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LONG TERM CARE SERVICES WAIVER
MI VIA AND COMMUNITY-BASED SERVICES WAIVER

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

8.314.6.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.314.6.1 NMAC - Rp, 8.314.6.1 NMAC, 10-15-12]

8.314.6.2 SCOPE: The rule applies to the general public.
[8.314.6.2 NMAC - Rp, 8.314.6.2 NMAC, 10-15-12]

8.314.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.
[8.314.6.3 NMAC - Rp, 8.314.6.3 NMAC, 10-15-12]

8.314.6.4 DURATION: Permanent.
[8.314.6.4 NMAC - Rp, 8.314.6.4 NMAC, 10-15-12]

8.314.6.5 EFFECTIVE DATE: October 15, 2012, unless a later date is cited at the end of a section.
[8.314.6.5 NMAC - Rp, 8.314.6.5 NMAC, 10-15-12]

8.314.6.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.314.6.6 NMAC - Rp, 8.314.6.6 NMAC, 10-15-12]

8.314.6.7 DEFINITIONS:

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

B. **Authorized agent:** The eligible recipient 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 eligible recipient in understanding waiver services. The eligible recipient will designate a person to act as an authorized agent by signing a release of information form indicating the eligible recipient'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 eligible recipient or his/her legal representative. The eligible recipient's authorized agent does not need a legal relationship with the eligible recipient. While the eligible recipient's authorized agent can be a service provider for the eligible recipient, the authorized agent cannot serve as the eligible recipient's consultant. If the authorized agent is an employee, he/she cannot sign his/her own timesheet.

C. **Authorized annual budget (AAB):** The eligible recipient works with his or her consultant to develop an annual budget request which is submitted to the third party assessor (TPA) for review and approval. The total annual amount of the mi via services and goods includes the frequency, the amount, and the duration of the waiver services and the cost of waiver goods approved by the TPA. Once approved, this is the annual approved budget (AAB).

D. **Brain injury (BI):** Eligible recipients (through age 65) with an injury to the brain of traumatic or acquired origin resulting in a total or partial functional disability or psychosocial impairment or both. The BI eligible recipient must have a documented BI diagnosis, as included in the international classification of diseases (ICD-9-CM or its successor).

E. **Category of eligibility (COE):** To qualify for a medical assistance program, an applicant must meet financial criteria and belong to one of the groups that the state has defined as eligible. An eligible recipient in mi via must belong to one of the categories of eligibility (COE) described in 8.314.6.13 NMAC.

F. **Centers for medicare and medicaid services (CMS):** Federal agency within the United States department of health and human services that works in partnership with the states to administer medical assistance programs operated under HSD.

G. **Consultant provider:** May be an agency or an individual. Provides consultant and support guide services to the eligible recipient that assist the eligible recipient (or the eligible recipient's family or legal

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

H. **Eligible recipient:** An applicant meeting the financial and medical LOC criteria who is approved to receive MAD services through the mi via program.

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

J. **Financial management agency (FMA):** Contractor that helps implement the AAB by paying the eligible recipient's service providers and tracking expenses.

K. **Home and community-based services (HCBS) waiver:** A MAD program that provides alternatives to long-term care services in institutional settings. The federal government waives certain statutory requirements of the Social Security Act to allow states to provide an array of community-based options through these waiver programs.

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

M. **Intermediate care facilities for individuals with intellectual disabilities (ICF/IID):** Facilities that are licensed and certified by the New Mexico department of health (DOH) to provide room and board, continuous active treatment and other services for eligible MAD recipients with a primary diagnosis of intellectually disabled.

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

O. **Legally responsible individual (LRI):** A legally responsible individual (LRI) is any person who has a duty under state law to care for another person. This category typically includes: the parent (biological, legal, or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; or a spouse.

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

Q. **Mi via:** Mi via is the name of the Section 1915 (c) MAD self-directed HCBS waiver program through which an eligible recipient has the option to access services to allow him or her to remain in the community.

R. **Reconsideration:** An eligible recipient who disagrees with a clinical/medical utilization review decision or action may submit a written request to the TPA for reconsideration of the decision. The eligible recipient may submit the request for a reconsideration through the consultant or the consultant agency or may submit the request directly to MAD.

S. **Self-direction:** The process applied to the service delivery system wherein the eligible recipient identifies, accesses and manages the services (among the state-determined waiver services and goods) that meet his or her assessed therapeutic, rehabilitative, habilitative, health or safety needs to support the eligible recipient to remain in his or her community.

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

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

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

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

[8.314.6.7 NMAC - Rp, 8.314.6.7 NMAC, 10-15-12; A, 6-28-13]

8.314.6.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

[8.314.6.8 NMAC - Rp, 8.314.6.8 NMAC, 10-15-12]

8.314.6.9 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER:

A. New Mexico's self-directed waiver program known as mi via is intended to provide a community-based alternative to institutional care that allows an eligible recipient to have control over services and supports. Mi via provides self-directed home and community-based services to eligible recipients who are living with disabilities, conditions associated with aging, certain traumatic or acquired brain injuries (BI), acquired immunodeficiency syndrome (AIDS), developmental disabilities (DD), or medically fragile conditions (MF). (See 42 CFR 441.300.)

B. Mi via is comprised of two MAD home and community-based waivers established under Section 1915(c) of the Social Security Act. One waiver is specifically for eligible recipients who meet the LOC otherwise provided in a nursing facility (NF). The second waiver is specifically for eligible recipients who meet the LOC otherwise provided in an ICF/IID.

(1) Both waivers are managed as a single self-directed program and are administered collaboratively by the DOH and HSD/MAD. MAD is responsible for the daily administration of mi via for eligible recipients living with disabilities, conditions associated with aging, and certain traumatic or acquired brain injuries who meet the LOC for admittance to an NF. DOH is responsible for the daily administration of mi via for eligible recipients living with developmental disabilities and medically fragile conditions who meet the LOC for admittance to an ICF/IID. The DOH also manages the waiver for eligible recipients living with AIDS who meet the LOC for admittance to an NF.

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

[8.314.6.9 NMAC - Rp, 8.314.6.9 NMAC, 10-15-12; A, 6-28-13]

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

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

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

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

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

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

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

(1) verify that the recipients are eligible for MAD services prior to making payment for services;

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

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

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

(5) process all payroll functions on behalf of the eligible recipients and EORs including:

(a) collect and process timesheets of employees;

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

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

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

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

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

(9) report any concerns related to the health and safety of the eligible recipient's or that the eligible recipient is not following the approved SSP and AAB to the consultant provider, MAD and DOH, as appropriate.
[8.314.6.10 NMAC - Rp, 8.314.6.10 NMAC, 10-15-12; A, 6-28-13]

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

A. **Requirements for individual employees, independent providers, provider agencies and vendors:** In order to be approved as an individual employee, an independent provider, including non-licensed homemaker/companion workers, a provider agency (excluding consultant providers which are covered in a different subsection) or a vendor, including those that provide professional services, each entity must meet the general and service specific qualifications set forth in this rule and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the FMA. In order to be an authorized provider for mi via and receive payment for delivered services, the provider must complete and sign an employee or vendor provider agreement and all required tax documents. The provider must have credentials verified by the eligible recipient or the EOR and the FMA. Prior to rendering services to a MAD eligible mi via recipient, an individual seeking to provide services as a homemaker/direct support, respite, community direct/support/navigation, employment supports, and customized in-home living support worker (1) must obtain an internal revenue service (IRS)-SS8 letter determining the worker's status as an independent contractor or as an employee; (2) provide to the FMA and CA the IRS SS-8 letter. If the IRS SS-8 letter either determines or informs the worker that he or she meets the status of an independent contractor, the CA must submit the SSP changes to the TPA. Once the SSP is approved the independent contractor may begin the enrollment process with the FMA. In order to be an authorized consultant provider for the mi via program, the provider must have approved provider agreements executed by the DOH/developmental disabilities supports division (DDSD) and MAD.

B. **General qualifications:**

(1) Individual employees, independent providers, including non-licensed homemaker/companion workers and provider agencies (excluding consultant providers) who are employed by a mi via eligible recipient to provide direct services shall:

(a) be at least 18 years of age;

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

(c) be able to communicate successfully with the eligible recipient;

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

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

(f) complete training specific to the eligible recipient's needs; an assessment of training needs is determined by the eligible recipient or his/her legal representative; the eligible recipient is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the eligible recipient's AAB; and

(g) meet any other service specific qualifications, as specified in this rule and service standards.

(2) Vendors, including those providing professional services:

(a) shall be qualified to provide the service;

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

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

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

(e) if currently approved waiver providers, are to be in good standing with the appropriate state agency; and

(f) meet any other service specific qualifications, as specified in the mi via rules.

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

(4) Individuals with legal responsibility to provide care (LRI), e.g., the parent (biological, legal or adoptive) of a minor child (under age 18) or a spouse of the eligible recipient, may be hired and paid for provision of waiver services (except consultant/support guide, assisted living, and customized community supports services) under extraordinary circumstances in order to assure the health and welfare of the eligible recipient, to avoid institutionalization when approved by MAD and provided that MAD is eligible to receive federal financial participation (FFP).

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

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

(c) Services provided by LRIs must:

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

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

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

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

(i) a parent, parents in combination, or a spouse, may not provide more than 40 hours of services in a consecutive seven-day period; for parents of the eligible recipient, 40 hours is the total amount of service regardless of the number of eligible recipients under the age of 21who receive services through the mi via waiver;

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

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

(e) An eligible recipient must be offered a choice of providers. There must be written approval from MAD when an eligible CoLTS (c) or BI recipient, or from DOH when an eligible DOH AIDS, DD or MF recipient chooses his or her spouse as a provider. This written approval must be documented in the SSP.

(f) Eligible recipients 16 years of age or older must be offered a choice of provider. There must be written approval from MAD when an eligible CoLTS (c) or BI recipient or from DOH when an eligible DOH AIDS, DD and MF recipient chooses his or her parent as a provider. This written approval must be documented in the SSP.

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

(5) Once enrolled, providers, vendors and contractors receive a packet of information from the eligible recipient or FMA, including billing instructions, and other pertinent materials. Mi via eligible recipients or legal representatives are responsible for ensuring that providers, vendors and contractors have received these materials and for updating them as new materials are received from the state MAD for CoLTS (c), and BI or DOH for AIDS, DD, and MF). 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 instructions, utilization review instructions, and other pertinent materials. When enrolled, an eligible recipient or legal representative, or provider, vendor or contractor receives instruction on how to access these documents. It is the responsibility of the eligible recipient or legal representative, or provider, vendor, or contractor to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The eligible recipient or legal representative, or provider, vendor, or contractor must contact HSD or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials.

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

(b) No provider agency is permitted to perform both LOC assessments and provide any services for the eligible recipients.

(c) Providers may market their services, but are prohibited from soliciting eligible recipients under any circumstances.

(6) The EOR is the individual responsible for directing the work of the eligible recipient's employees. MAD encourages an eligible recipient 18 years of age or older to be his or her own EOR. It is also possible to designate someone else to act as the EOR.

(a) An eligible recipient that is the subject of a plenary or limited guardianship or conservatorship may not be his or her own EOR.

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

(c) An EOR who lives outside New Mexico shall reside within 100 miles of the New Mexico state border. If the eligible recipient wants to have an EOR who resides beyond this radius, the eligible recipient must obtain written approval from MAD (when an eligible CoLTS (c) or BI recipient) or from DOH (when an eligible DOH AIDS, DD or MF recipient) prior to the EOR performing any duties. This written approval must be documented in the SSP.

(d) The eligible recipient's provider may not also be his/her EOR.

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

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

C. **Service specific qualifications for consultant services providers:** In addition to general requirements, a consultant provider shall ensure that all individuals hired or contracted consultant services meet the criteria specified in this section in addition to as well to perform all applicable rules and service standards.

(1) Consultant providers shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) **Qualifications of supported employment providers:**

(a) Job developers must have experience as a job developer for at least one year; have experience for at least one year developing and using job and task analyses; have experience for at least one year working with the division of vocational rehabilitation (DVR), a traditional DD waiver employment provider, an independent living center or other organization that provides employment supports or services for people with

disabilities; and be trained on the purposes, functions and general practices of entities such as the department of workforce solutions navigators, one-stop career centers, business leadership network, chamber of commerce, job accommodation network, small business development centers, retired executives and New Mexico employment institute.

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

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

G. **Service specific qualifications for providers of health and wellness supports:** In addition to the general qualifications, the following types of providers must meet additional qualifications specific to the type of services provided.

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

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

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

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

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

(a) acupuncture and oriental medicine;

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

(c) chiropractic medicine;

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

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

(f) massage therapy;

(g) naprapathic medicine;

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

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

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

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

(a) possess a valid, appropriate New Mexico driver's license;
(b) be free of physical or mental impairment that would adversely affect driving performance;
(c) have no DWI convictions or chargeable (at fault) accidents within the previous 24 months;
(d) have current CPR/first aid certification;
(e) be trained on DOH/DHI critical incident reporting procedures;
(f) have a current insurance policy and vehicle registration; and
(g) each agency will ensure vehicles have a current basic first aid kit in the vehicle.

(2) **Qualifications of emergency response providers:** Emergency response providers must comply with all laws, rules and regulations of the New Mexico state corporation commission for telecommunications and security systems.

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

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

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

[8.314.6.11 NMAC - Rp, 8.314.6.11 NMAC, 10-15-12; A, 6-28-13]

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

[8.314.6.12 NMAC - Rp, 8.314.6.12 NMAC, 10-15-12]

8.314.6.13 ELIGIBILITY REQUIREMENTS FOR RECIPIENT ENROLLMENT IN MI VIA: Enrollment in mi via is contingent upon the applicant meeting the eligibility requirements as described in the mi via rules, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated eligible recipients. When sufficient funding as well as waiver positions are available, the appropriate state administering agency will offer the opportunity to eligible recipients to apply for mi via. Once an allocation has been offered to the applicant, he/she must meet certain medical and financial criteria in order to qualify for mi via enrollment. Eligible recipients must meet the following eligibility criteria: financial eligibility criteria determined in accordance with 8.290.500 NMAC, and the eligible recipient must meet the LOC required for admittance to an NF or an ICF/IID and additional specific criteria as specified in the categories below.

A. **Developmental disability:** Eligible recipients who have:

(1) an intellectual disability: An individual is considered to have MR/ID if she/he has significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(2) a specific related condition: An individual is considered to have a specific related condition if she/he has a severe chronic disability, other than mental illness, that meets all of the following conditions:

(a) is attributable to:

(i) cerebral palsy or seizure disorder; or

(ii) is attributable to autistic disorder (as described in the fourth edition of the diagnostic and statistical manual of mental disorders); or

(iii) is attributable to chromosomal disorders (e.g. down), syndrome disorders, inborn errors of metabolism, or developmental disorders of the brain formation limited to the list in Paragraph (3) below;

(b) results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability and requires treatment or services similar to individuals with ID;

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

(d) is likely to continue indefinitely; and

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

(3) have a disorder of one or more of the following:

(a) **chromosomal disorders:** autosomes: 4p-, trisomy 4p, trisomy 8, 5p-, 9p-, trisomy 9p, trisomy 9p mosaic, partial trisomy 10q, 13q-, ring 13, trisomy 13 (Patau), 18p-, 18q-, trisomy 18 (Edwards), Ttisomy 20p, G (21,22) monosomy/deletion, trisomy 21 (down), translocation 21 (down), “cat-eye” syndrome; Prader-Willi syndrome (15);

(i) x-linked mental retardation: Allan syndrome; Atkin syndrome; Davis syndrome; Fitzsimmons syndrome; fragile x syndrome; fragile x phenotype (no fragile site); Gareis syndrome; glycerol kinase deficiency; Golabi syndrome; Homes syndrome; Juberg syndrome; Lujan syndrome; Renpenning syndrome; Schimke syndrome; Vasquez syndrome; nonspecific x-linked mental retardation;

(ii) other x chromosome disorders: xo syndrome (Turner); xyy syndrome; xxy syndrome (Klinefelter); xxyy syndrome; xxxy syndrome; xxxx syndrome; xxxxy syndrome; xxxxx syndrome (penta-x);

(b) **syndrome disorders:**

(i) neurocutaneous disorders: ataxia-telangiectasia (Louis-Bar); basal cell nevus syndrome; dyskeratosis congenital; ectodermal dysplasia (hyperhidrotic type); ectromelia ichthyosis syndrome; focal dermal hypoplasia (Goltz); ichthyosis-hypogonadism syndrome, incontinentia pigmenti (Bloch-Sulzberger); Ito syndrome; Klippel-Trenauney syndrome; linear sebaceous nevus syndrome; multiple lentigines syndrome; neurofibromatosis (Type 1); poikiloderma (Rothmund-Thomsen); Pollitt syndrome; Sjogren-Larsen syndrome; Sturge-Weber syndrome; tuberous sclerosis; xeroderma pigmentosum;

(ii) **muscular disorders:** Becker muscular dystrophy; chondrodystrophic myotonia (Schwartz-Jampel); congenital muscular dystrophy; Duchenne muscular dystrophy; myotonic muscular dystrophy;

(iii) **ocular disorders:** Aniridia-Wilm’s tumor syndrome; anophthalmia syndrome (x-linked); Leber amaurosis syndrome; Lowe syndrome; microphthalmia-corneal opacity-spasticity syndrome; Norrie syndrome; oculocerebral syndrome with hypopigmentation; retinal degeneration-trichomegaly syndrome; septo-optic dysplasia;

(iv) **craniofacial disorders:** acrocephaly-cleft lip-radial aplasia syndrome; acrocephalosyndactyly;type 1 (Apert); type 2 (Apert); type 3 (Saethre-Chotzen); type 6 (Pfeiffer); Carpenter syndrome with absent digits and cranial defects; Baller-Gerold syndrome; cephalopolysyndactyly (Greig) “cloverleaf-skull” syndrome; craniofacial dysostosis (Crouzon); craniotelencephalic dysplasia; multiple synostosis syndrome;

(v) **skeletal disorders:** acrodysostosis, CHILD syndrome; chondrodysplasia punctata (Conradi-Hunerman type); chondroectodermal dysplasia; Dyggve-Melchior-Clausen syndrome; frontometaphyseal dysplasia; hereditary osteodystrophy (Albright); hyperostosis (Lenz-Majewski); hypochondroplasia; Klippel-Feil syndrome; Nail-patella syndrome; osteopetrosis (Albers-Schonberg); pyknodysostosis; radial aplasia-thrombocytopenia syndrome; radial hypoplasia pancytopenia syndrome (Fanconi); Roberts-SC phocomelia syndrome;

(c) **inborn errors of metabolism:**

(i) **amino acid disorders:** phenylketonuria: phenylalanine hydroxylase (classical, Type 1); dihydropteridine reductase (type 4); dihydrobiopterin synthetase (type 5); histidinemia; gamma-glutamylcysteine synthetase deficiency; hyperlysinemia; lysinuric protein intolerance; hyperprolinemia; hydroxyprolinemia; sulfite oxidase deficiency; iminoglycinuria; branched-chain amino acid disorders: hypervalinemia; hyperleucine-isoleucinemia; maple-syrup urine disease; isovaleric academia, glutaric academia (type 2); 3-hydroxy-3-methylglutaryl CoA lyase deficiency; 3-kethothiolase deficiency;,biotin-dependent disorders: holocarboxylase deficiency; biotinidase deficiency; propionic academia: type A; Type BC; methylmalonic academia: mutase type (mut+); cofactor affinity type (mut-); adenosylcobalamin synthetase type (cbl A); ATP: cobalamin

adenosyltransferase type (cbl B), with homocystinuria, type 1 (cbl C), with homocystinuria, type 2 (cbl D); folate-dependent disorders: congenital defect of folate absorption; dihydrofolate reductase deficiency; methylene tetrahydrofolate reductase deficiency; homocystinuria; hypersarcosinemia; non-ketotic hyperglycinemia; hyper-beta-alaninemia; carnosinase deficiency; homocarnosinase deficiency; Hartnup disease; methionine malabsorption (oasthouse urine disease);

(ii) **carbohydrate disorders:** glycogen storage disorders: type 1, with hypoglycemia (von Gierke); type 2 (Pompe); galactosemia; fructose-1, 6-diphosphatase deficiency; pyruvic acid disorders: pyruvate dehydrogenase complex (Leigh); pyruvate carboxylase deficiency; mannosidosis; fucosidosis; aspartylglucosaminuria;

(iii) **mucopolysaccharide disorders:** alpha-L-iduronidase deficiency: Hurler type; Scheie type, Hurler-Scheie type; iduronate sulfatase deficiency (Hunter type); Heparan N-sulfatase deficiency (Sanfilippo 3A type); N-acetyl-alpha-D-glucosaminidase deficiency (Sanfilippo 3B type); Acetyl CoA; glucosaminide N-acetyltransferase deficiency (Sanfilippo 3C type); N-acetyl-alpha D-glucosaminide 6-sulfatase deficiency (Sanfilippo 3D type); beta-glucuronidase deficiency (Sly type);

(iv) **mucolipid disorders:** alpha-neuraminidase deficiency (type1); N-acetylglucosaminyl phosphotransferase deficiency: I-cell disease (Type 2); Pseudo-Hurler syndrome (type 3); mucolipidosis type 4;

(v) **urea cycle disorders:** carbamyl phosphate synthetase deficiency; ornithine transcarbamylase deficiency; argininosuccinic acid synthetase deficiency (citrullinemia); argininosuccinic acid (ASA) lyase deficiency; arginase deficiency (argininemia);

(vi) **nucleic acid disorders:** Lesch-Nyhan syndrome (HGPRTase deficiency); orotic aciduria; xeroderma pigmentosum (group A); DeSanctis-Cacchione syndrome;

(vii) **copper metabolism disorders:** Wilson disease; Menkes disease;

(viii) **mitochondrial disorders:** Kearns-Sayre syndrome; MELAS syndrome; MERRF syndrome; cytochrome c oxidase deficiency; other mitochondrial disorders;

(ix) **peroxisomal disorders:** Zellweger syndrome; adrenoleukodystrophy: neonatal (autosomal recessive); childhood (x-linked); infantile Refsum disease; hyperpipecolic academia; chondrodysplasia punctata (rhizomelic type);

(d) **developmental disorders of brain formation:**

(i) neural tube closure defects: anencephaly; spina bifida; encephalocele;

(ii) brain formation defects: Dandy-Walker malformation; holoprosencephaly; hydrocephalus: aqueductal stenosis; congenital x-linked type; Lissencephaly; pachygyria; polymicrogyria; schizencephaly;

(iii) cellular migration defects: abnormal layering of cortex; colpocephaly; heterotopias of gray matter; cortical microdysgenesis

(iv) intraneuronal defects: dendritic spine abnormalities; microtubule abnormalities;

(v) acquired brain defects: hydranencephaly; porencephaly; and

(vi) primary (idiopathic) microcephaly.

B. **Medically fragile:** Eligible recipients who have been diagnosed with a medically fragile condition before reaching age 22, and who:

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

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

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

(b) require an ICF/IID LOC.

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

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

E. **Brain-injury (BI):** Eligible recipients through age 65 with an injury to the brain of traumatic or acquired origin resulting in total or partial functional disability or psychosocial impairment or both. The BI eligible recipient must have a documented BI diagnosis, as included in the international classification of diseases (ICD-9-CM or its successor). The MAD usage of brain injury does not apply to brain injuries that are congenital, degenerative, induced by birth trauma or neurological disorders related to the aging process, or chemically caused brain injuries that are a result of habitual substance abuse. Additional criteria include:

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

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

(3) the individual must require NF LOC.

F. After initial eligibility has been established for a recipient, on-going eligibility must be re-determined on an annual basis.

[8.314.6.13 NMAC - Rp, 8.314.6.13 NMAC, 10-15-12; A, 6-28-13]

8.314.6.14 ELIGIBLE RECIPIENT AND EOR RESPONSIBILITIES: Mi via eligible recipients have certain responsibilities to participate in the waiver. Failure to comply with these responsibilities or other program rules and service standards can result in termination from the program. The eligible recipient and EOR have the following responsibilities:

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

B. To participate in mi via, the eligible recipient must:

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

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

(3) collaborate with the consultant to develop an SSP using the IBA in accordance with mi via program rules and service standards;

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

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

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

(b) revisions to the AAB may occur within the SSP year, and the eligible recipient is responsible for assuring that all expenditures are in compliance with the most current AAB in effect;

(i) the SSP must be amended first to reflect a change in the eligible recipient's needs or circumstances before any revisions to the AAB can be requested;

(ii) other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review within the last 60 calendar days of the budget year;

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

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

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

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

(8) report concerns or problems with any part of the mi via program to the consultant or if the concern or problem is with the consultant, to MAD or DOH;

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

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

(11) report to the local HSD income support division (ISD) office within 10 calendar days any change in circumstances, including a change in address, which might affect eligibility for the program; changes in address or other contact information must also be reported to the consultant provider and the FMA within 10 calendar days;

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

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

(14) have monthly contact and meet face-to-face quarterly with the consultant.

C. Additional responsibilities of the eligible recipient or EOR:

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

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

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

(4) Hire, manage, and terminate employees.

(5) Maintain records and documentation.

D. **Voluntary termination:** Eligible recipients are given a choice of receiving services through an existing waiver or mi via. Mi via eligible recipients, who transition from the current traditional waivers (CoLTS (c), DD, MF, or AIDS) and decide to discontinue self-directing their services, may return to the traditional waiver in accordance with the mi via rules and service standards. Eligible recipients who are eligible under the BI category of eligibility and choose to discontinue self direction may be transitioned to CoLTS (c) services.

E. **Involuntary termination:** A mi via eligible recipient may be terminated involuntarily by MAD and offered services through a non self-directed waiver or the medicaid state plan under the following circumstances.

(1) The eligible recipient refuses to follow mi via rules after receiving focused technical assistance on multiple occasions, support from the program staff, consultant, or FMA, which is supported by documentation of the efforts to assist the eligible recipient.

(2) The eligible recipient is in immediate risk to his/her health or safety by continued self-direction of services, e.g., the eligible recipient is in imminent risk of death or serious bodily injury related to participation in the waiver. Examples include but are not limited to the following:

(a) The eligible recipient refuses to include and maintain services in his/her SSP and AAB that would address health and safety issues identified in his/her medical assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, consultant, or FMA.

(b) The eligible recipient is experiencing significant health or safety needs, and, after a referral to the state contractor for level of risk determination and assistance, refuses to incorporate the state contractor's recommendations into his/her SSP and AAB.

(c) The eligible recipient exhibits behaviors which endanger him/herself or others.

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

(4) The eligible recipient commits medicaid fraud.

(5) The eligible recipient who is involuntarily terminated from mi via will be offered a non self-directed waiver alternative. If transfer to another waiver is authorized by MAD and accepted by the eligible recipient, he/she will continue to receive the services and supports from mi via until the day before the new waiver services start. This will ensure that no break in service occurs. The mi via consultant and the service coordinator in the new waiver will work closely together with the eligible recipient to ensure that the eligible recipient's health and safety is maintained.

[8.314.6.14 NMAC - Rp, 8.314.6.14 NMAC, 10-15-12; A, 6-28-13]

8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA: The services covered by mi via are intended to provide a community-based alternative to institutional care for an eligible recipient that allows

greater choice, direction and control over services and supports in a self-directed environment. Mi via services must specifically address a therapeutic, rehabilitative, habilitative, health or safety need that results from the eligible recipient qualifying condition. The mi via program is the payor of last resort. The coverage of mi via services must be in accordance with the mi via program rules and service standards.

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

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

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

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

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

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

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

(1) **Contact requirements:** Consultant providers shall make contact with the eligible recipient in person or by telephone at least monthly for a routine follow-up. Consultant providers shall meet in person with the eligible recipient at least quarterly; one visit must be conducted in the eligible recipient's home. Quarterly visits will be conducted for the following purposes:

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

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

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

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

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

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

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

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

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

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

(i) The DOH triages, and investigates all reports of alleged abuse, neglect, exploitation, and other incidents for mi via services provided by community-based waiver service agencies, to include expected and unexpected deaths. The reporting of incidents is mandated pursuant to 7.1.13 NMAC. Any suspected abuse, neglect, or exploitation must be reported to the children, youth and families department (CYFD)/child protective services (CPS) for eligible recipients under 18 years or to the ALTSD/adult protective services (APS) for eligible recipients 18 years or older by reporting or faxing an incident report (IR). Additionally, the IR form must be faxed to DOH within 24 hours of knowledge of an incident or the following business day when an event occurs on a weekend or holiday. Anyone may report an incident; however, the person with the most direct knowledge of the incident is the individual who is required to report the incident.

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

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

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

(i) ALTSD/APS for eligible recipients age 18 years or older or CYFD/CPS for eligible recipients under 18 years for critical incidents involving abuse, neglect or exploitation; and

(ii) MAD, quality assurance bureau as well as the MCO, if applicable; the consultant provider shall fax all critical incidents in the standardized format provided by the CYFD/CPS and ALTSD/APS.

D. **Personal plan facilitation:** Personal plan facilitation supports planning activities that may be used by the eligible recipient to develop his/her SSP as well as identify other sources of support outside the SSP process. This service is available to an eligible recipient one time per budget year.

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

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

(b) arrange for participation of invitees and location;

(c) conduct the personal planning session;

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

(2) Elements of this report shall include:

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

(b) services from sources other than MAD to aid the eligible recipient;

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

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

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

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

E. **Living supports:**

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

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

(b) Personal care services are covered under the medicaid state plan as enhanced early and periodic screening, diagnostic and treatment (EPSDT) benefits for waiver eligible recipients under 21 years.

(2) **Home health aide services:** Home health aide services provide total care or assist an eligible recipient 21 years and older in all activities of daily living. Home health aide services assist the eligible recipient in a manner that will promote an improved quality of life and a safe environment for the eligible recipient. Home health aide services can be provided outside the eligible recipient's home. State plan home health aide services are intermittent and provided primarily on a short-term basis. Mi via home health aide services are hourly services for eligible recipients who need this service on a more long-term basis. Home health aide services are not duplicative of homemaker services. Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Homemakers do not have this ability to perform such tasks.

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

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

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

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

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

(4) **Customized in-home living supports:** Customized in-home living supports are related to the eligible recipient's qualifying condition or disability and enable him/her to live in his /her apartment or house. Services must be provided in homes/apartments owned or leased by the eligible recipient or in the eligible recipient's home.

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

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

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

F. **Community membership supports:**

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

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

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

(c) Community direct support services include:

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(ii) payments that are passed through to users of supported employment programs; or

(iii) payments for training that is not directly related to an individual's supported employment program;

(iv) FFP cannot be claimed to defray expenses associated with starting up or operating a business.

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

G. **Health and wellness:**

(1) **Extended state plan skilled therapy for eligible recipients 21 years and older:** Enhanced state plan skilled therapy for adults includes physical therapy, occupational therapy or speech language therapy. Mi via services are provided when skilled therapy services under the state plan are exhausted or not a benefit. Eligible recipients 21 years and older on mi via access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Therapy services provided to eligible recipients 21 years or older in mi via focus on improving functional independence, health maintenance, community integration, socialization, and exercise, or enhance support and normalization of family relationships.

(a) **Physical therapy:** Diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities. Physical therapy addresses the restoration, maintenance and

promotion of optimal physical function, wellness and quality of life related to movement and health. Physical therapy activities do the following:

(i) increase, maintain or reduce the loss of functional skills;

(ii) treat a specific condition clinically related to the eligible recipient's disability;

(iii) support the eligible recipient's health and safety needs; or

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

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

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

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

(iii) skills assessments and treatment;

(iv) assistive technology recommendations and usage training;

(v) guidance to family members and caregivers;

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

(vii) treating specific conditions clinically related to the eligible recipient's developmental disability;

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) **Private duty nursing for adults:** Private duty nursing for eligible recipients 21 years or older includes activities, procedures, and treatment for the eligible recipient's physical condition, physical illness or chronic disability. Services include medication management, administration and teaching, aspiration precautions,

feeding tube management, gastrostomy and jejunostomy care, skin care, weight management, urinary catheter management, bowel and bladder care, wound care, health education, health screening, infection control, environmental management for safety, nutrition management, oxygen management, seizure management and precautions, anxiety reduction, staff supervision, behavior and self-care assistance.

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

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

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

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

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

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

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

(g) **Naprapathy:** Naprapathy focuses on the evaluation and treatment of neuro-musculoskeletal conditions, and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and other joints, and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles, and tendons) interfere

with nerve, blood, and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function. See naprapathic practitioners, 16.6.1 NMAC.

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

(i) **Play therapy:** Play therapy is a variety of play and creative arts techniques utilized to alleviate chronic, mild and moderate psychological and emotional conditions for an eligible recipient that are causing behavioral problems or are preventing the eligible recipient from realizing his/her potential. The play therapist works integratively using a wide range of play and creative arts techniques, mostly responding to the eligible recipient's direction.

H. **Other supports:**

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

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

(a) testing and maintaining equipment;

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

(c) 24-hour monitoring for alarms;

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

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

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

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

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

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

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

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

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

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

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

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

(vii) facilitate activities of daily living.

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

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

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

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

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

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

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

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

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

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

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

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

[8.314.6.15 NMAC - Rp, 8.314.6.15 NMAC, 10-15-12; A, 6-28-13]

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

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

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

C. formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the public education department (PED), division of vocational rehabilitation (DVR).

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

E. experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC *Experimental or Investigational Procedures, Technologies or Therapies*;

F. any goods or services that a household that does not include a person with a disability would be expected to pay for as a routine household expense;

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

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

I. animals and costs of maintaining animals including the purchase of food, veterinary visits, grooming and boarding but with the exception of training and certification for service dogs;

J. gas cards and gift cards;

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

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

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

N. firearms, ammunition or other weapons;

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

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

Q. purchase of usual and customary furniture and home furnishings, *unless* adapted to the eligible recipient's disability or use, or of specialized benefit to the eligible recipient's condition; requests for adapted or specialized furniture or furnishings must include a recommendation from the eligible recipient's health care provider and, when appropriate, a denial of payment from any other source;

R. regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, *except* upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the eligible recipient's qualifying condition or disability;

S. regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, *except* upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the eligible recipient's qualifying condition or disability; requests must include documentation that the adapted vehicle is the eligible recipient's primary means of transportation;

T. clothing and accessories, except specialized clothing based on the eligible recipient's disability or condition;

U. training expenses for paid employees;

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

W. consumer electronics such as computers, printers and fax machines, or other electronic equipment that does not meet the criteria specified in Subsection A of 8.314.6.15 NMAC; no more than one of each type of item may be purchased at one time; and consumer electronics may not be replaced more frequently than once every three years;

X. cell phone services that include: fees for data; or more than one cell phone line per eligible recipient;

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

Z. dental services utilizing mi via individual budgetary allotments.

[8.314.6.16 NMAC - Rp, 8.314.6.16 NMAC, 10-15-12; A, 6-28-13]

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

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

(1) **Assessments:**

(a) Assessment activities that occur prior to the SSP meeting assist in the development of an accurate and functional plan. The functional assessments conducted during the LOC determination process address the following needs of a person: medical, adaptive behavior skills, nutritional, functional, community/social and

employment; LOC assessments are conducted in person and take place in the or the eligible recipient's home, an agreed upon location or an inpatient setting.

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

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

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

(2) **Pre-planning:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the IBA.

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

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

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

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

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

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

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

(iv) services do not duplicate or supplant those available to the eligible recipient through the medicaid state plan or other programs;
(v) services are not duplicated in more than one service code;
(vi) job descriptions are complete for each provider and employee in the plan; job descriptions will include frequency, intensity and expected outcomes for the service;
(vii) the quality assurance section of the SSP is complete and specifies the roles of the eligible recipient, consultant and any others listed in this section;
(viii) the responsibilities are assigned for implementing the plan;
(ix) the back-up plans are complete; and
(x) the SSP is submitted to the TPA after the SSP meeting, in compliance with mi via waiver rules.

B. **Individual budgetary allotment (IBA):** Each mi via eligible recipient's annual IBA is determined by the state as follows.
(1) Budgetary allotments are based on calculations developed by the state for each mi via population group, including AIDS, CoLTS (c), DD or MF waiver, and BI category of eligibility, utilizing historical traditional waiver care plan authorized budgets within the population, minus the case management costs, and minus a 10 percent discount.
(2) The determination of each mi via eligible recipient's sub-group is based on a comprehensive assessment. The eligible recipient then receives the IBA available to that category of need, according to the eligible recipient's age.
(3) A mi via eligible recipient has the authority to expend the IBA through an AAB that is to be expended on a monthly basis and in accordance with the mi via rules and program service standards.
(a) The current mi via rate schedule, available on the HSD/MAD website under fee schedules, shall be used as a guide in evaluating proposed payment rates for services that are currently covered or similar to currently covered services. The eligible recipient must justify in writing the rate that he/she wishes to pay when that rate exceeds the rate schedule. The eligible recipient must include this justification with the SSP and annual budget request when it is submitted for approval.
(b) The AAB shall contain goods and services necessary for health and safety (i.e., direct care services and medically related goods) which will be given priority over goods and services that are non-medical or not directly related to health and safety. This prioritization applies to the IBA, AAB, and any subsequent modifications.

C. **SSP review criteria:** Services and related goods identified in the eligible recipient's requested SSP may be considered for approval if the following requirements are met:
(1) the services or goods must be responsive to the eligible recipient's qualifying condition or disability; and
(2) the services or goods must address the eligible recipient's clinical, functional, medical or habilitative needs; and
(3) the services or goods must accommodate the eligible recipient in managing his/her household; or
(4) the services or goods must facilitate activities of daily living; or
(5) the services or goods must promote the eligible recipient's personal health and safety; and
(6) the services or goods must afford the eligible recipient an accommodation for greater independence; and
(7) the services or goods must support the eligible recipient to remain in the community and reduce his/her risk for institutionalization; and
(8) the services or goods must be documented in the SSP and advance the desired outcomes in the eligible recipient's SSP; and
(9) the SSP contains the quality assurance criteria to be used to determine if the service or goods meet the eligible recipient's need as related to the qualifying condition or disability; and
(10) the services or goods must decrease the need for other MAD services; and
(11) the eligible recipient receiving the services or goods does not have the funds to purchase the services or goods; or
(12) the services or goods are not available through another source; the eligible recipient must submit documentation that the services or goods are not available through another source, such as the medicaid state plan or medicare; and
(13) the service or good is not prohibited by federal regulations, state rules and instructions; and

(14) each service or good must be listed as an individual line item whenever possible; when services or goods are 'bundled' the SSP must document why bundling is necessary and appropriate.

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

(1) the proposed annual budget request is within the eligible recipient's IBA; and

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

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

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

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

E. **Modification of the SSP:**

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

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

(3) The eligible recipient must provide written documentation of the change in needs or circumstances as specified in the mi via service standards. The eligible recipient submits the documentation to the consultant. The consultant initiates the process to modify the SSP by forwarding the request for modification to the TPA for review.

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

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

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

(1) Budget revisions involve requests to add new goods or services to a budget or to reallocate funds from any line item to another approved line item. Budget revisions must be submitted to the TPA for review and approval. Other than for critical health and safety reasons, budget revisions may not be submitted to the TPA for review within the last 60 days of the budget year.

(2) The amount of the AAB cannot exceed the eligible recipient's annual IBA. The rare exception would be the eligible recipient whose assessed or documented needs, based on his/her qualifying condition, cannot be met within the annual IBA, in which case the eligible recipient would initiate a request for an adjustment through his/her consultant.

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

(a) chronic physical condition: the eligible recipient has one or more chronic physical conditions, which are identified during the initial or reevaluation of the LOC, that result in a prolonged dependency on medical services or care, for which daily intervention is medically necessary; the eligible recipient's needs cannot be met within the assigned IBA or other current resources, including natural supports, medicaid state plan services, medicare or other sources; and which are characterized by at least one of the following:

(i) a life-threatening condition with frequent or constant periods of acute exacerbation that places the eligible recipient at risk for institutionalization; that could result in the eligible recipient's inability to remember to self-administer medications accurately even with the use of assistive technology devices; that requires a frequency and intensity of assistance, supervision, or consultation to ensure the eligible recipient's health and safety in the home or in the community; or which, in the absence of such skilled intervention, assistance, medical supervision or consultation, would require hospitalization or admission to an NF or ICF/IID;

(ii) the need for administration of specialized medications, enteral feeding or treatments that: are ordered by a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant; and require frequent and ongoing management or monitoring or oversight of medical technology;

(b) change in physical health status; the eligible recipient has experienced a deterioration or permanent change in her/her health status such that the eligible recipient's needs for services and supports can no longer be met within the AAB or other current resources, including natural supports, are not covered under the medicaid state plan, medicare or other sources; these are the types of changes that may necessitate an increase in the AAB; the eligible recipient now requires the administration of medications via intravenous or injections on a daily or weekly basis; the eligible recipient has experienced recent onset or increase in aspiration of saliva, foods or liquids; the eligible recipient now requires external feedings, e.g. naso-gastric, percutaneous endoscopic gastrostomy, gastric-tube or jejunostomy-tube; the eligible recipient is newly dependent on a ventilator; the eligible recipient now requires suctioning every two hours, or more frequently, as needed; the eligible recipient now has seizure activity that requires continuous monitoring for injury and aspiration, despite anti-convulsant therapy; the eligible recipient now requires increased assistance with activities of daily living;

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

(ii) the eligible recipient may submit additional supportive documentation by others involved in the eligible recipient's care, such as a current individual service plan if the eligible recipient is transferring from another waiver, a recent evaluation from a specialist or therapist, a recent discharge plan, relevant medical records or other documentation or recent statements from family members, friends or other support individuals;

(c) chronic or intermittent behavioral conditions or cognitive difficulties: the eligible recipient has chronic or intermittent behavioral conditions or cognitive difficulties, which are identified during the initial or reevaluation LOC assessment, or the eligible recipient has experienced a change in his/her behavioral health status, for which the eligible recipient requires additional services, supports, assistance, or supervision to address the behaviors or cognitive difficulties in order to keep the eligible recipient safe; these behaviors and cognitive difficulties are so severe and intense that they result in considerable risk to the eligible recipient, caregivers or the community; require a frequency and intensity of assistance, supervision or consultation to ensure the eligible recipient's health and safety in the home or the community; are likely to lead to incarceration or admission to a hospital, NF or ICF/IID; require intensive intervention or medication management by a doctor or behavioral health practitioner or care practitioner; and cannot be effectively addressed within the AAB or other resources, including natural supports, the medicaid state plan, medicare or other sources;

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

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

(iii) the eligible recipient may submit additional supportive documentation including a current individual service plan if the eligible recipient is transferring from another waiver, a positive behavioral support plan or assessment, recent notes, a summary or letter from a behavioral health practitioner or professional with expertise in developmental disabilities, brain injury or geriatrics, recent discharge plan, recent recommendations from a rehabilitation facility, any other relevant documentation or recent statements from family members, friends or other support individuals involved with the eligible recipient;

(d) change in natural supports: the eligible recipient has experienced a loss, as a result of situations such as death, illness, or disabling condition, of his/her natural supports, such as family members or other community resources that were providing direct care or services, whether paid or not; this absence of natural supports or other resources is expected to continue throughout the period for which supplemental funds are requested; the type, intensity or amount of care or services previously provided by natural supports or other

resources cannot be acquired within the IBA and are not available through the medicaid state plan, medicare, other programs or sources in order for the eligible recipient to live in a home and community-based setting.

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

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

G. **SSP and annual budget supports:** As specified in the mi via program rules and service standards, the mi via eligible recipient is assisted by the consultant in development and implementation of the SSP and AAB. The FMA assists the eligible recipient with implementation of the AAB. A debit card will be utilized for related good listed on an IBA. The process for loading funding on the debit card is as follows:

(1) following the approval of the SSP by the TPA, the eligible recipient must submit an invoice to the FMA;

(2) the FMA will verify the accuracy of the invoice, then load the funding onto the debit card for use by the eligible recipient;

(3) the recipient must utilize the funding for the approved related good(s) only and maintain the receipt of purchase for a period of up to six years;

(4) the FMA shall schedule and perform random audits of purchases;

(5) if requested, the eligible recipient must provide verification of the purchase to the FMA within three business days.

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

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

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

(3) Any revisions requested for other than critical health or safety reasons within 60 calendar days of expiration of the SSP and AAB are subject to denial for that reason.

[8.314.6.17 NMAC - Rp, 8.314.6.17 NMAC, 10-15-12; A, 6-28-13]

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

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

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

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

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

[8.314.6.18 NMAC - Rp, 8.314.6.18 NMAC, 10-15-12; A, 6-28-13]

8.314.6.19 REIMBURSEMENT:

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

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

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

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

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

(4) mi via eligible recipients and mi via service providers and vendors must follow all FMA billing instructions; and

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

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

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

[8.314.6.19 NMAC - Rp, 8.314.6.19 NMAC, 10-15-12]

8.314.6.20 RIGHT TO A HEARING:

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

(1) when a mi via applicant has been determined not to meet the LOC requirement for waiver services;

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

(3) when a mi via applicant is denied the services of his/her choice or the provider of his/her choice;

(4) when a mi via eligible recipient's services are denied, suspended, reduced or terminated;

(5) when a mi via eligible recipient has been involuntarily terminated from the program;

(6) when a mi via eligible recipient's request for a budget adjustment has been denied.

B. DOH and its counsel, if necessary, shall participate in any fair hearing involving a DD or MF eligible recipient, or an eligible recipient diagnosed with AIDS. HSD/MAD, and its counsel, if necessary, may participate in fair hearings.

[8.314.6.20 NMAC - Rp, 8.314.6.20 NMAC, 10-15-12]

8.314.6.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to eligible recipients who request a hearing within 13 calendar days of the notice. The notice will include information on the right to continued benefits and on the eligible recipient's responsibility for repayment if the hearing decision is not in the eligible recipient's favor.

B. Once the eligible recipient requests a continuation of benefits, his/her current AAB and SSP at the time of the request is termed a 'continuation of benefits'. The continuation budget may not be revised until the

conclusion of the fair hearing process unless one of the criteria to modify the budget in Paragraph (3) of Subsection F of 8.314.6.17 NMAC is met.
[8.314.6.21 NMAC - Rp, 8.314.6.21 NMAC, 10-15-12]

8.314.6.22 GRIEVANCE/COMPLAINT SYSTEM: HSD/MAD and DOH operate a grievance/complaint system that affords eligible recipients the opportunity to register grievances or complaints concerning the provision of services under the mi via program. HSD/MAD administers the grievance/complaint process for eligible recipient's in the mi via NF LOC waiver who are brain injured or disabled or elderly. DOH administers the grievance/complaint process for eligible recipients in the ICF/IID level of care (LOC) waiver and for eligible recipients in the AIDS program who are in the NF LOC waiver. Eligible recipients may register complaints with either department via e-mail, mail or phone. Complaints will be referred to the appropriate department for resolution. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing.

A. A grievance or complaint is required to be addressed within 30 calendar days from the date it was received.

B. Upon receipt of the grievance or complaint, DOH or HSD/MAD enters it into the complaint tracker and informs the contractor or provider of the grievance or complaint. DOH or HSD/MAD notifies the eligible recipient within one day of receipt of the grievance or complaint who will be responsible for resolution of the grievance or complaint.

C. DOH or HSD/MAD gives the contractor or provider 14 calendar days to resolve the grievance or complaint. If the grievance or complaint contains an issue that may compromise the health or safety of the participant, DOH or HSD/MAD remains involved with the parties until the grievance or complaint is resolved

D. The contractor or provider shall notify DOH or HSD/MAD of their progress toward resolution of the grievance or complaint. If the grievance or complaint has not been resolved in 14 calendar days, DOH or HSD/MAD becomes involved to ensure that an initial response is issued within 30 calendar days of receipt of the grievance or complaint.
[8.314.6.22 NMAC - Rp, 8.314.6.22 NMAC, 10-15-12; A, 6-28-13]

History of 8.314.6 NMAC:

History of Repealed Material:
8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, filed 11-16-2006 - Repealed effective 4-1-2011
8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, filed 3-15-2011 - Repealed effective 10-15-2012.