

Developmental Disabilities Waiver: Standards for the Fiscal Year 2007 Waiver Renewal
Frequently Asked Questions: Community Living (Chapter 6)

Topic: General Questions

QUESTION	ANSWER
<p>Case Managers approve ISPs and budgets including initial ISPs (page 64). Initial ISP may include Community Living but (page 65) NMMUR approves any initial Community Living. Does that mean that the case manager would approve all services except initial Community Living services on an initial waiver budget?</p>	<p>Yes, but with the following additional exceptions:</p> <ul style="list-style-type: none"> • NMMUR must also approve outlier services and supported living awake. • DDS must approve ARA “exceptions” for Supported Employment, Therapies, and Behavioral Support Consultant services. • DDS Office of Behavioral Services must approve Tier III Crisis Services.
<p>Are Community Living providers going to be forced to provide Tier III services?</p>	<p>No, however they are encouraged to do so.</p>
<p>Does residential agency now need to complete reviews and send to OBS regarding training, etc.?</p>	<p>No.</p>
<p>Why are Community Living providers required to have 3 months worth of daily progress notes in the home file? Why can't this be kept at the agency office if accessible at all times? What are the consequences if 3 months worth of daily progress notes are not kept in the home file? What is the Case Manager's responsibility as it relates to this requirement?</p>	<p>This standard has been changed to one month worth of daily progress notes in the home. Older notes can therefore be kept at the agency office. However, we still require that 3 months worth of Medication Administration Records (MAR) be kept in the home.</p> <p>The case manager will be reviewing progress notes as part of their monitoring during face-to-face visits in order to complete their monthly site visit form. If progress notes are missing, they will note this and inform the appropriate provider agency representative (supervisor) of the problem, but they are not responsible for the Community Living Provider's compliance.</p> <p>The Quality Management Bureau of the Division of Health Improvement will be monitoring compliance with this standard. Agencies that do not comply with this requirement will be subject to enforcement actions.</p>
<p>How can we make sure our services are reflected on the budget correctly?</p>	<p>Within 3 working days after the annual ISP, the case manager will fax, email or deliver a draft budget to for review. The provider agency has 5 working days from that point to provide the case manager with any needed corrections. If you do not provide corrections within that timeframe, the case manager will presume it is correct and okay to submit to NMMUR.</p>

Topic: Supported Living

QUESTION	ANSWER
Is Supported Living up to 3 or up to 4 people in a house?	Supported Living can be provided to four (4) or fewer individuals.
Is a full IDT required at 6 months for Supported Living Awake?	No, but a justification packet must be prepared by the provider and submitted to Blue Cross/Blue Shield (NMMUR) for approval to continue. Depending on the circumstances, the team or part of the team may decide they need to meet.

Topic: Family Living

QUESTION	ANSWER
With 340 days billable, do we average it at 28 days per month?	Family Living is a daily rate with a maximum of 340 billable days per ISP year. DDS/D did not put a limit on the number of days to be billed each month. Number of days billed cannot exceed the number of calendar days in a month.
If family providers use respite and the agency charges the caregiver \$5 per hour, does the agency still bill for Family Living for that day? How does it relate to the rate of \$97.33 daily (24 hours respite is \$120.00, 20 hours is \$100.00)?	Family Living agencies cannot bill for the same hours of the day that respite is provided. This is considered a duplication of service. Family Living agencies will reduce the daily rate billed by \$5 for every hour of respite used. If an individual is in respite for more than 19 hours in a single day, then Family Living cannot be billed for that day. Family Living agencies will not submit a payment claim for days in which more than 19 hours of respite was used – so there is no duplication of services on that day at all - and so the \$5 becomes irrelevant for those days.
If a Family Living provider chooses a different agency for respite, then how is the Family Living agency supposed to get that information on a timely basis?	The family/direct support provider is responsible for tracking their use of respite and providing this information to the Family Living agency in a timely manner. Medicaid will provide payment reports to the Family Living Agencies so they can reconcile payments and claims.
Has BC/BS been trained on the new Standards & March 30 th deadline?	Yes. DDS/D has been meeting monthly with BCBS on the changes to the standard. Per the revised instruction dated December 21, 2006 from DDS/D, the deadline to transition all individuals in Family Living is June 30, 2007.
Is BC/BS prepared for 1500 + budgets more than the norm in this upcoming quarter? Can they assume budgets will be returned within the 14-day deadline?	Case managers will be submitting new budgets for everyone with an annual ISP date between January 1, 2007 and June 30, 2007 that reflect daily Family Living units. For individuals who have an annual ISP date between July 1, 2007 and December 31, 2007 DDS/D, Medicaid and Blue Cross/Blue Shield have worked out a process by which the revision/conversion from monthly Home-based units to Family Living daily units will be directly data entered into the Omnicaid system. Therefore the case manager will not need to submit a MAD 046 revision for this to occur. There is a schedule whereby a certain number of individuals will be converted each month from March through June. Case Managers and Family Living providers will be notified of the effective date of the conversion for each of the individuals they serve so they will know when to switch the billing from monthly to daily units.
Can we convert from Home Based to Family Living earlier than delineated in Jennifer's 12-21-07 memo? Some clients want to	It is okay to do it earlier as part of a revision to change providers - but should not be done early otherwise.

change providers now.	
Family Living Service – 29 day max a month billable. If a Family Living provider uses their 25 days of unpaid service in the middle or the beginning of their budget, the provider will not be able to bill for the 340 days allowed on the annual budget.	<p>There is no maximum of 29 days per month. The maximum of 340 daily units per year can be used at whatever pace makes sense. The 340 units fund 365 days worth of service.</p> <p>Please remember that the full annual payment for 365 days worth of service was divided into 340 billable daily units per year to assure a full annual payment in order to retain the Family Living Service even if an individual is hospitalized or otherwise in a circumstance which removes them from waiver funded services for up to 25 total days during the year. <i>There is no intent to reduce the number of days an individual is in service. Individuals are not expected to spend 25 days away from home.</i></p>
With the new conversion formula switching from the old monthly rate to the new daily rate, will everyone receive the 649 hours of substitute care regardless of where they are in their budget year?	<p>The limit for substitute care has been increased to 1000 hours or 4000 fifteen minute units. For those with annual ISP dates between January 1, 2007 and June 30, 2007, they may now put up to 4000 units of substitute care into the MAD 046. If they had already put in just 649 hours, they may now submit a revision to Blue Cross/Blue Shield up to this amount. The revision to add more substitute care needs to read “increase to 4000 units” or up to whatever level of increase less than 4000 is desired.</p> <p>For those with annual ISP dates after June 30, 2007, the amount of substitute care allowed is being pro-rated based upon an average amount that is presumed to have been used up to this point in the individual’s ISP cycle. For most provider agencies, this averaging across all individuals should work out to cover whatever amount of “bundled respite” they have already provided. In particular instances where such averaging creates a problem for an individual, this can be brought to the attention of Roberta Duran at DDS for consideration of a potential adjustment after the conversions are complete.</p>
Can substitute care be provided by another individual living in the home (who is not the sub-contracted care provider)?	<p>The Family Living Agency is responsible for hiring or subcontracting with the substitute care provider. The Standards do not prohibit this service from being provided by someone living in the same household as the individual. The Family Living agency will need to assure that the substitute care provider meets the agency standards for employment as well as complies with DOH rules regarding criminal history screening, training and the CMS rule against service provision by legally responsible relatives and that the substitute care provider has the training, skills and knowledge to meet the individual’s needs. Legally responsible relatives include the spouse of the individual served and parents or legal guardians of children under age 18. Substitute care may not be billed when the direct support provider is physically in the same location as the individual, unless documentation is maintained to demonstrate that the subcontracted direct support provider was unable to provide the support needed during that period of time due to illness, or specified activities that required the use of a substitute.</p>
Because Family Living is billed 340 days in the year and now agencies can bill 340 days straight (not capped at 29 days/month), then if there is a Family Living change in the middle of the ISP year the new agency would be shorted.	<p>This is indeed a possibility. Currently, when an individual changes providers during the year, the new provider is only able to bill for the amount of units remaining in the budget at the time of the transition.</p> <p>We will be working with the Home-based Task Force and the ACQ to attempt to form alternatives to address this concern (it also comes up occasionally for Supported Living providers).</p>
Family Living services; can a blood related paid Home Based caregiver administer PRN medications	<p>Yes, and those related by adoption or marriage are also allowed to administer PRN medication without calling the nurse.</p>

without calling the agency nurse?	
How much does it cost for Respite Care for a Family Provider?	Respite is budgeted and paid for within the ARA. Neither the Family Living caregiver nor the Family Living agencies are paying for Respite services. Under current Centers for Medicare and Medicaid policy, Respite and Family Living are both considered residential services and therefore Respite cannot be billed during the same time period as Family Living is billed. To comply with this rule and still allow Family Living caregivers to use Respite, the daily rate of payment for Family Living agencies is reduced by \$5.00 for every hour of Respite used up to 19 hours a day. When more than 19 hours of Respite are used, the Family Living Agency may not bill for that day.
Is there a cap on Respite hours for Family Living?	No, there is no specific cap on the amount of Respite. The funding available to purchase Respite will depend on the amount of ARA funding budgeted for other services during each ISP year & the individual's ARA category budget cap.
Why was it possible to change the name from Respite to Substitute Care under bundled and not ARA?	Substitute care is a benefit offered as part of the Family Living Service – while Respite is a service purchased through the ARA. Respite is meant to provide relief from care giving duties <u>to the families or other caregivers of individuals</u> who do not receive DD waiver residential services. Family Living substitute care <u>is intended to assure that the individual can</u> continue to receive the level of support he or she needs when the family/direct support provider is not available. Substitute care is intended to address both the needs of the individual and the direct support provider. The federal Centers for Medicare and Medicaid Services (CMS) does not allow Respite in conjunction with any type of residential service, including the Family Living model. They were persuaded however, that just like employees in other settings, Family Living caregivers deserve vacation, holidays and sick leave. Therefore they allowed us, as part of the Family Living service, to provide “substitute care” just like a substitute teacher would be used if the main teacher is sick or on vacation.
Board of Pharmacy requires MAAT and certain procedures. Are the same rules required for the new waiver?	The DDS Policy & Procedure “Medication Assessment and Delivery” that has been in effect since 11-1-06 was developed in collaboration with the Board of Nursing and the Board of Pharmacy to ensure maximum flexibility in meeting individual support needs related to medication, while still assuring that our providers are in compliance with regulations/rules of both of these state agencies. This policy is still in effect for the waiver renewal. Certain providers have raised concerns regarding procedures required for delivery of PRN medications – the Board of Nursing has agreed to form a work group to review this aspect and determine if more practical alternatives can be identified and agreed upon. In the meantime however, this policy and procedure must be complied with in current form.
How many Substitute Care hours can a Family Living provider get?	Up to 4000 fifteen minute units, which equal 1000 hours per year.
Will the Substitute Care provider need to have training like the direct care staff?	Substitute care staff must have training equivalent to that required for respite workers in the DDS training policy. They will also need to have sufficient individual specific training to assure the health and safety of the individual.
Substitute care is no longer bundled; is it a separate service placed on 046? Outside of ARA?	Substitute care is outside the ARA and will have its own line on the budget (MAD046 form) even though it is part of the Family Living service. One reason substitute care has its own line item on the budget is so that a modifier can be used for billing purposes, in order to track the actual amount of substitute care used.
Can an individual choose a different agency than their Family Living agency to provide substitute care?	No. Substitute care is part of the Family Living Service and must be provided through the Family Living agency. However, Family Living agencies can choose to subcontract with another agency to deliver substitute care on their behalf.
Who can complete the Health Assessment Tool (HAT) for	For all service providers, the HAT can be completed by either the agency nurse or the individual's primary care physician (if the physician is willing). <u>For Family Living only</u> – we also allow the option of the family living caregiver completing

individuals in Family Living?	the HAT.
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Topic: Independent Living

QUESTION	ANSWER
Do Independent Living services HAVE to be done in the person's home? P. 107, 1c	No, Independent Living services are intended to enable the individual to live as independently as possible in the community setting; in addition to services provided in the individual's home, services may also be provided in other related settings such as the grocery store, Laundromat, bank, etc.. Independent Living Services may also be provided to individuals who live with their families.