance Financial Systems Bureau

Contract Mgmt & Procurement

Deputy Director

Deputy Director

Contract Admin Bureau

Benefits Bureau

Program Admin Bureau

Client Services Bureau

Program Information Bureau

Medical Director

Native American Liaison

Healthcare Manager

Quality Assurance Bureau

Long Term Services & Support Bureau

Insure NM Bureau

School Health Unit

Healthcare Operations manager

Deputy CIO IT Systems Services

Deputy CIO IT Software Engineering

Deputy CIO Business Operations

Production Support Bureau

Applications Support Bureau

Project Management Bureau

Systems Security Officer

Systems Admin Bureau

CSES Bureau

Engineering Compliance Bureau

ISD2R/YES Team

Deputy Director Community Services

Deputy Director Operations

Treatment Programs & Policy Bureau

Community Recovery & Support Bureau

Administratively Attached Agencies:
Office of African American Affairs(OAAA)
Commission on the Status of Women(CSW)

Updated: October 2010

Self-Direction Submittal Form

I. Participant Centered Service Plan Development

a. **Responsibility for Service Plan Development.** Specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☐	Case Manager. *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
■	Other (*specify the individuals and their qualifications*):
	The Mi Via consultant assists the participant with development of the Service and Support Plan (SSP). Consultants must hold a Bachelor's degree in social work, human services, counseling, nursing, special education or closely related field; have one year of supervised experience working with individuals with disabilities; have demonstrated experience with the Waiver's targeted populations; complete a training course in self-direction; and pass a criminal background check and abuse registry screen.

b. **Service Plan Development Safeguards.** *Select one:*

●	Entities and/or individuals that have responsibility for service plan development *may not provide* other services to the participant.
○	Entities and/or individuals that have responsibility for service plan development *may provide* other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

A consultant is available to the participant prior to the Service and Support Plan (SSP) meeting. The consultant provides an orientation to Mi Via, including describing the rights, risks, and responsibilities of self-direction. The consultant provides the participant with the Participant Guidebook and Participant/Employer Self-Assessment Tool to familiarize the participant with what will be required to be successful in Mi Via, including the range and scope of choices and options; and how to create an individualized plan.

The consultant informs the participant that anyone in his/her circle of support may be invited to the SSP development meeting. The participant's initial meeting is conducted by the consultant and includes the participant and the person(s) that the participant chooses to have at the meeting. This meeting is for information sharing, answering questions, and completing forms necessary to enter the program. The participant is also given additional program information literature such as: policies and procedures of the Consultant Agency, rights and responsibilities, incident reporting guidelines and training, Fair Hearing rights, and other documents.

d. **Service Plan Development Process** In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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 in a number of the following ways: through the Level of Care (LOC) assessment; through the participant's completion of his/her Participant/Employer Self-Assessment tool; and through the person-centered planning process that is undertaken between the consultant and participant to develop the participant's Service and Support Plan (SSP).

Assessments
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 level of care (LOC) determination process address the following needs of a person: medical, adaptive behavior skills, nutritional, functional, community/social and employment. Assessments occur on an annual basis or during significant changes in circumstance or the LOC. After the assessments are completed, the results are made available to the participant and his/her consultant for use in planning. The participant and the Consultant will assure that the SSP addresses the information and/or concerns identified through the assessment process.

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). Specifically, this tool addresses the following: activities of daily living assistance needs; health care needs; employee training on assistance with individual specific needs; environmental modifications; equipment needs; relationships in the home and community; personal safety and employer responsibilities. The SSP must address areas of need, as recognized in the Participant/Employer Self Assessment.

Pre-Planning
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, rights, risks, and responsibilities associated with self-direction. The Consultant provides the participant with the Mi Via Participant Guidebook which is the preparation to developing the SSP. The Guidebook includes exercises on how to interview and hire employees, what kinds of services and supports the participant needs, and other information that prepares the participant to develop his/her budget. The Consultant assists with the Participant/Employer Self Assessment and discusses areas of need to address on the participant's SSP. The Consultant provides support during the annual redetermination process to assist with completing medical and financial eligibility in a timely manner.

Services and Support Plan Meeting
The participant receives a Mi Via Guidebook, Participant/Employer Self Assessment, LOC assessment and local resource manual prior to the SSP meeting. Prior to the SSP meeting, the participant may begin planning and drafting the SSP utilizing those tools alone or with his/her circle of support.

During the SSP meeting, the Consultant assists the participant in ensuring 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/or concerns identified through the assessment process. The Consultant assists the participant in planning and documenting how the concerns will be addressed through natural or paid supports. The completed personal planning tool/report and the local resource manual may be referenced to assist with SSP development.

The Consultant ensures for each participant that:

- The planning process addresses the participant's needs and personal goals in at least the following areas: supports needed at home; community membership (including employment); and health and wellness;
- 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;
- The outcome of the assessment process for assuring health and safety is considered in the plan;
- MFP Demonstration and other services are coordinated and do not duplicate or supplant those available to the participant through the Medicaid State Plan or other public programs;
- Services are not duplicated in more than one service code;
- Job descriptions are complete for each provider and employee in the plan. Job descriptions will include frequency, intensity and expected outcomes for the service;
- The Quality Assurance section of the SSP is complete and specifies the roles of the participant, Consultant and any other listed in this section;
- The responsibilities are assigned for implementing and monitoring the plan;
- The Back-up plans are complete;
- The SSP is submitted to the Third-Party Assessor (TPA) after the SSP meeting, in compliance with Mi Via Waiver Service Standards; and
- The participant (or representative) receives a copy of the SSP.

SSPs are updated if personal goals, needs and/or life circumstances change that may or may not result in a change of the LOC. Revisions may be requested by the participant. The Consultant may also confer with the participant to initiate revisions. Mi Via participants submit SSP/budget revisions for an anticipated future start date. This supports continuity of service. If an unplanned, emergent need arises, there is an expedited review process for SSP/budget revisions. The participant is contacted by the Consultant to schedule the SSP meeting in compliance with Mi Via waiver rules. Consultants submit all SSPs.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Mi Via philosophy of self-direction reflects a strong commitment throughout the planning process to being sensitive to the person's preferences, including responsibilities and measures for reducing risks. However, the State must assure the participant's safety, and the consultant is required to work with the participant in developing a plan that addresses risks that have been identified during the participant's LOC assessment, the Participant/Employer Self-Assessment, and the SSP development process. Prior assessment activities will be instrumental in developing a SSP that mitigates risks.

The LOC packet (Long-Term Care Assessment Abstract [LTCAA] and other assessments such as the Client Individual Assessment [CIA]) addresses the following needs of a person: medical, adaptive behavior skills, nutritional, functional, community/social, and employment. Copies of the assessment and recommendations are provided to the participant and Consultant by the Third-Party Assessor (TPA) for use in planning. Assessments will occur on an annual basis. Assessments may occur earlier if there is a significant change in life circumstances or the LOC.

The Participant/Employer Self-Assessment tool aids the participant in being pro-active in identifying potential risk areas to be addressed in the SSP and considered in developing the back-up plan.

Back-up plans are required for all natural or paid supports that address critical areas of concern outlined in the LOC assessment/recommendation(s). All other paid services are required to have a back-up plan. The back-up plan is incorporated into the SSP. The Participant/Employer Self-Assessment tool is completed by the participant, in collaboration with the consultant, and the consultant uses the participant's responses to the tool in assisting the participant during development of the participant's SSP and back-up plan. Consultants monitor the use and effectiveness of back-up plans during monthly contacts and quarterly visits to mitigate any future health and safety risks. Specifically this tool addresses the following: employee training on individual specific needs, environmental modifications, equipment needs, relationships in the home and community, personal safety, and employer responsibilities.

An expedited SSP review process addresses risks identified in the Participant/Employer Self Assessment. Consultants can request an expedited process to address concerns for new enrollees or emergent concerns for current participants. This process is in accordance with the Mi Via waiver rules.

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

During the enrollment meeting, the participant is informed about every type of service offered in the Mi Via program. The participant has access to a list of State approved Medicaid consultant agency providers for Mi Via. Every Consultant Agency is required to maintain a resource listing. Each Consultant Agency can obtain provider information from the FMA and incorporate new local providers into the agency provider listing ongoing. The provider list is shared with participants during initial SSP development, SSP revisions and at any other time as requested by the participant. The resource list is required to be updated on a periodic basis. Resource lists are reviewed as part of the Quality Assurance review of each Consultant Agency to ensure that information is current. As for other providers and vendors, the Consultant assists the participant, as requested, in identifying qualified providers and vendors, including making available a list of providers and vendors in his/her area that are enrolled with the FMA, as well as information about other provider options. The self-directed philosophy in Mi Via encourages participants to identify their own providers. The provider list is shared with participants during initial SSP development, SSP revisions and at any other time as requested by the participant.

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency**. Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

Consultants submit SSPs and budgets to the TPA Contractor for approval.

On behalf of HSD/MAD, the TPA Contractor approves each participant's SSP annually or more often if there is a change in the participant's needs or circumstances. The TPA Contractor is required to monitor reviewers' approval accuracy and compliance with criteria during its monthly quality assurance activities and report findings to HSD/MAD quarterly. HSD/MAD reviews the TPA Contractor's approvals of MFP participants' SSPs during the annual contract compliance review. If HSD/MAD identifies any issues that are inconsistent with Medicaid requirements at any time, HSD/MAD ensures that the TPA Contractor

corrects the problem. The Quality Assurance (QA) Bureau of the Medicaid Assistance Division (MAD) conducts an annual systematic random sample audit for monitoring purposes.

h. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Money Follows the Person project plus one year. For example, if the state enrolls individuals into the MFP program for three years the state must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
☐	Operating agency
☐	Case manager
■	Other *(specify):* Consultant agency

II. Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring**. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Implementation
The Consultant assists the participant with implementing his/her SSP and budget. As part of the Consultant's services, if the participant needs more focused support to implement the SSP, the services of a Support Guide are available through the consultant agency.

Monitoring
Mi Via supports the participant in monitoring the services provided in accordance with his/her SSP. The SSP includes a quality assurance section that is developed by the participant to evaluate if services are addressing his/her needs and preferences.

The Consultant monitors the progress of the SSP to ensure that it is implemented as approved by the TPA Contractor. The Consultant supervises the Support Guide. The consultant agency trains the Support Guide on the policies and procedures of the consultant agency, reporting changes in participant status, reporting critical incidents and abuse, neglect, and exploitation. As part of the Consultant's services, if the participant is receiving Support Guide services, the Consultant works closely with and monitors the activities of the Support Guide.

The Consultant monitors the progress of the plan at least every month by contacting the participant. During the monthly contact, the Consultant:

- Reviews the participant's access to services and whether they were furnished, per the approved plan;
- Reviews the participant's exercise of free choice of provider;
- Reviews whether services received are meeting the participant's needs;
- Reviews whether the participant is receiving access to non-waiver services identified in the approved plan;
- Reviews activities conducted by the Support Guide;
- Follows-up on complaints against service providers;
- Documents changes in status;
- Monitors the use and effectiveness of the back-up plan;
- Documents and follows-up (if needed) if challenging events occurred;
- Determines if abuse, neglect or exploitation occurred; if not reported, takes remedial action to ensure correct reporting;
- Documents progress of time-sensitive activities outlined in the SSP including employee trainings and eligibility activities;
- Determines if health and safety issues are being addressed appropriately; and
- Discusses budget utilization concerns.

At least quarterly, during face-to-face visits, the Consultant ensures purchased goods are present and operational. The Consultant also reviews the quality assurance section of the SSP with the participant. The Consultant completes a quarterly review that addresses health and safety, employee issues, navigation of Mi Via services, eligibility process, complaints, and SSP implementation issues. As indicated, the consultant takes prompt remedial action on all identified problems. Methods for remedial action range from working directly with the participant to resolve the problems that are identified, and, if indicated, reporting the problems to the Consultant Agency leadership and the State for follow-up and

remedial action. Monitoring results are documented in the participant's record and reported to State program managers, as part of the Quality Improvement Strategy. Data collected from reports and on-site record reviews are aggregated and analyzed by the State, and remedial action is taken.

b. Monitoring Safeguards. *Select one:*

●	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

III. Overview of Self-Direction

a. **Description of Self-Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration's approach to participant direction.

Mi Via recognizes the essential direct role of participants in planning and purchasing of services and supports. To assume this leadership role and be successful in self-direction, the participant must have the requisite on-going education, training, information, tools, and support related to Mi Via, which includes but is not limited to information about: basic core values and philosophy of self-direction; Mi Via guiding principles and processes; rights, risks, and responsibilities; independent living; disability rights; range of services and supports; finding, training and managing providers; complaint process and incident reporting; individual budgeting and paying for services and supports; working with the consultant and financial management agent (FMA); and quality monitoring.

The participant develops his/her individualized service and support plan (SSP), within the State-assigned budgetary allotment, and directs all services and supports identified in his/her plan. These services and supports must address the participant's qualifying condition or disability and assist the individual to live at home, go to school, work, and integrate into the community as independently as possible. The breadth of services and supports should reflect all aspects of a participant's life, including but not limited to home, community, school, work, and productive activity. Using the person-centered approach, the SSP revolves around the individual participant and reflects his or her chosen lifestyle and culture. Planning should occur where, when and with whom the participant chooses. The participant directs development of the Plan, which serves as the foundation for participation in Mi Via.

The Consultant and the FMA support the participant in self-direction. As is discussed in Section I, consultants, who have strong interpersonal skills, know how to communicate with people who may have limited language skills and know how to generate trust, assist participants in understanding Mi Via and developing their person-centered plans. The participant identifies the individuals he/she wants to be involved in the development of his/her plan, and the Consultant helps the participant explore options and make informed choices, based on his/her individual needs. The Consultant also helps the participant to negotiate with family members, providers, and others and build consensus.

The Consultant is trained in and must demonstrate understanding of all aspects of the Mi Via program, such as the guiding principles for self-direction, role of the participant in the person-centered planning process, available service and support options, locating and securing services and supports, and development and management of the individual budget. The Consultant must have knowledge about community resources and how to seek out resources. The Support Guide is also available as an aspect of consultant services for an individual who may need more frequent and intensive hands-on support to direct and implement his/her SSP.

The FMA is independent of the entities/persons delivering services or supports to avoid conflicts of interest. The FMA is trained in and must demonstrate understanding of all aspects of Mi Via as it relates to the planning process and development and managing the individual budget. Based on the participant's individual Service and Support Plan and budget, the FMA sets up an individual account, makes expenditures that follow the authorized budget, handles all payroll functions on behalf of the participant who hires service providers and other support personnel, provides the participant with a monthly report of expenditures and budget status, answers inquiries, solves related problems, and provides the State with quarterly documentation of expenditures.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the demonstration. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
●	**Both Authorities.** The demonstration provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

■	Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.
■	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
■	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one):*

●	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Prior to enrolling in Mi Via, the participant (or the participant's representative) must have ready access to on-going education, training, information, tools, and support related to all aspects of Mi Via so that the

participant, or participant's representative, can make informed decisions regarding self-direction. A multifaceted approach is utilized to communicate Mi Via information, such as easy-to-understand written materials that address cultural diversity, video presentations, website information, alternative formats, and community education forums for participants, families, providers, and other interested parties. Materials and activities are developed in collaboration with and through contribution from participants, advocates, and families so that information is as clear as possible.

Learning objectives are focused on what the participant needs to learn in order to be successful, such as what Mi Via is, e.g., its goals, basic core values, guiding principles, who is eligible to participate, what self-direction and self-determination mean, and what services, supports, and goods are covered; as well as planning and budgeting; service and support plan and budget implementation; health; safety; and quality assurance. The training includes multiple topics to support the learning objectives.

ALTSD and HSD work together in regard to on-going education, training, and information-sharing. State staff as well as advocacy organization and peer trainers in local communities conduct initial and on-going training as well as information-sharing programs. The State also uses State websites and existing information-sharing and training networks, as appropriate, to disseminate information.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of demonstration services by a representative *(select one)*:

○	The State does not provide for the direction of demonstration services by a representative.	
●	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: *(check each that applies)*:	
	■	Demonstration services may be directed by a legal representative of the participant.
	☐	Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities), available for each demonstration service. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
Assisted Living	■	■
Behavior Support Consultation	■	■
Consultant/Support Guide	☐	☐

Customized Community Supports	■	■
Customized In-Home Living Supports	■	■
Emergency Response	■	■
Employment Supports	■	■
Environmental Modifications	■	■
Home Health Aide	■	■
Homemaker/Direct Support	■	■
Nutritional Counseling	■	■
Personal Plan Facilitation	■	■
Private Duty Nursing for Adults	■	■
Related Goods	■	■
Respite	■	■
Skilled Maintenance Therapy	■	■
Transportation	■	■
Case Management	☐	☐
Intensive Case Management *	☐	☐
Community Transition Services	☐	☐
Enhanced Community Support Services *	☐	☐

* Available only to Target Population 2.

h. Financial Management Services. Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the demonstration participant. *Select one:*

●	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
	☐ Governmental entities
	■ Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. *Select one*:

○	FMS are covered as a Demonstration service	Fill out i. through iv. below:
●	FMS are provided as an administrative activity. Fill out i. through iv. below:	

i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
	The FMA is procured according to New Mexico Procurement Code, a contract is signed, and individual participants are supported at the local level.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the activities that they perform:	
	Payment will be negotiated during the contracting process. The FMA Contractor is compensated by a monthly fee per participant, as negotiated with the FMA Contractor.	
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies)*:	
	Supports furnished when the participant is the employer of direct support workers:	
	■	Assist participant in verifying support worker citizenship status
	■	Collect and process timesheets of support workers
	■	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	☐	Other *(specify)*:
	Supports furnished when the participant exercises budget authority:	
	■	Maintain a separate account for each participant's self-directed budget
	■	Track and report participant funds, disbursements and the balance-of participant funds
	■	Process and pay invoices for goods and services approved in the service plan
	■	Provide participant with periodic reports of expenditures and the status of the self-directed budget
	☐	Other services and supports *(specify)*:
	Additional functions/activities:	
	■	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	■	Other *(specify)*: Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency.

	iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
		The Human Services Department holds the Financial Management Agent (FMA) contract. HSD conducts quarterly audits of the FMA to ensure compliance with the FMA's contract with the State. The audit monitors that: all services paid on behalf of the participant are included in the participant's approved SSP and budget; all services paid on behalf of the participant are accurately processed by the FMA; and all claims are submitted to the MMIS appropriately. In addition, the State conducts ongoing monitoring of complaints that are received regarding the FMA. In all cases, the State implements corrective actions against the FMA as necessary.

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

■	**Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:*
	Pre-Planning 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, rights, risks, and responsibilities associated with self-direction. The Consultant provides the participant with the Mi Via Participant Guidebook which is the preparation to developing the SSP. The Guidebook includes exercises on how to interview and hire employees, what kinds of services and supports the participant needs, and other information that prepares the participant to develop his/her budget. The Consultant assists with the Participant/Employer Self Assessment and discusses areas of need to address on the participant's SSP. The Consultant provides support during the annual redetermination process to assist with completing medical and financial eligibility in a timely manner. Services and Support Plan Meeting The participant receives a Mi Via Guidebook, Participant/Employer Self Assessment, LOC assessment and local resource manual prior to the SSP meeting. Prior to the SSP meeting, the participant may begin planning and drafting the SSP utilizing those tools alone or with his/her circle of support. During the SSP meeting, the Consultant assists the participant in ensuring 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/or concerns identified through the assessment process. The Consultant assists the participant in planning and documenting how the concerns will be addressed through natural or paid supports. The completed personal planning tool/report and the local resource manual may be referenced to assist with SSP development.

	Implementation The Consultant assists the participant with implementing his/her SSP and budget. As part of the Consultant's services, if the participant needs more focused support to implement the SSP, the services of a Support Guide are available through the consultant agency. Monitoring Mi Via supports the participant in monitoring the services provided in accordance with his/her SSP. The SSP includes a quality assurance section that is developed by the participant to evaluate if services are addressing his/her needs and preferences. The Consultant monitors the progress of the SSP to ensure that it is implemented as approved by the TPA Contractor. The Consultant supervises the Support Guide. The consultant agency trains the Support Guide on the policies and procedures of the consultant agency, reporting changes in participant status, reporting critical incidents and abuse, neglect, and exploitation. As part of the Consultant's services, if the participant is receiving Support Guide services, the Consultant works closely with and monitors the activities of the Support Guide. The Consultant monitors the progress of the plan at least every month by contacting the participant. During the monthly contact, the Consultant: • Reviews the participant's access to services and whether they were furnished, per the approved plan; • Reviews the participant's exercise of free choice of provider; • Reviews whether services received are meeting the participant's needs; • Reviews whether the participant is receiving access to non-waiver services identified in the approved plan; • Reviews activities conducted by the Support Guide; • Follows-up on complaints against service providers; • Documents changes in status; • Monitors the use and effectiveness of the back-up plan; • Documents and follows-up (if needed) if challenging events occurred; • Determines if abuse, neglect or exploitation occurred; if not reported, takes remedial action to ensure correct reporting; • Documents progress of time-sensitive activities outlined in the SSP including employee trainings and eligibility activities; • Determines if health and safety issues are being addressed appropriately; and • Discusses budget utilization concerns. At least quarterly, during face-to-face visits, the Consultant ensures purchased goods are present and operational. The Consultant also reviews the quality assurance section of the SSP with the participant. The Consultant completes a quarterly review that addresses health and safety, employee issues, navigation of Mi Via services, eligibility process, complaints, and SSP implementation issues. As indicated, the consultant takes prompt remedial action on all identified problems. Methods for remedial action range from working directly with the participant to resolve the problems that are identified, and, if indicated, reporting the problems to the Consultant Agency leadership and the State for follow-up and remedial action. The consultant agency is reimbursed by the State for services provided through a Medicaid provider agreement.

■	**Demonstration Service Coverage.** Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled: Case Management
	The State will assign a case manager called an Integrated Service Plan Coordinator who will be responsible for coordinating all of the other service coordinators (e.g., MCO Service Coordinator, Mi Via Consultant, nursing home discharge planner, Ombudsman representative, Community Service Agency) so that the individual has one person to call and there is one professional accountable for making the transition happen.
☐	**Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

k. Independent Advocacy *(select one).*

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy:*
●	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Mi Via participants may voluntarily terminate from self-direction. When a Mi Via participant decides to discontinue self-directing his/her services, he/she may return to the Coordination of Long-Term Services (CoLTS) (c) waiver. The participant is assisted with the transition process and access to services through CoLTS (c) by the consultant in Mi Via and the service coordinator in the CoLTS (c) waiver. Together, the consultant and service coordinator work with the participant to coordinate Mi Via and CoLTS services, plans and budgets to ensure that 1) there is a timely revision of the service and support plan; 2) there is continuity in delivery of needed services; and 3) the participant's health and safety are maintained.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Mi Via participants may be involuntarily terminated from self-direction through Mi Via and offered services

through the CoLTS (c) 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 and support from the program staff, consultant, or financial management agent (FMA).
(2) The participant is at 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 by are not limited to:
(a) The participant refuses to include and maintain services in his/her Service and Support Plan (SSP) and authorized annual budget that would address health and safety issues identified in his/her medical assessment and challenges assessment, after repeated and focused technical assistance and support from the program staff, consultant, and/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 recommendation into his/her SSP and authorized annual budget.
(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 and/or FMA.
(4) The participant commits Medicaid fraud.

A participant who is involuntarily terminated from the Mi Via waiver may be offered a non self-directed alternative through the CoLTS (c) waiver. If the transfer to CoLTS (c) is authorized by the State and accepted by the participant, he/she will continue to receive the services and supports from the Mi Via waiver until the day before the new waiver services start. This will ensure that no break in service occurs. The Mi Via consultant and the CoLTS service coordinator will work closely with the participant and each other to ensure that the participant's health and safety are maintained. The Fair Hearing notice and rights apply.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Demonstration Year	**Number of Participants**	**Number of Participants**
Year 1		19
Year 2		25
Year 3		31
Year 4		38
Year 5		38

Participant Employer

a. Participant – Employer Authority *(Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)*

1. **Participant Employer Status**. Specify the participant's employer status under the demonstration. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
■	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

2. **Participant Decision Making Authority**. The participant (or the participant's representative) has decision making authority over workers who provide demonstration services. Check the decision making authorities that participants exercise:

■	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
■	Select staff from worker registry
■	Hire staff (common law employer)
☐	Verify staff qualifications
☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
■	Specify additional staff qualifications based on participant needs and preferences
■	Determine staff duties consistent with the service specifications
■	Determine staff wages and benefits subject to applicable State limits
■	Schedule staff
■	Orient and instruct-staff in duties
■	Supervise staff
■	Evaluate staff performance
■	Verify time worked by staff and approve time sheets

■	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b)*

1. **Participant Decision Making Authority**. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Check all that apply:

■	Reallocate funds among services included in the budget
■	Determine the amount paid for services within the State's established limits
■	Substitute service providers
■	Schedule the provision of services
■	Specify additional service provider qualifications
■	Specify how services are provided,
■	Identify service providers and refer for provider enrollment
■	Authorize payment for demonstration goods and services
■	Review and approve provider invoices for services rendered
■	Other *(specify)*:
	Modifications to the participant's budget must be preceded by a change in and approval of the service plan and budget.

2. **Participant-Directed Budget**. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

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.

Participants eligible for Mi Via through the CoLTS (c) waiver: To derive the schedule of budgets for CoLTS (c) participants, the cost of prior authorized units are separated by age band: children young adults aged 0-20, and adults aged 21 and older. CoLTS (c) 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 (c) Adults (Age 21 and over) – Mi Via budgets, last available 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 CoLTS (c) 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 (10%) 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 (c) Children and Young Adults (Age0-20) – Existing prior authorized CoLTS (c) waiver services 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 participants 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 (c) waiver, but requests for prior authorization of this service have been omitted in many of the sampled 2007 care plans due to similar 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 CoLTS (c) 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 Mile/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.

Participants Eligible for Mi Via through the Brain Injury (BI) Category of Eligibility: Mi Via budgets for individuals with Brain Injury (BI) start with the base cost calculations used for Mi Via CoLTS 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 Traumatic Brain Injury (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 of 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 ages 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);**
- **Aged 21-64 years (Mild/None, Moderate, Extensive and Assisted Living);**

3. **Informing Participant of Budget Amount**. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant's Consultant has information regarding the budget and informs the participant of his/her individual annual budgetary allotment as the budget is being developed. The participant is also made aware of the total proposed SSP and budget amount once the budget development process is complete. The amount of the annual budget cannot exceed the participant's individual annual budgetary allotment. The rare exception would be a participant whose assessed or documented needs, based on his/her qualifying condition, cannot be met within the annual budgetary allotment, in which case the participant would initiate a request for an adjustment through his/her consultant. The participant tracks budget usage over the course of the year through the monthly spending reports provided by the FMA.

The participant's budget is sent by the Consultant to the Third-Party Assessor (TPA) for review. The TPA will either approve or deny the budget. The budget is then sent to the participant with a letter of approval or denial of services. If any action is taken resulting in a reduction, termination, modification, suspension or denial of services, the Participant is notified in writing by the TPA of that action and his/her

right to request a fair hearing with the State Medicaid agency.

4. **Participant Exercise of Budget Flexibility. Select one:**

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
●	Modifications to the participant-directed budget must be preceded by a change in the service plan.

5. **Expenditure Safeguards**. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMA and Consultant work with the participant to ensure that the budget is utilized according to the Service and Support Plan. When problems are identified, the Consultant and FMA work together with the participant to find solutions and make changes, as indicated. In addition, the FMA sets up an individual account, based on the participant's approved individual Service and Support Plan and budget, makes expenditures that follow the authorized budget, provides the participant with a monthly report of expenditures and budget status, and provides the State with a quarterly documentation of expenditures. The FMA sends a budget Utilization Report to the Consultant Agency and the participant. This report includes each service category, total approved dollars in the budget, total spent to date, and unused dollars.

Sample Excel Spreadsheet

Budget Breakdown for All Years - Federal Funds Only

State Name: New Mexico

Object Class Categories	FEDERAL FUNDS ONLY - Do Not Include State Funding						Total
	Year One (2011)	Year Two (2012)	Year Three (2013)	Year Four (2014)	Year Five (2015)	Year Six (2016)	
a. Personnel	$72,527	$147,013	$150,982	$155,059	$159,245	$163,545	**$848,372**
b. Fringe Benefits	$25,483	$51,653	$53,047	$54,480	$55,950	$57,461	**$298,074**
c. Travel	$6,250	$12,500	$12,838	$13,184	$13,540	$13,906	**$72,217**
d. Equipment	$2,250	$4,500	$4,622	$4,746	$4,874	$5,006	**$25,998**
e. Supplies	$1,250	$2,500	$2,568	$2,637	$2,708	$2,781	**$14,443**
f. Contractual	$10,500	$51,500	$89,000	$126,500	$149,000	$162,500	**$589,000**
g. Construction	$0	$0	$0	$0	$0	$0	**$0**
h. Other	$477,579	$2,655,985	$3,589,074	$4,718,052	$5,148,280	$5,287,284	**$21,876,254**
i. Total Direct Charges (sum of 6a-6h)	**$595,839**	**$2,925,651**	**$3,902,130**	**$5,074,658**	**$5,533,598**	**$5,692,483**	**$23,724,359**
j. Indirect Charges							**$0**
k. Totals (sum of 6i-6j)	**$595,839**	**$2,925,651**	**$3,902,130**	**$5,074,658**	**$5,533,598**	**$5,692,483**	**$23,724,359**

Money Follows the Person Demonstration

Worksheet for Proposed Budget (revised October 2010)

Instructions: Please fill in **only** the cells higlighted in YELLOW. All other cells will autopopulate. **Please DO NOT alter any formulas.** Please note: The enhance rate for FFY2009 thru FFY2011 is based on the increased FMAP rate related to the implementation of the Recovery Act of 2009 & the Education, Jobs and Medicaid Assistance Act of 2010. Budget calculations for the last quarter of CY2008 thru the first two quarters of CY2011 use these rates.

Date of Report: 1/6/2011

Name of State/Grantee:
New Mexico

Grant #:

Demonstration Program Title:
New Mexico Money Follows the Person

Please express FMAP as a decimal. (example: 68.32%=.6832)

		State FMAP (Hold Harmless Rate Oct 2008 - Dec 2010)	State Enhanced FMAP	Increased FMAP (Oct 2008 - Jun 2011)	ALLOWED Enhanced FMAP Not to Exceed 90%	Calculated Enhanced FMAP (Oct 2008 - Dec 2010)
	FFY 2007	0.7193	0.85965		0.85965	
	FFY 2008	0.7104	0.8552		0.8552	
10-12/2008	FFY 2009 Q1	0.7088	0.8544	0.7724	0.8862	0.8862
1-3/2009	FFY 2009 Q2	0.7088	0.8544	0.7724	0.8862	0.8862
4-6/2009	FFY 2009 Q3	0.7088	0.8544	0.7866	0.8933	0.8933
7-9/2009	FFY 2009 Q4	0.7088	0.8544	0.7944	0.8972	0.8972
10-12/2009	FFY 2010 Q1	0.7135	0.85675	0.8049	0.9	0.90245
1-3/2010	FFY 2010 Q2	0.7135	0.85675	0.8049	0.9	0.90245
4-6/2010	FFY 2010 Q3	0.7135	0.85675	0.8049	0.9	0.90245
7-9/2010	FFY 2010 Q4	0.7135	0.85675	0.8049	0.9	0.90245
10-12/2010	FFY 2011 Q1	0.6978	0.8489	0.8049	0.9	0.90245
1-3/2011	FFY 2011 Q2	0.6978	0.8489	0.7766	0.8883	0.8883
4-6/2011	FFY 2011 Q3	0.6978	0.8489	0.7578	0.8789	0.87890
7-12/2011	FFY 2011 Q4	0.6978	0.8489		0.8489	
	FFY 2012	0.6936	0.8468		0.8468	
	FFY 2013	0.6936	0.8468		0.8468	
	FFY 2014	0.6936	0.8468		0.8468	
	FFY 2015	0.6936	0.8468		0.8468	
	FFY 2016	0.6936	0.8468		0.8468	

Populations to be Transitioned (unduplicated count)

Unduplicated Count - Each individual is only counted once in the year that they physically transition.

All population counts and budget estimates are based on the *Calendar Year (CY)*.

	Elderly	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis	Total per CY
CY 2007						**0**
CY 2008						**0**
CY 2009						**0**
CY 2010						**0**
CY 2011	35					**35**
CY 2012	90			5		**95**
CY 2013	110			15		**125**
CY 2014	140			20		**160**
CY 2015	150			20		**170**
CY 2016	150			20		**170**
Total Count	675	0	0	80	0	
				Total of Populations	**755**	

Demonstration Budget Summary

Qualified HCBS Services, Demonstration HCBS Services and *Supplemental Services* are defined in the RFP.

Administration - Normal - costs that adhere to CFR Title 42, Section 433(b)(7); *Administrative - 75%* - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10); *Administrative - Federal Evaluation Supports* - costs related to adminstering the Quality of Life Survey (reimbursed @ $100 per survey).

Rebalancing Fund is a calculation devised by CMS to estimate the amount of State savings attributed to the *Enhanced FMAP Rate* that could be reinvested into rebalancing benchmarks.

Other - Other costs reimbursed at a flat rate (to be determined by CMS)

Total Expenditures (2007 - 2016)	Rate	Total Costs	Federal	State
Qualified HCBS		$ 16,029,206	$ 13,574,265	$ 2,454,941
Demonstration HCBS		$ 9,803,425	$ 8,301,989	$ 1,501,436
Supplemental		$ -	$ -	$ -
Administrative - Normal		$ 2,052,620	$ 1,026,310	$ 1,026,310
Administrative - 75%		$ -	$ -	$ -
Administrative - 90%		$ -	$ -	$ -
Federal Evaluation Supports		$ 821,797	$ 821,797	$ -
Administrative (Other) - 100%		$ 167,972	$ 359,901	$ -
State Evaluation		$ -	$ -	$ -
Total		$ 28,707,048	$ 23,724,360	$ 4,982,688

Per Capita Service Costs	$ 34,215
Per Capita Admin Costs	$ 2,941

Rebalancing Fund Calculation	
CY 2007	$ -
CY 2008	$ -
CY 2009	$ -
CY 2010	$ -
CY 2011	$ 85,007
CY 2012	$ 480,511
CY 2013	$ 649,322
CY 2014	$ 853,573
CY 2015	$ 931,408
CY 2016	$ 956,556
Rebalancing Fund Total	**$ 1,214,840**

CY 2007	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.85965	$ -	$ -	$ -	Grant Funding for CY 2007	$ -
Demonstration HCBS	0.85965	$ -	$ -	$ -	Total Fed Costs	$ -
Supplemental	0.7193	$ -	$ -	$ -	Balance (Carry Over)	$ -
Administrative - Normal	0.5	$ -	$ -	$ -	Supplemental Award Request for next year	$ -
Administrative - 75%	0.75	$ -	$ -	$ -	Total (Balance + Request)	$ -
Administrative - 90%	0.9	$ -	$ -	$ -		
Federal Evaluation Supports	1	$ -	$ -	$ -		
Administrative (Other) - 100%	1	$ -	$ -	$ -		
State Evaluation (if approved)	0.5	$ -	$ -	$ -		
Total		$ -	$ -	$ -		

CY 2008 (including Partial Year Increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan - Sept)	0.8552	$ -	$ -	$ -	Remaining Award Funding	$ -
Qualified HCBS (Oct - Dec increased FMAP)	0.8862	$ -	$ -	$ -	Total Fed Costs	$ -
Demonstration HCBS (Jan - Sept)	0.8552	$ -	$ -	$ -	Balance (Carry Over)	$ -
Demonstration HCBS (Oct - Dec increased FMAP)	0.8862	$ -	$ -	$ -	Supplemental Award Request for next year	$ -
Supplemental (Jan - Sept)	0.7104	$ -			Total (Balance + Request)	$ -
Supplemental (Oct - Dec increased FMAP)	0.7724	$ -	$ -	$ -		
Administrative - Normal	0.5	$ -	$ -	$ -		
Administrative - 75%	0.75	$ -	$ -	$ -		
Administrative - 90%	0.9	$ -	$ -	$ -		
Federal Evaluation Supports	1	$ -	$ -	$ -		
Administrative (Other) - 100%	1	$ -	$ -	$ -		
State Evaluation (if approved)	0.5	$ -	$ -	$ -		
Total		$ -	$ -	$ -		

CY 2009 (using Increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.8862	$ -	$ -	$ -	Remaining Award Funding	$ -
Qualified HCBS (Apr-Jun increased FMAP)	0.8933	$ -	$ -	$ -	Total Fed Costs	$ -
Qualified HCBS (Jul- Sep increased FMAP)	0.8972	$ -	$ -	$ -	Balance (Carry Over)	$ -
Qualified HCBS (Oct - Dec increased FMAP)	0.9	$ -	$ -	$ -	Supplemental Award Request for next year	$ -
Demonstation HCBS (Jan-Mar increased FMAP)	0.8862	$ -	$ -	$ -	Total (Balance + Request)	$ -
Demonstation HCBS (Apr-Jun increased FMAP)	0.8933	$ -	$ -	$ -		
Demonstation HCBS (Jul- Sep increased FMAP)	0.8972	$ -	$ -	$ -		
Demonstation HCBS (Oct - Dec increased FMAP)	0.9	$ -	$ -	$ -		
Supplemental (Jan-Mar increased FMAP)	0.7724	$ -	$ -	$ -		
Supplemental (Apr-Jun increased FMAP)	0.7866	$ -	$ -	$ -		
Supplemental (Jul- Sep increased FMAP)	0.7944	$ -	$ -	$ -		
Supplemental (Oct - Dec increased FMAP)	0.8049	$ -	$ -	$ -		
Administrative - Normal	0.5	$ -	$ -	$ -		
Administrative - 75%	0.75	$ -	$ -	$ -		
Administrative - 90%	0.9	$ -	$ -	$ -		
Federal Evaluation Supports	1	$ -	$ -	$ -		
Administrative (Other) - 100%	1	$ -	$ -	$ -		
State Evaluation (if approved)	0.5	$ -	$ -	$ -		
Total		$ -	$ -	$ -		

CY 2010 (using increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.9	$ -	$ -	$ -	Remaining Award Funding	$ -
Qualified HCBS (Apr-Jun increased FMAP)	0.9	$ -	$ -	$ -	Total Fed Costs	$ -
Qualified HCBS (Jul- Sep increased FMAP)	0.9	$ -	$ -	$ -	Balance (Carry Over)	$ -
Qualified HCBS (Oct - Dec increased FMAP)	0.9	$ -	$ -	$ -	Supplemental Award Request for next year	$ 595,839
Demonstation HCBS (Jan-Mar increased FMAP)	0.9	$ -	$ -	$ -	Total (Balance + Request)	**$ 595,839**
Demonstation HCBS (Apr-Jun increased FMAP)	0.9	$ -	$ -	$ -		
Demonstation HCBS (Jul- Sep increased FMAP)	0.9	$ -	$ -	$ -		
Demonstation HCBS (Oct - Dec increased FMAP)	0.9	$ -	$ -	$ -		
Supplemental (Jan-Mar increased FMAP)	0.8049	$ -	$ -	$ -		
Supplemental (Apr-Jun increased FMAP)	0.8049	$ -	$ -	$ -		
Supplemental (Jul- Sep increased FMAP)	0.8049	$ -	$ -	$ -		
Supplemental (Oct - Dec increased FMAP)	0.8049	$ -	$ -	$ -		
Administrative - Normal	0.5	$ -	$ -	$ -		
Administrative - 75%	0.75	$ -	$ -	$ -		
Administrative - 90%	0.9	$ -	$ -	$ -		
Federal Evaluation Supports	1	$ -	$ -	$ -		
Administrative (Other) - 100%	1	$ -	$ -	$ -		
State Evaluation (if approved)	0.5	$ -	$ -	$ -		
Total		$ -	$ -	$ -		

CY 2011 (using partial year increased FMAP)	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS (Jan-Mar increased FMAP)	0.88830	$ -	$ -	$ -	Remaining Award Funding	$ 595,839
Qualified HCBS (Apr-Jun increased FMAP)	0.87890	$ -	$ -	$ -	Total Fed Costs	$ 595,839
Qualified HCBS (Jul-Dec)	0.84890	$ 349,086	$ 296,339	$ 52,747	Balance (Carry Over)	$ -
Demonstation HCBS (Jan-Mar increased FMAP)	0.88830	$ -	$ -	$ -	Supplemental Award Request for next year	$ 2,925,651
Demonstation HCBS (Apr-Jun increased FMAP)	0.87890	$ -	$ -	$ -	Total (Balance + Request)	**$ 2,925,651**
Demonstration HCBS (Jul- Dec)	0.84890	$ 213,500	$ 181,240	$ 32,260		
Supplemental (Jan-Mar increased FMAP)	0.77660	$ -	$ -	$ -		
Supplemental (Apr-Jun increased FMAP)	0.75780	$ -	$ -	$ -		
Supplemental (Jul- Dec)	0.69780	$ -	$ -	$ -		
Administrative - Normal	0.5	$ 165,030	$ 82,515	$ 82,515		
Administrative - 75%	0.75	$ -	$ -	$ -		
Administrative - 90%	0.9	$ -	$ -	$ -		
Federal Evaluation Supports	1	$ 35,745	$ 35,745	$ -		
Administrative (Other) - 100%	1	$ -	$ -	$ -		
State Evaluation (if approved)	0.5	$ -	$ -	$ -		
Total		$ 763,361	$ 595,839	$ 167,522		

CY 2012	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.8468	$ 1,946,203	$ 1,648,045	$ 298,158	Remaining Award Funding	$ 2,925,651
Demonstration HCBS	0.8468	$ 1,190,293	$ 1,007,940	$ 182,353	Total Fed Costs	$ 2,925,651
Supplemental	0.6936	$ -	$ -	$ -	Balance (Carry Over)	$ -
Administrative - Normal	0.5	$ 358,989	$ 179,495	$ 179,495	Supplemental Award Request for next year	$ 3,902,130
Administrative - 75%	0.75	$ -	$ -	$ -	Total (Balance + Request)	**$ 3,902,130**
Administrative - 90%	0.9	$ -	$ -	$ -		
Federal Evaluation Supports	1	$ 90,172	$ 90,172	$ -		
Administrative (Other) - 100%	1	$ -	$ -	$ -		
State Evaluation (if approved)	0.5	$ -	$ -	$ -		
Total		$ 3,585,657	$ 2,925,651	$ 660,006		

CY 2013	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.8468	$ 2,629,934	$ 2,227,028	$ 402,906	Remaining Award Funding	$ 3,902,130
Demonstration HCBS	0.8468	$ 1,608,462	$ 1,362,046	$ 246,416	Total Fed Costs	$ 3,902,130
Supplemental	0.6936		$ -	$ -	Balance (Carry Over)	$ -
Administrative - Normal	0.5	$ 368,007	$ 184,004	$ 184,004	Supplemental Award Request for next year	$ 5,074,658
Administrative - 75%	0.75	$ -	$ -	$ -	Total (Balance + Request)	**$ 5,074,658**
Administrative - 90%	0.9	$ -	$ -	$ -		
Federal Evaluation Supports	1	$ 129,053	$ 129,053	$ -		
Administrative (Other) - 100%	1	$ -	$ -	$ -		
State Evaluation (if approved)	0.5	$ -	$ -	$ -		
Total		$ 4,735,456	$ 3,902,130	$ 833,326		

CY 2014	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.8468	$ 3,457,206	$ 2,927,562	$ 529,644	Remaining Award Funding	$ 5,074,658
Demonstration HCBS	0.8468	$ 2,114,419	$ 1,790,490	$ 323,929	Total Fed Costs	$ 5,074,658
Supplemental	0.6936	$ -	$ -	$ -	Balance (Carry Over)	$ -
Administrative - Normal	0.5	$ 377,268	$ 188,634	$ 188,634	Supplemental Award Request for next year	$ 5,533,598
Administrative - 75%	0.75	$ -	$ -	$ -	Total (Balance + Request)	**$ 5,533,598**
Administrative - 90%	0.9	$ -	$ -	$ -		
Federal Evaluation Supports	1	$ 167,972	$ 167,972	$ -		
Administrative (Other) - 100%	1	$ -	$ -	$ -		
State Evaluation (if approved)	0.5	$ -	$ -	$ -		
Total		$ 6,116,865	$ 5,074,658	$ 1,042,207		

CY 2015	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.8468	$ 3,772,460	$ 3,194,519	$ 577,941	Remaining Award Funding	$ 5,533,598
Demonstration HCBS	0.8468	$ 2,307,228	$ 1,953,761	$ 353,467	Total Fed Costs	$ 5,533,598
Supplemental	0.6936	$ -	$ -	$ -	Balance (Carry Over)	$ -
Administrative - Normal	0.5	$ 386,779	$ 193,390	$ 193,390	Supplemental Award Request for next year	$ 5,692,483
Administrative - 75%	0.75	$ -	$ -	$ -	Total (Balance + Request)	**$ 5,692,483**
Administrative - 90%	0.9	$ -	$ -	$ -		
Federal Evaluation Supports	1	$ 191,929	$ 191,929	$ -		
Administrative (Other) - 100%	1	$ -	$ -	$ -		
State Evaluation (if approved)	0.5	$ -	$ -	$ -		
Total		$ 6,658,396	$ 5,533,598	$ 1,124,798		

CY 2016	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.8468	$ 3,874,317	$ 3,280,772	$ 593,545	Remaining Award Funding	$ 5,692,483
Demonstration HCBS	0.8468	$ 2,369,523	$ 2,006,512	$ 363,011	Total Fed Costs	$ 5,692,483
Supplemental	0.6936	$ -	$ -	$ -	Balance (Carry Over)	$ -
Administrative - Normal	0.5	$ 396,547	$ 198,274	$ 198,274	Supplemental Award Request for next year	
Administrative - 75%	0.75	$ -	$ -	$ -	Total (Balance + Request)	$ -
Administrative - 90%	0.9	$ -	$ -	$ -		
Federal Evaluation Supports	1	$ 206,926	$ 206,926	$ -		
Administrative (Other) - 100%	1	$ -	$ -	$ -		
State Evaluation (if approved)	0.5	$ -	$ -	$ -		
Total		$ 6,847,313	$ 5,692,483	$ 1,154,830		

Mayor Richard J. Berry

CITY OF ALBUQUERQUE
Albuquerque, New Mexico
Department of Family and Community Services
Area Agency on Aging

January 3, 2011

To Whom It May Concern:

It is with great pleasure that the City of Albuquerque/Bernalillo County Area Agency on Aging submits this letter of support and collaboration on behalf of the New Mexico Human Services Department's (HSD) application for a federal Money Follows the Person (MFP) demonstration grant.

The City of Albuquerque/Bernalillo County Area Agency on Aging is committed to collaborate with HSD and the Aging and Long-Term Services Department in the development and implementation of a Money Follows the Person program in New Mexico.

There is increasing recognition that serving people in the community instead of in an institutional setting improves their quality of life and can lead to savings to the Medicaid program. MFP is a way to promote community services and partially overcome the Medicaid institutional bias.

The City of Albuquerque/Bernalillo County Area Agency on Aging is in strong support of this application and believes and MFP program in New Mexico will be a benefit to our elders and individuals living with a disability.

Sincerely,

Danny K. Placencio, Manager
City of Albuquerque/Bernalillo County
Area Agency on Aging

DISABILITY RIGHTS NEW MEXICO

1720 Louisiana Blvd. NE, Suite 204 • Albuquerque, New Mexico 87110
TEL/TTY: (505) 256-3100 • FAX: (505) 256-3184
State-wide Toll Free 1-800-432-4682
WEBSITE: www.drnm.org • EMAIL: info@drnm.org
James Jackson, Executive Director

Promoting and Protecting the Rights of Persons with Disabilities

January 5, 2010

To Whom It May Concern:

I am writing in support of New Mexico's application for a demonstration grant to implement Money Follows the Person. The application is being submitted by the New Mexico Human Services Department (HSD) in collaboration with the Aging and Long Term Services Department (ALTSD).

Disability Rights New Mexico is the designated Protection and Advocacy agency in New Mexico and we have long promoted efforts to serve persons with disabilities in the most integrated community setting appropriate to the person's needs. We are very pleased that the Affordable Care Act has provided our state with a second chance to participate in the federally-supported MFP demonstration.

New Mexico's proposed program will provide the opportunity for elders and persons with disabilities to move out of nursing homes and into the community. We hope that it will help fulfill the promise of the state's own Money Follows the Person statute, and increase access to community services funded through existing waiver programs.

New Mexico has been a national leader in supporting persons in home and community-based settings rather than in facilities. The state closed its large institutional ICF/MR facilities in the 1990's and has supported individuals with a wide range of disabling conditions in small community settings since then. It adopted the Personal Care Option for the Medicaid program around 10 years ago, and this program now assists over 15,000 individuals to remain in their homes and participate in community life. The proposed MFP project would be a further step forward for the state in supporting individuals in integrated settings.

Our agency is committed to collaborating with HSD and ALTSD by providing input and feedback on the design and implementation of the proposed project. We urge favorable consideration of the state's proposal.

Sincerely,

James Jackson
Executive Director

Main Office:
9500 Montgomery N.E., Suite 121
Albuquerque, NM 87111

With Offices in:
Las Cruces
Las Vegas
Roswell
Farmington

January 3, 2011

To Whom It May Concern:

It is with great pleasure that the Alzheimer's Association, New Mexico Chapter submits this letter of support and collaboration on behalf of the New Mexico Human Services Department's (HSD) application for a federal Money Follows the Person (MFP) demonstration grant.

The Alzheimer's Association, New Mexico Chapter is committed to collaborate with HSD and the Aging and Long-Term Services Department in the development and implementation of a Money Follows the Person program in New Mexico.

There is increasing recognition that serving people in the community instead of in an institutional setting improves their quality of life and can lead to savings to the Medicaid program. MFP is a way to promote community services and partially overcome the Medicaid institutional bias.

The Alzheimer's Association, New Mexico Chapter is in strong support of this application and believes and MFP program in New Mexico will be a benefit to our elders and individuals living with a disability.

Sincerely,

Agnes Vallejos
Executive Director

9500 Montgomery N.E., Suite 121, Albuquerque, NM 87111
Helpline 24/7 (800) 272-3900 Main Office (505) 266-4473 Fax (505) 266-0108
www.alz.org/newmexico

NM020-1000
8220 San Pedro NE, Ste 300
Albuquerque NM 87113

Tel: 877 236 0826
Fax: 505 449 4225

January 3, 2011

To Whom It May Concern:

It is with great pleasure that Evercare submits this letter of support and collaboration on behalf of the New Mexico Human Services Department's (HSD) application for a federal Money Follows the Person (MFP) demonstration grant.

Evercare is committed to collaborate with HSD and the Aging and Long-Term Services Department in the development and implementation of a Money Follows the Person program in New Mexico.

There is increasing recognition that serving people in the community instead of in an institutional setting improves their quality of life and can lead to savings to the Medicaid program. MFP is a way to promote community services and partially overcome the Medicaid institutional bias.

Evercare is in strong support of this application and believes and MFP program in New Mexico will be a benefit to our elders and individuals living with a disability.

Sincerely,

Kevin Kandalaft
Executive Director
Evercare of New Mexico, Inc.

Cc: Emily Kaltenbach, NMALTSD
Julie Weinberg, HSD/MAD

January 3, 2011

To Whom It May Concern:

It is with great pleasure that Amerigroup Community Care of New Mexico, Inc. (AGP) submits this letter of support and collaboration on behalf of the New Mexico Human Services Department's (HSD) application for a federal Money Follows the Person (MFP) demonstration grant.

AGP is committed to collaborate with HSD and the Aging and Long-Term Services Department in the development and implementation of a Money Follows the Person program in New Mexico.

There is increasing recognition that serving people in the community instead of in an institutional setting improves their quality of life and can lead to savings to the Medicaid program. MFP is a way to promote community services and partially overcome the Medicaid institutional bias.

AGP is in strong support of this application and believes and MFP program in New Mexico will be a benefit to our elders and individuals living with a disability.

Sincerely,

Laura Hopkins
CEO

AMERIGROUP Community Care of New Mexico • 6565 Americas Parkway NE, Suite 110 • Albuquerque, NM 87110 • (505) 875-4320 • (505) 883-2687 fax • www.amerigroupcorp.com

3655 Carlisle NE
Albuquerque, New Mexico 87110 - 1644
Phone: (505) 883-4630 • FAX: (505) 883-5564

January 3, 2011

To Whom It May Concern:

The Arc of New Mexico is pleased to offer this letter of support and collaboration on behalf of the New Mexico Human Services Department application for a federal Money Follows the Person demonstration grant.

The Arc of New Mexico is a nationally affiliated, not-for-profit organization whose mission is to improve the quality of life of individuals with developmental disabilities of all ages by advocating for equal opportunities and choice in where and how they learn, live, work, play and socialize. The Arc is committed to collaborating with the Human Services Department and the Aging and Long Term Services Department in the development and implementation of a Money Follows the Person program in New Mexico.

It is a fundamental belief of The Arc of New Mexico that individuals with disabilities have a better quality of life when they live and participate in their communities. Recognition of this position is becoming more widely accepted and is leading to savings to the Medicaid program. An institutional bias still exists in the Medicaid program and a Money Follows the Person program will help to overcome this bias and promote community services.

The Arc of New Mexico strongly supports this application and believes a Money Follows the Person program in New Mexico will be a benefit to the elderly and individuals living with a disability.

If anyone has questions or needs additional information, please do not hesitate to contact me or Doris Husted, Public Policy Director dhusted@arcnm.org

Sincerely,

Randy Costales, Executive Director
rcostales@arcnm.org

NEW MEXICO ASSOCIATION FOR HOME&HOSPICE CARE

January 3, 2011

To Whom It May Concern:

It is with great pleasure that the New Mexico Association for Home and Hospice Care submits this letter of support and collaboration on behalf of the New Mexico Human Services Department's (HSD) application for a federal Money Follows the Person (MFP) demonstration grant.

The New Mexico Association for Home and Hospice Care is committed to collaborate with HSD and the Aging and Long-Term Services Department in the development and implementation of a Money Follows the Person program in New Mexico.

There is increasing recognition that serving people in the community instead of in an institutional setting improves their quality of life and can lead to savings to the Medicaid program. MFP is a way to promote community services and partially overcome the Medicaid institutional bias.

The New Mexico Association for Home and Hospice Care is in strong support of this application and believes and MFP program in New Mexico will be a benefit to our elders and individuals living with a disability.

Sincerely,

Joie Glenn
Executive Director

NMAHHC • 3200 Carlisle Blvd. • Suite 117 • Albuquerque, NM 87110
Tel 505-889-4556• Fax 505-889-4928• www.nmahc.org

New Mexico State Office
535 Cerrillos Rd., Suite A
Santa Fe, NM 87501

January 3, 2011

To Whom It May Concern:

It is with pleasure that the AARP New Mexico State Office submits this letter of support and collaboration on behalf of the New Mexico Human Services Department's (HSD) application for a federal Money Follows the Person (MFP) demonstration grant. AARP New Mexico has long supported efforts to fully implement this program in New Mexico.

We are committed to collaborate with HSD and the Aging and Long-Term Services Department in the development and implementation of a Money Follows the Person program in New Mexico.

There is increasing recognition that serving people in the community instead of in an institutional setting improves their quality of life and can lead to savings to the Medicaid program. MFP is a way to promote community services and partially overcome the Medicaid institutional bias.

We are in strong support of this application and believe that the MFP program in New Mexico will be a benefit to our elders and individuals living with a disability.

Sincerely,

Stan Cooper

Stan Cooper
State Director

Susana Martinez, Governor

Matthew Onstott, Ph.D., Deputy Secretary

January 4, 2011

To Whom It May Concern:

It is with great enthusiasm that Adult Protective Services submits this letter of support and collaboration on behalf of the New Mexico Human Services Department's (HSD) application for a federal Money Follows the Person (MFP) demonstration grant.

Adult Protective Services is committed to supporting HSD and its sister division within the Aging and Long-Term Services Department in the development and implementation of a Money Follows the Person program in New Mexico.

Adult Protective Services recognizes that supporting people in remaining in their own homes in the community, rather than in an institutional setting, results in a better quality of life and can produce a savings to the Medicaid program. Money Follows the Person is a way to promote community services and partially overcome the Medicaid institutional bias.

The Adult Protective Services Division strongly supports this application. The MFP program in New Mexico will be a great benefit to our elders and individuals living with a disability.

Sincerely,

Kathleen Hart

Kathleen Hart, Director
Adult Protective Services Division
NM Aging and Long-Term Services Department

Susana Martinez, Governor
Matt Onstott, Deputy Secretary

January 3, 2011

To Whom It May Concern:

My Name is Raymond Espinoza; I am the Director of The Indian Area Agency on Aging in New Mexico. This letter is to inform you of my organizations support for the New Mexico Human Services Departments, application for a federal Money Follows the Person (MFP) demonstration grant.

The Indian Area Agency on Aging is committed to collaborate with HSD and the Aging and Long-Term Services Department in the development and implementation of a Money Follows the Person program in New Mexico.

With the increasing recognition that serving people in their community instead of in an institutional setting improves their quality of life and can lead to savings with the Medicaid program. Money Follows the Person program is an exceptional way to promote community services and partially overcome the Medicaid institutional bias.

The Indian Area Agency on Aging is in strong support of this application and confident that the MFP program in New Mexico will benefit our elders and individuals living with a disability.

Sincerely,

Raymond Espinoza
Director Indian Area Agency on Aging/ALTSD

STATE OF NEW MEXICO
GOVERNOR'S COMMISSION ON DISABILITY

Susana Martinez
Governor
Jim Parker
Director

Lamy Building
491 Old Santa Fe Trail
Santa Fe, New Mexico 87501
505-476-0412 / Fax: 505-827-6328
1-877-696-1470

gcd@state.nm.us
www.gcd.state.nm.us

January 4, 2011

To Whom It May Concern:

The Governor's Commission on Disability (GCD) is pleased to offer this letter of support on behalf of the New Mexico Human Services Department's (HSD) application for a Federal Money Follows the Person (MFP) demonstration grant.

GCD is committed to collaborate with HSD and the Aging and Long-Term Services Department in the development and implementation of a MFP program in New Mexico. GCD was integrally involved with the State and Federal efforts to design, develop and implement MFP as another in the range of long term services choices for all people, both young and old.

It has long been an ideal of advocates for community living that serving people in the community instead of in an institutional setting improves quality of life and more effective utilization of Medicaid funding. MFP is another method of promoting community living services and moving away from the historical Medicaid institutional bias.

GCD is in strong support of this application and believes a MFP program in New Mexico will be a real benefit to all people who need long term services, but are relegated to a nursing facility or an institution.

For Community Living,

Jim Parker
Director

'Creating Opportunities for Barrier Free Futures'

Maintenance of Effort (MOE) Form

Money Follows the Person Demonstration Grant Program (Nov 2010)

STATE:	NM	Grant #:	CMS-1LI-11-001

Reporting Year Format: ☑ State Fiscal Year (Fiscal Year Runs: July 1-June 30)
☐ FEDERAL FISCAL YEAR ☐ CALENDAR YEAR

Total State Expenditures for Home & Community-based Services

Base Year

	2007	2008	2009	2010	2011
				$433,198,384	

2012	2013	2014	2015	2016	2017

2018	2019

Attestation (required by Section 6071 of the Deficit Reduction Act of 2005)

I assert by my signature that the expenditure report above is accurate and follows the MFP MOE Form instructions. I also assert that all qualified HCBS programs operating under a waiver under section (d)in the case of a qualified HCB program operating under a waiver under subsection (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n), but for the amount awarded under a grant under this section, the State program would continue to meet the cost-effectiveness requirements of subsection (c)(2)(D) of such section or comparable requirements under subsection (d)(5) of such section, respectively.

Signature :	Julie Weinberg	Date:	1/7/2011
Title/Position:	Acting Director, New Mexico Human Services Department		

Instructions

1. Fill out your State and Official Grant Number.
2. Check off the Report year you will be using. If it is the State Fiscal Year, indicate the dates of the year the report covers. You must report by either State FY, Federal FY or Calendar year.
3. Fill in each year's expenditures for HCBS starting with the base year which you will fill in. The base year is the immediate previous full year of expenditures based on the reporting year format you have chosen. For new applicants for 2011 provide only your base year. For existing grantees only provide the base year and the first full year you began your grant through the latest reporting period.
4. Medicaid HCBS Expenditures include *all* non-institutional services and include waiver and HCBS State plan services such as personal care services, rehab services and other State plan services you cover that are non-institutional.
5. The State authorized signatory must sign and date as well as identify their Title or position as indicated. The second element to attest to is the continuation of meeting cost neutrality in the waivers your State provides.