

**NEW MEXICO DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
MEDICALLY FRAGILE WAIVER (MFW)**

GENERAL PROVIDER REQUIREMENTS

Effective July 1, 2019

These standards apply to all services provided through the Medicaid Home and Community-Based Services Waiver Program for participants with the Medically Fragile Waiver (MFW). These standards interpret and further enforce the New Mexico Human Services Department (HSD) Medicaid Policy Manual for MFW and the Centers for Medicare and Medicaid Services (CMS) requirements for Home and Community-Based Services Waivers

I. PROVIDER REQUIREMENTS

- A. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to meet any pertinent laws, regulations, rules, policies, and interpretive memoranda published by the New Mexico Department of Health (DOH) and the HSD.
- B. The Medicaid Medically Fragile Home and Community Based Services Waiver require providers to adhere to requirements as outline in the CMS HCBS Final Rule:
 - 1. Providers must ensure that settings are integrated in and support full access of individuals to the greater community including:
 - a. Providing opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources; and
 - b. Ensuring that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS.
 - 2. Providers must ensure that the individual selects from among setting options including non-disability specific settings and options for a private unit in a residential setting. The provider setting must have person-centered service plans that document the options based on the individual's needs and preferences. For residential settings the person-centered plan must document resources available for room and board.
 - 3. Providers must ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

4. Providers must ensure settings optimize individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.
 5. Providers must ensure settings facilitate individual choice regarding services and supports, and choice regarding who provides them.
 6. Additional HCBS Final Rule requirements relate to ensuring tenant protections, privacy, and autonomy for individuals receiving HCBS who do not reside in their own private (or family) home.
- C. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities Supports Division (DDSD) Provider Enrollment Unit process:
- a. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures.
 - b. All provider agencies that enter a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies and standards.
 - c. Reference: <http://dhi.health.state.nm.us/>
- D. All agencies must follow all applicable DDSD Policies and Procedures.
- E. All provider agencies that enter in to a contractual relationship with DOH to provide MFW services which comply with all applicable standards herein set forth and are subject to sanctions for noncompliance with the provider agreement and all applicable rules and regulations.
- F. Under no circumstances may a parent (or guardian), family member, or conservator receive payment for services delivered to their minor child under age eighteen (18). Also, under no circumstances may any individual receive payment for services delivered to their spouse.

II. PROVIDER AGENCY REPORT OF CHANGES IN OPERATIONS:

- A. The provider agency must notify the DOH in writing of any changes in the disclosures required in this section within ten (10) calendar days. This notice must include information and documentation regarding such changes as the following: any change in the mailing address of the provider agency, and any change in executive director, administrator, and classification of any services provided.
- B. Program Flexibility: If the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects conflicts with these standards, then prior written approval from the DOH is required. Such approval must provide for the terms and conditions under which the waiver of specific standard(s) is/are granted. The applicant or provider agency

is required to submit a written request and attach substantiating evidence supporting the request to the Medically Fragile Waiver Program Manager at DOH/DDSD. DOH will only approve requests that remain consistent with the current federally approved MFW application.

III. CONTINUOUS QUALITY MANGEMENT SYSTEM

- A. On an annual basis, MFW provider agencies are required to update and implement the Continuous Quality Improvement Plan. At the time of the DHI audit or upon request, the agency will submit a summary of each year's quality improvement activities and resolutions to the Provider Enrollment Unit.
- B. The provider agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and that comply with all DDS policies and procedures and all relevant New Mexico State statutes, rules and standards. The agency must review the policies and procedures every three years and update as needed.
- C. Appropriate planning must take place with all Interdisciplinary Team (IDT) members, Medicaid state plan provider, other waiver providers and school services to facilitate a smooth transition from the MFW Program. The person's choices are given consideration whenever possible DOH policies must be adhered to during this process as per the provider's contract.
- D. All provider agencies, in addition to requirements under each specific service standard, are required to develop, implement, and maintain, at the designated main agency office, documentation of policies and procedures, for the following:
 - a. Coordination with other provider agency staff serving individuals receiving MFW services that delineates the specific roles of each agency staff.
 - b. Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated.
 - c. Agency protocols for disaster planning and emergency preparedness.

IV. PARTICIPANT TRANSITION TO A DIFFERENT PROVIDER AGENCY

When a waiver participant/person is transferred to a similar provider agency, the receiving agency is provided the minimum following records:

- a. Complete file for the past 12 months;
- b. Current and prior year Individualized Service Plan (ISP); and
- c. Intake information from original admission to services

V. PROVIDER AGENCY CASE FILE FOR THE WAIVER PARTICIPANT

All provider agencies are required to maintain at the administrative office a confidential case file for each person that includes all the following elements:

- a. Emergency contact information for the following individuals/entities that includes addresses and telephone numbers for each:
 - i. Consumer
 - ii. Primary caregiver
 - iii. Family/relatives, guardians or conservators
 - iv. Significant friends
 - v. Physician
 - vi. Case manager
 - vii. Provider agencies
 - viii. Pharmacy;
- b. Individual's health plan, if appropriate;
- c. Individual's current ISP;
- d. Progress notes and other service delivery documentation;
- e. A medical history which includes at least: demographic data; current and past medical diagnoses including the cause of the medically fragile conditions and developmental disability; medical and psychiatric diagnoses; allergies (food, environmental, medications); immunizations; and most recent physical exam.

The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes.

VI. DOCUMENTATION

- A. Provider agencies must maintain all records necessary to fully disclose the service, quality, quantity, and clinical necessity furnished to individuals who are currently receiving services. The provider agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider agency, level of services, and length of service billed.
- B. The documentation of the billable time spent with an individual are kept in the written or electronic record that is prepared prior to a request for reimbursement from the HSD. The record must contain at least the following information:
 - a. date and start and end time of each service encounter or other billable service interval;
 - b. description of what occurred during the encounter or service interval; and
 - c. signature and title of staff providing the service verifying that the service and time are correct.
- C. All records pertaining to services provided to an individual must be maintained for at least six (6) years from the date of creation.

D. Verified electronic signatures may be used. An electronic signature must be HIPAA compliant, which means the attribute affixed to an electronic document must bind to a particular party. An electronic signature secures the user authentication, proof of claimed identity, at the time the signature is generated. It also creates the logical manifestation of signature, including the possibility for multiple parties to sign a document and have the order of application recognized and proven. In addition, it supplies additional information such as time stamp and signature purpose specific to that user and ensures the integrity of the signed document to enable transportability of data, independent verifiability and continuity of signature capability. If an entity uses electronic signatures, the signature method must assure that the signature is attributable to a specific person and binding of the signature with each particular document.