

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

**CASE MANAGEMENT**

**Effective July 1, 2019**

MFW nurse case management is a collaborative process of assessment, planning, facilitation, care coordination, advocacy for options and services to meet the medically fragile participant's/person's health needs through communication and available resources to promote quality cost-effective outcomes (see Case Management Society of America [CMSA] definition of case management, <http://www.cmsa.org>). The case manager will employ person-centered planning in this process. Person-centered planning is a process that is directed and led by the recipient, with assistance as needed or desired from a representative or other person 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.

MFW funded services are not replacements for the family system, informal caregiver support or other community services, but are supplements to the person's natural supports. The participant's/person's family and/or caregiver must continue all efforts in the care and support of the individual.

**I. SCOPE OF SERVICES:**

**A. Case Management Services Include:**

1. The case manager (CM) will identify and facilitate community resources for the participant/participant's representative and family, such as Family Infant Toddler (FIT) program, schools for the Individualized Educational Plan (IEP), Medicaid State plans (Centennial Care Managed Care Organizations [MCOs]), faith-based organizations and support organizations and family supports.
2. The CM will review and facilitate eligibility. At least annually and more often as needed, the CM will complete the Level of Care (LOC), Individual Service Plan (ISP) and appropriate budget(s), MAD 046, and coordinate EPSDT if client is under 21 years old. The CM will review the initial ISP and MAD 046 form at six (6) months from the date of approval.
3. The CM will have monthly contact with the participant/participant's representative to perform ongoing assessment of the MFW parameters and progress toward identified goals and objectives.

4. Any member of the Interdisciplinary Team (IDT) may call a meeting to consider changes to the LOC, ISP and/or MAD 046 form at any time.
  5. The CM cannot be an authorized (designated) participant's representative.
- B. Case Management Role in Pre-Assessments:
1. The date the applicant is logged into the DDS Central Registry is recognized as the date of registration.
  2. The contracted Case Management Agency will complete a telephonic pre-assessment for all applicants 30 years and younger, and others as requested by the MFW Program Manager.
  3. The CM will utilize the MFW Eligibility Training Manual to complete the pre-assessment tool. Other documents will be utilized in the pre-assessment as needed.
  4. The pre-assessment packet is forwarded to the MFW Program Manager for final determination of allocation.
- C. Eligibility Determination and Level of Care (LOC)/Funding Following Allocation:
1. The Case Management Agency will work to complete the following within 90 days of receipt of the Primary Freedom of Choice (PFOC) from the Department of Health (DOH):
    - Initial eligibility determination paperwork
    - Individual Service Plan (ISP)/MAD 046 budgetIf unable to complete this process, the Case Management Agency will submit a Client Information Update (CIU) with the reason why the process cannot be completed.
  2. The CM will meet with participant/participant's representative to review and explain the person's rights to privacy, dignity, respect and freedom from coercion and restraint, the MFW services and State Medicaid services. The CM will help the participant and family identify community resources. The participant and family will be given a Medically Fragile Family Handbook in paper or electronic form to assist in reinforcing this information.
  3. The CM will assist the participant/participant's representative to set up the required appointment with the primary care provider (PCP) for a history and physical (H&P) that will be submitted as part of the LOC packet necessary for prior authorization. The initial H&P must be completed within 90 days of submission of the PFOC and must be completed within 12 months of the annual LOC process. A H&P is required annually as part of the LOC process.
  4. The CM completes an assessment using the MFW parameters and other appropriate resources to write the Comprehensive Individualized Assessment-Family Centered Review (CIA/FCR). Refer to the MFW Eligibility Training Manual parameter instructions for details.
  5. The CM and PCP complete the DOH 378, Long Term Care Assessment Abstract (LTCAA). The PCP must sign and date the LTCAA form, stating that the PCP has seen and evaluated the person.

6. The Level of Care (LOC) packets consist of the following:
  - LTCAA DOH 378 form
  - PCP's signed H&P
  - CIU for extensions
  - Other supporting medical documents as needed
7. The LOC packet is submitted to Medicaid Third Party Assessor (TPA) who will make a determination of the LOC. The LOC determines the funding amount available to the medically fragile person based on needs identified in the ISP during the LOC/ISP cycle.
8. When the Medicaid TPA approves the LTCAA form, the person is then deemed to meet the LOC for the MFW.
9. Concurrent to the Medicaid TPA review of the LOC, Income Support Division (ISD) reviews financial and non-financial criteria to complete a financial eligibility determination. ISD will review financial and non-financial (citizenship, residency, disability determination etc.) to complete a financial eligibility determination. The CM will assist the person as needed to arrange the eligibility appointment with ISD and complete the ISD eligibility review.
10. The approved LOC is forwarded by the TPA to the ISD office to be included in eligibility determination.
11. The participant is funded for services based on LOC and age:
  - For those persons less than 21 years of age:
    - \$25, 000/year (regardless of assessed LOC.)
    - Persons less than 21 years of age are also eligible for EPSDT benefits. The EPSDT/MCO budget is utilized prior to accessing MFW funding.
  - For those persons age 21 years and older:
    - Adult Level I -- \$70,000
    - Adult Level II --\$60,000
    - Adult Level III --\$48,000

D. IDT Meeting and ISP Development and Budget Development (MAD 046 form):

1. The participant/guardian has the opportunity to be involved in all aspects of the ISP.
2. The purpose of IDT meetings is to develop the ISP, review effectiveness of the ISP and revise the ISP.
3. In preparation for an IDT meeting, the CM will offer the participant/participant's representative a list of waiver services as appropriate and will document selected services.
4. The IDT will be comprised of the participant/participant's representative, the PCP and all MFW providers and external providers. The MFW providers are expected to attend ISP meetings and all others are encouraged to attend.
5. The participant/guardian will choose a provider from the MFW secondary freedom of choice (SFOC) list. Each service listed on the MAD 046 form has a separate SFOC.

6. The participant/guardian is encouraged to contact provider agencies and interview the agency and potential providers. For private duty nursing (PDN) services, the participant/participant's representative will meet with the potential Home Health Agency representative to discuss specific needs and skills that will be expected from the nurse and/or home health aide in an effort to match nurse and/or home health aide with the person and family. The participant/guardian selects who provides services based on available choice. The participant/guardian's signature on the SFOC indicates their choice of provider agency for a specific service.
7. When the medically fragile participant is under the age of 21 years, Early Periodic Screening, Diagnostic & Treatment (EPSDT) services will be provided by the State Medicaid Plan. The CM will facilitate the choice of provider agency based on the network. The participant/guardian makes the decision of who provides services based on available choices.
8. The following chart lists services for individuals 21 years and over, and services for those under 21 years on the MFW:

SERVICE CHOICES ON THE MAD 046 FORM

<b>MFW Participant Less Than 21 Years of Age</b>	<b>MFW Participant More Than 21 Years of Age</b>
Ongoing RN/Case Management (OCM)	Ongoing RN/Case Management (OCM)
Nutritional Counseling	Registered Nurse (RN), Licensed Practical Nurse (LPN), Home Health Aide (HHA)
Behavior Support Consultation	Therapy Services (Physical Therapy [PT], Occupational Therapy [OT], Speech Language Therapy)
PDN In-Home Respite	Nutritional Counseling
Respite	Behavior Support Consultation
Specialized Medical Equipment	PDN In-Home Respite
	Respite
	Specialized Medical Equipment
	RN 2 hours/ISP cycle to attend IDT

9. The CM will facilitate the IDT meeting. The CM will contact team members at least two (2) weeks prior to the scheduled IDT meeting with date, time, location and purpose of the IDT meeting. This notification may be by phone, written or electronic communication. Documentation of phone, written or electronic notification will be maintained in the person's CM file. The CM will also notify IDT members of cancellations and changes of IDT meeting.

10. The CM is responsible for the ISP signature sheet at the IDT meeting. The date, beginning and end time of the IDT meeting will be written on the signature sheet by the CM.
11. The ISP signature sheet will be attached to the person's ISP and distributed to the IDT with the ISP package. Team members who participate in the IDT by phone will be so indicated on the signature sheet in lieu of an actual signature.
12. The original copy of the ISP will be maintained at the CM agency file.
13. It is the responsibility of each IDT member to request additional documents from the CM.
14. The ISP will include the following:
  - a. Basic information includes at a minimum: the medically fragile participant's name, address, phone number, date of birth, original identification number, parent/guardian information, insurance information, race/ethnicity, primary language, primary diagnosis, ISP cycle and date of the IDT/ISP meeting to develop the plan.
  - b. A list of IDT members that includes both waiver and non-waiver providers with the following information:
    - Name of team member, including the CM name
    - Title
    - Business location
    - Phone number
    - Fax number, if possible
    - Email address, if possible
    - Funding source
  - c. Present levels of functioning to include diagnosis, strengths and needs.
  - d. IDT members discuss and enumerate issues, strengths and needs with the medically fragile participant and family, and strategies that will be used to address them.
  - e. The ISP outcome is a statement of change that the participant/participant's representative wants to achieve. These include individualized goals and objectives and care activities/strategies for each service delivered. These are based on reasonable and measurable outcomes for the participant.
  - f. The participant/guardian has the opportunity to generate outcomes. Team members may assist the participant/participant's representative to identify goals/outcomes and support their choices.
  - g. Each ISP outcome statement is accompanied by a description of the methods, strategies and activities used to work towards the outcome, timelines, criteria for measuring progress and person(s) responsible. The participant/participant's representative with assistance from other medical team members (i.e., PCP and medical specialists) will prioritize the concerns involved in providing services.
  - h. An ISP statement for services and supports necessary to achieve the outcomes. The listing of services and supports shall include the frequency,

duration, location, intensity (group or individual), method of delivery, and applicable payment information. Services and supports not funded by the MFW are included.

15. The provider agencies will submit to the CM all service plan(s) within 10 working days following the initial IDT meeting and when revised.
16. The CM will complete the ISP within 15 working days following the IDT meeting.
17. The CM will submit the completed Waiver Review Form (MAD 046 form), commonly known as the budget, based on the decisions of the IDT meeting.
18. Each service requested on the MAD 046 form must have a corresponding care activity/strategy in the ISP.
19. Provider agencies must be present at the IDT meeting or provide their input to the CM or designee before the IDT meeting. The CM or designee contacts the provider following the meeting to update on changes.
20. The signed SFOC form for each service provider must be maintained in the participant's CM file and sent to the provider agencies.
21. It is the joint responsibility of the CM, provider agency, and participant/participant's representative to monitor the MAD 046 form's maximum dollar amount allocated per LOC and ISP cycle to assure the budget does not exceed approved LOC.
22. The ISP packet is submitted to the Medicaid TPA for prior authorization. The ISP packet is comprised of the following:
  - ISP with all corresponding care activity/strategy;
  - MAD 046 form;
  - Signature sheet of IDT meeting; and
  - CIU, if necessary.
23. The applicant for the MFW may begin receiving services only after the Medicaid MF Waiver Category of Eligibility (COE) is approved and a budget is in place.
24. The LOC and ISP cycle dates do not change for the participant. If for any reason the LOC, ISP or MAD 046 form are unable to be completed prior to the end of the cycle, the CM will submit a CIU form to the MFW Program Manager or designee informing him or her of the delay in completion. The MFW Program Manager or designee will approve the extension of services.

## II. CASE MANAGEMENT MONITORING

- A. The CM monitors the effectiveness of services provided to the participant as identified through the ISP, written reports, contacts and coordination of services.
- B. The CM is required to have monthly contact with the participant/family.
  1. Face-to-face visits with the participant must occur at least every other month.
  2. The CM will have a telephone conference with participant and/or family on the months that a face-to-face visit is not done.

3. Monthly contacts must have supporting documentation by the CM that reflects active implementation of the ISP.
  4. At the face-to-face visits with the medically fragile participant, health, safety and welfare are monitored. Face-to-face visits and phone contacts must have supporting documentation by the CM indicating the participant or family were actively involved in the input of strategies and decisions involving the coordination of services.
  5. When the medically fragile participant is not able to participate and provide input regarding needs, effectiveness of the ISP, or health and safety needs, the CM will clearly and concisely document in the monthly CM's contact notes that the participant was unable to directly convey his/her needs and the reasons why. The participant's representative will provide information regarding the effectiveness of the ISP, health and safety measures implemented and additional needs of the person.
  6. The CM and the Home Health Agency are required monthly to discuss nursing and home health aide services. This will be documented in CM contact notes. The discussion and notes will reflect review budget of utilization, and review of known or newly identified person/family needs for support by Home Health Agency personnel.
- C. The CM is required to comply with all policies and procedures regarding utilization review, including professional documentation standards.
- D. The CM reviews the services identified in the ISP and perceived effectiveness of each service with the participant/family.
- E. The CM will have ongoing contacts with waiver providers to review quality, effectiveness of the services and progress towards the ISP goals.
- F. The CM will identify and resolve known situations that may be harmful or deemed potentially dangerous to the participant and/or others.
- G. The CM, in conjunction with participant/family, will identify problems with providers. The specific problems will be reported to the provider agency for resolution. The CM may participate in the resolution of the problems.
- H. The CM monitors the timeliness of services delivered.
- I. The CM must report child and adult abuse, neglect and exploitation to the designated State agencies as per State and Federal regulations.

### III. CASE MANAGEMENT AGENCY REQUIRMENTS

A. Case Management Agency:

1. A CM may not provide any other MFW services to individuals for whom the agency provides case management services.
2. The Case Management Agency may not employ as a CM any immediate family member or guardian of an individual served by the agency.
3. The MFW may consider other options for contracting case management services when there is a lack of qualified Case Management Agencies within any geographic area of the State. At its discretion, the DOH may waive this requirement when there is a lack of qualified case management agencies within a specific geographic area of the state. This may include, for example, contracting with licensed Medicaid Home Health Agencies that have qualified licensed RNs for case management coordination of services.
4. The Case Management Agency must maintain a current MFW provider status per DOH Provider Enrollment Unit policies, including compliance with the DDS Accreditation Policy.
5. The Case Management Agency must provide readily accessible case management services to persons on a statewide basis or by DDS Region (preferred). At its discretion, the DOH may contract for case management services for one or more counties within a region.

B. Case Manager Requirements:

1. A MFW CM must be a licensed RN in the State of New Mexico with current licensure as defined by the New Mexico Board of Nursing.
2. A MFW CM must have at least two (2) years of experience with the target population in pediatrics, critical care or public health fields. Specifically, one (1) year should have been in a home health program, community health program, hospital, publicly funded institution, long term care program, or any other program addressing the needs of special populations.
3. The MFW CM will have knowledge and experience in:
  - a. Human growth and social development.
  - b. Various disease processes and assessment of the need for skilled intervention.
  - c. Accessing existing community resources as well as development of resources and programs.
  - d. Resources for support to individuals, families, and groups.
  - e. Planning and management of services for individuals with medical fragility and developmental disabilities.
  - f. Interpersonal communication skills.
  - g. Interventions to act appropriately and quickly in a crisis.
  - h. Working with the health, welfare, mental health, and agencies, such as Child Protective Services (CPS) and Adult Protective Services (APS) affecting the MFW population.
4. The MFW CM will be culturally sensitive to the needs and preferences of medically fragile persons and member of their households. Arrangement of



written or spoken communication in another language may need to be considered.

C. Administrative Requirements:

1. The Case Management Agency must comply with all applicable Federal, State, and waiver regulations, policies and procedures regarding case management code of ethics.
2. The Case Management Agency will have an established method of information and data collection.
3. The Case Management Agency will comply with all Federal, State, DOH and Human Services Department (HSD) regulations, policies and procedures, including but not limited to:
  - a. Policies and procedures related to timely submission of medical eligibility determination.
  - b. Policies and procedures related to service provision and appropriate supervision.
  - c. Policies and procedures related to case management training.
  - d. Policies and procedures related to reimbursement of case management services.
  - e. Establish and maintain written grievance procedures.
4. The Case Management Agency must purchase and maintain full professional liability insurance coverage.
5. The Case Management Agency is responsible for assuring that all CMs have current New Mexico RN licensure.
6. The Case Management Agency is responsible for providing ongoing and appropriate training to CMs.
7. The Case Management Agency shall notify the DOH in writing of any changes in the mailing address of the Case Management Agency or any change in executive director, administrator or geographic location of services provided.

D. Documentation Requirements:

1. Documentation must be completed in accordance with applicable Medically Fragile standards.
2. All documentation forms will contain at least: participant's name, date of birth, date of report, provider agency name, and CM's name and credentials.
3. All report pages and notes will include at least the participants' name, date and document title.
4. All documentation will be signed and dated by the CM. Verified electronic signatures may be used. CM name and credential typed on a document is not sufficient.
5. Each participant will have an individual clinical file (see general provider requirements).

IV. CARE COORDINATION

Under the MFW, participants receive ancillary/medical services through the Medicaid State Plan. Managed Care organizations (MCO) provide acute and ancillary medical and behavioral health services to the 1915 (c) HCBS recipients/MCO members. The MCO is responsible for ensuring a Comprehensive Care Plan is initiated upon enrollment and assigning a Care Coordinator for coordinating all services in the MCO Comprehensive Care Plan. Care coordination involves:

1. The Managed Care Organization (MCO) Care Coordinator (CC) will request a copy of the approved MFW LOC packet and ISP packet from the CM and utilize the LOC and ISP information to complete as much of the Client Needs Assessment (CNA) as possible prior to the MCO CC visit with the participant.
2. The CM and CC will work to coordinate MFW LOC assessments and/or CNA visits at the same time to reduce the burden on these families.
3. CC will not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF members. The CM will conduct monthly visits and provide the MCO with copies of the visit notes. The MCO will review the visit notes monthly and update the CNA as needed.

## V. REIMBURSEMENT

Each Case Management Agency is responsible for providing clinical documentation that identifies case management components of the provision of ISP services, including assessment information, care planning, intervention, communications care coordination, and evaluation. There must be justification in each medically fragile participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of contacts. All services must be reflected in the ISP that is coordinated with the participant/family and other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget.

- A. Payment for case management services through this Medicaid Waiver is considered payment in full.
- B. The case management services must abide by all Federal, State, HSD, and DOH policies and procedures regarding billable and non-billable items.
- C. All billed services must not exceed the capped dollar amount for LOC.

- D. Reimbursement for case management services will be based on the current rate allowed for the services.
- E. The Case Management Agency must follow all current billing requirements by the HSD and DOH for CM services.
- F. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.
- G. The Case Management Agency has the responsibility to review and assure that the information on the MAD 046 form for their services is current. If an error is identified, the Case Management Agency will work with the Medicaid TPA to correct the MAD 046 form.
- H. The MFW Program does not consider the following to be case management duties and will not authorize payment for:
  - 1. Performing specific errands for the participant/participant's representative or family that is not program specific;
  - 2. "Friendly visiting," meaning visits with participant outside of work scheduled;
  - 3. Financial brokerage services, handling of participant's finances or preparation of legal documents;
  - 4. Time spent on paperwork or travel that is administrative for the provider;
  - 5. Transportation of persons on the waiver;
  - 6. Pick up and/or delivery of commodities; and
  - 7. Other non-Medicaid reimbursable activities.