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

HOME HEALTH AIDE (HHA)

Effective July 1, 2019

All waiver participants are eligible to receive in-home Home Health Aide (HHA) services utilizing capped units/hours determined by approved Level of Care (LOC) Abstract and when justified on the Individual Service Plan (ISP) by the case manager (CM). The HHA is a paraprofessional member of the health care team who works directly under the supervision of a registered nurse (RN). The HHA performs total care or assists participant in all activities of daily living. The HHA will be assigned to assist in a manner that will promote an improved quality of life and a safe environment. The HHA duties/assignments will be in accordance with the participant's ISP and the Home Health (HH) Agency plan of care for the participant. The plan of care is a separate form from the CMS-485 form. HHA services for persons on the Medically Fragile Waiver (MFW) under the age of 21 are covered as under the Medicaid Early Periodic Screening, Diagnostic & Treatment (EPSDT) program. This service standard is written for the MFW participant 21years and older.

I. SCOPE OF SERVICES

A. Initiation of HHA Services:
When HHA is identified as a recommended service, the CM will provide the participant/participant's representative with a Secondary Freedom of Choice form (SFOC). The participant/participant's representative will select a HH Agency from the SFOC. The identified HH Agency will request a HHA referral/prescription from the primary care provider (PCP). This must be obtained before initiation of treatment. A copy of the written referral/prescription will be maintained in the participant's file with the HH Agency. The CM is responsible for including recommended units of HHA on the MAD 046. It is the responsibility of the participant/participant's representative, HH Agency and CM to assure that units/hours of HHA services do not exceed the capped dollar amount determined for the medically fragile participant's LOC and ISP cycle. Strategies, support plans, goals and outcomes will be developed based on the identified strengths, concerns, priorities and outcomes in the ISP.

B. HHA Service Includes:
1. Assisting with ambulation, transfer, and range of motion exercises under supervision of a Licensed Physical Therapist (PT), Licensed Occupational Therapist (OT) or Licensed Nurse (RN or LPN).

2. Assisting with menu planning, meal/snack preparation and assisting person with eating when necessary.
3. Assisting with bowel and bladder elimination, personal hygiene/personal care, pericare, catheter care, ostomy care, enemas, insertion of suppository (non-prescription), prosthesis care, and vital signs as ordered by a Physician/Healthcare provider and under supervision of a licensed nurse (RN or LPN).
4. The HHA may provide, with the approval of provider agency, services such as picking up medications and prompting participant to take medications.
5. The HHA will observe the general condition of participant and will report changes to the supervisor and primary caregiver/family. The HHA will document participant's status, changes in status, services furnished, and response to services.
6. The HHA will follow infection control practices.
7. The HHA will follow emergency procedures within scope of practice and report event to supervisor.
8. The HHA will respect participant's privacy, property and cultural differences.
9. The HHA may ride in the vehicle with the participant for the purpose of oversight during transportation. The HHA will accompany the participant to monitor or support him or her during transportation. This means the HHA many not operate the vehicle for purpose of transporting the participant without agency approval.
10. The HHA will follow regulations for HHA in State Regulations 7 NMAC 7.2 and Federal Regulations 42 CFR 484.
11. The HHA will follow documentation requirement per Federal Regulations 42 CFR 484 or State Regulations 4 NMAC 28.2 and MFW regulations.

C. Home Health Aide will not:
1. Administer medications or tube feedings,
2. Adjust oxygen levels,
3. Perform any intravenous procedures,
4. Perform any sterile procedures,
5. Perform housekeeping services for members of the medically fragile person's family.

II. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS

A. The HH Agency must be a current MFW provider with the Provider Enrollment Unit (PEU)/Developmental Disabilities Supports Division (DDSD).

B. HHA Qualifications:

1. HHA Certificate from an approved community-based program following the HHA training Federal regulations 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or;
2. HHA training at the licensed HH Agency which follows the Federal HHA training regulation in 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or;
3. A Certified Nurses' Assistant (CNA) who has successfully completed the employing HH Agency's written and practical competency standards and meets the qualifications for a HHA with the MFW. Documentation will be maintained in personnel file.
4. A HHA who was not trained at the employing HH Agency will need to successfully complete the employing HH Agency's written and practical competency standards before providing direct care services. Documentation will be maintained in personnel file.
5. The HHA will be supervised by the HH Agency RN supervisor or HH Agency RN designee at least once every 60 days in the participant's home.
6. The HHA will be culturally sensitive to the needs and preferences of the participants and their families. Based upon the individual language needs or preferences, HHA may be requested to communicate in a language other than English.

C. All supervisory visits/contacts must be documented in the participant's HH Agency clinical file on a standardized form that reflects the following:
   1. Service received;
   2. Participant's status;
   3. Contact with family members;
   4. Review of HHA plan of care with appropriate modification annually and as needed.

D. Requirements for the HH Agency Serving Medically Fragile Waiver Population:
   1. The HH Agency nursing supervisors(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and HHA.
   2. The HH Agency staff will be culturally sensitive to the needs and preferences of participants and households. Arrangement of written or spoken communication in another language must be considered.
   3. The HH Agency will document and report any noncompliance with the ISP to the case manager.
   4. All Physician orders that change the participant's service needs should be conveyed to the CM for coordination with service providers and modification to ISP/MAD 046 if necessary.
   5. The HH Agency will document in the participant's clinical file that the RN supervision of the HHA occurs at least once every sixty days. Supervisory forms must be developed and implemented specifically for this task.

6. The HH Agency and CM must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care.
7. The HH Agency supervising RN, direct care RN and LPN trains families, direct support professionals and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies or other areas of concern.
8. It is expected the HH Agency will consult with, Interdisciplinary Team (IDT) members, guardians, family, and direct support professionals (DSP) as needed.

III. ADMINISTRATIVE REQUIREMENTS

The administrative requirements are directed at the HH Agency, Rural Health Clinic or Licensed or Certified Federally Qualified Health Center.

A. The HH Agency will maintain licensure as a HH Agency, Rural Health Clinic or Federally Qualified Health Center, or maintain certification as a Federally Qualified Health Center.

B. The HH Agency will assure that HHA services are delivered by an employee meeting the educational, experiential and training requirements as specified in the Federal 42 CFT 484.36 or State 7 NMAC 28.2.

C. Copies of CNA certificates must be requested by the employer and maintained in the personnel file of the HHA.

D. The HH Agency will implement HHA care activities/plan of care per the participant's ISP identified strengths, concerns, priorities and outcomes.

E. A HH Agency may consider hiring a participant's family member to provide HHA services if no other staff are available. The intent of the HHA service is to provide support to the family, and extended family should not circumvent the natural family support system.

F. A participant's spouse or parent, if the participant is a minor child, cannot be considered as a HHA.

G. The HHA is not a primary care giver, therefore when the HHA is on duty; there must be an approved primary caregiver available in person. The participant and/or representative and agency have the responsibility to assure there is a primary caretaker available in person. The primary caregiver or a responsible adult must

be available on the property where the participant is currently located and within audible range of the participant and HHA.

H. All designated primary caretakers' names and phone numbers must be written in the backup plan and agreed upon by the agency and / representative. The designated approved back up primary caregiver will not be reimbursed by the MFW/DDSD.

I. An emergency back up plan for medical needs and staffing must be developed, written and agreed upon by the HH Agency and participant/participant's representative. This emergency back up plan will be available in participant's home. This plan will be modified when medical conditions warrant and will be reviewed at least annually.

IV. REIMBURSEMENT

Each provider of a service is responsible for providing clinical documentation that identifies direct care professional (DCP) roles in all components of the provision of home care, including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative 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 HHA services through the Medicaid Waiver is considered payment in full.

B. The HHA services must abide by all Federal, State, HSD and DOH policies and procedures regarding billable and non-billable items.

C. The billed services must not exceed capped dollar amount for LOC.

D. The HHA services are a Medicaid benefit for children birth to 21 years through the children's EPSDT program.

E. The Medicaid benefit is the payer of last resort. Payment for HHA services should not be requested until all other third party and community resources have been explored and/or exhausted.

F. Reimbursement for HHA services will be based on the current rate allowed for the services.

G. The HH Agency must follow all current billing requirements by the HSD and the DOH for HHA services.

H. Claims for services must be received within 90 calendar days of the date of service in accordance with 8.302.2.11 NMAC.

I. Providers of service have the responsibility to review and assure that the information on the MAD 046 for their services is current. If the provider identifies an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected.

J. The MFW Program does not consider the following to be professional HHA duties and will not authorize payment for:
   1. Performing 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 finances or preparation of legal documents;
   4. Time spent on paperwork or travel that is administrative for the provider;
   5. Transportation of participants without agency approval;
   6. Pick up and/or delivery of commodities; and
   7. Other non-Medicaid reimbursable activities.