TITLE 8 SOCIAL SERVICES
CHAPTER 314 LONG TERM CARE SERVICES - WAIVERS
PART 3 MEDICALLY FRAGILE HOME AND COMMUNITY-BASED SERVICES WAIVER SERVICES

8.314.3.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.314.3.1 NMAC - Rp, 8 .314.3.1 NMAC, 3/1/2018]

8.314.3.2 SCOPE: The rule applies to the general public.
[8.314.3.2 NMAC - Rp, 8 .314.3.2 NMAC, 3/1/2018]

8.314.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Section 27-2-12, NMSA 1978.
[8.314.3.3 NMAC - Rp, 8 .314.3.3 NMAC, 3/1/2018]

8.314.3.4 DURATION: Permanent.
[8.314.3.4 NMAC - Rp, 8 .314.3.4 NMAC, 3/1/2018]

8.314.3.5 EFFECTIVE DATE: March 1, 2018 unless a later date is cited at the end of a section.
[8.314.3.5 NMAC - Rp, 8 .314.3.5 NMAC, 3/1/2018]

8.314.3.6 OBJECTIVE: The objective of this rule is to provide policies for the service portion of the New Mexico medical assistance program (MAP). These policies describe eligible providers, covered services, non-covered services, utilization review, and provider reimbursement.
[8.314.3.6 NMAC - Rp, 8 .314.3.6 NMAC, 3/1/2018]

8.314.3.7 DEFINITIONS:

A. Activities of daily living (ADLs): Those activities associated with an individual's daily functioning. The basic skills of everyday living such as toileting, bathing, dressing, grooming, and eating and the skills necessary to maintain the normal routines of the day, such as housekeeping, shopping and preparing meals. The term also includes exercising, personal, social and community skills.

B. Adult: An individual who is 18 years of age or older.

C. Authorized representative: An individual designated by the eligible recipient or his or her guardian, if applicable, to represent the eligible recipient and act on his or her behalf. The authorized representative must provide formal documentation authorizing him or her to access the identified case information for this specific purpose. An authorized representative may be, but need not be, the eligible recipient's guardian or attorney.

D. Category of eligibility (COE): To qualify for medical assistance program (MAP) services, an applicant must meet financial criteria and belong to one of the groups that the New Mexico medical assistance division (MAD) has defined as eligible.

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

F. Child: An individual under the age of 18. For purpose of early periodic screening, diagnosis and treatment (EPSDT) services eligibility, "child" is defined as an individual under the age of 21.

G. Eligible recipient: An applicant meeting the financial and medical level of care (LOC) criteria to receive MAD services through the medically fragile program.

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

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

J. Level of care (LOC): The level of care an eligible recipient must meet to be eligible for the medically fragile program.

K. Medically Fragile: a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following: a life threatening condition characterized by reasonable frequent periods of acute exacerbation which require frequent medical supervision, or physician consultation and which in the absence of such supervision or consultation would require hospitalization; a condition requiring frequent, time consuming administration of specialized treatments which are medically necessary; or dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include but are not limited to ventilators, dialysis machines, enteral or parenteral nutrition support and supplemental oxygen.

L. Medically Fragile Waiver (MFW): New Mexico's 1915 (c) HCBS program serving individuals diagnosed with a medically fragile condition prior to the age of 22 and a developmental disability or who are developmentally delayed or at risk for developmental delay and meet an ICF/IID level of care.

M. Person centered planning: A service planning process that is directed and led by the recipient, with assistance as needed or desired from a representative or other persons of the recipient's choosing. Person-centered planning is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the recipient. The person-centered process is an ongoing process that enables and assists the recipient to identify and access a personalized mix of paid and non-paid services and supports that assists him or her to achieve personally defined outcomes in the community.

N. Recipient: Individual receiving waiver services.

O. Waiver: A program in which the CMS has waived certain statutory requirements of the Social Security Act to allow states to provide an array of HCBS options as an alternative to providing long-term care services in an institutional setting.

[8.314.3.7 NMAC - Rp, 8 .314.3.7 NMAC, 3/1/2018]

8.314.3.8 MISSION STATEMENT: [RESERVED]

8.314.3.9 MEDICALLY FRAGILE HOME AND COMMUNITY-BASED SERVICES WAIVER: The New Mexico MAP pays for medically necessary services furnished to eligible recipients. To help New Mexico recipients receive services in a cost-effective manner, the New Mexico medical assistance division (MAD) has obtained a waiver of certain federal regulations to provide home and community-based services (HCBS) waiver programs to recipients as an alternative to institutionalization. See 42 CFR 441.300. Section 8.314.3.9 NMAC describes the HCBS waiver program for the medically fragile population, including eligible providers, covered waiver services, service limitations, and general reimbursement methodology.

[8.314.3.9 NMAC - Rp, 8 .314.3.9 NMAC, 3/1/2018]

8.314.3.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico MAP provider participation agreements by MAD, providers who meet the following requirements are eligible to be reimbursed for furnishing waiver services to recipients:

(1) standards established by the HCBS waiver program; and

(2) provide services to recipients in the same scope, quality and manner as provided to the general public; see Section 8.302.1.14 NMAC.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD and the New Mexico DOH. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

C. Qualifications of case management agency providers: Agencies must meet the standards developed for this HCBS waiver program by the applicable division of the DOH. Case management agencies are required to have national accreditation. These accrediting organizations are the commission on accreditation of rehabilitation facilities (CARF), the joint commission or another nationally recognized accrediting authority. Case management assessment activities necessary to establish eligibility are considered administrative costs.

D. Qualifications of case managers: Case managers employed by case management agencies must have the skills and abilities necessary to perform case management services for recipients who are medically fragile, as defined by the DOH medically fragile waiver standards. Case managers must be registered nurses, as defined by the New Mexico state board of nursing and have a minimum of two years of supervised experience with the target population in one or more areas of pediatrics, critical care or public health.

E. Qualifications of home health aide service providers:

(1) Home health aide services must be provided by a licensed home health agency, a licensed rural health clinic or a licensed or certified federally qualified health center using only home health aides who have successfully completed a home health aide training program as described in 42 CFR 484.36(a) (1) and (2); or who have successfully completed a home health aide training program described in the New Mexico regulations governing home health agencies, Section 7.28.2.30 NMAC. Additionally, home health aides providing services must be deemed competent through a written examination and meet competency evaluation requirements specified in the 42 CFR 484.36(b) (1), (2) and (3); or meet the requirement for documentation of training or competency evaluation specified in the New Mexico regulations governing home health agencies, Section 7.28.2.30 NMAC.

(2) Supervision: Supervision must be performed by a registered nurse and shall be in accordance with the New Mexico Nursing Practice Act, Section 61-3-1, NMSA 1978. Supervision must occur at least once every 60 days in the recipient's home and be specific to the individual service plan (ISP). All supervisory visits must be documented in the recipient's file.

(3) The supervision of home health aides is an administrative expense to the provider and is not billable as a direct service.

F. Qualifications of private duty nursing providers:

(1) Private duty nursing services must be provided by a licensed home health agency, a licensed rural health clinic, or a licensed or certified federally qualified health center, using only registered nurses or licensed practical nurses holding a current New Mexico board of nursing license and having a minimum of one year of supervised nursing experience; nursing experience preferably with individuals with developmental disabilities or who are medically fragile.

(2) **Supervision:** Supervision must be performed by a registered nurse and shall be in accordance with the New Mexico Nursing Practice Act. Supervision must be specific to the ISP.

(3) The supervision of nurses is an administrative expense to the provider and not billable as a direct service.

G. Qualifications of skilled therapy providers: Skilled therapy services may be provided by a licensed group practice/home health agency that employs licensed occupational therapists, physical therapists, or speech therapists and certified occupational therapy assistants and certified physical therapy assistants in accordance with the New Mexico regulation and licensing department. Physical therapy services must be provided by a physical therapist currently licensed by the state of New Mexico. Occupational therapy services must be provided by an occupational therapist currently licensed by the state of New Mexico, and registered with the American occupational therapy association or be a graduate of a program in occupational therapy approved by the council on medical education of the American occupational therapist association. Speech therapy services must be provided by a speech therapist currently licensed by the state of New Mexico and certified by the national association for speech and hearing. A physical therapy assistant working only under the direction and supervision of a licensed physical therapist, Section 16.20.6 NMAC, may provide physical therapy services. An occupational therapy assistant working only under the direction and supervision of a licensed occupational therapist, Section 16.15.3 NMAC, may provide occupational therapy services.

H. Qualifications of behavior support consultation providers:

(1) Behavior support consultation providers must possess one of the following licenses approved by a New Mexico licensing board: psychiatrist; clinical psychologist; independent social worker (LISW); professional clinical mental health counselor (LPCC); professional art therapist (LPAT); marriage and family therapist (LMFT); mental health counselor (LMHC); master social worker (LMSW); psychiatric nurse, or psychologist associate (PA).

(2) Behavior support consultation may be provided through a corporation, partnership or sole proprietor.

(3) Providers of behavior support consultation must have a minimum of one year of experience working with individuals with developmental disabilities or who are medically fragile. All behavior support consultants must maintain current New Mexico licensure with their professional field licensing body.

I. Qualifications of respite care service providers:

(1) Respite may be provided in the following locations: participant's home or private place of residence, the private residence of a respite care provider, or specialized foster care home. The participant and or the participant's authorized representative has the option and gives final approval of location of the respite services being provided. A specialized foster care home must be certified by the New Mexico children, youth and families department.

(2) Respite services are provided by a licensed home health care agency, a licensed or certified federally qualified health center, or a licensed rural health clinic. The registered nurses (RNs) and licensed practical nurses (LPNs) who work for the home health agency and provide respite services must be licensed by the New Mexico state board of nursing as an RN or LPN. See the New Mexico Nursing Practice Act, Section 61-3-1, NMSA 1978, and Section 16.12.2 NMAC. The home health aides who work for the home health agency and provide respite services, must have successfully completed a home health aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a home health aide training program described in the New Mexico regulations governing home health agencies, Section 7.28.2 NMAC.

J. Qualifications of nutritional counseling providers: Nutritional counseling must be furnished by a licensed dietitian registered by the commission on dietetic registration of the American dietetic association, Nutrition and Dietetics Practice Act, Section 61-7A-1, NMSA 1978.

K. Qualifications of specialized medical equipment and supplies providers: Specialized medical equipment and supplies providers must have a business license for the locale they are in, a tax identification (ID) number for state and federal government, proof of fiscal solvency, proof of use of approved accounting principles, meet bonding required by the department of health (DOH), and comply with timeliness standards for this service.
[8.314.3.10 NMAC - Rp, 8 .314.3.10 NMAC, 3/1/2018]

8.314.3.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations, rules, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement and the DOH provider agreement. A provider also must meet and adhere to all applicable NMAC rules and instructions as specified in the MAD provider rules manual and its appendices, MFW service standards, MFW service definitions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and the centers for medicare and medicaid services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services. Provider must maintain current knowledge and adherence to MFW requirements.

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section 8.302.1 NMAC.
[8.314.3.11 NMAC - Rp, 8 .314.3.11 NMAC, 3/1/2018]

8.314.3.12 ELIGIBLE RECIPIENTS:

A. Enrollment in the MFW program is contingent upon the applicant meeting the eligibility requirements as described in this rule, the availability of funding as appropriated by the New Mexico legislature, and the number of federally authorized unduplicated eligible recipients. Once an allocation has been offered to the applicant, he or she must meet certain medical and financial criteria in order to qualify. This criteria is contained in Section 8.290.400 NMAC. The eligible recipient must meet the LOC required for admittance to an ICF/IID. After initial eligibility has been established for a recipient, on-going eligibility must be determined on an annual basis.

B. Eligibility is limited to individuals who in addition to a developmental disability, developmental delay, or are at risk of developmental delay, have a medically fragile condition, diagnosed before the age of 22, defined as a chronic physical condition, which results in a prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following:

(1) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which require frequent medical supervision, or physician consultation and which in the absence of such supervision or consultation, would require hospitalization;

(2) a condition requiring frequent, time consuming administration of specialized treatments which are medically necessary; or

(3) dependence on medical technology such that without the technology a reasonable level of health could not be maintained; examples include but are not limited to ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen.
[8.314.3.12 NMAC - Rp, 8 .314.3.12 NMAC, 3/1/2018]

8.314.3.13 COVERED WAIVER SERVICES: The services covered by the MFW program are intended to provide a home and community-based alternative to institutional care for an eligible recipient. In all services covered under the MFW the recipient has the right to privacy, dignity, and respect. The recipient further has the

right to freedom from coercion and restraint. The MFW program covers the following services for a specified number of medically fragile recipients. The program is limited by the number of federally authorized unduplicated recipient (UDR) positions and program funding.

A. Case management services: Case management services assist recipients in gaining access to needed waiver and other state plan services, as well as medical, social, educational, and other services regardless of the funding source for the services. Case management services are offered in a manner that allows direct communication between the case manager, the recipient, and the family and appropriate service personnel. Case managers provide a link between recipients and care providers and coordinate the use of community resources needed for that care. At least every other month, the case manager conducts a face-to-face contact with the recipient, and on a monthly basis conducts a telephonic or electronic contact with the recipient. The scope of the case manager's duties includes the following:

(1) identifying medical, social, educational, family and community support resources;

(2) scheduling and coordinating timely interdisciplinary team (IDT) meetings to develop and modify the ISP annually and as needed by any team member;

(3) documenting contacts with the recipient and providers responsible for delivery of services to the recipient;

(4) verifying eligibility on an annual basis;

(5) ensuring the medically fragile long-term care assessment abstract (LTCAA) is completed and signed by the physician, physician assistant or clinical nurse practitioner (CNP);

(6) submitting the LOC packet including the LTCAA to the third-party assessor (TPA) contractor for prior authorization on a timely basis;

(7) ensuring the waiver review form (MAD 046) is submitted timely, both annually and as needed;

(8) initiating an ongoing monitoring process that provides for evaluation of delivery, effectiveness, appropriateness of services and support provided to the recipient as identified in the ISP;

(9) performing an annual recipient satisfaction survey; and

(10) coordinating services provided though the MFW program and other sources (state plan, family infant toddler (FIT), commercial insurance, educational and community).

B. Home health aide: Home health aide services are covered under the state plan as expanded early and periodic screening, diagnosis and treatment EPSDT benefits for waiver participants under the age of 21. Home health aide services are provided in the eligible recipient’s own home or in the community. Home health aide services provide total care or assist a recipient in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampooing (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake. The home health aide services assist the recipient in a manner that promotes an improved quality of life and a safe environment for the recipient. Home health aide services can be provided outside the recipient's home. Home health aides perform simple procedures such as an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are normally self-administered, reporting changes in patient conditions and needs, and completing appropriate records. Home health aides may provide basic non-invasive nursing assistant skills within the scope of their practice.

C. Private duty nursing: Private duty nursing services are covered under the state plan as expanded EPSDT benefits for waiver recipients under the age of 21. Private duty nursing services are provided in the eligible recipient’s own home and in the community and include activities, procedures and treatment for a physical condition, physical illness, or chronic disability. Services may include medication management; administration and teaching; aspiration precautions; feeding management such as gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environmental management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance. DOH requires certain standards to be maintained by the private duty nursing care provider with which it contracts. In carrying out their role for DOH, private duty nursing care agencies must:

(1) employ only RNs and LPNs licensed in the state of New Mexico;

(2) assure that all nurses delivering services are culturally sensitive to the needs and preferences of the recipients and their families. Based upon the recipient’s individual language needs or preferences, nurses may be requested to communicate in a language other than English;

(3) inform the case manager immediately of the agency's inability to staff according to the ISP;

(4) develop and implement an individual nursing plan in conjunction with the recipient's physician and case manager in a manner that identifies and fulfills the recipient's specific needs;

(5) document all assessments, observations, treatments and nursing interventions;

(6) document and report to the case manager any non-compliance with the ISP; and

(7) document any incidence of recipient harm, medication error, or other adverse event in accordance with the New Mexico Nursing Practice Act.

D. Skilled therapy services for adults: Skilled therapy services are covered under the state plan as expanded EPSDT benefits for waiver recipients under the age of 21. Adults access therapy services under the state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. Waiver services are provided when the limits of the state plan skilled therapy services are exhausted. The amount, duration, and goals of skilled therapy services must be included in an ISP. A therapy treatment plan must be developed with the initiation of therapy services and updated at least every six months. The therapy treatment plan includes the following: developmental status of the recipient in areas relevant to the service provided; treatment provided, including the frequency and duration; and recommendation for continuing services and documentation of results. Skilled maintenance therapy services specifically include the following:

(1) Physical therapy: Physical therapy services promote gross/fine motor skills, facilitate independent functioning or prevent progressive disabilities. Specific services may include: professional assessment(s), evaluation(s) and monitoring for therapeutic purposes; physical therapy treatments and interventions; training regarding physical therapy activities, use of equipment and technologies or any other aspect of the individual's physical therapy services; designing, modifying or monitoring use of related environmental modifications; designing, modifying, and monitoring use of related activities supportive to the ISP goals and objectives; and consulting or collaborating with other service providers or family members, as directed by the recipient.

(2) Occupational therapy: Occupational therapy services promote fine motor skills, coordination, sensory integration, or facilitate the use of adaptive equipment or other assistive technology. Specific services may include: teaching of daily living skills; development of perceptual motor skills and sensory integrative functioning; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment; use of specifically designed crafts and exercise to enhance function; training regarding occupational therapy activities; and consulting or collaborating with other service providers or family members, as directed by the recipient.

(3) Speech language therapy: Speech language therapy services preserve abilities for independent function in communication; facilitate oral motor and swallowing function; facilitate use of assistive technology, or prevent progressive disabilities. Specific services may include: identification of communicative or oropharyngeal disorders and delays in the development of communication skills; prevention of communicative or oropharyngeal disorders and delays in the development of communication skills; development of eating or swallowing plans and monitoring their effectiveness; use of specifically designed equipment, tools, and exercises to enhance function; design, fabrication, or modification of assistive technology or adaptive devices; provision of assistive technology services; adaptation of the recipient's environment to meet his/her needs; training regarding speech language therapy activities; and consulting or collaborating with other service providers or family members, as directed by the recipient.

E. Behavior support consultation services: This medicaid waiver provides services to assist the medically fragile recipient, his or her parents, family members or primary care givers. Behavior support consultation includes assessment, treatment, evaluation and follow-up services to assist the recipient, parents, family members or primary care givers with the development of coping skills which promote or maintain the recipient in a home environment. Behavior support consultation:

(1) informs and guides the recipient's providers with the services and supports as they relate to the recipient's behavior and his/her medically fragile condition;

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

(3) supports effective implementation based on a functional assessment;

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

(5) monitors and adapts support strategies based on the response of the recipient and his/her service and support providers. Based on the recipient's ISP, services are delivered in an integrated/natural setting or in a clinical setting.

F. Respite care services: The IDT is responsible for determining the need for respite care. Respite services are provided to recipients unable to care for themselves that are furnished on a short-term basis to allow the primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite care is provided in the eligible recipient's own home, in a private residence of a respite care provider, or in a specialized foster care home. The recipient or the recipient's authorized representative has the option and gives final approval of where the respite services will be provided. Respite services include: medical and non-medical health care; personal care bathing; showering; skin care; grooming; oral hygiene; bowel and bladder care; catheter and supra-pubic catheter care; preparing or assisting in preparation of meals and eating; as appropriate, administering enteral feedings; providing home management skills; changing linens; making beds; washing dishes; shopping; errands; calls for maintenance; assisting with enhancing self-help skills; promoting use of appropriate interpersonal communication skills and language; working independently without constant supervision/observation; providing body positioning, ambulation and transfer skills; arranging for transportation to medical or therapy services; assisting in arranging health care needs and follow-up as directed by the primary care giver, physician, and case manager; ensuring the health and safety of the recipient at all times. Respite services are limited to 14 days or 336 hours per budget year.

G. Nutritional counseling: Nutritional counseling is designed to meet the unique food and nutrition requirements of recipients with medical fragility and developmental disabilities. Examples of recipients who may require nutritional counseling are children or adults with specific illnesses such as failure to thrive, gastroesophageal reflux, dysmotility of the esophagus and stomach etc., or who require specialized formulas, or receive tube feedings or parenteral nutrition. This does not include oral-motor skill development such as that provided by a speech language pathologist. Nutritional counseling services include assessment of the recipient's nutritional needs, regimen development, or revisions of the recipient's nutritional plan, counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan. These services advise and help recipients obtain appropriate nutritional intake by integrating information from the nutritional assessment with information on food, other sources of nutrients, and meal preparation consistent with cultural backgrounds and socioeconomic status. These services can be delivered in the home.

H. Specialized medical equipment and supplies: This medicaid waiver provides specialized medical equipment and supplies which include:

(1) devices, controls or appliances specified in the plan of care that enable recipients to increase their ability to perform activities of daily living;

(2) devices, controls, or appliances that enable the recipient to perceive, control, or communicate with the environment in which they live;

(3) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

(4) such other durable and non-durable medical equipment not available under the state plan that is necessary to address recipient functional limitations; and

(5) necessary medical supplies not available under the state plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the recipient. The costs of maintenance and upkeep of equipment are included in the cost of equipment and supplies. All items must meet applicable standards of manufacture, design, and installation. Medical equipment and supplies that are furnished by the state plan are not covered under this service. This service does not include nutritional or dietary supplements, disposable diapers, bed pads, or disposable wipes.

[8.314.13.10 NMAC - Rp, 8 .314.13.10 NMAC, 3/1/2018]

8.314.3.14 NON-COVERED SERVICES: Only services listed as covered waiver services are covered under the waiver program. Ancillary services can be available to waiver recipients through the MAP state plan services. These ancillary services are subject to the limitations and coverage restrictions which exist for other MAP services. See Section 8.301.3 NMAC for an overview of non-covered services.

[8.314.3.14 NMAC - Rp, 8 .314.3.14 NMAC, 3/1/2018]

8.314.3.15 INDIVIDUALIZED SERVICE PLAN: The CMS requires a person-centered individualized service plan (ISP) for each individual receiving services through a HCBS waiver program. The ISP is developed annually through an ongoing person-centered planning process.

A. The case manager assists the recipient in identifying his/her dreams, goals, preferences and outcomes for service. The case manager obtains information about the recipient's strengths, capacities, needs, preferences, desired outcomes, health status, and risk factors. This information is gained through a review of the LOC assessment; interviews between the case manager and recipient; and the person-centered planning process that takes place between the case manager and recipient to develop the ISP.

B. The ISP addresses: activities of daily living assistance needs, health care needs, equipment needs, relationships in the home and community, personal safety and provider responsibilities.

C. During the pre-planning process, the case manager provides the recipient with information about the MFW program. The case manager provides information about the range and scope of service choices and options, as well as the rights, risks, and responsibilities associated with the MFW program. The case manager is responsible for completing the CIA and obtaining other medical assessments needed for the ISP; completing the annual LOC redetermination process; and referring the recipient to the New Mexico human services department (HSD) income support division (ISD) for financial eligibility determination annually and as needed.

D. The case manager works with the recipient to identify service providers to participate in the IDT meeting. State approved providers are selected from a list provided by the case manager. The recipient sets the date and time of the IDT meeting. The case manager works with the recipient to plan the IDT meeting and encourages him/her to lead the IDT meeting to the extent possible.

E. The case manager assists the recipient in ensuring that the ISP addresses the recipient's goals, health, safety and risks along with addressing the information or concerns identified through the assessment process. The case manager writes up the ISP as identified in the IDT meeting. Each provider develops care activities and strategies for each outcome, goal, and objective identified at the IDT meeting. The case manager assures the ISP budget is within the capped dollar amount (CDA). Implementation of the ISP begins when provider service plans have been received by the case manager and recipient, and the plan and budget have been approved by the TPA contractor.

F. The case manager ensures for each recipient that:

(1) the plan addresses the recipient's needs and personal goals in medical supports needed at home for health and wellness;

(2) services selected address the recipient's needs as identified during the assessment process; needs not addressed in the ISP are addressed through resources outside the MF waiver program;

(3) the outcomes of the assessment process for assuring health and safety are considered in the plan;

(4) services do not duplicate or supplant those available to the recipient through the medicaid state plan or other public programs;

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

(6) the parties responsible for implementing the plan are identified and listed within the document;

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

(8) the ISP is submitted to and reviewed by the TPA contractor in compliance with the MF waiver service standards.

G. The ISP is updated if personal goals, needs or life circumstances change that may or may not result in a change of the LOC. Revisions may be requested by the recipient. Each member of the IDT may request an IDT meeting to address changes or challenges. The case manager contacts the recipient to initiate revisions to the budget. The case manager initiates the scheduling of IDT meetings and assures the IDT meeting is in compliance with the MF waiver service standards.

H. The case manager is responsible for monitoring the ISP pre-planning and development process. The case management agency conducts internal quality improvement monitoring of service plans. The ISP is monitored monthly via phone, electronically, and face-to-face by the case manager.

I. After the initial ISP, the IDT reviews the ISP at least annually or more often as needed, in order to assess progress toward goal achievement and determine any needed revisions in care.

[8.314.3.15 NMAC - Rp, 8 .314.3.15 NMAC, 3/1/2018]

8.314.3.16 UTILIZATION REVIEW: All medicaid services, including services covered under the MFW, are subject to utilization review for medical necessity and program compliance. Reviews can be performed before

services are furnished, after services are furnished and before payment is made, or after payment is made. See Section 8.310.2.14 NMAC. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: To be eligible for MFW program services, recipients must require an ICF/IID LOC and meet the eligibility requirements defined in Subsection B of Section 8.314.3.12 NMAC. LOC determinations are made by MAD or its designee. The ISP must specify the type, amount and duration of services. Certain procedures or services specified in the ISP can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for MAP. Providers must verify that individuals are eligible for MAP at the time services are furnished and determine if recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and reconsideration. See Section 8.350.2 NMAC.

[8.314.3.16 NMAC - Rp, 8 .314.3.16 NMAC, 3/1/2018]

8.314.3.17 REIMBURSEMENT: Waiver service providers must submit claims for reimbursement to MAD's fiscal contractor for processing. Claims must be filed per the billing instructions in the medicaid policy manual. Providers must follow all medicaid billing instructions. See Section 8.302.2 NMAC. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Reimbursement to providers of medicaid waiver services is made at a predetermined reimbursement rate.

[8.314.3.17 NMAC - Rp, 8 .314.3.17 NMAC, 3/1/2018]

8.314.3.18 RIGHT TO A HSD ADMINISTRATIVE HEARING:

A. Pursuant to 42 CFR Section 431.220(a)(1) and (2), Section 27-3-3 NMSA 1978 an eligible recipient may request a HSD administrative hearing to appeal an adverse action or adverse decision. See Section 8.352.2 NMAC for a description of the HSD administrative hearing process. In addition to adverse actions defined in Section 8.352.2 the recipient may request an administrative hearing in the following circumstances:

(1) when an applicant has been determined not to meet the LOC requirement for medically fragile waiver program services; and

(2) when an applicant has not been given the choice of HCBS as an alternative to institutional care.

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

[8.314.3.18 NMAC - N, 3/1/2018]

8.314.3.19 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL:

A. Continuation of benefits may be provided to an eligible recipient who requests a HSD administrative hearing within the timeframe defined in Section 8.352.2 NMAC.

B. The continuation of a benefit is only available to an eligible recipient that is currently receiving the appealed benefit. The continuation of the benefit will be the same as the eligible recipient's current allocation, budget or LOC. See Section 8.352.2 NMAC for a complete description, instructions and process of a HSD administrative hearing and continuation of benefits process of a MAP eligible recipient.

[8.314.3.19 NMAC - N, 3/1/2018]

8.314.3.20 GRIEVANCE SYSTEM: An eligible recipient has the opportunity to register a grievance or complaint concerning the MFW program. An eligible recipient may register complaints with DOH via e-mail, mail or phone. Complaints will be referred to the appropriate DOH division or as appropriate referred to MAD for resolution. The filing of a complaint or grievance does not preclude an eligible recipient from pursuing a HSD administrative hearing. The eligible recipient is informed that filing a grievance or complaint is not a prerequisite or substitute for requesting a HSD administrative hearing.

[8.314.3.20 NMAC - N, 3/1/2018]

HISTORY OF 8.314.3 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives.
ISD-Rule 310.2300, Medically Fragile Individuals In-Home Care Program, (Services), 1/13/1986.

History of Repealed Material:
8.314.3 NMAC, Medically Fragile Home and Community-Based Services Waiver Services (filed 4/16/2002) - Repealed effective 3/1/2018.