



Consultant Guide

Department of Health
Developmental Disabilities Supports Division

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Introduction

Mi Via which means “my path”, “my way” or “my road” is the State’s self-directed Home and Community Based Services (HCBS) Waiver program. The goal of Mi Via is to provide a community based alternative to the services provided by institutions. The program mobilizes consultants to facilitate greater participant choice and direction of his or her services and goods. When participants are minor children or have cognitive impairments, the term “participant” also includes families (i.e. any relative and other legally and/or authorized decision-maker).

There are actually two (2) Mi Via waivers corresponding to the two (2) levels of care (LOC) served by the program: Nursing Facility (NF) Level of Care and ICF-MR Level of Care. The program is administered through a partnership between the Department of Health (DOH) and the Human Services Department (HSD). HSD also monitors and oversees the program operations of the two (2) Mi Via Waivers.

Mi Via is the result of the efforts of many individuals and groups statewide that sought to include self-direction as an option in New Mexico’s HCBS Waivers. Mi Via’s guiding principles are:

- All people have value and potential.
- People shall be viewed in terms of their abilities.
- People have the right to participate and be fully included in their communities.
- People have the right to live, work, learn and receive services and supports appropriate to their individual needs and in the most integrated settings within their communities.

Mi Via’s covered services address the participant’s qualifying condition in order for the participant to live at home and participate in the community as independently as possible. The array of services and supports are structured around key life areas: community living; community membership; health and wellness; and employment.

Consultants who are well versed in the philosophy and practice of self-direction are valuable in assisting participants in developing and implementing the Services and Support Plan (SSP). Participants’ easy access to information and navigation through the program is critical for a successful experience and program.

What is Self Direction?

Self direction is the application of the self determination movement in Medicaid funded programs. The Centers for Medicare and Medicaid Services defines self direction as:

Self-directed Medicaid services means that participants, or their representatives, if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports.

http://www.cms.gov/CommunityServices/60_SelfDirectedServices.asp

The Centers for Medicare and Medicaid Services (CMS) defines programs with the following elements as self directed:

- Person Centered Planning Process Service Plan Individualized Budget Information and Assistance in Support of Self Direction
- Quality Assurance and Improvement

Mi Via Agency Structure

Human Services Department (HSD)

HSD provides program oversight and operations. The department ensures that CMS guidelines and New Mexico regulations are followed. HSD manages the contract for the third party assessor (TPA) and for the fiscal management agency (FMA). HSD also operates the Mi Via Nursing Facility (NF) LOC Waiver for disabled and elderly (D&E) and brain injured participants .

Department of Health (DOH)

DOH holds and manages the agreements for consultant providers. DOH/DDSD operates the ICF-MR LOC Waiver serving persons with Developmental Disabilities and Medically Fragile conditions. DOH/PHD is responsible for the operation of the AIDS waiver under the Mi Via NF waiver.

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

See Appendix P. for State contact information.

Mi Via – Entity Roles

Consultant

- Provides program information and orientation;
- Assists participants with the eligibility process, planning and implementation with Service and Support Plans (SSPs) and Budgets; and
- Submits SSP and Budget paperwork to TPA.

Third Party Assessor (TPA)

- Schedules and completes face-to-face assessments;
- Reviews documentation to determine Level of Care (LOC);
- Approves or denies each participant's Service and Support Plan and Budget based on his/her needs; and
- Participates in all Fair Hearing/Appeal procedures.

See Appendix Q. for TPA contact information.

Financial Management Agent (FMA)

- Establishes the employer identification number (EIN) for participants;
- Credentials employees and vendors;
- Reviews employee/vendor agreements and approved SSP and Budget to appropriately pay services and goods within Medicaid regulations and program rules;
- Pays taxes and worker's compensation; and
- Tracks and reports spending and related data.

See Appendix R. for FMA contact information.

Consultant – TPA Roles

	Consultant	TPA
SSP & Budget	Provides guidance and community resources; submits to TPA per participant's instructions;	Reviews; approves or denies; requests additional information; requests administrative action;
Re-consideration	Enters Reconsideration in GCESonline; submits additional documentation obtained by participant	Reviews decision with <u>new</u> documentation
Fair Hearings (FHs)	May attend if requested	Prepares summary of evidence; attends all FHs; adjusts budget per FH decision
Employees/ Vendors	Assists with employer and provider enrollment process	Approves rates outside the range of rates
Environmental-Modifications	Provides guidance on process; submits request and paperwork on behalf of participant	Reviews documentation and makes a decision

Consultant – FMA Roles

	Consultant	FMA
SSP and Budget	Provides guidance and information on community resources; submits to TPA per participant's instructions;	Pays vendors and employees within guidelines of the approved SSP and Budget and agreements
Re-consideration	Enters reconsideration in <i>GCESonline</i> ; submits additional documentation obtained by participant	No Role
Fair Hearings (FHs)	May attend if requested	May attend as requested by the State; Facilitate payments won through FH
Employees/ Vendors	Assists with enrollment process	Credentials all employees and vendors; notify consultants when credentialed. Links to budget after credentialed by FMA.
Environmental-Modifications	Provides guidance on process; submits request and paperwork on behalf of participant	Credentials vendors and makes payments within guidelines of the approved budget
<i>GCESonline</i>	Accesses to monitor progress of SSP and budget implementation	Develops and maintains the system; Xerox call center assists or routes issues

Consultant – FMA Communication Plan

Consultant Agency

The consultant agency will contact the Xerox call center directly regarding the following GCESonline issues:

- Passwords
- Connectivity issues (CA will inform Xerox, DOH designate and HSD designate (FMA contract manager)

The consultant agency will contact the designated DOH Provider Agreement Liaison to coordinate the following:

- Set up system access levels or designations.
- Change system access level or designations.
- Consultant agency employee status changes.
- Completion of User Agreements and other required paperwork.

Mi Via Eligibility

Individuals must meet financial and medical eligibility on an annual basis. To meet financial eligibility, individuals must complete the financial eligibility forms provided by the local income support division (ISD) office. Individuals must also meet medical eligibility. Individuals entering the program through the Colts C Waiver and the AIDS Waiver must meet nursing facility (NF) LOC. Individuals that enter the program through the Developmental Disabilities and Medically Fragile Waivers must meet the ICF/MR LOC. Consultants need to be aware of the eligibility processes to advise participants of submission timelines.

Population	COE #	LOC	Operating Agency
AIDS	090	NF	DOH
Brain Injury	092	NF	HSD
CoLTS (formerly Disabled & Elderly)	091, 093, 094	NF	HSD
Developmental Disabilities	096	ICF/MR	DOH
Medically Fragile	095	ICF/MR	DOH

Population	Medical Assessments
AIDS	HIV-AIDS Assessment Tool Comprehensive Individual Assessment (CIA) Current physical and medical/clinical history
BI	ICD form (initial assessment only – year 1) Universal Assessment Tool (UAT) Current physical and medical/clinical history (H&P) Long Term Care Medical Assessment (Abstract)
DD	Abstract History and Physical (H&P) Norm-referenced Adaptive Behavior Scale (ABS or Vineland) CIA Current physical and medical/clinical history
D&E	Comprehensive Individual Assessment (CIA) Current physical and medical/clinical history (H&P) Long Term Care Medical Assessment (Abstract)
MF	Comprehensive Family Centered Review Current physical and medical/clinical history

What Consultants/Support Guides Can Do to Help Participants Navigate HSD/ISD:

1. Understand the requirements for eligibility
 - Application required for initial eligibility determination and annually
 - Determination of disability as per the Social Security Administration's definition, if the person is a Supplemental Security Income (SSI) recipient, he/she meets the SSA definition of disability
 - If the person isn't a current SSI recipient, disability will have to be determined by the Disability Determination Contractor, current medical reports will be needed
 - Current Level of Care from TPA
 - Current bank statements, trust information, verification of income and resources
 - Income maximum \$2022/mo Resources \$2000
2. Use the same language as ISD, this reinforces what the client/parent/guardian hears from ISD and needs to do
3. Suggest the participant/parent/guardian start keeping a notebook for both a journal and a place to store medical reports, referrals, names of doctors, dates, treatments, facilities, internet research, etc.
4. Suggest the participant /parent/guardian keep a record and date of benefit programs they have applied for such as SSI or another waiver wait list.
5. Suggest the participant /parent/guardian keep a calendar not just for medical or family events but to include when the annual review of eligibility is due with ISD.
6. The biggest help you can give is to help the participant /parent/guardian obtain medical records.

7. ISD can give you limited information about the participant's application: the application is approved, when, that it is still pending, or that it is denied. ISD cannot tell you the reason for denial. If the participant chooses to sign a release of information form giving you access to information, or chooses to have you be an authorized representative, then you access that information. Use the web portal.

8. In almost all instances, if you have a question about a participant's case, ask. If the participant or ISD has indicated the case is approved but you don't see it on the web portal, contact Kathy Karnowsky at Kathryn.karnowsky1@state.nm.us or at (505)476-6867.

Navigating Eligibility

Individuals in the Mi Via program are required to obtain medical and financial eligibility prior to accessing services in Mi Via (other than consultant services). When an individual is sent an allocation letter from the State, he or she receives a packet that contains: allocation letter, primary freedom of choice (PFOC) and applicable medical and financial eligibility forms.

For newly allocated individuals, medical and financial eligibility determination is required within 90 calendar days from the date stamped on the PFOC. After the initial eligibility determination, individuals are to complete the financial and medical eligibility process on an annual basis, 90 calendar days prior to the expiration of medical and financial eligibility. Consultants are to assist the participant by providing individualized support to help ensure completion prior to the expiration of the level of care date.

The medically fragile population is provided assistance with medical eligibility from the Medically Fragile Case Management program at University of New Mexico under contract with the TPA.

During the pre-eligibility process participants may face barriers with:

Losing the allocation packet with the blank documents

Finding a health professional

Scheduling the physical

Transportation - medical appointment

Transportation - Income Support Division (ISD) for financial eligibility

Coordinating, participating and keeping face-to-face assessment appointments

Mailing documentation to the TPA

Consultants may also face barriers in navigating the participant through the eligibility process:

- Participants losing documents
- Participants missing scheduled appointments at HSD/ISD
- Obtaining confirmation of eligibility

A participant should receive an appointment within 10 business days of submitting the application to the ISD office. If the participant permits, the consultant may be physically present or on the phone with the participant for appointments and calls.

Consultants **should not** contact the income support division (ISD) with questions. Consultants are required to contact either HSD/MAD or DOH/DDSD, depending on the participant's COE.

Participant Enrollment (Orientation)

Consultants must provide participants with information, support and assistance during the Medicaid eligibility processes, including the medical level of care (LOC) evaluation and financial process.

Consultants will inform participants about the Mi Via program rules and provide an overview of the following:

- Key agencies and contact information
- Training - Critical incidents
- Medicaid Application and timelines
- History and Physical
- Long Term Care Medical Assessment (Abstract)
- For BI ONLY: Review ICD form and timelines
- For BI ONLY: Universal Assessment Tool
- Comprehensive Individual Assessment form
- SSP Documents (<http://www.mivianm.org/docs/pdf/msword/mivia-SSP-hard-copy> planning process and timelines)
- Employer of Record Information sheet and guidelines
- Legally Responsible Individual guidelines (appendix H.)
- Authorized Agent form (appendix G.)
- Environmental Modifications forms and guidelines (appendix F.)
- Overview of FMA role
- Overview of TPA role
- Process to hire employees
- Process to hire vendors
- Process to enroll in FMA trainings, (including training related to obtaining online access)

The consultant will review and obtain signatures on the following documents:

- Agency specific required documents
- Participant Responsibilities form
- Release of Information (ROI) if needed (for other providers)
- Authorized Agent form (if applicable)
- Legally Responsible Individual (LRI) form (if requested)
- Employer of Record (EOR) Information Sheet

Making the Most of Meetings

(Adapted from: A Resource Guide for Independent Case Managers for the Developmental Disabilities Waiver, 2008)

Meetings that Enhance the Individual's Life

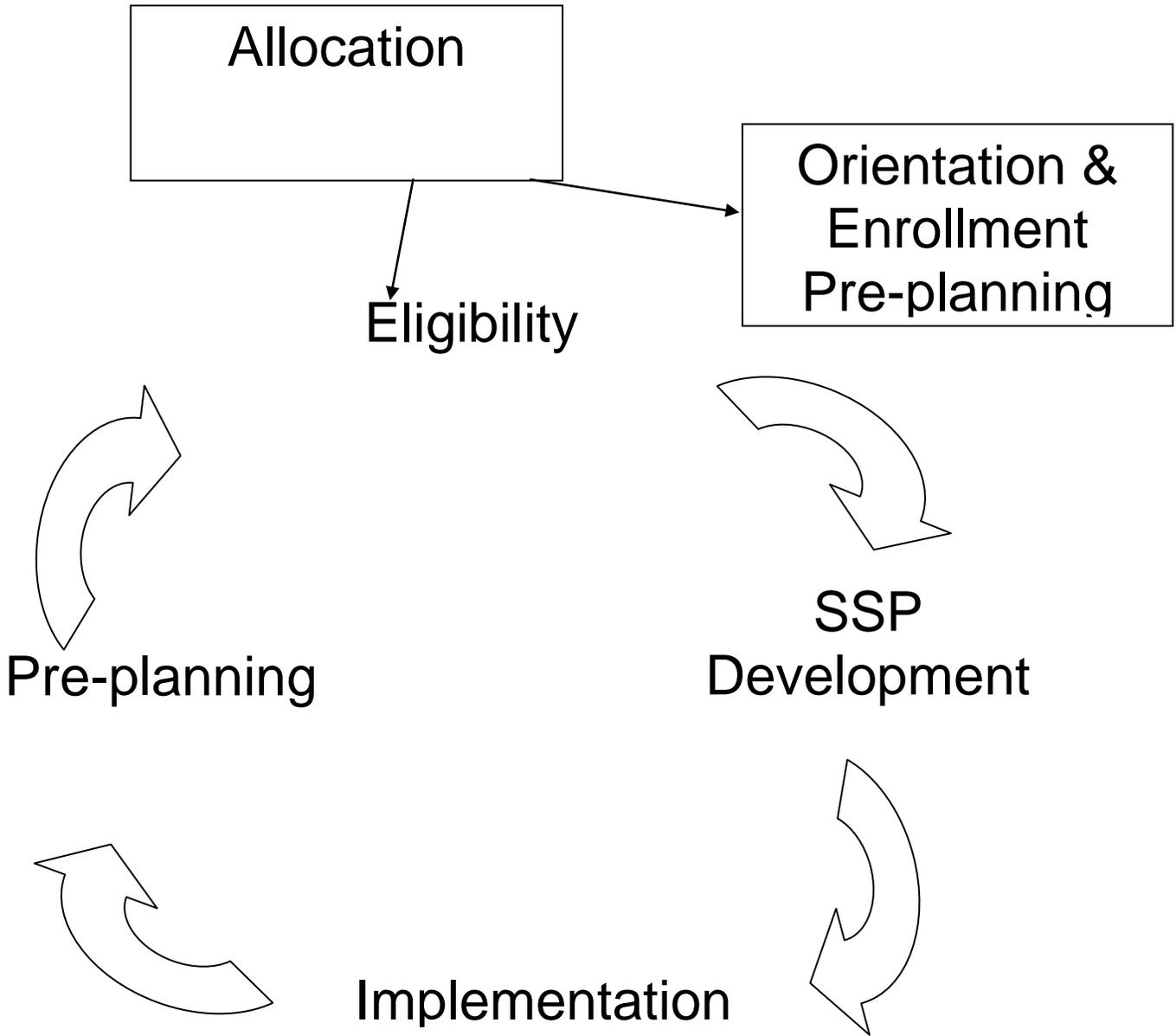
The primary consultant function is to provide information to the participant and the participant's circle of support that will result in effective planning. The consultant must be a skilled facilitator. A valuable consultant is knowledgeable of the participant's needs, Mi Via Service Standards, Mi Via Regulations and local community resources. During the participant's facilitation of the meeting, the consultant will provide guidance to the participant to ensure the Services and Support Plan is in compliance with and addresses the needs of the participant and is in compliance with Mi Via's regulations and standards.

Meaningful Participation and Self-Advocacy

Some participants may require assistance to prepare for and facilitate meetings. It is the role of the consultant to encourage the participant to express and document his/her needs throughout the planning and monitoring process.

Tips to Support Individuals' Participation & Self-Advocacy	
	During every contact encourage the participant to express his or her needs, personal goals and concerns.
	Direct participants to resources that may match or assist the participant in obtaining needs, personal goals or concerns.
	Provide information on local self-advocacy groups.
	Prior to meeting, talk to the participant about the purpose and desired outcome(s) of the meeting and how you may assist.

Mi Via Cycle



Planning With the Participant

Service planning is an essential support provided to the participant. The Services and Support Plan (SSP) is an individualized and person-centered plan, based on the individual's needs, and supports him or her to live in the community as independently as possible. Furthermore, the SSP must describe in detail the services/goods needed, how the service or good relates to the individual's qualifying disability or condition and how it supports the individual to remain in the community and reduce the risk for institutionalization.

The Mi Via philosophy of self-direction reflects a strong commitment throughout the planning process to being sensitive to the person's preferences, responsibilities and arrangements when reducing any identified risks. The State must ensure planning occurs to address the participant's safety. All services, supports or goods must address the participant's qualifying disability and meet clinical, functional, medical and/or social habilitation needs.

For new allocants, prior to the planning process the consultant and participant receive a level of care letter and ICD approval or denial letters for BI participants during year one (1). For individuals transitioning from other waivers, the SSP planning process may begin soon after the consultant agency receives the waiver change form.

To be effective in the planning process, the SSP should be built with the following:

Individual Budgetary Allotment (IBA)

The amount of funding provided to the participant. This amount is provided to the consultant with the Level of Care (LOC). The IBA levels for each population can be found in the Mi Via schedule of participant budgets.

Please use the following guidelines when calculating budgets for individuals transitioning from other waivers:

1. Review the relevant IBA levels
2. Read the transitioning Individual Service Plan (ISP)
3. Find the IBA as entered in *GCESonline* by TPA
4. Build a budget based on the individual's current services and needs – staying within the IBA unless additional funding is necessary.

5. Divide the IBA by 12 (months) and multiply the monthly amount by the number months left in the budget year to obtain the prorated Mi Via Budget. A helpful tool may be found online at:
http://www.jwsuretybonds.com/info/tool_prorate.php

SSP Support Documentation

There are times when a participant provides supportive documentation for services that may be paid by another source or a physician may provide documentation to support the request for a good or service. All supporting documentation is sent to the TPA. The Legally Responsible Individual (LRI) form must be approved by the appropriate program manager annually. The approved LRI form is to be submitted to the TPA and the FMA with the initial, annual SSP or SSP revision. The environmental modifications packet is also to be submitted to the TPA when that service is requested. In the notes sections of *GCESonline* indicate: the name of accompanying documents, date documents submitted, particular notes of interest (i.e. “revision due to change in level of care or fair hearing”) to the reviewer.

State of New Mexico				
Mi Via Schedule of Participant Budgets			Updated 4/1/12	
Waiver group	AGE BAND	Further Breakout By Assessed Category of Need	Mi Via Annual Budget	
AIDS	Any age	No further breakout for AIDS	\$36,249	
D&E	0-20	Rated need for homemaker care hours		
		Mild	\$13,522	
		Moderate	\$16,148	
			Extensive	\$18,775
	21 and older	Participant in Assisted Living		\$18,794
		Otherwise...		
		Mild	\$12,179	
		Moderate	\$20,695	
		Extensive	\$33,065	
	Brain Injury	0-18	Rated need for homemaker care hours	
Mild			\$14,959	
Moderate			\$17,585	
			Extensive	\$20,212
19-20		Mild	\$25,986	
		Moderate	\$28,612	
		Extensive	\$31,239	
21 and older		Participant in Assisted Living		\$30,740
		Otherwise...		
		Mild	\$24,643	
		Moderate	\$33,159	
		Extensive	\$45,529	
DD and Medically Fragile		0-18	Maximum - no further break out	\$23,443
	18-20	Maximum - no further break out	\$54,589*	
	21 and over	Maximum - no further break out	\$72,710	
	*\$68,589 only if using	Customized In home Living Supports		

Request for Additional Funds

Requests for additional funds may be made in the SSP. See 8.314.6.17 F (3) NMAC. The participant must submit documentation that a need(s) cannot be met within the current IBA. The participant must show one (1) of the following circumstances:

- (a) chronic physical condition
- (b) change in physical health status;
 - (i) the participant must submit a written, dated, and signed evaluation or letter from a medical specialist either a medical doctor, doctor of osteopathy, certified nurse practitioner or physician's assistant that documents the change in the participant's health status relevant to the above criteria; the evaluation or letter must have been completed since the last LOC assessment or less than one (1) year from the date the request is submitted, whichever is most recent;
 - (ii) the participant may submit additional supportive documentation by others involved in the participant's care, such as a current ISP if the participant is transferring from another waiver, a recent evaluation from a specialist or therapist, a recent discharge plan, relevant medical records or other documentation or recent statements from family members, friends or other support individuals;
- (c) chronic or intermittent behavioral conditions or cognitive difficulties:
 - (ii) the participant must submit a written dated and signed evaluation or letter from a medical doctor, doctor of osteopathy, certified nurse practitioner, physician's assistant, psychiatrist or psychologist with a doctorate of psychology that documents the participant's mental health or behavioral status relevant to the criteria; if the need for additional budgetary allotment is identified during the LOC assessment, it must be reflected in the assessment; if there has been a change in the participant's behaviors or cognitive difficulties, additional documentation is required; with a change in the participant's behavior or cognitive difficulties, the evaluation or letter must have been completed since the last LOC assessment or less than one (1) year from the date the request is submitted, whichever is more recent;
 - (iii) the participant may submit additional supportive documentation including a current ISP if the participant is transferring from another waiver, a positive behavioral support plan or

assessment, recent notes, a summary or letter from a mental health practitioner or professional with expertise in developmental disabilities, brain injury or geriatrics, recent discharge plan, recent recommendations from a rehabilitation facility, any other relevant documentation or recent statements from family members, friends or other support individuals involved with the participant;

(d) Change in natural supports:

Consultants prepare an additional funding goal(s) for requested services that either by themselves or in conjunction with other needed supports exceed the IBA that applies to the individual participant. There is a checkbox to indicate additional funding within the *GCESonline* system. If additional funding supports are not approved the participant will still have supports approved within the IBA to meet their needs.

Request for Information (RFI) by TPA

When additional information is needed to make a decision, the TPA will issue a request for information letter. The TPA will also send a copy of this letter to consultants. Agencies need to keep consultant assignments updated in *GCESonline*. The Consultant will work with the participant to submit any needed information.

Please refer to the State direction for RFA/RFI on the following page.

Request for Administrative Action (RFA) by TPA

The TPA reviewer may send a plan back to a consultant agency if there are administrative corrections needed. The consultant agency will submit the corrections within 5 business days and note in the plan notes section of the SSP.

Request for TPA Expedited Review

There is a provision to request that the LOC and/or SSP review be completed quicker than normal processing timelines. The entire review can be expedited or specific steps in the review process may also be expedited such as ICD review, expedited in-home assessment. All expedite requests and justification must be submitted in writing to the appropriate waiver PM. The PM must send written approval of the expedite request to the TPA. An expedite request may include a situation such as: the participant is facing a health and safety risk and must get the revision reviewed quickly.



SUSANA MARTINEZ, GOVERNOR

CARING FOR NEW MEXICO

CATHERINE D. TORRES, M.D., CABINET SECRETARY

September 16, 2011

To: Mi Via Consultant Agencies

From: Tallie Tolen, Mi Via Staff Manager - HSD
Pat Syme, Mi Via Program Manager/ DOH - DDS

Re: Clarification on Mi Via Request for Information (RFI)/ Request for Administrative Action (RFA) Process

Effective September 19, Molina will be implementing a new process for RFI for the Mi Via program. Currently, when more information is requested by Molina through an RFI letter for one (1) or more items in the submitted budget (annual or revision) Molina suspends the entire budget while the RFI process is conducted. Effective September 19, Molina will actually approve all items that are not denied or RFI'd on an individual basis. Participants will be able to access the approved items while completing the RFI process on the other item(s). Molina will reflect these changes in their letters to participants. All RFI letters will be sent to the participant, the consultant, and the provider as applicable (usually related to environmental modifications).

It is very important for consultants to understand that while items are in the RFI process, any revisions to the approved items/budget cannot be submitted to Molina for consideration.

Information must be submitted to Molina within 15 days or the items will be denied.

Resubmission/correction of RFI'd items through GCES is necessary only when the description of the item or amount of the item is changed. These are not considered new revisions and will not be held to the 90/60 day rule.

For RFAs, there is a 5 working day timeframe for the consultant to make the change or notify Molina that they need additional time. If Molina does not receive a response from the consultant within 5 business days, Molina will inform the State and HSD or DOH may instruct Molina to deny the item. **Additionally, when an item has been RFA'd, any revisions to the approved items/budget cannot be submitted to Molina for consideration until the RFA issue is resolved.**

It should be noted that per the Mi Via regulations there are certain timeframes for submitting revisions. Consultant agencies are reminded that revisions may not be sent to Molina within the first 90 days of the approval of the budget, or within 60 days of the expiration of the budget.

Exceptions may be made for critical health and safety reasons and those requests must be sent by the consultant to the State for approval.

Please contact Tallie Tolen with any questions related to this process at (505) 827-3176 or tallie.tolen@state.nm.us

C.c. Genevieve Rel, DOH /PHD
Orlando Vasquez, HSD
Gina Burtram, Molina

SSP and Budget Implementation

Once the SSP and budget are approved, participants enter the implementation phase of the program. The consultant will make a contact either by phone or in person on a monthly basis with the participant. Consultants/support guides are required to provide an additional level of support on either an as needed basis or according to the plan developed by the participant and consultant at the SSP development meeting. Consultant will document any demographic changes and institutionalization for three (3) consecutive nights (or more) with the Status Notification form.

Monthly Contacts

Consultants will discuss the successes and barriers to implementing the SSP. Participants may express barriers to accessing services such as credentialing of vendors, credentialing of employees, vendor payments and employee payments. For payment issues and credentialing issues, Consultant will contact the FMA using the communication guidelines. Participants may request additional contact to address a barrier in implementing the SSP. Participants may also ask for guidance and assistance with due process procedures. Consultant will document any changes in demographics and update *GCESonline*. Other life events that qualify for Status Notification will be documented. The Consultant/Support Guide will document the request and schedule the follow up contact.

Quarterly Visits

Consultants are required to visit the participant in person every quarter of the SSP year and complete the quarterly visit form (appendix E.). At least one (1) visit per year most will be in the participant's residence. During quarterly visits, the consultant will review the following with the participant: spending patterns, changes in program rules, and new community resources. Participants may express barriers to access of services such as credentialing of vendors, credentialing of employees, vendor payments and employee payments. For payment issues and credentialing issues, Consultant will contact the FMA using the communication guidelines. Consultants will also inform and guide participants to utilize the FMA process to address payment concerns. Consultant will document the use and effectiveness of the back-up plan and services in comparison to the participant's quality plan. Participants may also ask for guidance and assistance with due process procedures. Consultants will partner with participants to discuss and document strategies to ensure the completion of the annual medical and eligibility process is completed within deadline. Participants not receiving support guide services may request support guide assistance solely for more assistance with the annual eligibility process.

Support Guides or additional support

Support guide services are more intensive supports that help participants more effectively self-direct services based upon their needs. The amount and type of support needed must be specified in the SSP and is reviewed quarterly. All new Mi Via participants are required to receive the level of support outlined in this section, based upon need, for the first three (3) months of Mi Via program participation. The support guide may be another staff of the consultant provider agency or the consultant. The support guide or additional supports are outlined in the *Mi Via Service Standards*.

Examples of task specific items:

Eligibility or Re-Certification of Eligibility:

- Reminder(s) and follow up with participant to schedule physical and completion of medical eligibility paperwork
- Assisting the participant to plan for transportation needs to medical and ISD appointments
- Reminder(s) to mail documents
- Reminder(s) to attend medical and ISD appointments

SSP Pre-Planning

- Reminder(s) to obtain quotes for services or goods
- Reminder(s) to identify any natural supports
- Reminder(s) that employee(s) need to complete pre-hire packets
- Reminder(s) and instruction to obtain denial letters

SSP Implementation

- Reminders/assistance with timesheet submission timelines, completing timesheets correctly including approval in *GCESonline*.
- Follow up assistance with weekly or other vendor payment request forms (PRF, process, timelines and correct completion)

Support Guide or Additional – more than a monthly contact

- Advise and provide direct support to participants on the completion of the Pre-Hire packet for each proposed employee:
 - Criminal History Authorization for Release of Information
 - Three (3) Fingerprint Cards
 - Copy of Identification Card that contains a photograph
 - Fingerprint reimbursement request (optional)
- Advise participant and employee(s) on the completion of the Employee Enrollment packet:

- Employee Information Form
 - Employee Agreement (remind participant/EOR that the rate cannot exceed the rate approved by TPA)
 - Declaration of Relationship
 - Federal W-4 Tax Withholding Form
 - State W-4 Tax Withholding Form (if different from Federal W-4, advise participant/EOR to call Xerox call center with questions)
 - I-9 Employment Eligibility Verification Form
 - Direct Deposit Authorization (optional)
 - Publication 797 Earned Income Credit (optional)
- Advise participant on the completion of the Vendor Enrollment Packet:
 - Vendor Information Form
 - Vendor Agreement (remind participants that rate must not exceed the rate that was approved by TPA)
 - Federal W-9 Request for Taxpayer Identification Number (required if providing services, please direct participant/EOR to Xerox call center with additional questions)
 - Vendor Direct Deposit (optional)
 - Other credentials as required. E.g. licenses, criminal background checks
 - All these forms/documents must be completed/provided BEFORE an employee begins working with any Mi Via participant

Consultant will receive an alert/email from Xerox to confirm that a provider/employee has been credentialed.

Tools for Monitoring SSP Implementation

There are several tools to aid in the monitoring of the participant's progress in implementing the SSP:

GCES – Monthly Utilization Review Report

GCES – Accrual Report

GCES – Forms page

CA – Quarterly Visit form

Personal Plan Facilitation

Personal plan facilitation is a service that supports a planning activity which results in a holistic person-centered plan. The plan may be used by the participant to develop his/her SSP as well as identify other sources of support outside of Mi Via funding. Participants may access the service after it is added to the plan and approved by the TPA.

Services and Supports Plan (SSP)

The Mi Via SSP is developed and submitted by Consultants using an on-line tool, which is available in printed form. This document aids the participant to express his/her needs in relation to 4 key life areas: living supports, community membership supports, health and wellness supports and other related supports and goods. There are also sections for environmental modifications, emergency back up plans, Consultant/Support guide services and SSP preparation information. The questions in each section are reflective of a self assessment process and prompt responses for a thorough planning process.

The SSP begins with an overview of the Mi Via waiver and proceeds to ask the participant to think about and indicate the overall benefit or goal he or she wishes to achieve by participating in the program and what personal strengths can be marshaled to achieve that benefit or goal. Personal Plan facilitation services are then offered and for those who have gone through these types of planning processes, there is a prompt indicating information can also be utilized in preparing the Mi Via SSP.

Each section includes a definition, the support models or services available by category and includes a grid for identification of the supports needed to increase independence, integration and prevent institutionalization. Participants are encouraged to identify activities that require support, type of support needed or available, both paid and unpaid and the hours of support needed in a typical week. The online system includes a calculator that rolls up requested Mi Via supports into monthly totals for inclusion on the SSP budget. Aside from assisting in the budgeting process, these sections also identify unpaid supports or supports paid through another source that will indicate to the TPA that key health and safety needs are addressed. Each section also addresses goods related to the supports and goals in each key life area. Each section, with the exception of the environmental modification and backup plan sections, includes a quality measurement question that encourages the participant to develop a personal criterion of whether the supports, goods and services are working well in addressing the identified needs.

The Consultant/Support Guide Services section helps the participant or Employer of Record (EOR) identify what types of help they may need in carrying out the

employer and purchasing functions for implementing the SSP and the agreement for provision of those services.

Back-up plans are required to address critical areas of concern outlined in the TPA's recommendation(s). Critical services are required to be addressed in the back-up plan. The participant may document back up plans for other services that are important to the participant. The participant is encouraged to copy and have the backup plan readily available in the home if providers are not available to work with the participant. The consultant has the participant initial the Mi Via Service and Support Plan Emergency Backup Plan Acknowledgement Form, which includes information for reporting abuse, neglect and exploitation and provides a copy for the participant as part of the SSP.

Goals or action plans provide details to a descriptive activity or good that will occur or be utilized with or by the participant during the plan year. The goal statement includes details regarding the rate, cost, frequency and rationale. A summary of job duties (congruent with the service provided) should be included in the SSP goal for the requested service. These descriptions are entered into the goal sections of GCESonline.

Budget Naming Convention

1. Initial or Version 1 (V1)
2. Annual or Version 1 (V1)
3. Revisions must be identified with ascending versions for each submission (e.g. V2, V3, V4)
4. Additional Funding must be identified with version number AF (e.g. V1AF, V2AF, V3AF)
5. Reconsiderations must be identified in GCES goal notes (e.g. V1RC, V1AFRC,) as well as under administrative action tab utilizing reconsideration radial button with date.

Standard Operational Procedures for Consultants

This portion of the Consultant Guide outlines the details of the daily processes and tasks entailed with the service.

New Allocations

The appropriate state agency determines when an individual is able to receive an allocation. For Community Re-Integration allocations, an individual must meet a 30 consecutive day stay in a skilled nursing facility. When an individual is allocated, the state agency mails the individual a primary freedom of choice (PFOC). The individual chooses Mi Via or CoLTS C waiver (HSD) or Mi Via or Traditional waiver (DOH). If Mi Via is chosen, a Consultant Agency is selected on the PFOC. Once the individual returns the PFOC to the state agency, the state agency sends it to the Consultant Agency, the TPA and HSD/ISD. HSD/ISD schedules an interview with the individual within 10 business days. The TPA schedules a face-to-face assessment with the individual within two (2) business days. The state agency sends the individual a packet with medical eligibility forms (abstract, History & Physical) and the Medicaid application (MAD 381). Completing the forms and beginning financial and medical eligibility are the first steps to becoming Mi Via eligible.

Service and Support Planning Process – New Allocation

Step 1: Consultant receives primary freedom of choice

- Consultant will contact the participant within five (5) business days of receipt of primary freedom of choice (PFOC) to establish that the participant is completing the eligibility process, and to provide information and assist, if needed.
- TPA schedules an assessment within two (2) business days of receiving PFOC.

Step 2: Consultant conducts an orientation

- Consultant informs participants about program rules (LRIs, EORs, CBC process, environmental modifications, ICD form, financial and medical eligibility)
- Participant's Rights and Responsibilities document is reviewed and signed

- Consultant informs participant about timelines and risks
- Reviews LOC packet and financial eligibility documents, processes and timelines
- Reviews Backup Plan process
- Consultant provides overview of Xerox's role and processes
- Consultant provides overview of TPA's role and processes
- Consultant reviews and leaves copies of the following documents:
 - Xerox contact for training on the *GCESonline* system
 - LRI form (if necessary)
 - SSP Planning Document
 - Mi Via Service Standards
 - Provider Listings and/or Resource Manual or information on accessing
 - EOR information sheet
 - Environmental Modification packet (if applicable)
 - Mi Via Authorized Agent form as necessary

After the orientation, the consultant will update any information (including legal relationship and authorized reps into *GCESonline*).

Step 3: Consultant assists participant through financial and medical eligibility process and pre-planning activities

- FOR BI POPULATION ONLY: Consultant informs participant of the ICD process and timeliness. Consultant ensures the ICD form has been completed and submitted to the TPA. The TPA will review in two (2) business days. The approved ICD form will be maintained in the participant's file. ICD approval is only required **once** and during the first year of participation. Two (2) business days after the review, the TPA will mail the ICD form to the consultant agency.
- Consultant will submit the LRI to the appropriate PM or designate
 - AIDS Program Manager - Genevieve Rel
Genevieve.Rel@state.nm.us
 - Developmental Disabilities and Medically Fragile – Pat Syme
Pat.Syme@state.nm.us
 - Disabled and Elderly, Brain Injury –, Betty Sangre
Betty.sangre@state.nm.us

- Consultant will submit the EOR information sheet to Xerox /TNT using Xerox SharePoint. The EOR information sheet will be uploaded two (2) calendar days after receipt from the participant.
- Consultant receives Molina's assessment within 16 calendar days from the date the documents were received. If you have not received an assessment please contact Kim Shipman (Molina):
Kim.Shipman@molinahealthcare.com
- Consultant receives level of care (LOC) letter, abstract and History and Physical from Molina within 30 business days from the date all documents were sent to Molina. If you have not received an LOC letter please contact Kim Shipman (Molina):
Kim.Shipman@molinahealthcare.com
- Consultant Agency will receive the ISD2 Notice that declares financial eligibility prior to the SSP development meeting or during the process. If it is not received the ISD2 Notice, contact Kathryn Karnowsky at Kathryn.Karnowsky1@state.nm.us. Eligibility dates can be found in the ISD2 Notice. These dates are also on the *GCESonline* Participant Information Screen and in Omnicaid.

Step 4: Consultant conducts the SSP meeting(s)

- Complete SSP will be submitted so that SSPs start within 90 calendar days of the date of program eligibility.
- Consultant will ensure that the back-up plan is completed
- Consultant will assist as needed with job descriptions for employees.
- Consultant will review the hiring and credentialing process for employees and /or vendors. **It is essential the process begins as soon as the participant has an employee identified.**
 - Provide contact information for questions on hiring/credentialing/billing Xerox Customer Service: 866-916-0310

- Consultants will inform participant that fingerprinting is offered at the Xerox Albuquerque office. Xerox also provides assistance to find locales throughout the state.
 - Call Xerox Customer Service
 - Consultant will provide information to the participant on requesting training and access to the *GCESonline* system.

Step 5: Consultant enters the SSP into GCESonline

Consultant will submit the SSP, goals and budget online for TPA review.

- Consultant will enter SSPs within five (5) calendar days of the meeting or when all information is submitted by the participant. This should be accomplished within 60 calendar days of program eligibility so that the SSP may be in place to start within 90 calendar days of eligibility per the Lewis lawsuit.
- The accompanying documents (e.g. LRI and emod packet) must be submitted to the TPA with the SSP if they need to start when the SSP starts.
- Community Re-integration participants do not need to start on the first day of a month in Mi Via. They may start as soon as discharged from the nursing home.

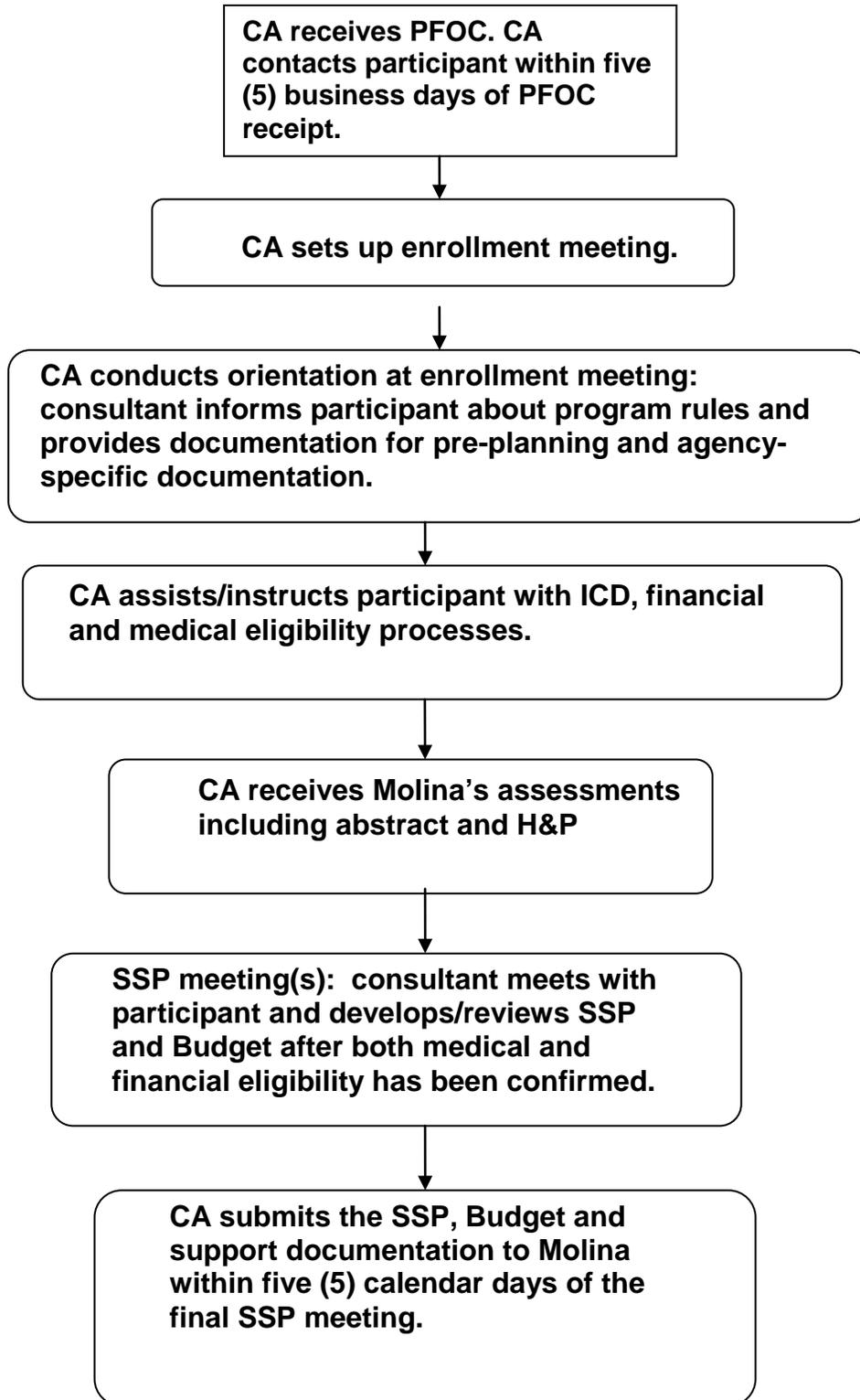
Step 6: Consultant Receives Decision Letter from TPA

- TPA will send approval/denial letter to consultants, participants, and HSD/ISD office showing decision of SSP request.

Step 7: Consultant/Support Guide Assists Participant With Implementation

- Assist participants with following Xerox’s processes to hire employees
- Assist participants with finding vendors and employees
- Follows up during monthly contact on progress with:
 - Progress on hiring employees
 - Progress on credentialing employees
 - Progress on credentialing vendors

- Progress on obtaining environmental modifications
- Issues accessing the emergency backup plan
- Use of any incident management procedures
- Payment issues with Xerox



Service and Support Plan and Budget Revision

Step 1: Consultant and participant determines revision type

(All revisions are sent to the TPA)

- Addition of Services – no additional funding needed
- Transfer of Funds
- Editorial SSP Changes
- Level of care or natural supports changes = additional funds
- Revisions cannot be submitted less than 60 calendar days prior to the expiration date of the SSP unless there is a critical need related to health and safety
- Only one (1) revision may be submitted at a time
- Continuation budgets as a result of a fair hearing request may not be revised.

Step 2: Consultant Enters Revision into GCESonline

Consultant will submit the SSP, goals and budget online for TPA review.

- Consultant will enter SSP revisions within five (5) calendar days of the meeting or when all information is submitted by the participant.
- The accompanying documents (e.g. LRI and e-mod packet) must be submitted to the TPA with the SSP revision if they need to start when the SSP starts.

Step 3: Consultant Receives Decision Letter from TPA

- TPA will send approval/denial letter to consultants, participants, and HSD/ISD office showing decision of SSP revision request.

Step 4: Consultant/Support Guide Assists Participant Implementation (as applicable)

(To access services, participants, vendors and employees need to complete Xerox's paperwork accurately and as soon as possible.)

- Assist participants with following Xerox's processes to hire employees
- Assist participants with finding vendors
- Consultant will receive notification from Xerox to confirm that a provider/employee has been credentialed.

SSP and Budget Annual Process

Step 1: Begin Pre-planning 60 to 90 calendar days prior to expiration

- It is recommended the consultant begin working with the participant on the next SSP 60 to 90 calendar days prior to the end date of the current SSP
- Participant will relay the satisfaction of services and goods on the current SSP
- Participant must resubmit LRI form to maintain LRI
- Participant may decide to change the EOR therefore the EOR information sheet needs to be uploaded to Xerox /TNT in a timely manner
- Participant will re-new the authorized agent form
- Consultant will verify guardianship information
- Participant will begin identifying natural supports
- Consultant will review program rules and changes
- Participant may request an additional level of support for pre-planning activities such as:
 - Reminder(s) to complete new employee and vendor agreements
 - Reminder(s) to obtain quotes for services or goods
 - Reminder(s) to identify any natural supports
 - Reminder(s) that employee(s) need to complete pre-hire packets as necessary
 - Reminder(s) and instruction to obtain denial letters

Step 2: Consultant conducts the SSP meeting(s)

- If not fully completed or if participant requests guidance, consultant will assist participant with the SSP
- Consultant reviews the completed SSP document for compliance with program rules and TPA's assessment. Consultant will provide program letter (see your agency's forms) to address items outside of program rules. Ensure health and safety issues or concerns either self identified or on TPA's recommendations are addressed by paid or natural supports.
- Consultant will assist with and/or review the backup plan as well as providing a copy of the Emergency Backup Acknowledgement form.
- Consultant will assist as needed with job descriptions for employees.

- Consultant will review the hiring and credentialing process for employees.
- Provide contact information for questions on hiring/credentialing/billing-Xerox Customer Service: 866-916-0310
- Consultants will inform participant that fingerprinting is offered at the Xerox Albuquerque office. Xerox also provides assistance to find locales throughout the state.

Step 3: Consultant enters the SSP into GCESonline

Consultant will submit the SSP, goals and budget online for TPA review.

- Consultant will enter SSPs within five (5) calendar days of the meeting or when all information is submitted by the participant. This should be accomplished within 60-90 calendar days prior to the end date of the current SSP.
- The accompanying documents (e.g. LRI and e-mod packet) must be submitted to the TPA with the SSP if they need to start when the SSP starts.

Step 4: Consultant submits SSP documentation to TPA

- The review process will not begin prior to the TPA receiving all documentation.

Step 5: Consultant Receives Decision Letter from TPA

- TPA will send approval/denial letter to consultants, participants, and HSD/ISD office showing decision of SSP requests.

Step 6: Consultant/Support Guide Assists Participant Implementation

- Assist participants with following Xerox processes to hire employees
- Assist participants with finding vendors
- Follows up during monthly contact on progress with:
 - Progress on hiring employees
 - Progress on credentialing employees
 - Progress on credentialing vendors
 - Progress on obtaining environmental modifications
 - Issues accessing the emergency backup plan
 - Use of any incident management procedures
 - Payment issues with Xerox

Waiver Transitions

Participants wishing to transition to Mi Via from another waiver must request a Waiver Change Form (WCF) from the appropriate Mi Via Program Manager or Regional office (for the DD waiver). Transitions will not be allowed if the participant is within 120 calendar days on Colts C or 90 calendar days for the AIDS, DD or MF Waivers from the expiration of the Level of Care (LOC). Upon receipt of the signed form the Program Manager or the Regional Mi Via liaison for DD sends the WCF to the current Case Manager, receiving consultant agency, TPA and ISD. Consultants are to make contact with the individual/agency listed on the waiver change form to schedule a transition meeting. During or prior to the transition meeting the Consultant needs to request a copy of the individual's file including the current ISP, LOC abstract, ISD approval letter, History and Physical, relevant LOC assessments and any other important information. The participant, Consultant and Case Manager all agree upon a reasonable transition date – always the first of the month for Mi Via. Transitions from another Waiver to Mi Via should occur within 90 calendar days unless there are circumstances related to the participant's services that require more time. The case manager will prepare a revision to close out the Waiver ISP based on the agreed transition date unless there are circumstances conveyed that require a change of dates.

Using the documents received from the Case Manager, the Consultant works with the participant to orient and enroll in the program and to develop and submit the Mi Via SSP. The SSP should be submitted 30 calendar days in advance of the proposed start date to allow sufficient time for approval.

Service and Support Planning Process –Waiver Transition

Step 1: Consultant contacts the participant

- Consultant will contact the participant within five (5) business days from the receipt of waiver change form (WCF).
- If you have difficulty scheduling a meeting with the current case manager, contact the appropriate Program Manager for the Waiver.
- Consultant will enter additional demographic information into *GCESonline*. (Refer to Greystone CES Training Manual: Consultants, 2010)

Step 2: Consultant conducts an orientation

- Consultant informs participants about program rules (LRIs, EORs, Criminal Background Check process, environmental modifications, financial and medical eligibility)
- Participant's Rights and Responsibilities document is signed
- Consultant informs participant about timelines and risks
- Review LOC packet and financial eligibility documents, processes and timelines
- Review Backup Plan process
- Consultant provides overview of FMA role and processes
- Consultant provides overview of TPAs role and processes
- Consultant reviews and leaves copies of the following documents:
 - Xerox contact for GCESonline training dates
 - LRI form (if necessary)
 - SSP Planning Document hard copy
 - Mi Via Service Standards
 - Provider Listings and/or Resource Manual or instructions on accessing
 - EOR information sheet
 - Environmental Modification packet (if applicable)
 - Mi Via Authorized Agent form

Step 3: Consultant attends transition meeting

- Consultant will receive the current paper file from the current case management agency or service coordinator (CoLTS) to include: assessments, LOC documentation, ISP, MAD046 and eligibility approval.
- The participant, case manager or service coordinator and consultant will collaborate to develop a start date to ensure there will not be a break in services necessary to maintain health and safety. The transition date must be the first date of a month.
- Consultant will verify that the transition date is no less than 90 calendar days from the LOC expiration date.
- Participant and Consultant will schedule the SSP meeting(s). (Note: State staff will review the LOC upon receipt of the WCF. DOH participants cannot transition if the LOC will expire in less than 90 calendar days. Disabled & Elderly and BI participants cannot transition if the LOC will expire in less than 120 calendar days.)

Step 4: Consultant assists with EOR, vendor and employee enrollments

- Consultant will submit EOR information sheet to ACS within two (2) calendar days of receipt to Xerox/TNT SharePoint site.
- If employees are known, the consultant/support guide is available to guide and provide direct support to the participant in the enrollment process and direct participant to Xerox as necessary

Step 5: Consultant conducts the SSP meeting(s)

- If not completed or if the participant requests guidance, consultant will assist participant with the plan
- Consultant reviews the completed SSP document for compliance with program rules and TPA's assessment. Consultant will provide notification to the TPA to address items outside of program rules. Ensure health and safety issues or concerns either self identified or in relation to the TPA's recommendations are addressed by paid or natural supports.
- Consultant will assist and/or review the backup plan and provide a copy of the Emergency Backup Acknowledgement form.
- Consultant will assist as needed with job descriptions for employees.
- Consultant will review the hiring and credentialing process for employees.
- Provide contact information for questions on hiring/credentialing/billing Xerox Customer Service: 866-916-0310
- Consultants will inform participant that fingerprinting is offered at the Xerox Albuquerque office. Xerox also provides assistance to find other locations for fingerprinting throughout the state.

Step 6: Consultant calculates SSP budget amount

- SSP budget term remains the same as the ISP term in the previous waiver. Consultant prorates the budget for the remainder of the budget term. Molina enters full-year IBA amount into *GCESonline*, based on CoLTS "c" waiver existing level of care.
- Consultant uses the following guidelines when calculating budgets for individuals transitioning from other waivers:
 1. Review the relevant IBA levels
 2. Read the transitioning Individual Service Plan (ISP)
 3. Find the IBA as entered in *GCESonline* by Molina

4. Build a budget based on the individual's current services and needs
 - staying within the IBA unless additional funding is necessary.

Divide the IBA by 12 (months) and multiply the monthly amount by the number months left in the budget year to obtain the prorated Mi Via Budget. A helpful tool may be found at:

http://www.jwsuretybonds.com/info/tool_prorate.php

Step 7: Consultant enters the SSP into GCESonline

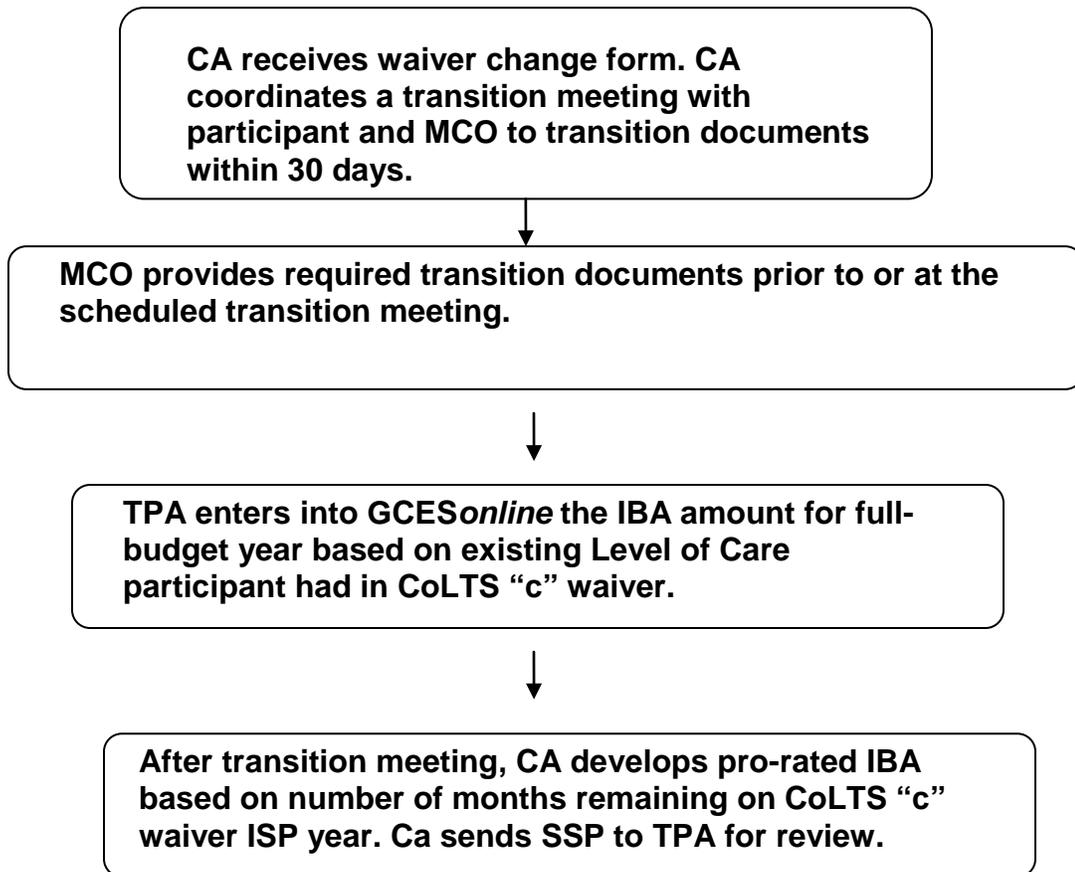
Consultant will enter the SSP and accompanying documents (e.g. LRI and e-mods) within five (5) calendar days after the SSP meeting but no more than 60 calendar days from the first contact with the participant unless other arrangements are needed by the participant.

Step 8: Consultant and Participant Receive TPA Decision Letter

- TPA will send approval/denial letter to consultants, participants, and HSD/ISD office showing decision of SSP requests.

Step 9: Consultant/Support Guide Assists Participant with SSP Implementation

- Assist participants with following Xerox's processes to hire employees
- Supports participants with finding vendors
- Follows- up during monthly contact on progress with:
 - Progress with finding employees and vendors
 - Progress on hiring employees
 - Progress on credentialing employees
 - Progress on credentialing vendors
 - Progress on obtaining environmental modifications
 - Issues accessing the emergency backup plan
 - Use of any incident management procedures
 - Payment issues with Xerox



Consultant Agency Transfers

A participant may choose to transfer to a different consultant agency at any time after their waiver eligibility has been established. The same Mi Via services/goods are available within each agency. Participants wishing to transfer to a different agency must request a Consultant Agency Change form (CAC) from the appropriate Mi Via Program Manager or Regional office (for the DD waiver). Upon receipt of the signed form (appendix I), the Program Manager or the Regional Mi Via liaison for DD sends the CAC to the current consultant agency and the receiving consultant agency. The participant and both consultant agencies meet to agree upon a reasonable transfer date – always the first of the month—and to transfer case documents to the new agency. Transfers between consultant agencies must occur within 90 calendar days unless there are circumstances related to the participant’s services that require more time.

Step 1: Consultant receives Consultant Agency Change (CAC) form

Upon receipt of the signed form from the participant, the Program Manager or the Regional Mi Via liaison for DD sends the CAC to the current consultant agency and the receiving consultant agency.

Step 2: Current Consultant Agency

- Contact new consultant agency to schedule transfer meeting. The meeting and transfer of files must occur within 30 calendar days of the receipt of the consultant change form.
- Current consultant will contact participant and new agency to coordinate the transfer meeting.

Step 3: New (receiving) Consultant Agency

- Obtain a release of information (ROI) if needed prior to attending the transfer meeting.

Step 4: Transfer of paper documents

- After receiving the ROI, the current CA will provide copies of the following documents in person or via registered mail by the transfer meeting date:

- Current year's assessments
- Current LOC: approval letter, Long Term Care Abstract, Individual Budgetary Allocation (IBA)
- ICD form (BI population only)
- Current hard copies of SSP and SSP revisions
- Current TPA documents: approval/denial letters, requests for information, support documents to the SSP including justification or denial letters from Third Parties, LRI permissions, additional funding documentation, environmental modification paperwork or any relevant reports or documents used to prepare the SSP.
- Current ISD approval letter
- Meeting notes and correspondence as available
- Medical reports (primary care physician, specialists that may impact the SSP or LOC)
- Other evaluations as applicable (therapy, vocational, rehabilitation)
- Current Individual Education Plan (IEP), Division of Vocational Rehabilitation(DVR) plan, Private Duty Nursing (PDN) plan (if applicable)
- Allocation letter/WCF
- Guardianship/ Power of Attorney(POA)paperwork
- EOR Information Form
- One (1) full year of case notes (narratives) and quarterly visit forms
- Other pertinent information

Step 5: Transfer Meeting

- The participant or legal representative must be present during the meeting.
- Discussion of critical clinical issues that need immediate follow up as well as historical information regarding the individual which include, but are not limited to:
 - Date of LOC
 - Date of SSP
 - Current Services on the SSP budget
 - Any budget revisions in process
 - Any Medical Issues (medications, adaptive equipment, allergic reactions, therapy needs etc...)

- Guardianship and POA orders and related documents
 - Medicaid, Medicare, other Third Party Coverage
 - Problems identified by the transferring agency
 - Participant will coordinate the transfer date with the current and new consultant agency
- The new consultant agency will present the Letter of Transfer and Receipt to current CA to verify:
 - Required documents have been transferred
 - Missing documents are noted
 - LOC, SSP and ISD expiration dates
 - Release of Information (ROI) for new consultant agency was provided
 - Notation of issues that need immediate follow up

Step 6: New CA Sends Letter of Transfer to Program Manager (PM)

- Letter of Transfer and Receipt will be submitted to appropriate PM within five (5) business days.

Step 7: New CA receives access to participant's record in GCESonline

- Once Letter of Transfer and Receipt is received, state staff will enter transfer into *GCESonline*.
- New CA will receive access no earlier than the date listed on the Letter of Transfer and Receipt and the official transfer date. Transfer date will always be the first of the month.

CA receives consultant change form. Current CA coordinates a transfer meeting and transfer of documents within 30 days.



Current CA provides required transfer documents prior to or at the scheduled transfer meeting.



After transition meeting, Letter of Transfer and Receipt is sent to appropriate PM within five (5) business days.



New CA will gain access to participant's electronic records on the date of the official transfer (Letter of Transfer and Receipt). Transfer will always be 1st of the month.

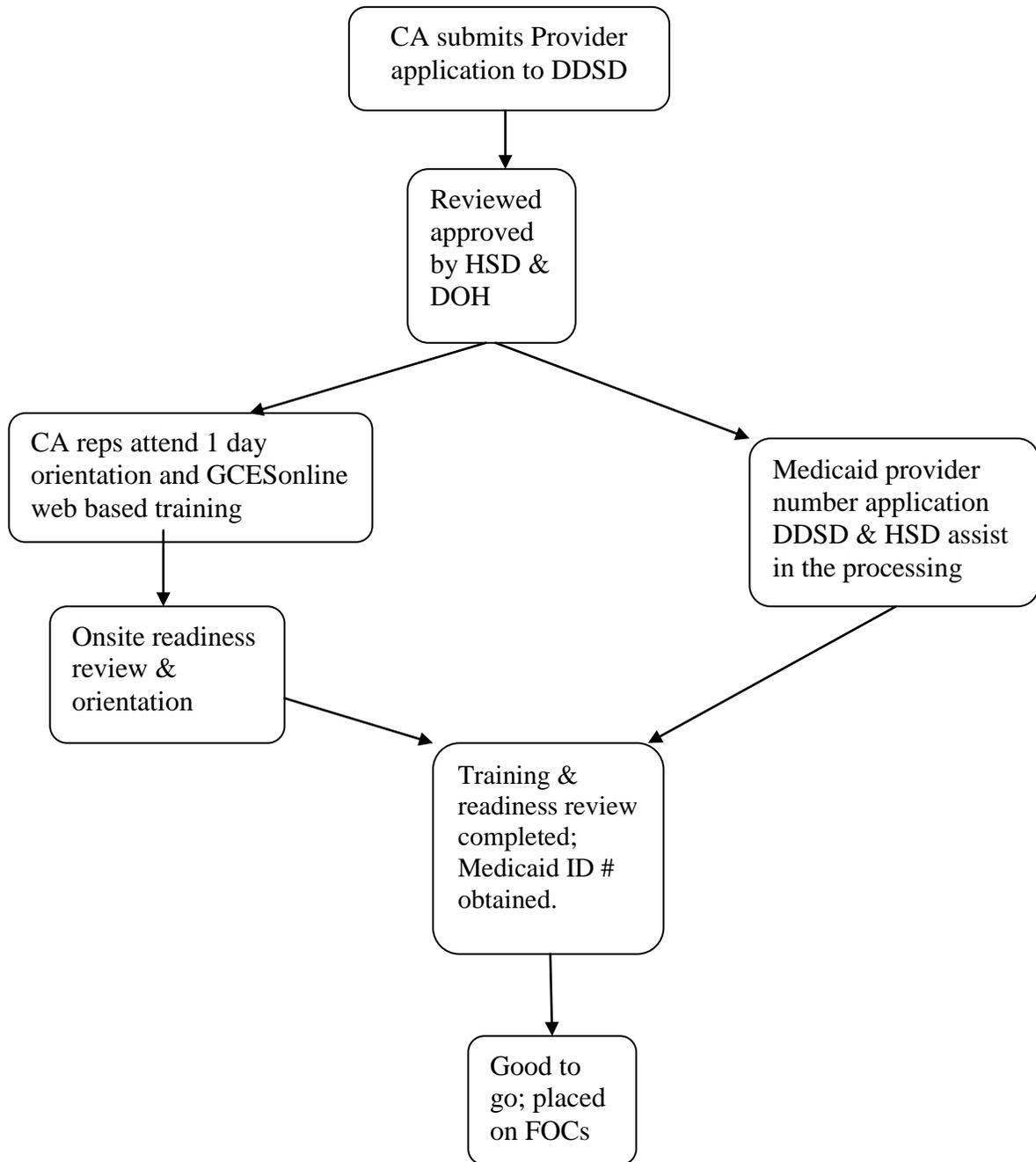
Consultant Training Policy

New Consultant agencies will be oriented by the DOH Program Manager, HSD staff, Third Party Assessor staff and Financial Management Agency staff using the Consultant Guide after approval of the their provider agreement. Either webinar or face- to face-computer lab training will be provided to new Consultant Agency employees on utilizing the *GCESonline* system.

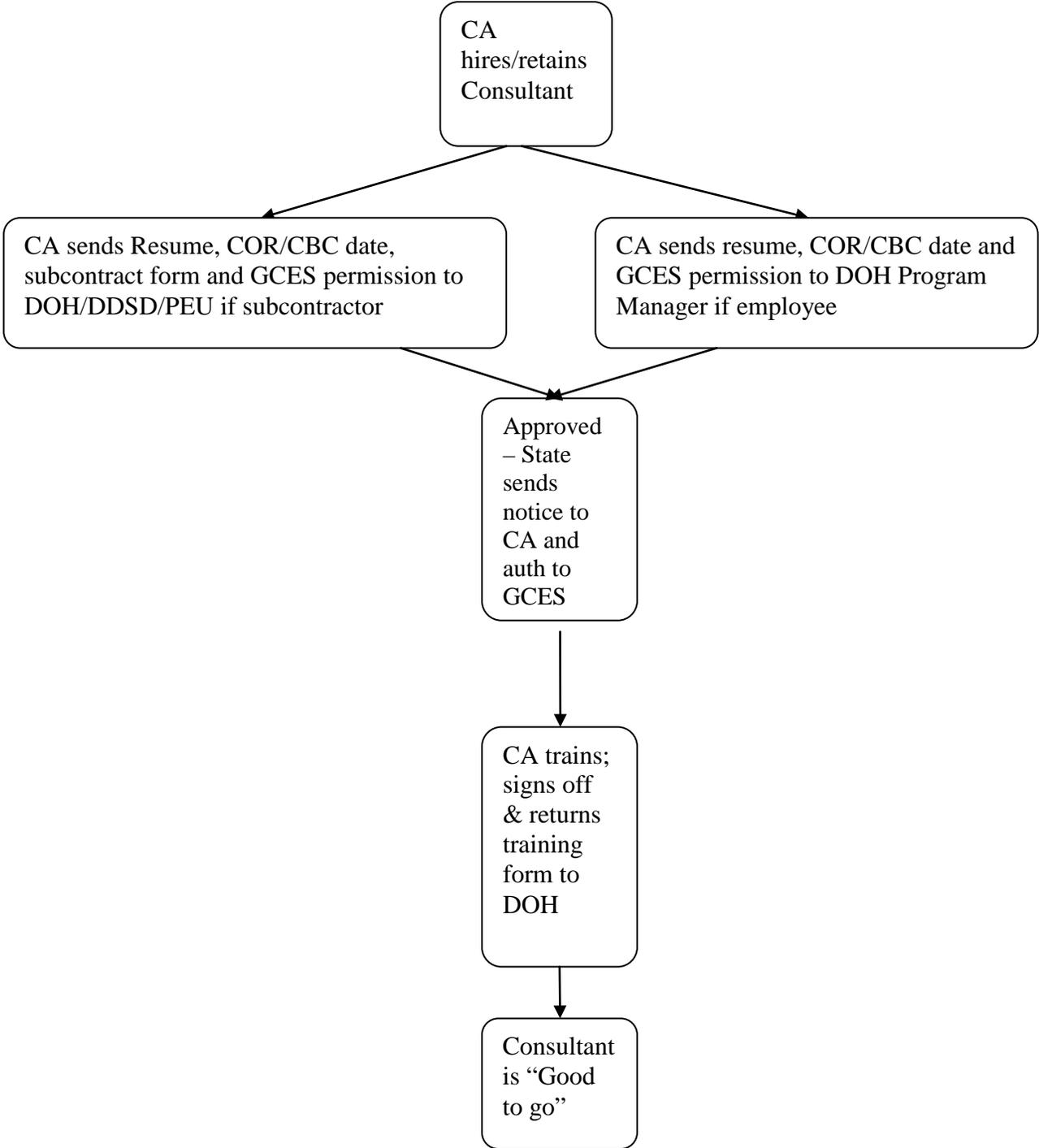
New Consultants hired by already approved Consultant Agencies will be trained internally by persons who have already taken the state prescribed Consultant training and by the GCES online trainers. The required topics are listed on the following checklist. The designated Consultant Agency trainer(s) will review the Consultant Guide and other materials relevant to the topics with the new consultant and attest to competency by initialing and dating when each module is completed. Initial orientation must be completed within 60 days of hire and the signed checklist returned to the DOH Program Manager for verification and tracking. After completion of all aspects of the initial orientation including the *GCESonline* Training, and in conjunction with submittal of all appropriate paperwork for or verification of credentials, the Consultant will be considered able to independently serve participants on Mi Via.

Also following is a flowchart describing the process for new hires/subcontractors. During the initial 60 day period, each new consultant will need to be authorized to gain access to the *GCESonline* system. To obtain authorization for employees, a copy of a resume for the new consultant indicating qualifications per the service standards and date of Criminal Background Check clearance or COR check /fingerprint submittal should be submitted to the DOH/DDSD Program Manager. For subcontractors, the subcontractor approval form, must be submitted along with the resume and date of Criminal Background Check clearance or COR check/fingerprint submission to Felicia Martinez, Provider Enrollment Unit who will then forward to the DOH/DDSD Program Manager. The subcontract form can be faxed to (505) 476-8894 or emailed to Felicia at Felicia.martinez2@state.nm.us

New Consultant Agency



New Consultant





Initial Orientation and Training for New Consultants – Agency Sign -off Form

Consultant Name: _____

Date of Hire: _____

CA Trainer(s) _____

Agency Manager, Supervisor or Trainer will conduct the initial training and orientation of new consultants utilizing the Consultant Guide provided by the State. The designated Consultant Agency trainer(s) will review the materials with the new consultant and attest to competency by initialing and dating when the training module has been completed. A copy of the completed Initial Orientation and Training for New Consultants form will be submitted to the DOH Program Manager or designate. This training must be completed within 60 days of hire.

Training Module	CA Trainer Initials	Date completed
<p>1. Introduction to Mi Via Objective: Provide history, an overview of the agencies involved, key communications protocol between agencies and contractors. Principles of Self- Direction.</p>		
<p>2. Medicaid/Waiver Eligibility / ISD Interface Objective: Provide an overview of the eligibility process, overview of Medicaid service in NM and detailed review of the Mi Via specific interface with ISD.</p>		
<p>3. Incident Management Objective: Provide training on expectations for CA on reporting, training participants/EOR, overview of incidents, policies and procedures.</p>		

Training Module	CA Trainer Initials	Date completed
<p>4. Mi Via Service and Support Plan Objective: Overview of Planning process and documents/forms, timelines, service codes/ definitions, required documentation, non - covered services/goods.</p>		
<p>5.TPA Interface Objective: Provide training on communication protocol, SSP submission expectations, interface with CA and TPA, SharePoint with TPA.</p>		
<p>6.Budget Monitoring and Plan Implementation Objective: Overview of Support Guide Function.</p>		
<p>7. FMA Interface Objective: Provide training on communication protocol, CA uploads on SharePoint, CA/TPA interface, processes and tool kits, set up for email and SharePoint.</p>		
<p>8. Due Process Objective: Provide an overview of Due Process policies, timelines and Activities in Mi Via.</p>		
<p>9. Environmental Modifications Objective: Provide overview of documentation and processes for requesting and Environmental Modification.</p>		
<p>10. GCES training Objective: Obtain password, Basic</p>		

Training Module	CA Trainer Initials	Date completed
Navigation of the system as a Consultant, includes formal GCES web based training offered every other month		

Mi Via Subcontract Form

New Request Renewal Request

DDSD REQUEST FOR SUBCONTRACT APPROVAL FORM MI VIA WAIVER
 (If this form is being filled out by hand please PRINT clearly, those not legible will be sent back)

1.	Requesting Agency: <input style="width: 500px;" type="text"/> Address <input style="width: 250px;" type="text"/> Contact Person <input style="width: 200px;" type="text"/> City <input style="width: 60px;" type="text"/> State <input style="width: 30px;" type="text"/> Zip Code <input style="width: 60px;" type="text"/> Phone Number <input style="width: 80px;" type="text"/> Fax Number <input style="width: 60px;" type="text"/> DATE SUBMITTED TO DDSD <input style="width: 100px;" type="text"/> Section 3 (below) must be completed and this form must be returned to DDSD once Subcontractor is no longer employed with your agency .																	
2.	Name of Proposed Subcontractor: <input style="width: 450px;" type="text"/> Address <input style="width: 250px;" type="text"/> Phone Number <input style="width: 80px;" type="text"/> SSN <input style="width: 60px;" type="text"/> City <input style="width: 60px;" type="text"/> State <input style="width: 30px;" type="text"/> Zip Code <input style="width: 60px;" type="text"/> <small>(last 4-digits)</small> Employee Start Date (for new hires) <input style="width: 150px;" type="text"/> Does this Subcontractor have Professional Licensure/Certification: <input type="checkbox"/> YES <input type="checkbox"/> NO License # <input style="width: 150px;" type="text"/> Licensing Agency <input style="width: 250px;" type="text"/> License Expiration Date <input style="width: 150px;" type="text"/>																	
3.	Employment End Date <input style="width: 150px;" type="text"/> Would you Rehire/Subcontract with this person <input type="checkbox"/> Yes <input type="checkbox"/> No <p style="text-align: center;">If not please include reason below:</p> <div style="border: 1px solid black; height: 50px; width: 100%;"></div>																	
4.	Complete the information below. It is the sole responsibility of the provider to ensure the Mi Via Consultant is in compliance with all Medicaid & Mi Via requirements including but not limited to degree qualifications, experience and criminal background check.																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2" style="width: 10%;">Program</th> <th rowspan="2" style="width: 10%;">Service</th> <th rowspan="2" style="width: 50%;"></th> <th colspan="2" style="width: 30%;">Effective Dates</th> </tr> <tr> <th style="width: 15%;">Start</th> <th style="width: 15%;">End</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/> Mark service below</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> MIVIA</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Program	Service		Effective Dates		Start	End	<input checked="" type="checkbox"/> Mark service below					<input type="checkbox"/> MIVIA				
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Authorized Provider Signature

INFORMATION BELOW IS COMPLETED BY DDSD (FOR OFFICIAL USE ONLY):

Date of Review: _____	<input type="checkbox"/> APPROVED	Comments: _____
DOH Signature: _____	<input type="checkbox"/> DENIED	_____

Legal Relationships

Understanding and Working With the Guardian

Individuals naturally become legal adults at the age of 18. However, the Courts can legally appoint others to assist the individual with decision-making. The Probate Code governs most appointed guardians. The Mental Health and Developmental Disabilities Code governs treatment guardians.

Consultant Agencies must maintain a copy of the Court Order appointing guardianship in the primary file. Consultant agencies should be aware of the levels of guardianship, the timelines for appointment and the parameters of authority for each to ensure decisions are made appropriately.

The Developmental Disabilities and Support Division (DDSD) Individual Assistance and Advocacy Unit (IAA) and Continuum of Care are sources of additional information:

IAA 505.841.5528 or 800.283.5548

Continuum Care www.unmcoc.org

Types of Guardianship

Guardian Ad Litem: Court appointed attorney who protects and ensures the rights of individuals (including minors) in Court proceedings. A guardian ad litem is always appointed to represent the individual in a guardianship proceeding.

Treatment Guardian: Person temporarily appointment by the Court to assist with decisions for specific mental health treatment (i.e. medication) of an individual in a mental health facility; responsibilities are limited to these decisions. Treatment guardians should not be confused with other types of guardians.

Temporary Guardian: Person temporarily appointed (60 days) by the Court when physical health is in jeopardy. A process is available for quick appointment so emergency health and safety decisions can be made in a timely manner.

Testamentary Guardian: Person appointment by, and named in the will of, a parent and/or other legal guardian. The appointment becomes effective after the guardian's death.

Limited Guardian: Person appointed by the Court if the individual is able to make some, but not all, personal decisions and can manage some, but not all, aspects of personal care. A Court Order for limited guardianship will specify responsibilities and powers of this guardian. The individual will retain all decision-making authority.

Plenary or Full Guardian: Person appointed by the Court as responsible for all major decisions on behalf of the individual. An Order for Plenary Guardianship notes only decisions the guardian is excluded from making (i.e. decisions regarding sterilization and marriage). All other authority and responsibilities are vested in the guardian. Effective guardians work with the individual to ensure desires are identified and considered. If the guardian and individual disagree, conflicts must be resolved in a manner that supports the individual to the maximum degree possible.

Surrogate Health Care Decision-Maker: An individual with decisional capacity can appoint a surrogate health care decision-maker. If the appointment is made verbally, the individual must personally inform the health provider with primary responsibility for health care, of the appointment. The surrogate informs health care providers of treatment to provide or withhold, in accordance with the individual's wishes should the individual become unable to make his/her own decisions. If the individual does not have a guardian or appointed decision maker, the hospital's policy for designating a surrogate should be followed.

Conservatorship: Person appointed by the Court to manage the property and/or financial affairs of an individual deemed incapable of doing so (adult or minor child).

Durable Power of Attorney: Legal instrument empowering a designated person to act on another's behalf. The durable power does not lapse if the individual who executed it becomes incapable of making informed decisions. This support was originally intended to permit financial or property transactions; however, durable powers of attorney are also used to delegate authority for medical decisions.

Representative Payee: Person appointed as a representative payee to receive and manage financial benefits of the individual. The Social Security Administration, Veteran's Administration and other government agencies have specific procedures to appoint a representative payee; the appointment only applies to the specific program(s) for which it is granted.

Trust: Legal relationship created by a person (settor), in which another (trustee) manages assets for the benefit of a third party (beneficiary). A trust can help to ensure a higher quality of life for an individual, including funds to support additional education, assistance, recreation, vacations, gifts or personal amenities.

Due Process

Participants have the right to appeal a process when a service or good has been denied or if there is an adverse action. A participant must request a fair hearing within 90 calendar days from the date of the denial letter. Continuation of benefits must be requested within 13 calendar days from the date of the TPA decision letter. The TPA will mail a decision letter on the participant's request to continue benefits while a fair hearing is pending.

A re-consideration is when the participant requests another TPA review and provides additional documentation for the TPA review. The reviewer may overturn a denial based on the additional documentation. Reconsideration must be requested within 30 calendar days of the date on the denial notice. Reconsideration requests must be entered in *GCESonline* by the consultant and provide additional documentation or clarifying information regarding the participant's request for the denied services or goods.

Consultants may be requested by the State to attend a fair hearing. A summary of evidence (SOE) will be provided to the consultant agency prior to the fair hearing. Please read *Mi Via Fair Hearing Tip Sheet* and "The 16 Things You Should Know about Fair Hearings" (Appendix C and D).

The HSD fair hearings regulations are online at:

http://www.hsd.state.nm.us/mad/pdf_files/provmanl/prov83522.pdf

APPENDICES

Acronyms

Acronyms

AIDS – Auto Immune Deficiency Syndrome
ALTSD – Aging and Long-Term Services Department
BI – Brain Injury
BIA – Brain Injury Alliance of New Mexico
BIG – Brain Injury Guide
CIU – Client Information Update
CA – Consultant Agency
CM – Case Manager
CMS – Centers for Medicare and Medicaid Services
COE – Category of Eligibility
CoLTS – Coordination of Long-Term Services
DDW – Developmental Disabilities Waiver
DDSD – Developmental Disabilities Support Division
DOH – Department of Health
EDSD – Elderly and Disability Services Division
FOC – Freedom of Choice Form
FMA – Fiscal Management Agency
GCES – Greystone Computer Empowerment Systems
HCBS – Home and Community Based Services
H&P – History and Physical (form)
HSD – Human Services Department
IBA – Individual Budgetary Allotment
ICD – International Classification of Diseases
ICF/MR – Intermediate care facility for persons with developmental disabilities
ISD – Income Support Division
ISP – Individual Service Plan
LOC – Level of Care
MAD – Medical Assistance Division
MCO – Managed Care Organization
NF – Nursing Facility
PCP – Person Centered Planning
PFOC – Primary Freedom of Choice form
SOE – Summary of Evidence
SSP – Services and Support Plan and Budget
TPA – Third Party Assessor
WCF – Waiver Change Form

Incident Management Process for Disabled & Elderly and Brain Injury

Incident Management Process and Notification Forms

HSD/MAD INCIDENT MANAGEMENT SYSTEM

For: PCO, CoLTS C, Mi Via, BI Trust Fund

HSD/MAD Incident Management System refers to the reporting of abuse, neglect, and exploitation of consumers served in Medicaid-funded, community-based service programs. Incident Management also includes the reporting of consumer involvement with law enforcement or emergency services; the reporting of environmental hazards that compromise the health and safety of a consumer; and reporting the death of a consumer.

Agencies that do not comply with incident reporting requirements are in violation of state statute and Medicaid regulations and may incur provider sanctions or termination of the provider agreement by the MCO or by HSD.

Incident Management includes the policies and procedures an agency develops to address and respond to incidents; the training it provides to caregivers and consumers; and actions the agency takes to improve the quality of care provided to ensure the health and safety of consumers served. Incident Management is a critical component of a Quality Assurance/Improvement Program

INCIDENT MANAGEMENT PRINCIPLES

- Consumers should have a quality of life that is free of abuse, neglect, and exploitation
- Staff must receive initial and ongoing training to be competent to respond to, report, and document incidents, all in a timely and accurate manner
- Consumers, legal representatives, and guardians must be made aware of and have available incident reporting processes
- Any individual who, in good faith, reports an incident or makes an allegation of abuse, neglect, or exploitation will be free from any form of retaliation.
- Quality starts with those who work most closely with persons receiving services.
- Exploitation comes in many forms including Medicaid fraud.

INCIDENT MANAGEMENT REQUIREMENTS

- NMSA 1978, Section 27-7-30
http://law.justia.com/codes/new-mexico/2006/nmrc/jd_ch27art7-b845.html
Adult Protective Services
- 7.1.13 NMAC
http://dhi.health.state.nm.us/elibrary/regs/7.1.13NMAC_Incident_REP_INTAKE.pdf
Department of Health
- 8.315.4.12 NMAC B. (14), (15)
http://www.hsd.state.nm.us/mad/pdf_files/provmanl/prov83154.pdf
Personal Care Options
- 8.307.18.10 NMAC E.
http://www.nmaging.state.nm.us/EDSD/pdf_files/CoLTS-provider-dfs/8_307_18_CoLTS_C_Regulations.pdf
CoLTS C Waiver
- 8.314.6 NMAC
http://www.hsd.state.nm.us/mad/pdf_files/provmanl/prov83146.pdf

DEFINITION OF REPORTABLE INCIDENTS*

1. **Abuse, Neglect, and Exploitation**
 - a. **Abuse** is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a consumer.
 - b. **Neglect** is defined as the failure to provide goods and service necessary to avoid physical harm, mental anguish, or mental illness to a consumer.
 - c. **Self-Neglect** is defined as an act or omission by an incapacitated adult that results in the deprivation of essential services or supports necessary to maintain...minimal mental, emotional or physical health and safety;
 - d. **Exploitation** is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a consumer's belongings or money without the consumer's consent.
2. **Death**
 - a. **Unexpected Death** is a death caused by an accident or an unknown or unanticipated cause.
 - b. **Natural/Expected Death** is a death caused by a long-term illness, a diagnosed chronic medical condition, or other natural/expected conditions resulting in death
3. **Other Reportable Incidents**
 - a. **Environmental Hazard** is defined as an unsafe condition that creates an immediate threat to life or health of a consumer
 - b. **Law Enforcement Intervention** is defined as the arrest or detention of a person by a law enforcement agency, involvement of law enforcement in an incident or event, or placement of a person in a correctional facility.
 - c. **Emergency Services** refers to admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care, that is not anticipated for this consumer and that would not routinely be provided by a primary care provider.

* Incident Management System Guide for Community Based Service Provider Agencies.

REPORTING GUIDELINES

First and foremost, always ensure the safety of the consumer.

The New Mexico Adult Protective Services (APS) Act mandates: *Any person having reasonable cause to believe an incapacitated adult is being abused, neglected, or exploited shall immediately report that information to the department.*

In addition to any other reporting, incidents involving suspected/alleged abuse, neglect, and exploitation must be referred immediately to:

Adult Protective Services Statewide Central Intake
 Telephone: 866.654.3219
 Facsimile: 505.476.4913

Deaths that are the result of natural causes and/or are expected do not need to be reported to APS.

Deaths that are suspected of being related to abuse or neglect must be reported immediately to APS. If the death occurs outside of a medical facility, local law enforcement must be notified.

APS will screen all incident reports and make a determination whether investigation is warranted. If the incident involves a criminal act, local law enforcement must be notified immediately.

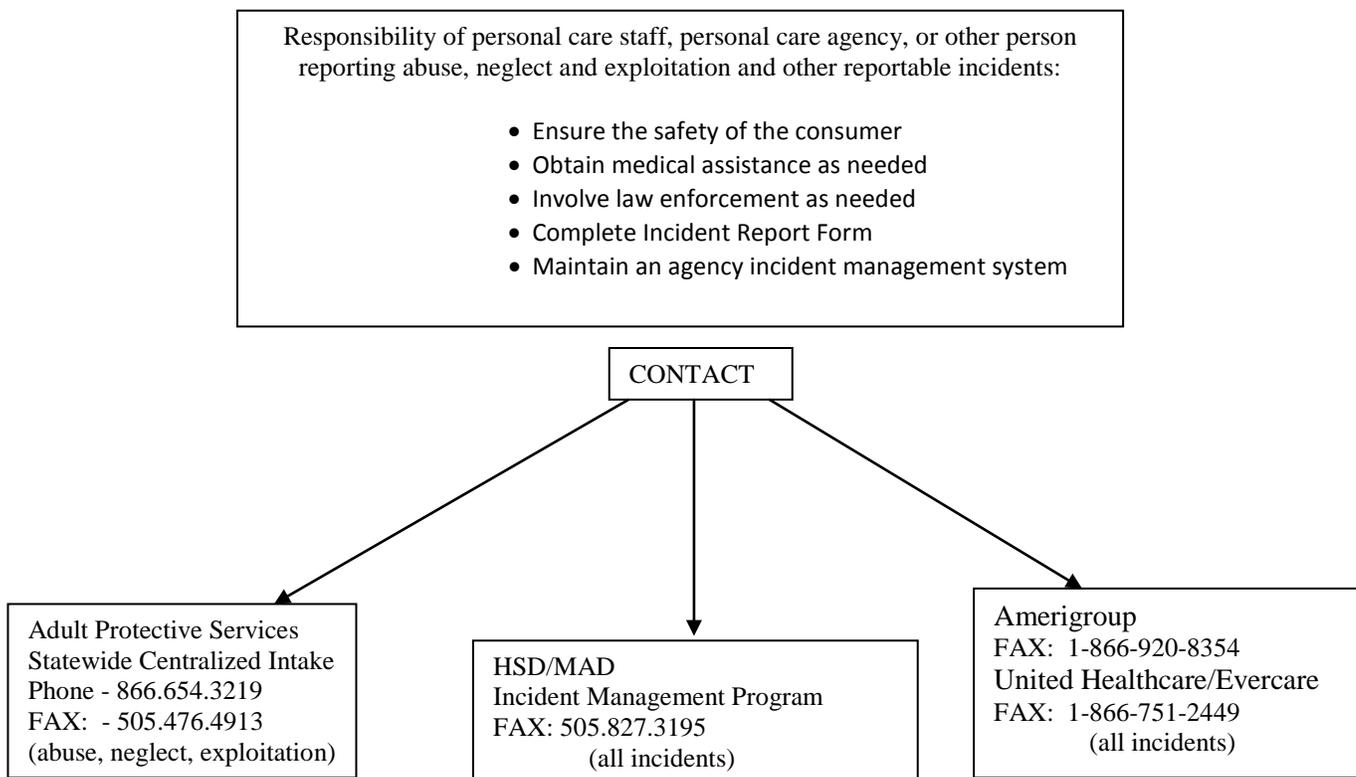
Incident reports must be submitted to the Consumer's Managed Care Organization (UnitedHealthcare/Evercare or Amerigroup) and HSD within 24 hours of knowledge of the incident. Incident reports are submitted to HSD via facsimile at 505.827.3195. The form to be used is the most

current DOH Incident form (but the reports do not go to DOH/DHI) or an Incident Report Form in Word available by faxing a request to HSD with your email address.

Submitting an Incident Report regarding abuse, neglect or exploitation to the MCO or to HSD does not relieve a provider of mandated reporting requirements to APS.

Agencies that do not comply with incident reporting requirements are in violation of state statute and Medicaid regulations and may incur provider sanctions or termination of the provider agreement by the MCO or by HSD.

CRITICAL INCIDENT REPORTING FLOW CHART



New Mexico Department of Health
Developmental Disabilities Supports Division and Public Health Division
Serving ICF and NF populationsAIDS, Developmental Disabilities and
Medically Fragile**

INCIDENT MANAGEMENT DEFINITION

Incident Management refers to the reporting and prevention of abuse, neglect, and exploitation of Participants served in Medicaid-funded, community-based service programs. Incident Management also includes the reporting of Participant involvement with law enforcement or emergency services; the reporting of environmental hazards that compromise the health and safety of a Participant; and reporting the death of a Participant. Incident Management includes the policies and procedures an agency develops to address and respond to incidents; the training it provides to agency staff and Participants; and measures the agency takes to improve the quality of care provided to ensure the health and safety of participants served in the program.

INCIDENT MANAGEMENT PRINCIPLES

- Participants should have a quality of life that is free of abuse, neglect, and exploitation
- Staff must be competent and trained to respond to, report, and document incidents, all in a timely and accurate manner
- Participants, legal representatives, guardians, employees and providers must be made aware of and have available incident reporting processes
- Any individual who, in good faith, reports an incident or makes an allegation of abuse, neglect, or exploitation will be free from any form of retaliation
- A provider's incident management system must emphasize prevention and staff involvement in order to provide safe environments for the individuals they serve
- Quality starts with those who work most closely with persons receiving services

REPORTABLE INCIDENTS

For Adults, 18 and older:

1. **Abuse, Neglect, and Exploitation**
 - a. **Abuse** is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a consumer.
 - b. **Neglect** is defined as the failure to provide goods and service necessary to avoid physical harm, mental anguish, or mental illness to a consumer.
 - c. **Self-Neglect** is defined as an act or omission by an incapacitated adult that results in the deprivation of essential services or supports necessary to maintain...minimal mental, emotional or physical health and safety;
 - d. **Exploitation** is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a consumer's belongings or money without the consumer's consent.
2. **Death**
 - a. **Unexpected Death** is a death caused by an accident or an unknown or unanticipated cause.
 - b. **Natural/Expected Death** is a death caused by a long-term illness, a diagnosed chronic medical condition, or other natural/expected conditions resulting in death.
3. **Other Reportable Incidents**
 - a. **Environmental Hazard** is defined as an unsafe condition that creates an immediate threat to life or health of a consumer.
 - b. **Law Enforcement Intervention** is defined as the arrest or detention of a person by a law enforcement agency, involvement of law enforcement in an incident or event, or placement of a person in a correctional facility.

c. **Emergency Services** refers to admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care, that is not anticipated for this consumer and that would not routinely be provided by a primary care provider.

4. **Medicaid Fraud:** The intentional deception or misrepresentation that an individual knows, or should know to be False, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other persons(s); Definition by Centers for Medicare & Medicaid (CMS).

REPORTABLE INCIDENTS

It is important for every person to take child abuse and neglect seriously and to be able to recognize when it happens. Abuse and neglect may be physical, sexual or emotional.

Definitions of Abuse and Neglect (Abuse and Neglect Act (32A-4-A, NMSA, 1978))

For Children, under 18 years:

1. **Physical Abuse includes:**
 - a. Cases in which a child exhibits evidence of a skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of a bone, subdural hematoma, tissue swelling or death, AND,
 - b. There is not a justifiable explanation for the condition or death.
2. **Sexual Abuse includes:**
 - a. Criminal sexual contact
 - b. Incest or criminal sexual penetration
 - c. Sexual exploitation (acts such as allowing, permitting or encouraging a child to engage in prostitution or obscene or pornographic photographing, or filming a child for obscene or pornographic commercial purposes)
3. **Neglect includes:**
 - a. The abandonment of a child by a parent or guardian or custodian.
 - b. The failure of a parent, guardian or custodian to provide the child with proper parental care and control or subsistence, education, medical or other care or control necessary for the child's well-being.
 - c. When a child is physically or sexually abused and the child's parent, guardian or custodian knew or should have known of the abuse and failed to take reasonable steps to protect the child from further harm.
 - d. Parental inability to discharge their responsibilities to and for the child because of parental incarceration, Hospitalization, or physical or mental disorder or incapacity
4. **Death:**
 - a. Unexpected Death is a death caused by an accident or an unknown or unanticipated cause.
 - b. Natural/Expected Death is a death caused by a long-term illness, a diagnosed chronic medical condition, or other natural/expected conditions resulting in death
5. **Other Reportable Incidents:**
 - a. Environmental **Hazard** is defined as an unsafe condition that creates an immediate threat to life or health of a consumer.
 - b. Law **Enforcement Intervention** is defined as the arrest or detention of a person by a law enforcement agency, Involvement of law enforcement in an incident or event, or placement of a person in a correctional facility.

- c. **Emergency Services** refers to admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care, that is not anticipated for this consumer and that would not routinely be provided by a primary care provider.
6. **Medicaid Fraud:** The intentional deception or misrepresentation that an individual knows, or should know to be False, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other persons(s); Definition by Centers for Medicare & Medicaid (CMS).

Mi Via CRITICAL INCIDENT REPORTING REQUIREMENTS

NF* Level of Care for AIDS

ICF Level of Care for Developmental Disabilities and Medically Fragile

First and foremost, always ensure the safety of the participant.

1. ADULT PROTECTIVE SERVICES: The New Mexico Adult Protective Services (APS) Act mandates: *Any person having reasonable cause to believe an incapacitated adult is being abused, neglected, or exploited shall immediately report that information to the department.*

Incidents involving suspected/alleged abuse, neglect, and exploitation must be referred immediately to:

Adult Protective Services Intake, 24 hours a day, 7 days a week

Telephone: 1-866-654-3219

Facsimile: 1-505-476-4913

2. CHILD PROTECTIVE SERVICES: All individuals are required by the Children's Code, Section 32A-4-3(A) NMSA 1978 to report suspected child abuse or neglect immediately to SCI or law enforcement if he or she knows, or has a reasonable suspicion that a child has been abused or neglected.[8.10.2.9 NMAC - Rp, 8.10.2.9 NMAC, 03/31/10]

CYFD Statewide Central Intake Child Abuse Hotline (1-800-797-3260); 24 hours a day, 7 days a week.

3. MEDICAID FRAUD: Fraud can take many forms including participant exploitation. All Mi Via provider agencies are responsible for preventing, reporting, and responding to Medicaid Fraud. If you know anyone committing Medicaid Fraud or are not sure if something constitutes Medicaid Fraud, please contact:

NM Human Services Department/Medical Assistance Division, Quality Assurance Bureau: 505-827-3100;

FAX 505-476-7040; email NMMedicaidFraud@state.nm.us

4. DEPARTMENT OF HEALTH; DIVISION OF HEALTH IMPROVEMENT: For all critical incidents that occur in a community-based waiver agency service setting, submit an incident report via fax or email; fax **800-584-6057**, email incident.management@state.nm.us or contact DHI at 1-800-445-6242.

5. DEPARTMENT OF HEALTH; DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION & PUBLIC HEALTH DIVISION: All incident reports must be submitted to DOH within 24 hours of the agency learning of the incident. Fax incidents to DDS at 505-841-6523 for DD and Medically Fragile or to PHD at for the AIDS waiver.

INCIDENT MANAGEMENT REQUIREMENTS FOR MI VIA CONSULTANT AGENCIES

RESPONSIBILITY OF MI VIA CONSULTANT AGENCY

- Establish and maintain Incident Reporting System
- Train all Consultant Staff on Incident Reporting
- Train all Mi Via Participants and Legal Representatives on Incident Reporting
- Ensure the safety of the Participant
- Obtain medical assistance as needed
- Involve law enforcement as needed
- Complete Incident Report Form
- Follow process below

FAX
Copy of the
Incident Report

Adult Protective Services
Phone 1-866-654-3219
FAX: 1-505-476-4913
Child Protective Services
Hotline 1-800-797-3260
Abuse, neglect, exploitation
24 hours day/7 days a week

DOH/DDS
505-841-6523
(All incidents DD & Medically Fragile)
DOH/PHD
(All incidents AIDS)

Agencies that do not comply with incident reporting requirements may incur provider sanctions or termination of the provider agreement. Community-based Waiver funded individuals who are being served by agencies that are contractors with DOH must also fax the incident report to DOH/DHI.

Fair Hearing Tip Sheet

Mi Via Fair Hearing Tip Sheet

This document is intended to help Mi Via participants and stakeholders understand the HSD Fair Hearings process. Please refer to the Mi Via regulations (8.314.6 NMAC) and the Recipient Fair Hearings regulations (8.352.2 NMAC) for the legal details.

1. Prior to requesting a fair hearing, a participant may work with his/her consultant to ask for a reconsideration of the denied request or may submit a revision to the Mi Via Third Party Assessor (TPA), Molina. Asking for a reconsideration or revision may resolve a participant's concern. Requesting a reconsideration or revision does not take away a participant's right to a HSD Fair Hearing. A reconsideration must be requested by the consultant within 30 calendar days after the date of the decision letter. The participant is responsible for asking their consultant to submit the request for reconsideration to Molina.
2. A participant may ask for a fair hearing through HSD and at the same time submit a request for a reconsideration or revision to Molina. A participant can still file for a fair hearing, per the notice in the Molina denial letter, if the reconsideration or revision does not resolve the issue.
3. A participant or the participant's authorized representative is entitled to a fair hearing through the HSD fair hearing process every time a requested good or service is denied [see regulation 8.352.2.7J NMAC at <http://www.nmcpr.state.nm.us/nmac/parts/title08/08.352.0002.htm>].
4. Molina notifies participants of their fair hearing rights through the denial letter that is mailed to the participant.
5. Other reasons for Mi Via fair hearings may include: denial of medical eligibility or reduction of the level of care by Molina (letter is sent by Molina); or a denial of financial eligibility for Medicaid (letter is sent by HSD/ Income Support Division {ISD}).
6. As stated in the Recipient Fair Hearing regulations and the Molina denial letter a fair hearing must be requested within **90 calendar days** from the date on the notice of action letter. For example, this is 90 calendar days from the date on the Molina/ISD denial letter.
7. Participants may often experience a faster resolution by communicating through their consultant to help understand the reason(s) for the denial(s). The participant may request their consultant to contact Molina on their behalf, or the participant may contact Molina directly at 1-800-916-3250.
8. The HSD or DOH Mi Via program manager may need to contact the participant to clarify the issue/denial that is being appealed through the HSD Fair Hearings Bureau.
9. Pre-hearing conference: At the hearing officer's request, a pre-hearing conference may be scheduled prior to the hearing to clarify the issues and to examine the evidence introduced by both parties. The pre-hearing conference will not delay or replace the hearing itself. Pre-hearing conferences may include the recipient and/or representative, HSD staff, DOH Staff and Molina or Xerox staff. The purpose of the conference is to informally discuss the issues, the policy that the actions are based on, sharing of evidence, and examination of pertinent correspondence.
10. A recipient, consultant or participant representative may request and be approved for one postponement of the scheduled fair hearing as long as it does not interfere with the decision time frames. [See regulations 8.352.2.13B NMAC at http://www.hsd.state.nm.us/mad/pdf_files/provmanl/prov83522.pdf]
11. Continuation of benefits means that services previously approved will continue until there is a fair hearing decision. Continuation of benefits requests are made through the HSD Fair Hearings Bureau and must be requested by the participant within 13 calendar days

from the date on the notice of action letter, for example; the notice of action is the denial letter from Molina or HSD/ISD.

12. It is important to note that a participant who receives continued benefits may be required to pay for any services or goods received under the continuation budget if the decision is in favor of the Department (8.352.2.16 (B) NMAC). In addition, while there is a continuation budget in place, no revisions may be made to the participant's budget.
13. Participants can ask anyone they wish to attend a fair hearing with them and/or testify on their behalf including an advocate or an attorney. Documentation of legal guardianship or Power of Attorney (POA) must be sent to the HSD/Fair Hearings Bureau before the fair hearing if the recipient will not appear for the fair hearing.
14. Other attendees at the fair hearing will include representatives from HSD and/or DOH, Xerox, Molina, and possibly attorneys. Depending on the issue on appeal, the consultant and/or a representative from Xerox may be asked by the state to attend as well.
15. The participant and the HSD Fair Hearings Bureau will receive a copy of the Summary of Evidence (SOE) that has been prepared, as appropriate, by HSD, DOH, Molina and/or Xerox prior to the fair hearing.
16. The participant may send any documents to the Fair Hearings Bureau to be included as evidence in the fair hearing record. The participant should send the same documents to HSD and Molina as well, because sometimes the Fair Hearings Bureau doesn't have time to forward them. Participants are encouraged to send documentation as soon as possible before the fair hearing.
17. All fair hearings are conducted by telephone, unless the participant has asked for and received an exception from the Fair Hearings Bureau to hold the meeting in person. To request an in-person fair hearing, the participant must contact the Fair hearings Bureau @ 1-800-432-6217, option 6.
18. The Fair Hearings Bureau may not be able to schedule a fair hearing for several weeks, but must give at least a 10-day advance notice of the fair hearing date/time.
19. When the participant feels that his/her issue has been resolved, the participant should withdraw the fair hearing request at any time before the actual hearing is held. Only the participant (or authorized representative) can withdraw the fair hearing request. A telephone request to withdraw can be made to the HSD Fair Hearings Bureau, but a written request will also need to be submitted via U. S. Mail to Fair Hearings Bureau, P. O. Box 2348, Santa Fe, NM 87504-2348 or fax to 1-505-476-6215.
20. Once the fair hearing is completed, the Administrative Law Judge (ALJ) writes a report and makes a recommendation for a decision. The report and recommended decision is forwarded to the Medicaid Director, who may agree with the ALJ's recommendations or may reach a different decision. **The Director's final decision will be issued to the participant within 90 days from the date of the fair hearing request (unless rescheduled, postponed or an extension has been granted).**
21. Once the Medicaid Director has issued a final decision the recipient or authorized representative has the right to file an appeal within 30 days of the date on the HSD/Medical Assistance Division final decision letter in the 1st Judicial District Courts in Santa Fe or the State District Court in the county where the person lives.

Top Sixteen Things Every Mi Via Consultant Needs to Know About Fair Hearings

Top Sixteen Things Every Mi Via Consultant Needs to Know About Fair Hearings

This is just a guidance document, sort of a 'cheat sheet' to help you understand the hearings process. Please refer to the Mi Via regulations and service standards, and the Recipient Hearings regulations for the legal details.

These are the simple facts:

1. *Every participant is entitled to a fair hearing every time a requested good or service is denied.*
2. Fair hearings must be requested within 90 calendar days from the date of the Molina decision letter.
3. Continuation of benefits must be requested within 13 calendar days from the date of the Molina decision letter. When a participant requests continued benefits, HSD/MAD will contact the consultant and let them know to develop the continuation budget.
4. Participants can ask anyone they wish to attend a hearing with them and/or testify on their behalf. However, only a legal guardian, someone with a Power of Attorney or an attorney may actually represent the participant at a hearing. Documentation of guardianship or POA must be sent to the Hearings Bureau before the hearing.
5. Other attendees at the hearing will include representatives from HSD or DOH and Molina. Depending on the issue at hand, the consultant and/or a representative from the Xerox may be asked to attend as well.
6. At least 10 days before the hearing, the participant will receive a copy of the Summary of Evidence (SOE) that has been sent from the state agencies, Molina and/or Xerox to the Hearings Bureau. The participant may also send any documents to the Hearings Bureau that they would like to be included in the hearing record. It's a wise idea to send the same documents to Molina as well, because sometimes the Hearings Bureau doesn't have time to forward them. Participants should send documentation at least 10 days before the hearing, if possible – if no one has time to review the documents prior to the hearing, the hearing may very well be postponed.
7. All hearings are telephonic, unless the participant has asked for and received an exception from the Hearings Bureau to hold the meeting in person.
8. Only the participant can withdraw their hearing request. A request to withdraw can be called in to the Hearings Bureau, but a written request will also need to be submitted via mail, fax or email.

And this is the simple reality:

9. Hearings can be very nerve-wracking for participants, mostly because they do not know what to expect. You can help them with this part of the process by making sure they understand the process and the possible outcomes and try to ensure that they have reasonable expectations. For example, a lot of participants get so upset by slow payments that they request a Fair Hearing. But the Hearings Bureau has no jurisdiction over payment issues – they can only make recommendations in cases where a service or good has been denied, reduced, or suspended.
10. Sometimes participants want to go to hearing even if they understand all this, just so that they can have their say “on the record.” That is surely their right, but experience shows that it is often not all that rewarding in the end. A lot of people will say they want to do this, and then have second thoughts and change their minds and just not show up to the hearing. That, too, is their right ... but it is also a pretty significant waste of state resources.
11. Hearings are a slow way to resolve problems. The Hearings Bureau may not be able to schedule a hearing for several weeks or even months, and then the Administrative Law Judge (ALJ) writes a recommended decision. That gets forwarded to HSD Secretary, who may agree with the ALJ’s recommendations or may reach a different decision. Her final decision will be issued to the participant within 90 days from the date of the hearing request (unless there has been an extension). If the hearing decision is not in the participant’s favor and the participant wishes to proceed with contesting a hearing decision, the next step is for the participant to file a case with the NM District Court.
12. Participants often find a smoother, quicker outcome by working with their consultant and Molina to understand the reasons for the denial(s) they are unhappy with. Then they can submit a re-consideration or revision request that may very well successfully resolve their concerns. Doing a reconsideration or revision does not take away rights to a Fair Hearing; because the participant can still file for a hearing later, if the reconsideration or revision do not solve the problem(s).
13. If a participant files for a Fair Hearing and requests a continuation of benefits, they may be required to pay for any services or goods received under the continuation budget if they eventually lose the hearing. In addition, while there is a continuation budget in place, no revisions may be made to the participant’s budget. This is because the participant has asked the state to continue benefits at a certain level, and we must honor that request which means that we cannot make any changes until after the hearing process has concluded, whether or not the participant wants us to. For this same reason, even if Molina decides half-way through the process to reverse part of the original denial, the participant will not be able to access those goods or services until after the hearing has concluded.
14. If a participant files for a Fair Hearing, Molina will begin their internal re-assessment process. That means that the whole case will get another review and consideration.

Sometimes, this results in a change of the original decision by Molina. Sometimes it opens the way for some further negotiation with Molina and the state. Of course, sometimes Molina decides to continue denying a good or service. This is another window of opportunity to try to work things out, if possible. The consultant may be contacted by Molina or the state to assist with this process.

15. While there is a Fair Hearing pending, and if there is no continuation budget in place, a participant may proceed with a revision request, maybe to try to re-work the original request and see if the problems can be resolved. Any denied items that are the subject of the hearing MUST be included on any revision request that is submitted to Molina while the hearing is pending. Why? If something is denied on the base budget, and it is not then included on the revision request, and then the revision is approved by Molina, the participant will have effectively replaced the base budget with the v2 budget which means that they will have said they no longer want the things denied on the base budget and instead want the things on the v2 budget. An alternative way of understanding this is to imagine that a service denied from the base budget is approved at the end of the Fair Hearing (or in a negotiation while the hearing is pending) – the budget that item was requested on no longer exists, because it has been replaced by a revision. So how would we add the service back to the budget?
16. A lot of the time, hearing requests are not clearly worded or there may be some other point of confusion about what the participant is trying to say or accomplish with the hearing request. Someone from one (1) of the state agencies and/or Molina may contact the consultant to ask for some assistance in better understanding the situation. Please feel free to provide all of the assistance you can – the point here is not to use anything you might say against the participant, but rather to make sure that everyone understands everyone else’s expectations and concerns. And hopefully, all that understanding will ultimately lead to the best result possible for the participant.

If you have any questions about the process in general, any of the above points, or perhaps a specific case that you are involved in, please do not hesitate to contact Kathryn Gallegos at HSD, or Pat Syme at DOH for assistance.

For a complete copy of the New Mexico Human Services Department, Hearings Bureau Policies, 8.352.2 NMAC, please go to http://www.hsd.state.nm.us/mad/pdf_files/registers05/FairHearingspro.pdf.

Mi Via Quarterly Update Form

Mi Via Quarterly Update Form

Participant: _____ Location of Update: _____
Consultant: _____ Date of Quarterly Update: _____
Quarter (Circle one): **1** **2** **3** **4** Date of last Annual Plan: _____

1. Do you feel your quality of life has improved in any way as a result of your participation in the Mi Via Program? If so, how? If not, why?

2. What services have you been able to access through Mi Via during this budget year?

3. Describe the quality of the **services** you have been able to access through Mi Via.

4. What goods have you been able to access through Mi Via during this budget year?

5. Describe your satisfaction with **goods** you have received through Mi Via.

6. What goods and services have you **not** accessed? Why?

For in person meeting only: Please show me any of the goods or environmental modifications you have received through Mi Via?

7. Have you faced any barriers in accessing goods or services through Mi Via?

8. If yes, what barriers have you faced?

9. Let's review the Emergency-/ Back up Plan. Have you had to use your emergency back-up plan since developing it?

10. Is your emergency back-up plan still working for you?

11. Are the phone numbers and contacts up to date? Can we do anything to update it or bring it current?

12. Would additional training to a provider(s) support you to be more successful in Mi Via? If so, in what areas?

13. Since your last quarterly, have you been in any of the following settings?

- a. Hospital (__/__/__ to __/__/__)
- b. Nursing Home or inpatient Rehabilitation Facility
(__/__/__ to __/__/__)
- c. Correctional setting/ Jail (__/__/__ to __/__/__)
- d. Out of state for an extended period (one month or more)
(__/__/__ to __/__/__)

14. Do you feel, you have been abused, neglected or exploited? Do you feel your rights have been violated in any way?

15. Have you had any contact with APS?

16. Is there anything else you would like to include in this Quarterly Update?

Topics for review with the Consultant during the Quarterly Meeting:

1. Mi Via spending and budget utilization, using the monthly Spending Report or other report generated from the GCESonline system.
2. Any changes in need, access to services/caregivers or Level of Care
3. Level of Care and ISP dates, including reminders as appropriate
4. Review of guidelines for personal representative and participant support, when applicable, in completing release of information or Authorized Agent form.
5. Review of guidelines related to Legally Responsible Individuals and participant support, where necessary, to obtain necessary justification
6. Documentation that will be needed for justification of services/ goods anticipated in the coming budget year.
7. Do you have a copy or have access to the most current Mi Via Regulations and Service Standards? (If not, the Consultant can direct them to Xerox to have a copy mailed or show them how to access from the Mi Via Website.)

Environmental Modification Funds Verification



ENVIRONMENTAL MODIFICATION (EM) FUNDS VERIFICATION FORM

Mi Via EM services are not funded through the participant's annual authorized budget. Funding for adaptations is available & limited up to \$7,000 every five (5) years. An individual transferring into Mi Via from a traditional waiver shall carry forward history of EM funding; for a new Mi Via participant, the 5 year time period shall be tracked starting on the date of the first SSP approved & paid EM Payment Request Form (EM PRF). State staff shall verify payments in Omnicaid. This Funds Verification form shall accompany the EM Service Cost Quote Packet for TPA review.

1.) CCA completes and **emails** to appropriate state agency:

HSD/MAD -- DE and BI: Betty.Sangre@state.nm.us

DOH/DDSD -- DD, MF: Pat.Syme@state.nm.us

DOH/PHD -- AIDS: Genevieve.Rel@state.nm.us

Consultant: _____ FAX: _____ Phone: _____

Participant Name: _____ **SS#:** _____ **Phone:** _____

Complete address:

- Which program did the participant enter Mi Via? DE _____ DD _____ MF _____ AIDS _____ BI _____
 - Has the participant received environmental modification funds in the past? Yes _____ No _____
-

2.) STATE completes this section:

- Date inquiry received: _____
- History: Has the participant used EM funds prior to, or in, Mi Via? Yes _____ No _____
- If yes, what modifications did the participant use the funds for? (Include date, list funds authorized, by amount, approved for what item(s) and what company, if billed, if paid, etc.) _____
- Begin/End date of 5 year period: _____
- Funds or balance available: \$ _____

Comments:

HSD/MAD: _____
Signature/date

DOH: _____
Signature/date

Reviewed by: _____
Signature/date

3.) CCA, upon return from the state, please attach this completed form with SSP & Budget for review by TPA.

Authorized Agent Instructions & Form

Appointment of Authorized Agent Instructions

This form provides step by step instructions on how to fill out the Appointment of Authorized Agent Form that was submitted with this form. The Authorized Agent Form will allow you as a Mi Via Participant, to choose someone to be your Authorized Agent. Your Authorized Agent you chose will be able to talk to the companies about you and the Mi Via Program. Below are the steps on completing the form.

Page 1 of the form:

1. Enter the participant's name in the box labeled "Name of Participant".
2. Enter the participant's Date of Birth in the box labeled "Date of Birth".
3. Enter the last four (4) digits of the participant's Social Security Number in the box labeled "last four (4) digits of the Participant's Social Security Number".
4. Enter the first and last name of the authorized agent in the box labeled "Name of Authorized Agent".
5. Enter the Authorized Agent's Date of Birth in the box labeled "Authorized Agent's Date of Birth".
6. Enter the Authorized Agent's Street Address in the box labeled "Authorized Agent's Street Address, City, State, and Zip Code."
7. Enter the Authorized Agent's Relationship to the participant and telephone number in the box labeled, "Relationship to the Participant, Telephone Number".
8. Enter the last four digits of the Authorized Agent's Social Security Number in the box labeled, "Last four (4) digits of Authorized Agent's Social Security Number".
9. The Authorized Agent must sign the box labeled, "I agree to be the Authorized Agent for this participant, Signature, Date".

Page 2 of the form:

1. The participant is to check off the boxes and initial next to the company that can release information to his/her Authorized Agent.
2. Sign and date the Form.



Martinez

Governor **Susana**

Catherine Torres, MD, Cabinet Secretary, Department of Health
Sidonie Squier, Cabinet Secretary, Human Services Department

Appointment of Authorized Agent

This form allows me, as a Mi Via Participant, to choose someone to be my Authorized Agent. My Authorized Agent can be anyone of my choosing; even if they are my Legal Guardian, Power of Attorney (POA), parent or spouse. The person I choose to be my Authorized Agent will be able to help me and will also have my permission to talk to the companies I have chosen on this form. After we (I and my chosen Authorized Agent) sign this form, my Authorized Agent will be able to talk to these companies about me and the Mi Via Program.

This form does NOT allow my Authorized Agent to do the job of the Employer of Record (EOR) as written in the Mi Via Regulation, found in 8.314.6 NMAC. Also, my Authorized Agent may NOT hire or terminate any employee.

Last four (4) digits of the Participant’s Social Security Number: _____

Name of Authorized Agent: _____

Authorized Agent’s Date of Birth _____

Authorized Agent’s Street Address: _____

City: State: Zip Code: _____

Relationship to Participant: Telephone Number: _____

Last four (4) digits of Authorized Agent’s Social Security Number: _____

I agree to be the Authorized Agent for this participant _____

Signature: Date: _____

These companies can give my Authorized Agent information about me on the Mi Via Program.

The Participant must check the checkboxes and also write their initials next to each company so that the company can provide information to the Authorized Agent.

- ___ Financial Management Agency (FMA): Xerox
Phone: 866-916-0310
- ___ Third Party Assessor (TPA): Molina
Phone: 866-916-3250
- ___ Consultant Agency: _____
(Consultant agency name)
Phone: _____

Authorization Signature

I understand that by completing and signing this form, I give my permission to the companies shown above to give information to my Authorized Agent. After both my Authorized Agent and I sign this form, my Authorized Agent will be able to get information about me on the Mi Via Program; but he or she will NOT be able to make decisions for me. For example, my Authorized Agent will not be able to hire or terminate any employee. My Authorized Agent will also NOT be able to sign any paperwork for me as the Employer of Record (EOR). Even though I have an Authorized Agent, my mail will still be sent to me. If I want to stop having mail sent to me and I want it to be sent to someone else, I will send a letter to ACS with the name and address of where I want my mail to be sent. I also understand that if I want to stop someone from being my Authorized Agent, I will contact ACS and let them know I no longer want this person to be my Authorized Agent.

I have read and understand the above information.

Signature of Participant /Legal Guardian/POA/Parent (if Participant is a minor):

Date: *Note: Expiration Date is one (1) year from the signature date.*

I understand that if the information on this form is not complete it will be returned to me to make corrections. The person I have chosen will not start as my Authorized Agent until this form has been filled out correctly with all the necessary information.

I understand that I can have more than one Authorized Agent. If I want more than one person to be my Authorized Agent, I will fill out a form for each person. If I need more forms, I can get them from ACS-FMA or my Consultant.

**REQUEST FOR SERVICES BY
LEGALLY RESPONSIBLE
INDIVIDUALS (LRI)**



REQUEST FOR SERVICES BY LEGALLY RESPONSIBLE INDIVIDUALS

Mi Via Self-Directed Medicaid Waiver Program services provided by a legally responsible individual (LRI) MUST be justified, in writing, and submitted for State approval. An LRI is any person who has a duty under State law to care for another person and typically includes: the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or a spouse of a waiver participant. LRIs may be paid for waiver services, under extraordinary circumstances, in order to assure the health and welfare of the participant and avoid institutionalization. The LRI request must be completed with both initial and annual Service and Support Plans (SSP).

Criteria for an LRI request:

- The waiver service the LRI is requesting to provide must not be a service the LRI would ordinarily perform in the household for individuals of the same age who did not have a disability or chronic illness.
- The waiver service the LRI is requesting to provide must not be a service available to the participant through another source. **Example:** Children who receive homemaker/companion services through the state plan, including EPSDT program or Medicaid school-based services, would not be able to purchase duplicate homemaker/companion services through Mi Via.
- The LRI must not be the Employer of Record for the participant.
- The LRI request must list the waiver service that the LRI wishes to provide and must include documentation describing in detail how the LRI request meets the criteria.
- All sections (1-5) of the LRI request form must be completed or included on additional paper as needed. The LRI request will be denied if all sections (1-5) are not completed.

Participant Name _____ Date of Birth _____

Medicaid Card ID # _____ Phone _____

Address _____

Employee Name _____ Waiver Service to be provided _____

SSP Dates _____ Initial _____ Annual _____ Revision _____

Legal Relationship to Mi Via Participant _____

Participant/Legal Rep Signature _____ Date _____

Mi Via Participant Name

_____ (First) (Middle) (Last)

All sections (1-5) of the LRI request form must be completed or included on additional paper as needed. The LRI request will be denied if all sections (1-5) are not completed. The following information MUST be submitted with each LRI request:

1. Extraordinary circumstances of the participant’s situation that lead to making this request.

2. Attempts that have been made to find other qualified, suitable providers.

3. Unique needs of the participant that requires the LRI to provide the service.

4. Special skills and abilities that enable the LRI to meet the unique needs of the participant.

5. Specific job duties/tasks the LRI is requesting to provide.

Mi Via Participant Name

(First)

(Middle)

(Last)

Additional Information (optional):

Your Right to a Fair Hearing

If you disagree with the action taken on your request for a Legally Responsible Individual (LRI) to provide waiver services, you have a right to request a fair hearing within 90 days of the date of this letter. The request must be received by the Human Services Department (HSD) Hearings Bureau/Medical Assistance Division and the Aging and Long-Term Services Department no later than the close of business on the 90th day. You can request a fair hearing orally or in writing. You can send your written request for a fair hearing to HSD's Hearings Bureau at P.O. Box 2348, Santa Fe, New Mexico 87504-2348; you can also request a fair hearing by telephoning the Hearings Bureau at 1-800-432-6217 or (505) 827-8164. You may also contact your local Income Support Division office or the Hearings Bureau to receive help with submitting a request for a fair hearing.

You have the right to look at any documentation used to make the decision regarding your request for a Legally Responsible Individual (LRI) to provide waiver services. At the hearing, you may represent yourself or have a friend, relative, attorney or other person represent you, as well as an opportunity to present your case. You will receive a written decision based on the record made at the hearing.

<p>Mi Via State Office Use Only <input type="radio"/> Approved <input type="radio"/> Denied</p> <p>Notes _____</p> <p>_____</p> <p>State Authorized Signature _____ Date _____</p>
--

Consultant Agency Change Letter of Transfer

Letter of Transfer



Date:

Participant:

SS #:

DOB:

Complete address:

Phone number:

This letter is to confirm that the transition meeting and the transfer of records from the previous consultant agency, _____, to the new consultant agency, _____ has occurred. This transition will be effective as of _____. (Must be the first of a month)

Meeting Minutes:

The records included in the transfer contain the following information:

Document(s)	Y/N/NA	Title/Date of Document	Pending or not yet obtained who will be responsible for obtaining	Date received
Current Year Assessments				
LOC				
ICD 9 form (BI only)				
SSP; attached documents & SSP & budget revisions				
Current Approval Letter from ISD				
Meeting notes and correspondence as available				
Medical Reports/History & Physical				
Other evaluations				
Current IEP, DVR Plan, Private Duty Nursing Plan				
Allocation Letter/Waiver Change Form (s)				
Guardianship/POA paperwork				
EOR Information form				
One full year of case notes (narratives) and quarterly visit forms				
Other pertinent information				

If there are any questions, the previous agency's contact person is (name, title and phone):

Signature/title of sending agency/date Signature/title of receiving agency/date

By signing below, I confirm that I attended the transition meeting in person or by phone. I understand that in addition to the documents included in this Letter of Transfer _____ Consultant Agency, the receiving consultant agency, will have view-only access to my electronic Mi Via records to assist in the transition and make sure that I do not have any break in consultant services. View-only access will be granted to _____ upon submission of this signed form to the appropriate Program Manager or Regional Office for entry into the system. Complete access will be provided on the effective date of this transition.

Signature of participant/legal representation



Transfer to a Different Consultant Agency

If a participant/legal representative chooses to select a different consultant agency, the steps listed below must be followed so important information is provided to the receiving agency and to ensure the participant's health and safety. ***Participants are not responsible for the transfer of required paperwork but they or their legal representative must participate in the transfer process.***

At any time the participant can decide not to change CAs and remain with the current CA. The participant is not required to tell the CA why they wish to transfer, but CA may ask for quality purposes. Participant may offer such info to the State but the State will not ask the participant.

1. *It is the responsibility of the participant or their legal representative to contact the appropriate Mi Via state staff to initiate a consultant agency change.*
 - a. *For the DD Mi Via population, contact the local Developmental Disabilities Supports Division (DOH/DDSD) Regional Office to initiate the Freedom of Choice (FOC). For the AIDS and MF Mi Via population, contact the appropriate Mi Via Program Manager at DOH to initiate the FOC process.*
 - b. *For the CoLTS or BI Mi Via population, contact the appropriate Mi Via Program Manager at HSD to initiate the Consultant Agency Change form (CAC) process.*
2. Once the FOC/CAC has been received by the appropriate Mi Via Program Manager and/or by DDSD Regional Office, it is forwarded to both the current and new consultant agency within 5 working days. Transfer meetings must occur or be scheduled within 5 calendar days of receipt by the consultant agency and the transfer must be completed within 30 days of receipt of the FOC/CAC.
3. The transferring consultant agency will contact the receiving consultant agency and participant /legal representative to schedule a transfer meeting.

4. The participant or their legal representative must be present. A Release of Information (ROI) shall be completed prior to the meeting so the exchange of information may occur. The transfer meeting must occur in person.
5. The transfer meeting will include the following:
 - a. Discussion of the critical clinical issues that need immediate follow up as well as historical information regarding the individual which include, but are not limited to:
 - i. Date of the Level of Care (*LOC*) and Service and Support Plan (*SSP*)
 - ii. Current services/goods on the SSP budget
 - iii. Any budget revisions in process
 - iv. Any Medical Issues (medications, adaptive equipment, allergic reactions, therapy needs etc.)
 - v. Guardianship and Power of Attorney orders and related documents
 - vi. Medicaid, Medicare, other Third Party Coverage documents
 - vii. Problems identified by the transferring consultant agency that the receiving consultant agency should be aware of.
 - viii. Agreement on the date that the receiving consultant agency will become the official consultant agency of record. The effective date must always be the first of a month.
6. Copies of the following documents must be presented to the receiving consultant agency in person or via registered mail by the transfer meeting date. The transfer meeting may not be held until all required documents are available for transfer to the receiving consultant agency. The actual transition cannot occur until all documents are provided to the new consultant agency. The transferring consultant agency retains the original documents, which may be archived but must be available at the request of the HSD or DOH in accordance with Medicaid regulations.
 - a) Current year assessments

- b) Current LOC: TPA approval letter, Long Term Care Abstract, Individual Budgetary Allocation (IBA)
 - c) ICD 9 Form (BI only)
 - d) Current SSP and SSP revisions –Current TPA documents, approval/denial letters, Requests for Information, support documents to the SSP including justification or denial letters from Third Parties, Legally Responsible Individual permissions, additional funding documentation, environmental modification paperwork or any relevant reports or documents used to prepare the SSP
 - e) Current approval letter from ISD
 - f) Meeting notes and correspondence as available
 - g) Medical reports (primary care physician, specialists that may impact the SSP or LOC)
 - h) Other Evaluations as applicable (therapy, vocational, rehabilitation)
 - i) Current Individual Education Plan, DVR Plan, Private Duty Nursing plan (if applicable)
 - j) Allocation letter/Waiver change form
 - k) Guardianship/POA paperwork
 - l) Employer of Record Information Form
 - m) One full year of case notes (narratives) and quarterly visit forms
 - n) Other pertinent information
7. After the transfer meeting occurs, a *Letter of Transfer and Receipt* must be presented by the receiving consultant agency to the transferring consultant agency that lists:
- a) Effective date of consultant agency transfer;
 - b) Documents that are transferred;
 - c) Missing documents;
 - d) *LOC*, *SSP*, and *ISD* expiration dates;

- e) *Release of Information* for the receiving consultant agency to complete in order to request documents from generic or other supports that the transferring consultant agency may not have requested or received; and
- f) Issues that need immediate follow-up.

Representatives of both consultant agencies must sign the Letter of Transfer and Receipt document as well as the participant/ legal representative. The Letter of Transfer will be sent by the receiving agency to the appropriate Mi Via Program Manager or Regional Office (DD only) for entry into the *GCESonline* system to be associated with the participant on the effective date of the transfer. The State will send the Letter of Transfer to Molina and HSD/ISD to inform them of the transfer. Alerts will be sent to both transferring and receiving consultant agencies when final agency transfer has been made in the *GCESonline* system.

Improper Solicitation Policy

Department of Health Developmental Disabilities Supports Division <p style="text-align: center;">POLICY</p>	Policy Number: Supersedes: Improper Solicitation of Business Policy 1-1-03; Guideline, Solicitation of Business, 7-1-99, Ms. Flores-Lopez
Policy Title: Improper Solicitation of Business	
Effective Date: February 12, 2010	
Approved: Signature on File	Date: February 11, 2010

I. PURPOSE

To ensure that an individual's right to freedom of choice of case management agencies and direct service providers is honored and respected.

II. POLICY STATEMENT

A. Selection of a Case Management Agency

1. Individuals have the right to choose a case management agency from a list of providers approved by the Developmental Disabilities Supports Division (DDSD). This right pertains to the selection of an agency, not of specific case managers who work within the agency.
2. Agencies conducting intake and other procedures pertaining to application for services have an obligation to share information with individuals about all of the case management agencies, presented in an unbiased manner. Choosing a case management agency (Primary Freedom of Choice) may not be initiated by a direct service provider, as this may unduly influence in the individual's selection. Individuals should contact the DDSD Regional Office to initiate the Primary Freedom of Choice process. The Regional Office staff will discuss the individual's desire to change case management agency. Once the individual has submitted the completed Primary Freedom of Choice form to DDSD, it will be forwarded to the local ISD office.

B. Selection of Direct Service Providers

1. Individuals have the right to choose direct service providers approved by DDSD.

2. Choosing a direct service provider (Secondary Freedom of Choice) is an action carried out by the individual with the case management agency. If an individual indicates a desire to change a direct service provider, the individual is to contact their case manager to complete a Secondary Freedom of Choice form.
3. Case managers have an obligation to share information about all of the choices of service providers, including a responsibility to advise the individual to consider another provider when the current one is not providing services to the satisfaction of the consumer. However, the case management agency should inform a provider of the individual's issues and attempt to resolve those issues prior to the selection of an alternative provider.

C. Improper Solicitation by Case Management or Direct Service Providers

1. Agencies and their staff shall not engage in improper solicitation with the intent of getting a client and/or parent/guardian to select a specific provider.
2. Federal Medicaid regulations prohibit the use of marketing materials and practices that are inaccurate or misleading, confuse, or defraud an individual.
3. For the purpose of this policy, improper solicitation includes, but is not limited to, the following actions:
 - a. Asserting or implying a client will lose benefits if the individual fails to select a certain provider;
 - b. Making inaccurate, misleading, or exaggerated statements designed to influence the individual's choice of a provider;
 - c. Asserting or implying that the provider offers unique services when other providers offer the same or similar services;
 - d. Asserting that a specific provider will gain benefits for the individual; for example, get a service approved when it was previously denied;
 - e. Using gifts or the promise of gifts or other improper incentives to influence or entice an individual to select a provider.
4. Providers may develop and distribute information or educational materials about their agency and services.
5. A current list of approved providers for all DDS services is available by contacting the DDS Community Programs Bureau Chief or a DDS Regional Office.

III. DEFINITIONS

- A. *Case Manager*: the person who performs case management or service coordination duties in accordance with DDS regulations and standards for these services; the term case manager is synonymous with service coordinator for the purpose of this policy.

- B. *Freedom of Choice*: the selection of service providers under the Medicaid Waiver Programs. *Primary freedom of Choice*: refers to selection of a case management agency. *Secondary Freedom of Choice*: refers to selection of other direct service providers.
- C. *Gifts*: any item with a value greater than ten dollars; e.g. cash, coupons, or prizes.
- D. *Individual*: is the person receiving services, through DDS to whom this policy applies; or, the individual who is in the process of eligibility determination for applicable services; or who has been determined eligible. The term also applies to legal guardian or parent of a minor child.
- E. *ISD*: Income Support Division, of the New Mexico Human Services Department.
- H. *Solicitation (Improper)*: is the act of approaching someone with a request or a plea with the intent of influencing a decision; includes verbal or written communication that has the potential to unfairly bias an individual's selection of either a specific case management agency or direct service provider

IV. APPLICABILITY

This policy applies to all services to any entity with a provider agreement or contract with the Developmental Disabilities Supports Division, Department of Health.

V. REFERENCES

- A. 8 NMAC 200.430.10
- B. 7 NMAC26.9.9.1
- C. 7 NMAC26.9.8.5
- B. 42 CFR Section 431.54(e)
- C. MAD-604, Medical Management

Status Notification Form



STATUS NOTIFICATION FORM

Date <i>(m/d/yyyy)</i>		Submitted by which Agency		Submitted by Whom	
Participant		SSN		Current Waiver	...
Status Updates		Date <i>mm/dd/yyyy (dates are required)</i>		Comments -Specify Changes <i>(e.g., name of institution, contact info, change reported by whom)</i>	
<input type="checkbox"/>	Death	Date of Death			
<input type="checkbox"/>	Hospitalization	Admit Date	Discharge Date		
<input type="checkbox"/>	ICF/SNF	Admit Date	Discharge Date		
<input type="checkbox"/>	Moved Out of State	Last Date of NM Residency			
<input type="checkbox"/>	Incarceration	Admit Date	Release Date		
<input type="checkbox"/>	Participant chose to hold allocation (DD and MF only)	Date Allocation-Hold was Requested			
<input type="checkbox"/>	Change in contact information				
<input type="checkbox"/>	Other				
Distribution by email only. Type Status Notification in email Subject line.				Contact	
<input type="checkbox"/>	HSD/Medical Assistance Division (HSD/MAD – DE, BI)		Betty Sangre Betty.Sangre@state.nm.us		
<input type="checkbox"/>	Department of Health (DOH – DD, MF)		Pat Syme Pat.Syme@state.nm.us		
<input type="checkbox"/>	Department of Health (DOH -- AIDS)		Genevieve Rel Genevieve.Rel@state.nm.us		
<input type="checkbox"/>	HSD/Income Support Division (HSD/ISD)		<i>Specify ISD County Office (required)</i>		
<input type="checkbox"/>	Mi Via Consultant Agency (CA):				
<input type="checkbox"/>	Mi Via Third Party Assessor (TPA): Molina HealthCare (Molina)		Kim Shipman kim.shipman@molinahealthcare.com		
<input type="checkbox"/>	Mi Via Financial Management Agency (FMA): Affiliated Computer Services, Inc (ACS)		Mi Via mi.via@acs-inc.com		
<input type="checkbox"/>	Managed Care Organization (MCO): AMERIGROUP		Mi Via nmlcscomm@amerigroupcorp.com		
<input type="checkbox"/>	Managed Care Organization (MCO): Evercare		John J. Bennett john_j_bennett@uhc.com		

Status Notification Form 03/23/12

MAD Documentation Policy

MAD Documentation Policy

8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. [42 CFR 431.107(b)]. Services billed to MAD not substantiated in the eligible recipient's records are subject to recoupment. Failure to maintain records for the required time period is a violation of the Medicaid Provider Act, NMSA 1978 section 27-11-1, et. seq., and a crime punishable under the Medicaid Fraud Act, NMSA, section 30-44-5. See 8.351.2 NMAC, *Sanctions and Remedies*.

A. Detail required in records: Provider records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services; length of a session of service billed, diagnosis and medical necessity of any service.

(1) When codes, such as the international classification of disease (ICD) or current procedural terminology (CPT), are used as the basis for reimbursement, provider records must be sufficiently detailed to substantiate the codes used on the claim form.

(2) Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

C. Services billed by units of time: Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.

D. Recipient funds accounting systems: If an eligible recipient entrusts his personal funds to a nursing facility, intermediate care facility for the mentally retarded, or swing bed hospital, or any other facility, the facility provider must establish and maintain an acceptable system of accounting. See 42 CFR 445.22.

E. Record retention: A provider who receives payment for treatment, services, or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

- (1) treatment or care of any eligible recipient;
- (2) services or goods provided to any eligible recipient;
- (3) amounts paid by MAD on behalf of any eligible recipient; and
- (4) any records required by MAD for the administration of medicaid.

[2-1-95; 2-1-99; 8.302.1.17 NMAC - Rn, 8 NMAC 4.MAD.701.8, 7-1-01; A, 9-15-08]

Billing Instructions

Billing Instructions for the Consultant Agency for Mi Via

	S5190- Pre-Eligible – No Medicaid Eligibility	S5190- Pre-Eligible – Non-Waiver Medicaid Eligibility	T2025- Waiver Eligibility
Eligibility	Client does not have any Medicaid eligibility.	Client has Medicaid eligibility, but does not have waiver (090-096) eligibility.	Client must have waiver (090-096) eligibility.
Client ID	Bill using the dummy client ID- COE + two zeros + SSN (09600123456789)	Bill using the Medicaid client ID.	Bill using the Medicaid client ID.
Billing Limit	Three months*	Three months*	None (assuming the client is eligible for the waiver)
Dates of Service	First Date of Service- First day of the month Last Date of Service- Last day of the month	First Date of Service- First day of the month Last Date of Service- Last day of the month	First Date of Service- First day of the month Last Date of Service- Last day of the month
Monthly Rate	\$143.00* plus GRT	\$143.00* plus GRT	\$215.00* plus GRT

- Confirm that the correct client ID is being submitted for the appropriate client based on name.
- Confirm eligibility prior to billing.
- Claims are processed the week they are submitted and are paid or denied and will appear on the Remittance Advice the following week. Clean claims will be paid the week after they are submitted assuming no exceptions posted to the claim to make it suspend.
- If consultant begins working with the client on 10/13/11, then the Consultant Agency would bill for dates of service of 10/1/11-10/31/11. The provider should bill the first date of service as the first day of the month in which the consultant began working with the client, other than for transitioning clients. All clients should transition on the first of the month, so this should not be an issue.
- Claims cannot be billed prior to the last date of service.
- Confirm if there is a Date of Death on file.
- For claims that are being submitted for clients that are deceased, the Consultant Agency would bill the first date of the month as the first date of service and the date of death as the last date of service. Even though the submitted amount is a monthly per member per month rate, the last date of service cannot be past the date of death due to audits and potential recouping of claims.
- Any participant transitioning from one CA to another CA needs to transition on the first of the month.
- For community reintegration's, the CA would still bill according to the instructions above.
- For transitions from the traditional waiver to Mi Via or vice versa, the CA should bill the waiver eligible code assuming the client still has active waiver eligibility while they work to transition the client.
- Place of Service: 12 – Home
- Units: 1 (since this is a monthly code)

- The client's actual diagnosis code should be included on the claim. This is the diagnosis from the physician. If the diagnosis is not known because the client has not seen a physician yet, then the 799.9 diagnosis code should be used.

- If more than three months of pre-eligibility are required, then documentation supporting the justification must be submitted to the State for approval. Please submit the documentation to the appropriate program manager.

BI and CCW- Orlando Vasquez at Orlando.Vasquez@state.nm.us

DD and MF- Pat Syme at Pat.Syme@state.nm.us

AIDS- Genevieve Rel at Genevieve.Rel@state.nm.us

Consultant Agencies Contact List

Consultant Agencies Contact List– 2/14/12

AAA Participant Direction – serves Statewide

- Contact Dave Murley
- Phone: 505-450-5974; Fax 888-334-7353
- Address: POB 8368, ABQ 87198-8368
- Email: aaapd4@gmail.com

Care Network Resource Group –serves Metro, SE and SW

- Contact Gale Idstein
- Phone: 575-650-0053; fax 877-702-8014
- Address: 133 Wyatt Ste. 10, Las Cruces, NM 88005
- Email: gidstein@cnragusa.com

Center for Development and Disability (UNM) - serves Statewide

- Contact Tanya Baker-McCue
- Phone: 505-272-5641; fax 505-272-5883
- Address: 2300 Menaul NE, Albuquerque NM 87107
- Email: tbaker-mccue@salud.unm.edu

Consumer Direct Personal Care – serves Statewide

- Contact Lucas O’Connell
- Phone: 505-884-3116 or toll free 866-786-4999; fax 866-786-4955
- Address: 3311 Candelaria NE, Suite K, ABQ 87107-1959
- Email: lucaso@consumerdirectonline.net

Self Directed Choices, LLC – Serves Metro, NE & NW

- Contact Sandy or Don Skaar
- Phone: Office number: 505-508-1663; Toll-Free phone number: 877-464-1252; Sandy Cell phone: 505-301-5179; Don Cell phone: 505-301-2098
- Address: 3909 Juan Tabo Blvd NE, Suite 2 Albuquerque, NM 87111
- Email: Sandy@SDChoices.com ; Email: Don@SDChoices.com
- Web: www.SDChoices.com

Toll-Free Fax: 1-888-541-7076

Please try to avoid contacting ISD as much as possible.

- They are absolutely swamped with food stamps and cash assistance
- Very few workers have access to the web portal
- Workers can't fix anything on Omnicaid
- It's a lot better and can be faster, if I can figure out what the problem is first

Contact Kathryn Karnowsky directly when:

- There appears to be an error in Social Security number, date of birth, gender
- There are retroactive coverage issues
- The client says (s)he approved it or the client is notified that it was approved but it's not visible on the web portal
- Names appear to be mixed up
- Problems you can't figure out

Kathryn Karnowsky - 505 476-6867

Kathryn.karnowsky1@state.nm.us (email is preferable as I can view it remotely)

**Mi Via Contacts
Developmental Disabilities
Supports Division**

Mi Via Contacts- Developmental Disabilities Supports Division

<p>Metro Regional Office 5301 Central Avenue NE Suite 1700 Albuquerque, NM 87108 Main: (505) 841-5500 Toll Free: (800) 283-5548</p>	<p>Serves the counties of Bernalillo, Sandoval, Torrance, and Valencia Contact: Rose Mary Williams Regional Director: Kathleen Linnehan</p>
<p>Northwest Regional Office 2910 E 66 Gallup, NM 87301 Main: (505) 863-9937 Toll Free: (866) 862-0448</p>	<p>Serves the counties of Cibola, McKinley and San Juan Contact: Dennis O’Keefe Regional Director: Crystal Wright</p>
<p>Northeast Regional Office 224 Cruz Alta Suite B Taos, NM 87571 Main: (575) 758-5934 Toll Free: (866) 315-7123</p>	<p>Serves the counties of Colfax, Harding, Los Alamos, Mora, Rio Arriba, San Miguel, Santa Fe, Taos and Union Contact: Fabian Lopez Regional Director: Charlene Cain</p>
<p>Southwest Regional Office 1170 N. Solano Drive, Suite G Las Cruces, NM 88001 Main: (575) 528-5180 Toll Free: (866) 742-5226</p>	<p>Serves the counties of Catron, Dona Ana, Grant, Hidalgo, Luna, Otero, Sierra and Socorro Contact: Zack Robinson Regional Director: Scott Doan</p>

<p>Southeast Regional Office 726 South Sunset, Suite B Roswell, NM 88023 Main: (575) 624-6100 Toll Free: (866) 895-9138</p>	<p>Serves the counties of Chaves, Curry, De Baca, Eddy, Guadalupe, Lea, Lincoln, Quay and Roosevelt Contact: Jessica Renteria Regional Director: Jessica Renteria</p>
	<p>For Medically Fragile</p>
<p>Metro Regional Office 5301 Central Avenue NE Suite 1700 Albuquerque, NM 87108 Main: (505) 841-5500 Toll Free: (800) 283-5548</p>	<p>Contact: Suzanne Shaffer, Medically Fragile Program Manager</p>

Appendix P

**Human Services Department
&
Department of Health
Contact Information**

**Human Services Department/Medical Assistance Division and
Department of Health/Developmental Disability Support Division**

Human Services Department / Medical Assistance Division

Functions:

- Operates the Mi Via Program for CoLTS C (formerly D&E) and Brain Injury Waiver
- Manages the Financial Management Agency/Xerox Inc. contract
- Manages the Third Party Assessor/Molina contract

**Department of Health / Developmental Disabilities Supports Division and
Public Health Division**

Functions:

- Operates the Mi Via Program for Developmental Disability (DD), Medically Fragile (MF) and AIDS Waiver Populations
- Oversees consultant agency contracts

Developmental Disabilities Supports Division

5301 Central NE, Suite 203

Albuquerque, NM 87108

1-800-283-5548

Pat Syme, Mi Via Program Manager (DD and MF population),

Functions: Consultant Agency Oversight, All issues for DD and MF Mi Via participants,

Phone: 505-841-5511

Email: Pat.Syme@state.nm.us

DOH/ Public Health Division

PO Box 26110

Santa Fe, NM 87502

Genevieve Rel, AIDS Waiver Coordinator

Functions: All issues for AIDS Mi Via participants

Phone: 505-476-3618

Email: Genevieve.rel@state.nm.us

Waiver Change Forms

Mi Via to CoLTS	Betty Sangre	(505) 476-7255	betty.sangre@state.nm.us
CoLTS to Mi Via	Juan Medina	(505) 476-7261	juan.medina@state.nm.us
AMERIGROUP	Fax # 888-881-6169	"CW to MI VIA"	Include name, ID#, DOB, SSN
United Health Care	Ann Z. Strenger	work(505) 449-4113	cell:(505) 379 - 8972

CoLTS "c" Waiver MCO assistance (DE, BI)

AMERIGROUP	Cindy Keiser	(505) 476-7263	cynthia.keiser@state.nm.us
United Health Care	Jackie Gonzales	(505) 476-7262	jackiec.gonzales@state.nm.us

Consultant Agency Change Forms

DE, BI	Teresa Garcia	(505) 476-7256	teresajo.garcia@state.nm.us
AIDS	Genevieve Rel	(505) 476-3618	Genevieve.rel@state.nm.us

Waiver Change Forms and Consultant Agency Change Forms - DD,MF

Metro - DD	Rose Mary Williams	(505) 841-5500	rosemary.williams@state.nm.us
Northwest - DD	Dennis O'Keefe	(505) 863-9937	dennis.okeefe@state.nm.us
Northeast - DD	Fabian Lopez	(575) 758-5934 1-866-315-7123	fabian.lopez@state.nm.us
Southwest -DD	Zack Robinson	(575) 528-5180 1-866-742-5226	zack.robinson@state.nm.us
Southeast - DD	Jessica Renteria	(575) 624-6100 1-866-895-9138	jessica.renteria@state.nm.us
Statewide - MF	Suzanne Shaffer	(505) 841-2913 1-800-283-5548	suzanne.shaffer@state.nm.us

Status Notification Forms, Legally Responsible Individuals, Environmental Modifications

DE, BI	Betty Sangre	(505) 476-7255	betty.sangre@state.nm.us
DD, MF	Pat Syme	(505) 841-5511	Pat.syme@state.nm.us
AIDS	Genevieve Rel	(505) 476-3618	Genevieve.rel@state.nm.us

Requests for Expedited Reviews

DE, BI	Orlando Vasquez	(505) 827-6264	Orlando.vasquez@state.nm.us
DD, MF	Pat Syme	(505) 841-5511	Pat.syme@state.nm.us
AIDS	Genevieve Rel	(505) 476-3618	Genevieve.rel@state.nm.us

Questions on Xerox issues - Gina Gallardo	(505) 476-7254	gina.gallardo@state.nm.us
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Questions on HSD/ISD issues - Kathryn Karnowsky	(505) 476-6867	kathryn.karnowsky1@state.nm.us
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Questions on New Community Re-Integration Allocations (HSD)

DE, BI	Teresa Garcia	(505) 476-7256	teresajo.garcia@state.nm.us
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Questions on New Allocations (DOH)

DD, MF	Pat Syme	(505) 841-5511	Pat.syme@state.nm.us
AIDS	Genevieve Rel	(505) 476-3618	Genevieve.rel@state.nm.us

Information on how to get on the Central Registry and register for Waiver Services - ALTSD Aging & Disability Resource Center (DE, BI)	1-800-432-2080 (505) 476-4710
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Information on Central Registry

DD	Phil Moskal	1-800-283-5548	phil.moskal@state.nm.us
MF	Suzanne Shaffer	(505) 841-2913	suzanne.shaffer@state.nm.us

**MOLINA HEALTHCARE
OF NEW MEXICO
MI VIA STAFF
Contact Information**

MOLINA HEALTHCARE OF NEW MEXICO MI VIA STAFF

Physical Address: 8801 Horizon Boulevard, Albuquerque, NM 87113
 Mailing Address: P O Box 3909, Albuquerque, NM 87190

Phone Numbers

(505) 348-0311 (866) 916-3250

Fax Numbers

(866) 553-9268 (866) 553-9272

**ALL EMAIL MUST BE SENT THROUGH MOLINA HEALTHCARE INC SECURE
 EMAIL TO ENSURE PROTECTION OF HEALTH INFORMATION (HIPAA):**

MiViaBudgets@Molinahealthcare.com

Name	Title	Phone #	Email	Primary Responsibilities
	Manager	505-348-0281		Manages clinical staff
Kim Shipman	Supervisor	505-348-0921	Kim.Shipman@Molinahealthcare.com	Supervises non-clinical staff
Renee Rico RN	Review Nurse	505-348-2039	Renee.Rico@Molinahealthcare.com	Reviews Plans; Reviews Level of Care; Reviews Reconsiderations; Attends Fair Hearings
Ermila Ortiz	Review Nurse	505-348-0301	Ermila.Ortiz@Molinahealthcare.com	Reviews Plans; Reviews Level of Care; Reviews Reconsiderations; Attends Fair Hearings
Janet Brown RN	Review Nurse	505-348-1552	Janet.Brown@Molinahealthcare.com	Reviews Plans; Reviews Level of Care; Reviews Reconsiderations; Attends Fair Hearings
Jill Zaluga-Herman RN	Review Nurse	505-348-0468	Jill.Zaluga-Herman@Molinahealthcare.com	Reviews Plans; Reviews Level of Care; Reviews Reconsiderations; Attends Fair Hearings
Christopher Salazar	Care Coordinator	505-348-0279	Christopher.Salazar@MolinaHealthcare.com	Works with review nurse(s) primarily in assisting participants with obtaining needed LOC materials &

				follow-up with physician offices for needed documentation supporting Plan and LOC reviews
Megan Keefer	Care Coordinator	505-348-0215	Megan.Keefer@MolinaHealthcare.com	Works with review nurse(s) primarily in assisting participants with obtaining needed LOC materials & follow-up with physician offices for needed documentation supporting Plan and LOC reviews
Brittney Foss	Care Coordinator	505-348-0923	Brittney.Foss@MolinaHealthcare.com	Works with review nurse(s) primarily in assisting participants with obtaining needed LOC materials & follow-up with physician offices for needed documentation supporting Plan and LOC reviews
Janelle Tellez	Care Coordinator		Janelle.Tellez@molinahealthcare.com	Works with review nurse(s) primarily in assisting participants with obtaining needed LOC materials & follow-up with physician offices for needed documentation supporting Plan and LOC reviews
Carolina Wright	Care Specialist	505-348-0915	Carolina.Wright@MolinaHealthcare.com	Makes assignments to independent assessors for in-home assessments & follow-up
katarina Ferrales	Care Specialist		Katarina.Ferrales @molinahealthcare.com	Makes assignments to independent assessors for in-home assessments & follow-up
Rose Cardenas	Care Specialist	505-348-1524	Rose.Cardenas@MolinaHealthcare.com	Makes assignments to independent assessors for in-home assessments & follow-ups

Appendix R

Xerox Contact List for Consultants

Xerox Contact List for Consultants

Topic:	Who To Contact:
<ul style="list-style-type: none"> • Employee/Vendor Payments • Employer of Record (EOR), Employee, or Vendor Enrollment Questions • Spending Reports • GCES Technical Support • Greystone Password Reset • Payment Status 	<p>Xerox Help Desk: 866-916-0310 Email: mi.via@xerox.com</p> <p>Mailing Address: P.O. Box 27478 Albuquerque, NM 87125</p> <p>Physical Address: Xerox Inc. Mi Via Program 1720A Randolph Rd. Albuquerque, NM 87106</p>
Consultant Collaboration Meetings	Karalee Lambert Ext. 135
Participant Liaisons: 505-246-9988	Mark Fenton Ext. 162 Jim Brannen Ext. 202 Pat Olguin Ext. 139
Issue Resolution Specialist	Janeth Montoya Ext. 168
Enrollment Supervisor	Kristen Brice Ext. 216
Help Desk & Data Entry Supervisor	Carolyn Thompson Ext. 246
Operations Manager	Lawrence Mirabal Ext. 104
Deputy Account Manager	Heather Ingram Ext. 235