

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, 3/1/2016]

8.314.6.2 SCOPE: The rule applies to the general public.
[8.314.6.2 NMAC - Rp, 8.314.6.2 NMAC, 3/1/2016]

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 Titles XI, XIX, and XXI of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978.
[8.314.6.3 NMAC - Rp, 8.314.6.3 NMAC, 3/1/2016]

8.314.6.4 DURATION: Permanent.
[8.314.6.4 NMAC - Rp, 8.314.6.4 NMAC, 3/1/2016]

8.314.6.5 EFFECTIVE DATE: March 1, 2016, unless a later date is cited at the end of a section.
[8.314.6.5 NMAC - Rp, 8.314.6.5 NMAC, 3/1/2016]

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 (MAP).
[8.314.6.6 NMAC - Rp, 8.314.6.6 NMAC, 3/1/2016]

8.314.6.7 DEFINITIONS:

A. 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 services and the cost of goods approved by the TPA. Once approved, this is the AAB.

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

C. Category of eligibility (COE): To qualify for medical assistance program (MAP) services, an applicant must meet financial criteria and belong to one of the groups that the New Mexico medical assistance division (MAD) has defined as eligible. An eligible recipient in the mi via program must belong to one of the MAP categories of eligibility (COE) described in 8.314.6.13 NMAC.

D. Centers for medicare and medicaid services (CMS): Federal agency within the United States department of health (DOH) and human services that works in partnership with New Mexico to administer medicaid and MAP services under HSD.

E. Consultant provider: An agency or an individual that provides consultant and support guide services to the eligible recipient that assist the eligible recipient (or the eligible recipient's family, personal representative or the authorized representative, as appropriate) in arranging for, directing and managing mi via services and supports, as well as developing, implementing and monitoring the service and support plan (SSP) and AAB.

F. Eligible recipient: An applicant meeting the financial and medical level of care (LOC) criteria who is approved to receive MAD services through the mi via program.

G. 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 is required to have an EOR when he or she utilizes employees for mi via services. An eligible recipient may be his or her own EOR unless the eligible recipient is a minor, or has a plenary or limited guardianship or conservatorship over financial matters in place. An eligible recipient may also designate an individual of his or her choice to serve as the EOR, subject to the EOR meeting the qualifications specified in this rule. A power of attorney (POA) or other legal instrument may not be used to assign the EOR responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR as designated in this rule.

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

I. Home and community-based services (HCBS) waiver: A set of MAD services that provides alternatives to long-term care services in institutional settings, such as the mi via waiver program. CMS waives certain statutory requirements of the Social Security Act to allow HSD to provide an array of community-based options through these waiver programs.

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

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

L. Legally responsible individual (LRI): A person who has a duty under state law to care for another person. This category typically includes: the parent (biological, legal, or adoptive) of a minor child, or a guardian who must provide care to an eligible recipient under 18 years of age or the spouse of an eligible recipient.

M. Level of care (LOC): The level of care an eligible recipient must meet to be eligible for the mi via program.

N. 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.

O. Personal representative: The eligible recipient may select an individual to act as his or her personal representative for the purpose of offering support and assisting the eligible recipient understand his or her mi via services. The eligible recipient does not need a legal relationship with his or her personal representative. The personal representative will not have the authority to direct the member's mi via waiver services or make decisions on behalf of the eligible recipient. Directing services remains the sole responsibility of the eligible recipient or his or her authorized representative. The personal representative cannot serve as the eligible recipient's consultant and cannot approve his or her specific timesheet.

P. Reconsideration: An eligible recipient who disagrees with a clinical or medical utilization review decision or action may submit a written request to the third-party assessor for reconsideration of its decision. The eligible recipient or his or her authorized representative may submit the request for a reconsideration through the consultant or the consultant agency or may submit the request directly to MAD.

Q. Self-direction: The process applied to the service delivery system wherein the eligible recipient identifies, accesses and manages the services (among the MAD approved mi via 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.

R. Service and support plan (SSP): A plan that includes mi via services that meet the eligible recipient's needs that include: the projected amount, the frequency and the duration of the services; the type of provider who will furnish each service; other services the eligible recipient will access; and the eligible recipient's available supports that will compliment mi via services in meeting his or her needs.

S. 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 or vendor functions or with other aspects of implementing his or her SSP.

T. Third-party assessor (TPA): The MAD 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 mi via services.

U. Waiver: A program in which the CMS has waived certain statutory requirements of the Social Security Act to allow states to provide an array of HCBS 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, 3/1/2016; A, 11/1/2018]

8.314.6.8 [RESERVED]

[8.314.6.8 NMAC - Rp, 8.314.6.8 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.9 MI VIA HOME AND COMMUNITY-BASED SERVICES WAIVER:

A. New Mexico's medicaid 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 developmental disabilities (DD), or medically fragile (MF) conditions. (See 42 CFR 441.300.)

B. The mi via program is for an eligible recipient who meets the LOC otherwise provided in an ICF/IID.

(1) DOH, at the direction of MAD, is responsible for the daily administration of the mi via program.

(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, 3/1/2016]

8.314.6.10 MI VIA CONTRACTED ENTITIES AND PROVIDERS SUPPORTING SELF-DIRECTED

SERVICES: Services are to be provided in the least restrictive manner. HSD does not allow for the use of any restraints, restrictive interventions, or seclusions to an eligible mi via recipient. 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 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 a LOC assessment, assigning the applicable IBA, approving the SSP and authorizing an eligible recipient's annual budget in accordance with 8.314.6 NMAC and the mi via service standards. The TPA:

(1) determines medical eligibility using the LOC criteria in 8.314.6.13 NMAC; determinations are done initially for an eligible recipient who is newly enrolled in the mi via program 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 or her home, a location agreed upon by the eligible recipient and TPA and approved by HSD, 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 medical condition or LOC has changed;

(2) applies the information from the LOC documentation and the following assessments: long-term care assessment abstract (ICF/IID), the comprehensive individual assessment (CIA), or other MAD approved assessment tools, as appropriate for the COE, to assign the IBA for the eligible recipient that is 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 8.314.6 NMAC and mi via 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 there is eligible recipient and program compliance with state and federal employment requirements, monitors, and makes available to the eligible recipient the 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 recipient is 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 8.314.6 NMAC and mi via 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 recipient 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 or her consultant, and quarterly and annual documentation of expenditures to MAD;
 - (6) receive and verify employee and vendor 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 recipient and solve problems related to the FMA's responsibilities; and
 - (9) report to the consultant provider, MAD and DOH any concerns related to the health and safety of an eligible recipient or if the eligible recipient is not following the approved SSP and AAB.
- [8.314.6.10 NMAC - Rp, 8.314.6.10 NMAC, 3/1/2016; A, 11/1/2018]

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 or direct support worker, a provider agency, (excluding consultant providers which are covered in a different subsection) or a vendor, including those that provide professional services, each individual or entity must meet the general and service specific qualifications set forth in this rule initially and continually meet licensure requirements as applicable, and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the FMA. The provider agency is responsible to ensure that all agency employees meet the required qualifications. In order to be an authorized provider for the mi via program and receive payment for delivered services, the provider must complete and sign an employee or vendor provider agreement and all required tax documents. Individual employees may not provide more than 40 hours of services in a consecutive seven-day work week. The provider must have credentials verified by the eligible recipient or the EOR and the FMA.

(1) Prior to rendering services to an eligible mi via recipient as an independent contractor for homemaker or direct support worker, respite, community direct support, employment supports, and in-home living support provider, an individual seeking to provide these services must complete and submit a nature of services questionnaire to the FMA. The FMA will determine, based on the nature of services questionnaire if the relationship is that of an employee or an independent contractor.

(2) An authorized consultant provider must have a MAD approved provider participation agreement (PPA) and the appropriate approved DOH developmental disabilities division (DDSD) agreement.

B. General qualifications:

(1) Individual employees, independent providers, including non-licensed homemaker/direct support workers 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) prior to the initial hire and every three years after initial hire pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC; additionally employees must pass the employee abuse registry (EAR) pursuant to 7.1.12 NMAC, certified nurse aide registry pursuant to 16-12.20 NMAC, office of inspector exclusion list pursuant to section 1128B(f) of the Social Security Act; and the national sex offender registry pursuant to 6201 as federal authority for active programs.
- (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 or her authorized 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 its service standards.

(2) Vendors, including those providing professional services shall meet the following qualifications:

- (a) shall be qualified to provide the service;
- (b) shall possess a valid business license, if applicable;
- (c) meet financial solvency, maintain and adhere to training requirements, record management, quality assurance policy and procedures, if applicable;
- (d) be in good standing with and comply with his or her New Mexico practice board or other certification or licensing required to render mi via services in New Mexico; and
- (e) must not have a DOH current adverse action against them.
- (f) assure that employees of the vendor:
 - (i) are at least 18 years of age;
- (ii) are qualified to perform the service and demonstrate capacity to perform required tasks;
 - (iii) are able to communicate successfully with the eligible recipient;
 - (iv) pass a nationwide caregiver criminal history screening pursuant to Section 29-17-2 et seq. NMSA 1978 and 7.1.9 NMAC and an abuse registry screen pursuant to Section 27-7a-1 et seq. NMSA 1978 and 8.11.6 NMAC;
 - (v) complete training on critical incident, abuse, neglect, and exploitation reporting;
 - (vi) complete training specific to the eligible recipient's needs; an assessment of training needs is determined by the eligible recipient or his or her authorized 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 its service standards.

(3) Qualified and approved relatives, authorized representatives or personal representatives may be hired as employees and paid for the provision of mi via services (except consultant and support guides, customized community group supports services, transportation services for a minor, and individual directed goods and services). The services must be identified in the eligible recipient's approved SSP and AAB, and the EOR is responsible for verifying that services have been rendered by completing, signing, and submitting documentation, including the timesheet, to the FMA. These services must be provided within the limits of the approved SSP and AAB and may not be paid in excess of 40 hours in a consecutive seven-day work week. LRIs, authorized representatives, personal representatives or relatives may not be both a paid employee for the eligible recipient and serve as the eligible recipient's EOR. An authorized or personal representative who is also an employee may not approve his or her own timesheet.

(4) A LRI may be hired and paid for provision of mi via services (except transportation services when requested for a minor, a consultant and support guide, and customized community group supports services, and related goods) under extraordinary circumstances (i) in order to assure the health and welfare of the eligible recipient and (ii) to avoid institutionalization when approved by DOH. MAD must be able to receive federal financial participation (FFP) for the services.

(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 mi via 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) A LRI who is a service provider must comply with the following:

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

(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 DOH when a provider is chosen who is:

(i) a parent or legal guardian of an eligible recipient who is a minor; or

(ii) the eligible recipient's spouse.

(f) 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 EOR's or authorized representatives are responsible for ensuring that providers, vendors and contractors have received these materials and for updating them as new materials are received from MAD and DOH. MAD makes available on its website, and in hard copy format, information necessary to participate in medical assistance programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. DOH makes available on its website information, instructions and guidance on its administrative requirements for the mi via program. When enrolled, an eligible recipient or his or her authorized representative, or the provider, vendor or contractor receives instruction on how to access these documents. It is the responsibility of the eligible recipient or authorized representative, or the 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 authorized representative, or the 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 employee of any type may be paid in excess of 40 hours within the established consecutive seven day 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 such as offering an eligible recipient or his or her authorized representative gratuities in the form of entertainment, gifts, financial compensation to alter that eligible recipient's selection of provider agencies, service agreements, medication, supplies, goods or services.

(d) Those signing a payment request form for vendor services rendered to an eligible recipient may not serve as an employee, contractor or subcontractor of that vendor for that eligible recipient. An eligible recipient who does not have an authorized representative providing oversight of the eligible recipient's financial matters may sign off on the payment request form.

(6) The EOR is the individual responsible for directing the work of the eligible recipient's employees. An eligible recipient is required to have an EOR when utilizing employees. The EOR may be the eligible recipient or a designated qualified individual. A recipient through the use of the mi via EOR questionnaire will determine if an individual meets the requirements to serve as an EOR. The recipient's consultant will provide him or her with the questionnaire. The questionnaire shall be completed by the recipient with assistance from the consultant upon request. The consultant shall maintain a copy of the completed questionnaire in the recipient's file. When utilizing both vendors and employees, an EOR is required for oversight of employees and to sign payment request forms for vendors. The EOR must be documented with the FMA, whether the EOR is the eligible recipient or a designated qualified individual. A POA or other legal instrument may not be used to assign the EOR responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR as designated in 8.314.6 NMAC.

(a) An eligible recipient that has a plenary or limited guardianship or conservatorship over the eligible recipient's financial matters may not be his or her own EOR nor sign payment vendor request forms for vendors.

(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. Any out of state EOR residing beyond this radius who has been approved prior to the effective date of this rule may continue to serve as the EOR.

(d) The eligible recipient's provider may not also be his or her EOR nor sign payment vendor request forms for vendors.

(e) An EOR whose performance compromises the health, safety or welfare of the eligible recipient, may have his or 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, or subcontractor 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.

(g) An EOR is not required if an eligible recipient is utilizing only vendors for services; however, an EOR can be identified by an eligible recipient to assist with the use of vendors. In some instances an EOR for vendor services may be required by MAD. A recipient utilizing vendors only who selects not to have an EOR will submit documentation to the FMA identifying an authorized signer who will be responsible for signing payment request forms. The authorized signer for vendor services rendered to an eligible recipient may not serve as an employee, contractor or subcontractor of that vendor for that eligible recipient. An eligible recipient who does not have a plenary or limited guardianship or conservatorship providing oversight of the eligible recipient's financial matters may be his or her own authorized signer for the payment request form. A POA may not be used to assign the responsibilities of the authorized signer, in part or in full, to another individual and may not be used to circumvent the requirements of the authorized signer as designated in this rule.

(h) An EOR, or authorized signer, is required to complete and provide documents to the FMA according to the timelines and rules established by the state. Documents include, but are not limited to: vendor and employee enrollment agreements, vendor information forms, criminal background check forms, timesheets, payment request forms, invoices, and other documents needed by the FMA to enroll and process payment to employees and vendors. The mi via program requires that employee timesheets be submitted online unless the recipient has an approved exception from HSD.

C. Service specific qualifications for consultant services providers: In addition to general requirements, a consultant provider shall ensure that all individuals hired or contracted to provide consultant services meet the criteria specified in this section and comply with all applicable NMAC MAD rules and mi via 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 people living with disabilities; or

(b) have a minimum of six years of direct experience related to the delivery of social services to people living with disabilities; and

(c) be employed by an enrolled mi via consultant provider agency; and

(d) complete all required mi via program orientation and training courses; and

(e) be at least 21 years of age.

(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 rule;

(b) have experience working with 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; and

(g) be at least 18 years of age.

D. Service specific qualifications for personal plan facilitation providers: In addition to general MAD 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 mentored 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 MAD 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:** Provider agencies must be homemaker agencies certified by the MAD or its designee or a home health agency holding a New Mexico home health agency license. A homemaker and home health agency 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 or 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 (RN) 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 in-home living supports providers:** Provider agencies must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. In-home living agency staff and its direct staff rendering the service must have one year of experience working with people with disabilities. In-home living support agencies must assure appropriate staff for a 24 hour response capability to address scheduled or unpredictable needs related to health, safety, or security in order to meet the needs of the recipient. In-home living support agencies are not fiscal intermediaries and cannot bill nor be paid for work that the recipient or EOR are responsible for as required by Paragraph (6) of Subsection B of 8.314.6.11 NMAC and the mi via service standards.

F. Service specific qualifications for community membership support providers: In addition to general MAD requirements, the following types of providers must meet additional qualifications specific to the type of services provided. An agency providing community membership 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) A job developer, whether an agency or individual provider, must:
- (i) be at least 21 years of age;
 - (ii) pass criminal background check and abuse registry screen;
 - (iii) have experience developing and using job and task analyses;
 - (iv) have experience 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, local businesses, retired executives, DDSD resources, and have substantial knowledge of the Americans with Disabilities Act (ADA); and

- (v) complete training on critical incident, abuse, neglect, and exploitation.
- (b) Job coaches whether an agency or individual provider, must:
- (i) be at least 18 years of age;
 - (ii) have a high school diploma or GED;
 - (iii) pass criminal background check and abuse registry screen;
 - (iv) be qualified to perform the service;
 - (v) have experience with providing employment supports and training
- methods;
- (vi) be knowledgeable about business and employment resources;

(vii) have the ability to successfully communicate with the employer and with the eligible recipient and his or her coworkers to develop and encourage natural supports on the job; and
(viii) complete training on critical incident, abuse, neglect, and exploitation.

(2) **Qualifications of customized community group supports providers:** Agencies providing community group support services must hold a current business license, and meet financial solvency, training, records management, and quality assurance rules and requirements. Providers, whether an agency staff or an individual provider must meet the following qualifications:

(i) must be at least 18 years of age;
(ii) pass criminal background check and abuse registry screen;
(iii) demonstrate capacity to perform required tasks;
(iv) complete training on critical incident, abuse, neglect, and exploitation reporting; and

(v) have the ability to successfully communicate with the eligible recipient.

G. Service specific qualifications for providers of health and wellness supports: In addition to the general MAD 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, physical therapy assistants and occupational therapy assistants must possess a therapy license in their respective field from the New Mexico regulation and licensing department (RLD). Speech clinical fellows must possess a clinical fellow license from the New Mexico RLD.

(2) **Qualifications of behavior support consultation providers:** Behavior support consultation provider agencies shall have a current business license issued by the state, county or city government, if required. Behavior support consultation provider agencies shall comply with all applicable federal, state, and rules and procedures regarding behavior consultation. Providers of behavior support consultation services must possess qualifications in at least one of the following areas:

(a) a licensed psychiatrist by his or her New Mexico practice board;
(b) a regulation and licensing department (RLD) licensed clinical psychologist;
(c) a RLD licensed psychologist associate, (masters or Ph.D. level);
(d) a RLD licensed independent social worker (LISW);
(e) a RLD licensed master social worker (LMSW);
(f) a RLD licensed professional clinical counselor (LPCC);
(g) a licensed clinical nurse specialist (CNS) or a certified nurse practitioner (CNP) who is certified in psychiatric nursing by a national nursing organization who can furnish services to adults or children as his or her certification permits;

(h) a RLD licensed marriage and family therapist (LMFT); or
(i) a RLD licensed practicing art therapist (LPAT) by RLD.

(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 and licensed by the RLD, (Nutrition and Dietetics Practice Act Section 61-7A-7 et seq. NMSA 1978).

(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, (Sections 61-3-14 and 61-3-18 NMSA 1978).

(5) **Qualifications of specialized therapy providers:** For each type of specialized therapy providers, the provider must hold the appropriate New Mexico licensure or certification for the services he or she renders to an eligible recipient:

(a) a RLD license in acupuncture and oriental medicine;
(b) a license or certification with the appropriate specialized training and clinical experience and supervision whose scope of practice includes biofeedback;
(c) a RLD license in chiropractic medicine;
(d) a license or certification for which he or she has appropriate specialized training and clinical experience and whose scope of practice includes cognitive rehabilitation therapy;
(e) a RLD license in a physical therapy, or occupational therapy, or speech therapy and whose scope of practice includes hippotherapy with the appropriate specialized training and experience;
(f) a RLD license in massage therapy;
(g) a RLD license in naprapathic medicine;

(h) a master's or a higher level behavioral health degree with specialized play therapy training, clinical experience and supervision and whose RLD license's scope of practice includes play therapy; and

(i) a native American healer who is recognized as a traditional healer within his or her community.

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

(1) Qualifications of transportation providers:

(a) Individual transportation providers must:

(i) possess a valid New Mexico driver's license with the appropriate classification;

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

(iii) have a current insurance policy and vehicle registration.

(b) Transportation vendors must hold a current business license and tax identification number. Each agency will ensure any vehicle used to transport an eligible recipient is equipped with an up-to-date first aid kit. Each agency will ensure transportation drivers meet the following qualifications:

(i) holds a valid New Mexico driver's license of the appropriate classification to transport an eligible recipient;

(ii) holds a current vehicle insurance policy meeting New Mexico's insurance mandates in place for the vehicle used to transport an eligible recipient; and

(iii) holds a New Mexico vehicle registration for the vehicle used to transport an eligible recipient.

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

(3) **Qualifications of respite providers:** Respite services may be provided by eligible individual respite providers; RN or practical nurses (LPN); or respite provider agencies. Individual RN or LPN providers must be licensed by the New Mexico 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 individual directed goods and services vendors:** Individual directed goods and services vendors must hold a current business license and tax identification for New Mexico and the federal government. Vendors for individual directed goods and services are retail stores, community health centers, or medical supply stores.

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

[8.314.6.11 NMAC - Rp, 8.314.6.11 NMAC, 3/1/2016; A, 11/1/2018]

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 NMAC MAD 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, as detailed in applicable NMAC MAD provider rules 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 PPA requirements and NMAC MAD rules and requirements, including but not limited to 8.310.2 NMAC and 8.321.2 NMAC and 8.302.1 NMAC.

[8.314.6.12 NMAC - Rp, 8.314.6.12 NMAC, 3/1/2016]

8.314.6.13 ELIGIBILITY REQUIREMENTS FOR RECIPIENT ENROLLMENT IN MI VIA:

Enrollment in the mi via program is contingent upon the applicant meeting the eligibility requirements as described in this rule, 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, DOH

will offer the opportunity to eligible recipients to select mi via. Once an allocation has been offered to the applicant, he or she must meet certain medical and financial criteria in order to qualify for mi via enrollment located in 8.290.400 NMAC. The eligible recipient must meet the LOC required for admittance to an ICF-IID. After initial eligibility has been established for a recipient, on-going eligibility must be determined on an annual basis. [8.314.6.13 NMAC - Rp, 8.314.6.13 NMAC, 3/1/2016]

8.314.6.14 ELIGIBLE RECIPIENT AND EOR RESPONSIBILITIES: Mi via eligible recipients have certain responsibilities to participate in the program. 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, or authorized signer if the recipient has vendors only, have the following responsibilities:

A. To maintain eligibility the 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, or in a location approved by the state and seek assistance with the application and the recertification process as needed from a mi via consultant.

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

(1) comply with applicable NMAC rules to include this rule, mi via service standards and requirements 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 applicable NMAC rules to include this rule and service standards;

(4) use mi via program 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 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;

- (13) keep track of all budget expenditures and assure that all expenditures are within the AAB;
- (14) have monthly contact and meet face-to-face quarterly with the consultant; and
- (15) have an EOR if utilizing employees for services; the eligible recipient may be his or her

own EOR unless the eligible recipient is a minor, or he or she has a plenary or limited guardianship or conservatorship over financial matters; 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. If the recipient is using vendors only and selects not to have an EOR then the recipient will identify an authorized signer for payment request forms; the eligible recipient may be his or her own authorized signer unless the eligible recipient is a minor, or he or she has a plenary or limited guardianship or conservatorship over financial matters. A POA or other legal instrument may not be used to assign the EOR, or authorized signer, responsibilities, in part or in full, to another individual and may not be used to circumvent the requirements of the EOR, or authorized signer, as designated in this rule.

C. Additional responsibilities of the eligible recipient or EOR, or authorized signer, are detailed below:

(1) Submit all required documents to the FMA according to the timelines and rules established by the state 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. The EOR is responsible for submitting mi via employee timesheets online unless the recipient has an approved exception from HSD.

(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 for at least six years from first date of service and ongoing.

D. **Voluntary termination:** An eligible recipient has a choice of receiving services through the non-self-directed waiver or through the mi via HCBS waiver. If the eligible recipient wishes to change to the non-self-directed HCBS waiver, a waiver change must occur in accordance with the mi via NMAC rule and mi via service standards. Transitions can only occur at the first of a month.

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

(1) The eligible recipient refuses to comply with this rule and mi via service standards 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 or 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 mi via program. Examples include but are not limited to the following.

(a) The eligible recipient refuses to include and maintain services in his or her SSP and AAB that would address health and safety issues identified in his or 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 contractor's recommendations into his or her SSP and AAB.

(c) The eligible recipient exhibits behaviors which endanger himself or 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) When DOH is notified the eligible recipient continues to utilize either an employee or a vendor, or both who have consistently been substantiated against for abuse, neglect, exploitation while providing mi via services after notification of this on multiple occasions by DOH.

(6) The eligible recipient who is involuntarily terminated from the mi via program will be offered a non self-directed waiver alternative. If transfer to another waiver is authorized and accepted by the eligible recipient, he or 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 case manager

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, 3/1/2016; A, 11/1/2018]

8.314.6.15 SERVICE DESCRIPTIONS AND COVERAGE CRITERIA: The services covered by the mi via program 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's qualifying condition. The mi via program is the payor of last resort. The coverage of mi via services must be in accordance with 8.314.6 NMAC and mi via service standards. Waiver recipients in all living arrangements are assessed individually and service plan development is individualized. The TPA will assess the service plans of recipients living in the same residence to determine whether or not there are services that are common to more than one recipient living in the same household in order to determine whether one or more employees may be needed to ensure that individual different cognitive, clinical, and habilitative needs are met. Mi via services must be provided in integrated settings and facilitate full access to the community; ensure the recipient receives services in the community to the same degree of access as those individuals not receiving HCBS services; maximize independence in making life choices; be chosen by the recipient in consultation with the guardian as applicable; ensure the right to privacy, dignity, respect, and freedom from coercion and restraint; optimize recipient initiative, autonomy and independence in making life choices; provide an opportunity to seek competitive employment; and facilitate choice of service and who provides them.

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 and enrollment services: Consultant pre-eligibility and enrollment services are intended to provide information, support, guidance, and assistance to an individual 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 program services is offered to an individual, he or 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 offers pre-eligibility and enrollment services as well as on-going consultant services. Once the individual is determined to be eligible for mi via services, the consultant service provider will continue to render 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 or 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 or 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 their mi via services.

(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 face-to-face with the eligible recipient at least quarterly; one visit must be conducted in the eligible recipient's home at least annually. During monthly contact the consultant:

- (a) reviews the eligible recipient's access to services and whether they were furnished per the SSP;
- (b) reviews the eligible recipient's exercise of free choice of provider;
- (c) reviews whether services are meeting the eligible recipient's needs;
- (d) reviews whether the eligible recipient is receiving access to non-waiver services per the SSP;
- (e) reviews activities conducted by the support guide, if utilized;
- (f) documents changes in status;

- (g) monitors the use and effectiveness of the emergency back-up plan;
- (h) documents and provides follow up, if necessary, if challenging events occur that prevent the implementation of the SSP;
- (i) assesses for suspected abuse, neglect, or exploitation and report accordingly; if not reported, takes remedial action to ensure correct reporting;
- (j) documents progress of any time sensitive activities outlined in the SSP;
- (k) determines if health and safety issues are being addressed appropriately; and
- (l) discusses budget utilization concerns.

(2) 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 emergency backup plan;
- (c) review SSP and 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 sections of the 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, including but not limited to complaints, eligibility issues, and health and safety issues, raised by the eligible recipient, authorized representative or personal representative.

(3) **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.

(4) **Critical incident management responsibilities and reporting requirements:** The consultant provider shall report incidents of abuse, neglect, exploitation, suspicious injury, environmental hazards, and eligible recipient death as directed by the appropriate state agency(ies). The consultant provider shall provide training to eligible recipients EOR, authorized representatives or other designated individuals regarding recognizing and reporting critical incidents. Critical incidents include abuse, neglect, exploitation, suspicious injury, environmental hazards and eligible recipient deaths. 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 eligible recipient to help ensure health and safety when a critical incident has occurred. Critical incident reporting requirements for mi via eligible recipients who have been designated with an ICF/IID LOC, critical incidents should be directed in the following manner.

(a) DOH triages, and investigates all reports of alleged abuse, neglect, exploitation, suspicious injury, environmental hazards, and eligible recipient deaths for mi via services and eligible recipients to include expected and unexpected deaths. The reporting of these critical incidents is mandated for all those providing mi via services pursuant to 7.1.14 NMAC. Any critical incidents must be reported to the children, youth and families department (CYFD) child protective services (CPS) or the DOH division of health improvement (DHI) incident management bureau (IMB) for eligible recipients under 18 years. For eligible recipient's 18 years and older, IMB is contacted to report any critical incidents. The reporter must then fax DHI the abuse, neglect and exploitation or report of death form within 24 hours of a verbal report. If the reporter has internet access, the report form shall be submitted via DHI's website. 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.

(b) With respect to mi via services provided by any employee, contractor, vendor or other community-based waiver service agency having a provider agreement with DOH, any suspected abuse, neglect, exploitation, suspicious injury, environmental hazard, eligible recipient death must be reported to the CYFD/CPS or DOH/DHI/IMB for the eligible recipient under 18 years or to IMB for eligible recipients age 18 years or older. See Sections 27-7-14 through 27-7-31 NMSA 1978 (Adult Protective Services Act) and in Sections 32A-4-1 through 32A-4-34 NMSA 1978 (Child Abuse and Neglect Act).

(5) **Conflict of interest:** An eligible recipient's consultant may not serve as the eligible recipient's EOR, authorized representative or personal representative for whom he or she is the consultant. A consultant may not be paid for any other services utilized by the eligible recipient for whom he or she is the consultant, whether as an employee of the eligible recipient, a vendor, an employee or subcontractor of an agency. A consultant may not provide any other paid mi via services to an eligible recipient unless the recipient is receiving consultant services from another agency. The consultant agency may not provide any other direct services for an eligible recipient that has an approved SSP, an approved budget, and is actively receiving services in the mi via

program. The consultant agency may not employ as a consultant any immediate family member or guardian for an eligible recipient of the mi via program that is served by the consultant agency. A consultant agency may not provide guardianship services to an eligible recipient receiving consultant services from that same agency. The consultant agency may not provide any direct support services through any other type of 1915 (c) Home and Community Based Waiver Program. A consultant agency shall not engage in any activities in their capacity as a provider of services to an eligible recipient that may be a conflict of interest. As such a consultant agency shall not hold a business or financial interest in an affiliated agency that is paid to provide direct care for any individuals receiving mi via services. An affiliated agency is defined as a direct service agency providing mi via services that has a marital, domestic partner, blood, business interest or holds financial interest in providing direct care for individuals receiving mi via services. Affiliated agencies must not hold a business or financial interest in any entity that is paid to provide direct care for any individuals receiving HCBS services. Any direct service agency or consultant agency that has been referred to the DOH internal review committee (IRC) or is on a moratorium will not be approved to provide mi via services.

D. Personal plan facilitation: Personal plan facilitation supports planning activities that may be used by the eligible recipient to develop his or 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 or her family (or authorized representative, or personal 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, his or her authorized representative, or personal representative, 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 eligible recipient 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 timelines.

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

E. Living supports: Living supports are provided in the individual's own home or in the community and may not be provided in residential facilities or agency owned homes.

(1) **Homemaker direct support services:** Homemaker direct support services are provided on an episodic or continuing basis to assist an eligible recipient 21 years and older with activities of daily living, performance of general household tasks, and enable the eligible recipient to accomplish tasks he or she would normally do for himself or herself if he or she did not have a disability. Homemaker direct support services are provided in the eligible recipient's own 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 for him or herself, the eligible recipient arranges for the needed training. Services are not intended to replace supports available from a primary caregiver. Personal care services are covered under the medicaid state plan as enhanced early and periodic screening, diagnostic and treatment (EPSDT) benefits for mi via eligible recipients under 21 years of age and are not to be included in an eligible recipient's AAB.

(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 in the eligible recipient's own home and outside the eligible recipient's home. Home health aide services under the waiver differ in nature, scope, supervisory arrangements, or provider type from home health aide services in the state plan. Home health aide services under the waiver provide total care

or assistance to a recipient in all activities of daily living in a manner that will promote an improved quality of life and a safe environment to support the recipient's independence and health needs in the home and in the community. Home health aide services can be provided on a long-term basis for the recipient's habilitative supports whereas, state plan home health aide services address acute conditions; the purpose of which is curative and restorative, with the goal of assisting the recipient to return to an optimum level of functioning and to facilitate timely discharge of the recipient to self-care or to care by his or her family. 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. Home health aides are supervised by a RN. Supervision must occur at least once every 60 calendar days in the eligible recipient's home and be in accordance with the New Mexico Nurse Practice Act, Section 61-3-4 et seq. NMSA 1978.

(3) In-home living supports: In-home living supports are related to the eligible recipient's qualifying condition or disability and enable him or her to live in his or her apartment or house. Services must be provided in the home or apartment owned or leased by the eligible recipient or in the eligible recipient's home, not to include homes or apartments owned by agency providers. Service coordination and nursing services are not included in this service.

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

(b) 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 and may be up to 24 hours per day as specified in the eligible recipient's SLRISP.

(c) Eligible recipients receiving in-home living supports may not use homemaker and direct support home health aide services or respite because they duplicate 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. This service does not include formal educational (including home schooling and tutoring related activities), or vocational services related to traditional academic subjects or vocational training.

(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 or her residence;

(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: The objective of employment supports services is to provide assistance that will result in community employment jobs for an eligible recipient which increases economic independence, self-reliance, social connections and the ability to grow within his or her career. Employment supports services are geared to place and support an eligible recipient with disabilities in competitive, integrated employment settings with non-disabled co-workers within the general workforce; or assist the eligible recipient in business ownership. Employment supports include job development and job coaching supports after available

vocational rehabilitation supports have been exhausted, including programs funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) to an eligible recipient. Employment Services are to be individualized to meet the needs of the recipient and not the needs of a group.

- (a) Job development is a service provided to an eligible recipient by a skilled individual. The service has several components:
- (i) conducting situational and or vocational assessments;
 - (ii) developing and identifying community based job opportunities that are in line with the eligible recipient's skills and interests;
 - (iii) supporting the eligible recipient in gainful skills or knowledge to advocate for his or herself in the workplace;
 - (iv) promoting career exploration for the eligible recipient based on interests within various careers through job sampling, job trials or other assessments as needed;
 - (v) arranging for or providing benefits counseling;
 - (vi) facilitating job accommodations and use of assistive technology such as communication devices for the eligible recipient's use;
 - (vii) providing job site analysis (matching workplace needs with those of the eligible recipient); and
 - (viii) assisting the eligible recipient in gaining or increasing job seeking skills (interview skills, resume writing, work ethics, etc.).
- (b) The job coach provides the following services:
- (i) training the eligible recipient to perform specific work tasks on the job;
 - (ii) vocational skill development to the eligible recipient;
 - (iii) employer consultation specific to the eligible recipient;
 - (iv) eligible recipient co-worker training;
 - (v) job site analysis for an eligible recipient;
 - (vi) education of the eligible recipient and co-workers on rights and responsibilities;
 - (vii) assistance with or utilization of community resources to develop a business plan if the eligible recipient elects to start his or her own business;
 - (viii) conduct market analysis and establish the infrastructure to support a business specific for the eligible recipient; and
 - (ix) increasing the eligible recipient's capacity to engage in meaningful and productive interpersonal interactions co-workers, supervisors and customers.
- (c) Employment supports will be provided by staff at current or potential work sites. When 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 the eligible recipient receiving mi via services as a result of his or her disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Federal financial participation (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 the eligible recipient's supported employment program; and
 - (iv) FFP cannot be claimed to defray expenses associated with an eligible recipient's start-up or operation of his or her business.

(3) **Customized community group supports:** Customized community group supports can include participation in congregate community day programs and community 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 group supports may include adult day habilitation programs, and other day support models. Customized community group supports are provided in integrated community settings such as day programs and community centers which can take place in non-institutional and non-residential settings. These services are available at least four or more hours per day one or more days per week. Service hours and days are specified in the eligible recipient's SSP.

G. Health and wellness:

(1) Extended skilled therapy for eligible recipients 21 years and older: Extended skilled therapy for adults may include physical therapy, occupational therapy or speech language therapy when skilled therapy services under the medicaid state plan are exhausted or are not a covered benefit. Eligible recipients 21 years and older in the mi via program access therapy services under the state medicaid 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 and older in the mi via program 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
- (iv) identify, implement, and train on therapeutic strategies to support the eligible recipient and his or 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 the eligible recipient 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 or 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 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) provide consultation on usage and training for augmentative communication devices;
- (iv) identify, implement and train therapeutic strategies to support the eligible recipient and his or 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, positive behavior support plan that is part of the eligible recipient's 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 or 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 support plans;
- (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 or her service and support providers in order for services to be provided in the least restrictive manner; HSD does not allow the use of any restraints, restrictive interventions, or seclusion to an eligible recipient.

(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 behavioral health 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 16.2.1 NMAC.

(b) **Biofeedback:** Biofeedback uses visual, auditory or other monitors to provide eligible recipients with 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 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 an eligible recipient's 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 an eligible recipient 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. An eligible recipient with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production. Hippotherapy must be performed by a RLD licensed physical therapist, occupational therapist, or speech therapist.

(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 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 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 or 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:** Payment for transportation is limited to the costs of transportation needed to access waiver services, activities, and resources identified in the recipient's SSP. 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. Non-medical transportation services enable recipients to gain access to waiver and non-medical community services, events, activities and resources as specified in the recipient's SSP related to community resources and services, work, volunteer sites, homes of local family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events. 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. Transportation services for minors cannot be provided by a LRI as these are services a LRI would ordinarily provide for household members of the same age who do not have a disability of chronic illness.

(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;

equipment;

- (b) training eligible recipients, caregivers and first responders on use of the
- (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 flexible family support service, the primary purpose of which is to provide intermittent support to the recipient and give the unpaid primary caregiver relief from his or her duties on a short-term basis. Respite is provided on a short-term basis to allow the recipient's primary unpaid caregiver a limited leave of absence in order to reduce stress, accommodate a caregiver illness, or meet a sudden family crisis or emergency. Services must only be provided on an intermittent or short-term basis because of the absence or need for relief of those persons normally providing care to the recipient. If there is a paid primary caregiver residing with the eligible recipient providing living supports or community membership supports, or both, respite services cannot be utilized. 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 or 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. Respite cannot be used for purposes of day-care nor can it be provided to school age children during school (including home school) hours.

(4) **Individual directed goods and services:** Individual directed goods and services are equipment, supplies or services, not otherwise provided through mi via, the medicaid state plan, or medicare. Individual directed goods and services must directly relate to the member's qualifying condition or disability. Individual directed goods and services must explicitly address a clinical, functional, medical, or habilitative need and:

- (a) Individual directed goods and services must address a need identified in the eligible recipient's SSP and meet the following requirements:
 - (i) supports the eligible recipient to remain in the community and reduces the risk for institutionalization; and
 - (ii) promote personal safety and health; and afford the eligible recipient an accommodation for greater independence; and
 - (iii) decrease the need for other medicaid services; and
 - (iv) accommodate the eligible recipient in managing his or her household or facilitate activities of daily living.

- (b) Individual directed goods and services must be documented in the SSP, comply with 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 individual directed good or service that is requested. If the eligible recipient requests a good or service, the consultant TPA and MAD can work with the eligible recipient to find other, including less costly, alternatives.

- (c) The individual directed goods and services must not be available through another source and the eligible recipient must not have the personal funds needed to purchase the goods or services.

- (d) These items are purchased from the eligible recipient's AAB and advance outcomes in the eligible recipient's SSP.

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

- (f) Services and goods that are recreational or diversional in nature are excluded. Recreational and diversional in nature is defined as inherently and characteristically related to activities done for enjoyment.

- (g) Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of federal financial participation (FFP) for waiver services.

(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) Singular or in combination of adaptations include:

- (i)** the installation of ramps;
- (ii)** widening of doorways and hallways;
- (iii)** installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;
- (iv)** installation of lifts or elevators; modifications of a bathroom facility, such as roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals, bidet adaptations and plumbing;
- (v)** turnaround space adaptations;
- (vi)** specialized accessibility and safety adaptations or additions;
- (vii)** trapeze and mobility tracks for home ceilings; automatic door openers and doorbells;
- (viii)** voice-activated, light-activated, motion-activated, and other such electronic devices;
- (ix)** fire safety adaptations;
- (x)** air filtering devices; heating and cooling adaptations;
- (xi)** glass substitute for windows and doors;
- (xii)** 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:

- (i)** ensure proper design criteria is addressed in the planning and design of the adaptation;
- (ii)** be a licensed and insured contractor or approved vendor that provides construction and remodeling services;
- (iii)** provide administrative and technical oversight of construction projects;
- (iv)** provide consultation to family members, mi via providers and contractors concerning environmental modification projects to the eligible recipient's residence; and
- (v)** 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 \$5,000 every five years. An eligible recipient transferring into the mi via program will carry his or her history for the previous five years of MAD reimbursed environmental modifications. 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, 3/1/2016; A, 11/1/2018]

8.314.6.16 NON-COVERED SERVICES: The waiver does not pay for the purchase of goods or services that a household without a person with a disability would be expected to pay for as a routine household or personal expense. 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; the TPA may verify that a good or service is not covered by another payor source by requesting a denial letter;

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

(1) including property-related costs, such as rental or purchase of real estate and furnishing, maintenance, utilities and utility deposits; and

(2) 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 8.310.2 NMAC;

F. home schooling materials or related supplemental materials and activities;

G. any goods or services that are considered recreational or diversional in nature as defined in Subparagraph (f) of Paragraph (4) of Subsection (H) of 8.314.6.15 NMAC including but not limited to tickets for movies, theatrical and musical performances, sporting events; zoos, or museums;

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, cell phone, health, life, burial, renters, home-owners, service warranties 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; mileage or driver time reimbursement for vacation travel by automobile;

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 adaptive clothing or accessories 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, including laptops or any electronic tablets, 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; an eligible recipient transferring into the mi via program will carry his or her history for the previous three years of MAD reimbursed consumer electronics;

X. cell phone services that include more than one cell phone line per eligible recipient; cell phone service, including cell phone service that includes data, is limited to the cost of one hundred dollars per month;

Y. dental services utilizing mi via individual budgetary allotments.

[8.314.6.16 NMAC - Rp, 8.314.6.16 NMAC, 3/1/2016; A, 11/1/2018]

8.314.6.17 SERVICE AND SUPPORT PLAN (SSP) AND AUTHORIZED ANNUAL BUDGET(AAB):

A SSP and an annual budget request are developed at least annually by the 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 eligible recipient, assisting the eligible recipient to understand the mi via

program, and with developing and implementing the SSP and the AAB. The SSP and annual budget request are developed and implemented as specified in 8.314.6 NMAC and mi via 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. This process 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 his or her SSP. If the eligible recipient 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, behavioral health, adaptive behavior skills, nutritional, functional, community/social and employment; LOC assessments are conducted in person and take place in the eligible recipient's home, or in a HSD approved location.

(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 or 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.

(2) Pre-planning:

(a) The consultant contacts the eligible recipient upon his or her choosing enrollment in the mi via program to provide information regarding this program, 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 re-determining 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 mi via services that are furnished to the 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 or 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 mi via services in meeting the needs of the eligible recipient;

(d) methods for coordination with the medicaid 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 or her qualifying condition or disability;

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

(h) methods to address the eligible recipient's health and safety, such as 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 his or her 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; a job description 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 emergency and back-up plans are complete; and

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

B. Individual budgetary allotment (IBA): Each eligible recipient's annual IBA is determined by MAD or its designee as follows.

(1) Budgetary allotments are based on calculations developed by MAD for each mi via population group, utilizing historical traditional waiver care plan authorized budgets within the population, minus the case management costs, and minus a ten percent discount.

(2) The determination of each 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) An 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 state and CMS approves a range of rates, as applicable, for mi via services wherein each recipient or EOR can self-direct and establish his or her own rate with a particular provider of a service. The current rate schedule is available on the HSD and DOH websites. Mi via recipients, or EORs, are required to negotiate and determine the rate for their employees and services within the range of rates established by the state. Justification for paying more than the established rates must be submitted, in writing, to the TPA for consideration. The established rate may not be exceeded in order to pay for additional services the employee or provider may provide which are outside the scope of the specific service for which the employee or provider is approved; nor can a rate exception be approved for credentials that exceed those required to provide the service unless the credentials specifically meet criteria below. To exceed the established range of rates the following criteria must be met:

(i) behavioral conditions: the recipient's behaviors are of a severity that pose considerable risk to the eligible recipient, caregivers or the community; and require a frequency and intensity of assistance to ensure the eligible recipient's health and safety in the home or the community or supervision or consultation requiring specialized or unique behavioral supports; these services cannot be accessed through other services; or

(ii) medical conditions: the recipient has ongoing need for intense medical supports including oxygen monitoring, diabetic monitoring, skin breakdown, J and G tube feedings, ostomy and urology care, catheter insertion, digital extractions, suctioning, nebulizer treatments, routine order treatments in the prevention of infections, and responsive awareness to severe allergic reactions; or

(iii) specialized supports: in order to support the recipient's inclusion in the community the recipient requires specialized support that can enhance communicative or functional skills such as american sign language or programming of adaptive communication devices; or

(iv) location: the recipient lives in a geographic location, within New Mexico, with limited providers. The recipient, or guardian, has researched multiple providers and has been unable to identify another provider in the geographic location available to provide the service within the range of rates. The service goal must specify the recipient's need for this service and contact with available local provider within six months of the date of request including reason why alternate providers are not available.

(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 must address the eligible recipient's clinical, functional, medical or rehabilitative needs; and
- (2) the services or goods must accommodate the eligible recipient in managing his or her household; or
- (3) the services or goods must facilitate activities of daily living; or
- (4) the services or goods must promote the eligible recipient's personal health and safety; and
- (5) the services or goods must afford the eligible recipient an accommodation for greater independence; and
- (6) the services or goods must support the eligible recipient to remain in the community and reduce his/her risk for institutionalization; and
- (7) the services or goods must be documented in the SSP and advance the desired outcomes in the eligible recipient's SSP; and
- (8) 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
- (9) the services or goods must decrease the need for other MAD services; and
- (10) the eligible recipient receiving the services or goods does not have the funds to purchase the services or goods; or
- (11) 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
- (12) the service or good is not prohibited by federal regulations, NMAC rules, billing instructions, standards, and manuals; and
- (13) each service or good must be listed as an individual line item whenever possible; however, when a service or a good 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 work week.

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., a 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-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 calendar days of expiration of the current SSP.

F. Modifications to the eligible recipient's 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 for the eligible recipient, budget revisions may not be submitted to the TPA for review within the last 60 calendar 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 or 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 or her consultant.

(3) Mi via budgets are developed by service. A recipient may request an increase to his or her budget above his or her annual IBA, or AAB, as applicable if services necessary for health and safety cannot be met within the IBA, or AAB. Prioritization, as described in Subparagraph (b) of Paragraph (3) of Subsection B of 8.314.6.17 NMAC applies. Requests for additional funding are built in the annual budget and are specific to the service that is being requested. If the eligible recipient requests an increase in his or her budget above his or her annual IBA, or AAB, as applicable, the eligible recipient must show at least one of the following four circumstances related to the specific service for which an increase to the additional funding is being requested:

(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; and 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; the eligible recipient must submit a written, dated, and signed evaluation or letter from a medical doctor (MD), doctor of osteopathy (DO), a certified nurse practitioner (CNP) or a physician assistant (PA) that documents the chronic physical condition in the eligible recipient's health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the chronic physical conditions 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; or 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 a 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; which require frequent and ongoing management or monitoring or oversight of medical technology;

(b) **change in physical status:** the eligible recipient has experienced a deterioration or permanent change in his or her health status such that the eligible recipient's needs for services and supports can no longer be met within the IBA, current AAB or other current resources, including natural supports, medicaid state plan services, medicare or other sources; the eligible recipient must submit a written, dated, and signed evaluation or letter from a MD, OD, CNP, or PA that documents the change in the eligible recipient's health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the eligible recipient may submit additional supportive documentation by others involved in the eligible recipient's care, such as a current individual service plan (ISP) 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; types of physical health status changes that may necessitate an increase in the IBA or current AAB are as follows:

(i) the eligible recipient now requires the administration of medications via intravenous or injections on a daily or weekly basis;

(ii) the eligible recipient has experienced recent onset or increase in aspiration of saliva, foods or liquids;

(iii) the eligible recipient now requires external feedings, e.g. naso-gastric, percutaneous endoscopic gastrostomy, gastric-tube or jejunostomy-tube;

(iv) the eligible recipient is newly dependent on a ventilator;

(v) the eligible recipient now requires suctioning every two hours, or more frequently, as needed;

(vi) the eligible recipient now has seizure activity that requires continuous monitoring for injury and aspiration, despite anti-convulsant therapy; or

(vii) the eligible recipient now requires increased assistance with activities of daily living as a result of a deterioration or permanent changes in his or her physical health status;

(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 or 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 or cognitive difficulties are so severe and intense that they result in considerable risk to the eligible recipient, caregivers or the community; and 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; in addition, these behaviors are likely to lead to incarceration or admission to a hospital, nursing facility or ICF-IID; require intensive intervention or medication management by a doctor or behavioral health practitioner or care practitioner which cannot be effectively addressed within the IBA, current AAB or other resources, including natural supports, the medicaid state plan services, medicare or other sources;

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

(ii) the eligible recipient must submit a written, dated, and signed evaluation or letter from a licensed MD, doctor of osteopathy (DO), CNP, physician assistant (PA), psychiatrist, or RLD licensed psychologist that documents the change in the eligible recipient's behavioral health status relevant to the criteria; the evaluation or letter must have been completed after the last LOC assessment or less than one year from the date the request is submitted, whichever is most recent; the eligible recipient may submit additional supportive documentation including a current ISP 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 intellectual or developmental disabilities, recent discharge plan, recent recommendations from a rehabilitation facility, any other relevant documentation or recent statements from family members, friends or other support individuals involved with the 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 or her natural supports, such as family members or other community resources that were providing direct care or services, whether paid or not. This absence of natural supports or other resources is expected to continue throughout the period for which supplemental funds are requested. The type, intensity or amount of care or services previously provided by natural supports or other resources cannot be acquired within the IBA and are not available through the medicaid state plan services, medicare, other programs or sources in order for the eligible recipient to live in a home and community-based setting.

(4) The 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 8.314.6 NMAC and its service standards, the eligible recipient is assisted by his or her consultant in development and implementation of the SSP and AAB. The FMA assists the eligible recipient with implementation of the AAB.

H. Submission for approval: The TPA must approve the SSP and associated annual budget request (resulting in an AAB). The TPA must approve certain changes in the SSP and annual budget request, as specified in 8.314.6 NMAC and mi via service standards and in accordance with 8.302.5 NMAC.

(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 seven working days from the date of the initial request to respond with additional documentation. The TPA will issue a second request for information on the seventh day if information was not received and issue a final request for information 14 working days after the initial request. The eligible recipient has a total of 21 working days to respond with 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, 3/1/2016; A, 11/1/2018]

8.314.6.18 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services, including services covered under the mi via program, are subject to utilization review for medical necessity and program requirements. Reviews by 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 8.310.2 NMAC.

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. Prior authorization of services does not guarantee that applicants or eligible recipients are eligible for MAP or mi via services.

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 reconsideration from the TPA that performed the initial review and issued the initial decision. Reconsideration must be requested within 30-calendar days of the date on the denial notice, 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 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, 3/1/2016]

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, employees, and vendors.

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

- (1) mi via service provider and vendor must enroll with the FMA;
- (2) the eligible recipient receives instructions and documentation forms necessary for a service provider's and a vendor's claims processing;
- (3) an eligible recipient must submit claims for payment of his or her mi via service provider and vendor to the FMA for processing; claims must be filed per the billing instructions provided by the FMA;
- (4) the eligible recipient and his or her mi via service provider and vendor must follow all FMA billing instructions; and
- (5) reimbursement of a mi via service provider and vendor is made at a predetermined reimbursement rate negotiated by the eligible recipient with the mi via service provider or vendor, approved by the TPA contractor, and documented in the SSP and in the mi via provider or vendor agreement; at no time can the total expenditure for services exceed the eligible recipient's AAB.

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

D. Reimbursement may not be made directly to the eligible recipient, either to reimburse him or 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, 3/1/2016]

8.314.6.20 RIGHT TO A HSD ADMINISTRATIVE HEARING:

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

- (1) when an applicant has been determined not to meet the LOC requirement for mi via program services;
- (2) when an applicant has not been given the choice of HCBS as an alternative to institutional care;
- (3) when an applicant is denied the services of his or her choice or the provider of his or her choice;
- (4) when an eligible recipient's services are denied, suspended, reduced or terminated;
- (5) when an eligible recipient has been involuntarily terminated from the program;
- (6) when an eligible recipient's request for a budget adjustment has been denied; and
- (7) when any other adverse action is taken by MAD against the eligible recipient, see 8.352.2 NMAC.

B. DOH and its counsel, if necessary, shall participate in any relevant HSD administrative hearing involving an eligible recipient. HSD's office of general counsel may elect to participate in the administrative hearing. See 8.352.2 NMAC for a complete description, instructions, and hearing process of a HSD administrative hearing for an eligible recipient.

[8.314.6.20 NMAC - Rp, 8.314.6.20 NMAC, 3/1/2016]

8.314.6.21 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to an eligible recipient who requests a HSD administrative hearing within the timeframe defined in 3.352.2 NMAC. The notice will include information on the right to continue the eligible recipient's benefits and on his or her responsibility for repayment if the HSD administrative final hearing decision is not in the eligible recipient's favor. See 8.352.2 NMAC for a complete description of the continuation of benefits process of a HSD administrative hearing for an eligible recipient.

B. The continuation of a benefit is only available to an eligible recipient that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the eligible recipient's current allocation, budget or LOC. The continuation budget may not be revised until the conclusion of the HSD administrative hearing process unless one of the criteria to modify the budget in 8.314.6.17 NMAC is met. See 8.352.2 NMAC for a complete description, instructions and process of a HSD administrative hearing and continuation of benefits process of a MAP eligible recipient.

[8.314.6.21 NMAC - Rp, 8.314.6.21 NMAC, 3/1/2016]

8.314.6.22 GRIEVANCE/COMPLAINT SYSTEM: An eligible recipient has the opportunity to register a grievance or complaint concerning the mi via program. An eligible recipient may register complaints with DOH via

e-mail, mail or phone. Complaints will be referred to the appropriate DOH division or as appropriate referred to MAD for resolution. The filing of a complaint or grievance does not preclude an eligible recipient from pursuing a HSD administrative hearing. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for requesting a HSD administrative hearing.
[8.314.6.22 NMAC - Rp, 8.314.6.22 NMAC, 3/1/2016]

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.

8.314.6 NMAC, Mi Via Home and Community-Based Services Waiver, filed 10/2/2012 - Repealed effective 3/1/2016.