MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 24, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF OPERATIONS

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2300 – HOME AND COMMUNITY BASED WAIVER (HCBW) FOR PERSONS WITH PHYSICAL DISABILITIES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2300 – Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities are being proposed to include mandate as per the 21st Century Cures Act.

In December 2016, Congress passed H.R. 34 - 21st Century Cures Act, mandating that all States require the use of an Electronic Visit Verification (EVV) System for all Medicaid funded personal care services that are provided under a State plan or a waiver of the plan, including services provided under section 1915(c).

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering specific waiver services. Those provider types include, but are not limited to: Waiver for Persons with Physical Disabilities (PT 58).

Financial Impact on Local Government: Unknown at this time.

These changes are effective September 25, 2019.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL N/A MSM Ch 2300 – Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities	MTL 08/13, 33/10 MSM Ch 2300 – Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2301	**Authority**	Added new authorities as per the new policy mandate.
2303.3B	**Provider Responsibilities**	Deleted information regarding prior authorization as not every waiver service requires a prior authorization. Added information regarding Electronic Visit Verification policy under new section 2303.3B.2b.
2303.3C	**Recipient Responsibilities**	Corrected/renumbered list at the end of this section and added two new recipient responsibilities.
2303.4B	**Homemaker Provider Responsibilities**	Added two new provider responsibilities related to EVV policy.
2303.5B	**Chore Provider Responsibilities**	Added provider responsibility related to EVV policy and further clarification regarding requirement, expectations and documentation.
2303.6B	**Respite Provider Responsibilities**	Added provider responsibility related to EVV policy and further clarification regarding requirement, expectations and documentation.
2303.7B	**Environmental Accessibility Adaptation Provider Responsibility**	Added specific service requirement regarding prior authorization.
2303.9B	**PERS Provider Responsibilities**	Added specific service requirement regarding prior authorization.
2303.10B	**Assisted Living Provider Responsibilities**	Added specific service requirement regarding prior authorization.
2303.11B	**Home Delivered Meals Provider Responsibilities**	Added specific service requirement regarding prior authorization.
2303.12B	**Attendant Care Provider Responsibilities**	Added two new provider responsibilities related to EVV policy.

2301 AUTHORITY

Section 1915(c) of the Social Security Act permits states to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services that an individual requires to remain in a community setting and avoid institutionalization. The Division of Health Care Financing and Policy's (DHCFP) Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities is an optional program approved by the Centers for Medicare and Medicaid Services (CMS). The waiver is designed to provide to eligible Medicaid waiver recipients State Plan Services and certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes or community settings, when appropriate.

Nevada has the flexibility to design this waiver and select the mix of waiver services best meeting the goal to keep people in the community. Such flexibility is predicated on administrative and legislative support, as well as federal approval.

Statutes and Regulations

- Social Security Act: 1915 (c)
- Social Security Act: 1916 (e)
- Social Security Act: 1902 (w)
- Omnibus Budget Reconciliation Act of 1987
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- State Medicaid Manual, Section 44442.3.B.13
- State Medicaid Director Letter (SMDL) #01-006 attachment 4-B
- Title 42, Code of Federal Regulations (CFR) Part 441, subparts G
- 42 CFR Part 431, Subpart E
- 42 CFR Part 431, Subpart B
- 42 CFR 489, Subpart I

- Nevada's Home and Community Based Waiver Agreement for People with Physical Disabilities Nevada Revised Statutes (NRS) Chapter 449, 706, 446, 629, 630, 630a, and 633
- Nevada Administrative Code (NAC) Chapters 441A.375 and 706.
- 21st Century Cures Act, H.R. 34, Sec. 12006 – 114th Congress
- H.R. 6042 – 115th Congress

2303.2B MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The children made eligible for Medicaid through their enrollment in the HCBW for Persons with Physical Disabilities receive all medically necessary Medicaid covered services available under EPSDT. A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary service(s) required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2303.3 WAIVER SERVICES

The DHCFP determines which services will be offered under the HCBW for Persons with Physical Disabilities. Providers and recipients must agree to comply with the requirements for service provision.

2303.3A COVERAGE AND LIMITATIONS

Under the waiver, the following services are covered if identified in the POC as necessary to avoid institutionalization:

1. Case Management;
2. Homemaker Services;
3. Chore Services;
4. Respite;
5. Environmental Accessibility Adaptations;
6. Specialized Medical Equipment and Supplies;
7. Personal Emergency Response System (PERS);
8. Assisted Living Services;
9. Home Delivered Meals; and/or
10. Attendant Care Services.

2303.3B PROVIDER RESPONSIBILITIES

1. All Providers

a. Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering service.

b. Providers must meet and comply with all provider requirements as specified in MSM Chapter 100.

c. Must enroll and maintain an active HCBW for Persons with Physical Disabilities provider number (type 58).

d. May only provide services that have been identified in the recipient POC and, if required, have prior authorization.

e. The total weekly authorized hours for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The provider and recipient will determine how to use the weekly authorized hours on an ongoing basis; however, any changes that do not increase the total authorized hours can be made within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider.

f. Payments will not be made for services provided by a recipient's legally responsible individual.

~~g. All waiver services must be prior authorized.~~

2. Provider Agencies

a. Agencies employing providers of service for the waiver program must arrange training in at least the following subjects:

1. policies, procedures and expectations of the contract agency relevant to the provider, including recipient's and provider's rights and responsibilities;

2. procedures for billing and payment, if applicable;

3. record keeping and reporting;

4. information about the specific disabilities of the persons to be served and, more generally, about the types of disabilities among the populations the provider will serve, including physical and psychological aspects and implications, types of resulting functional deficits, and service needs;

5. recognizing and appropriately responding to medical and safety emergencies;

6. working effectively with recipients including: understanding recipient direction and the independent living philosophy; respecting consumer rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; respecting personal property; active listening and responding; emotional support and empathy; ethics in dealing with the recipient, legally responsible individual and other providers; handling conflict and complaints; dealing with death and dying; and other topics as relevant.

7. Exemptions from Training

   a. The agency may exempt a prospective service provider from those parts of the required training where the agency verifies the person possesses adequate knowledge or experience, or where the provider's duties will not require the particular skills.

   b. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's and caregiver's case record. Where the recipient or other private third party functions as the employer, such individuals may exercise the exemption authority identified above.

8. Recipients Providing Training

   a. Where a recipient desires to provide training and the recipient is able to state and convey his/her needs to a caregiver, the agency will allow the recipient to do so.

   b. Any such decision shall be agreed to by the recipient and documented in the case record as to what training the recipient is to provide.

   c. Where the recipient or other private third party functions as the employer such individual may exercise the exemption from training authority identified above.

9. Completion and Documentation of Training
   The provider shall complete required training within six months of beginning employment. Training as documented in the MSM 2303.2 B.2.b., except for the service areas requiring completion of Cardiopulmonary

Resuscitation (CPR) (as listed in the specific service area sections of this chapter) which should be completed in a six month timeframe, and 2303.2 B.2.b.(6-8), which must be completed prior to service provision.

10. Each provider agency must have a file for each recipient. In the recipient's file, the agency must maintain the daily records. Periodically, the DHCFP Central Office staff may request this documentation to compare to billings submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.

11. Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization. Reference Section 2303B.e.

b. ELECTRONIC VISIT VERIFICATION (EVV):

The 21st Century Cures Act requires the use of an EVV system to document services that are provided for all personal care services under a Medicaid State plan or waiver program. This mandate requires provider agencies to use an EVV system to record service delivery visit information. Nevada Medicaid utilizes the open-system model, procuring a vendor but also allows agencies to utilize their own if it meets the 21st Century Cures Act requirements for documentation.

All service information must be recorded in an electronic system that interfaces with either a telephone or an electronic device that generates a timestamp. The provider agency must verify the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV record. All claims must be supported by an EVV entry into an EVV system prior to claim submission.

Agencies must ensure each personal care attendant has a unique identifier (National Provider Identification – NPI) associated with their worker profile in the EVV system.

1. STATE OPTION:

a. The EVV system electronically captures:

1. The type of service performed, based on procedure code;

2. The individual receiving the service;

3. The date of the service;

4. The location where service is provided;

5. The individual providing the service;

6. The time the service begins and ends.

b. The EVV system must utilize one or more of the following:

1. The agency/personal care attendant's smartphone;

2. The agency/personal care attendant's tablet;

3. The recipient's landline telephone;

4. The recipient's cellular phone (for Interactive Voice Response (IVR) purposes only);

5. Other GPS-based device as approved by the DHCFP.

2. DATA AGGREGATOR OPTION:

a. All Personal Care Agencies that utilize a different EVV system (as approved by the DHCFP) must comply with all documentation requirements of this chapter and must utilize the data aggregator to report encounter or claim data.

1. Appropriate form must be approved by the DHCFP before use of system to ensure all data requirements are being collected to meet the 21st Century Cures Act.

2. At a minimum, data uploads must be completed monthly into data aggregator.

c. All waiver providers must provide the local DHCFP District Office Waiver Case Manager with written notification of serious occurrences involving the recipient within 24 hours of discovery.

Serious occurrences include, but are not limited to the following:

1. Unplanned hospital or Emergency Room (ER) visit;

2. Injury or fall requiring medical intervention;

3. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;

4. abuse or neglect of a child or contributory delinquency;
5. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in NRS 454;

6. a violation of any provision of NRS 200.700 through 200.760;

7. criminal neglect of a patient as defined in NRS 200.495;

8. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;

9. any felony involving the use of a firearm or other deadly weapon;

10. abuse, neglect, exploitation or isolation of older persons;

11. kidnapping, false imprisonment or involuntary servitude;

12. any offense involving assault or battery, domestic or otherwise;

13. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;

14. conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; or

15. any other offense that may be inconsistent with the best interests of all recipients.

g. Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. An "undecided" result is not acceptable. If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: http://dps.nv.gov under Records and Technology.

2303.3C RECIPIENT RESPONSIBILITIES

The recipient or the recipient's authorized representative will:

1. notify the provider(s) and case manager of a change in Medicaid eligibility.
2. notify the provider(s) and case manager of changes in medical status, service needs, address, and location, or of changes of status of legally responsible individual(s) or authorized representative.
3. treat all staff and providers appropriately.
4. if capable, sign the provider daily record to verify services were provided.
5. notify the provider when scheduled visits cannot be kept or services are no longer required.
6. notify the provider agency of missed visits by provider agency staff.
7. notify the provider agency of unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver.
8. furnish the provider agency with a copy of their Advance Directives.
9. establish a back-up plan in case a waiver attendant is unable to work at the scheduled time.
10. not request a provider to work more than the hours authorized in the service plan.
11. not request a provider to work or clean for a non-recipient, family, or household members.
12. not request a provider to perform services not included in the care plan.
13. contact the case manager to request a change of provider.
14. sign all required forms.

~~1.~~15. ~~Recipients must~~ meet and maintain all criteria to be eligible, and to remain on the HCBW for Persons with Physical Disabilities.

~~15.~~16. ~~Recipient~~ may have to pay patient liability. Failure to pay is grounds for termination from the waiver.

17. agree to utilize an approved EVV system for the waiver services being received from the provider agency.

18. confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2303.3D DIRECT SERVICE CASE MANAGEMENT

Direct Service Case Management is limited to eligible participants enrolled in HCBW services program, when case management is identified as a service on the POC. The recipient has a choice to have direct service case management services provided by qualified state staff or qualifying provider agency staff.

2303.3E COVERAGE AND LIMITATIONS

These services include:

1. Identification of resources and assisting recipients in locating and gaining access to waiver services, as well as needed medical, social, educational and other services regardless of the funding source;

2. Coordination of multiple services and/or providers;

3. Monitoring the overall provision of waiver services, in an effort to protect the safety and health of the recipient and to determine that the POC goals are being met;

4. Monitoring and documenting the quality of care through monthly contact:

   a. The direct service case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every six months. More contacts may be made if the recipient has indicated a significant change in his or her health care status or is concerned about his or her health and/or safety.

   b. When recipient service needs increase, due to a temporary condition or circumstance, the direct service case manager must thoroughly document the increased service needs in their case notes. The POC does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days.

   c. During the monthly contact, the direct service case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and

d. washing, ironing and mending the recipient's personal laundry. The recipient pays any laundromat and/or cleaning fees;

e. assisting the recipient and legally responsible individuals or caregivers in learning a homemaker routine and skills, so the recipient may carry on normal living when the homemaker is not present;

f. accompanying the recipient to homemaker activities such as shopping or the laundromat. Any transportation to and from these activities is not reimbursable as a Medicaid expense;

g. routine clean-up after up to two household pets. Walking a pet is not included unless it is a service animal.

4. Activities the homemaker shall not perform and for which Medicaid will not pay include, but are not limited to the following:

a. transporting (as the driver) the recipient in a private car;

b. cooking and cleaning for the recipient's guests, other household members, or for entertaining;

c. repairing electrical equipment;

d. ironing sheets;

e. giving permanents, dying or cutting hair;

f. accompanying the recipient to social events;

g. washing walls;

h. moving heavy furniture, climbing on chairs or ladders;

i. purchasing alcoholic beverages which were not prescribed by the recipient's physician;

j. doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow covered areas, and vehicle maintenance.

2303.4B HOMEMAKER PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, please reference Section 2303.3B of this chapter regarding Provider Responsibilities.

1. Providers are required to arrange and receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment.

2. A legally responsible individual may not be paid for homemaker services.
3. The DHCFP is not responsible for replacement of goods damaged in the provision of service.

4. Service must be prior authorized and documented in an approved EVV.

5. Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

2303.5 CHORE SERVICES

2303.5A COVERAGE AND LIMITATIONS

1. This service includes heavy household chores such as:

   a. cleaning windows and walls;

   b. shampooing carpets;

   c. tacking down loose rugs and tiles;

   d. moving heaving items;

   e. minor home repairs;

   f. removing trash and debris from the yard; and

   g. packing and unpacking boxes.

2. Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of, or responsible for, their provision and without these services the recipient would be at risk of institutionalization. This is not a skilled, professional service.

3. In the case of rental property, the responsibility of the landlord pursuant to the lease

agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any waiver program covered services.

2303.5B CHORE SERVICES PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, reference Section 2303.3B of this Chapter regarding Provider Responsibilities.

1. Persons performing heavy household chores and minor home repair services need to maintain the home in a clean, sanitary, and safe environment.

2. Service must be prior authorized and documented in an approved EVV.

Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

2303.6 RESPITE CARE

2303.6A COVERAGE AND LIMITATIONS

1. Respite care is provided for relief of the primary unpaid caregiver.

2. Respite care is limited to 120 hours per waiver year per individual.

3. Respite care is only provided in the individual's home or place of residence.

2303.6B RESPITE CARE PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, reference Section 2303.3B of this Chapter regarding Provider Responsibilities.

1. Respite providers must:

   a. perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their homes to provide temporary relief for a primary caregiver;

   b. have the ability to read and write and to follow written or oral instructions;

   c. have had experience and or training in providing the personal care needs of people with disabilities;

d. meet the requirements of NRS 629.091, Section 2303.3B of this Chapter, and MSM Chapter 2600 if a respite provider is providing attendant care services that are considered skilled services;

e. demonstrate the ability to perform the care tasks as prescribed;

f. be tolerant of the varied lifestyles of the people served;

g. identify emergency situations and act accordingly, including completion of CPR certification which may be obtained outside the agency;

h. have the ability to communicate effectively and document in writing services provided;

i. maintain confidentiality regarding details of case circumstances;

j. arrange training in personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment, homemaking and household care.

k. Services must be prior authorized and documented in an approved EVV System.

l. Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

2303.7 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

2303.7A COVERAGE AND LIMITATIONS

1. Adaptations may include the purchase of environmental controls, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient. Adaptations must be prior authorized and are subject to legislative budget constraints.

2. All services, modifications, improvements or repairs must be provided in accordance with applicable state or local housing and building codes.

3. Excluded Adaptations
   a. Improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

b. Adaptations which increase the total square footage of the home except when necessary to complete an adaptation, for example, in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair.

2303.7B ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS PROVIDER RESPONSIBILITIES

1. All agencies contracting with the DHCFP who provide environmental accessibility adaptation assessments will employ persons who have graduated from an accredited college or university in Special Education, rehabilitation, rehabilitation engineering, occupational or speech therapy or other related fields and who are licensed to practice if applicable and have at least one year experience working with individuals with disabilities and their families or graduation from high school and three years experience working with individuals with disabilities and their families as a technologist and possess a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Technology Certification.

2. All sub-contractors must be licensed or certified if applicable. Modifications, improvements or repairs must be made in accordance with local and state housing and building codes.

3. Durable Medical Equipment (DME) providers must meet the standards to provide equipment under the Medicaid State Plan Program.

4. The service must be prior authorized.

2303.8 SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

2303.8A COVERAGE AND LIMITATIONS

1. Specialized medical equipment and supplies are those devices, controls, or appliances specified in the plan of care that enable recipients to increase their abilities to perform ADLs.

2. This service also includes devices, controls, or applications which enable the recipient to perceive, control, or communicate with the environment in which they live; items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

3. Items reimbursed with waiver funds shall be, in addition to any medical equipment and supplies, furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient.

3. The waiver service pays for the device rental and funds ongoing monitoring on a monthly basis.

2303.9B PERS PROVIDER RESPONSIBILITIES

1. The provider must provide documentation showing tax identification number.

2. The provider is responsible for ensuring that the response center is staffed by trained professionals at all times.

3. The provider is responsible for any replacement or repair needs that may occur.

4. Providers of this service must utilize devices that meet FCC standards, Underwriter's Laboratory standards or equivalent standards.

5. Providers must inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

6. The service must be prior authorized.

2303.9C RECIPIENT RESPONSIBILITIES

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider when the equipment is no longer working.

2. The recipient must return the equipment to the provider when it is no longer needed or utilized, when the recipient terminates from the waiver program, or when the recipient moves out of state.

3. The recipient may not throw away the PERS equipment. This is leased equipment and belongs to the PERS provider.

2303.10 ASSISTED LIVING SERVICES

2303.10A COVERAGE AND LIMITATIONS

1. Assisted living services are all inclusive services furnished by the assisted living provider. Assisted living services are meant to provide all support services needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/ transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, therapeutic social and recreational programming, provided in a

4. Must have current CPR certification which may be obtained outside the agency prior to initiation of services to a Medicaid recipient.

5. Caregiver Supervisors will:

   a. possess at least one year of supervisory experience and a minimum of two years experience working with adults with physical disabilities, including traumatic brain injury.

   b. demonstrate competence in designing and implementing strategies for life skills training and independent living.

   c. possess a bachelor's degree in a human service field preferably, or education above the high school level combined with the experience noted in paragraph (a) above.

      Supporting Qualifications of the Caregiver Supervisor are:

      1. experience in collecting, monitoring, and analyzing service provision; ability to identify solutions and satisfy staff/resident schedules for site operations.

      2. ability to interpret professional reports.

      3. knowledge of life skills training, personal assistance services, disabled advocacy groups, accessible housing, and long-term care alternatives for adults with physical disabilities and/or traumatic brain injuries.

      4. dependable, possess strong organization skills and have the ability to work independent of constant supervision.

6. Assisted Living Attendants

   Assisted living attendants shall provide personal care services, community integration, independent living assistance, and supervisory care to assist the recipient in following the POC. Assisted living attendants shall possess:

   a. a high school diploma or GED.

   b. some post-secondary educational experience is desired.

   c. a minimum of two positive, verifiable employment experiences.

   d. two years of related experience is desired.

e. job experience demonstrating the ability to teach, work independently without constant supervision, and demonstrating regard and respect for recipients and co-workers.

f. verbal and written communication skills.

g. the ability to handle many details at the same time.

h. the ability to follow-through with designated tasks.

i. knowledge in the philosophy and techniques for independent living for people with disabilities.

j. if the attendant is providing attendant care services, that include skilled services, the attendant must meet the requirements of NRS 629.091.

k. a current CPR certificate.

7. Supporting Qualifications of the assisted living attendant are:

a. dependability, able to work with minimal supervision;

b. demonstrates problem solving ability;

c. the ability to perform the functional tasks of the job.

8. The service must be prior authorized.

2303.11 HOME DELIVERED MEALS

2303.11A COVERAGE AND LIMITATIONS

Home delivered meals are the provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to a person's home.

Recipients who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician.

1. Home delivered meals must be prepared by an agency and be delivered to the recipient's home.

2. Meals provided by or in a child foster home, adult family home, community based residential facility or adult day care are not included, nor is meal preparation.

3. The direct purchase of commercial meals, frozen meals, Ensure, or other food or nutritional supplements is not allowed under this service category.

4. Home delivered meals are not intended to meet the full daily nutritional needs of a recipient. More than one provider may be used to meet a recipient's need.

5. Case managers determine the need for this service based on a Standardized Nutritional Profile, or assessment, and by personal interviews with the recipient related to individual nutritional status.

6. All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services (DHHS) and the United States Department of Agriculture; and provide a minimum of 33 and 1/3 percent of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.

7. Nutrition programs are encouraged to provide eligible participants meals which meet particular dietary needs arising from health or religious requirements or the ethnic background of recipients.

2303.11B HOME DELIVERED MEALS PROVIDER RESPONSIBILITIES

1. Meals are provided by governmental or community providers who meet the requirements of a meal provider under NRS 446 and who are enrolled with the DHCFP as a Medicaid Provider.

2. Pursuant to NRS 446: All nutrition sites which prepare meals must have a Food Service Establishment Permit as follows:

   a. All Nutrition Programs must follow the Health and Safety Guidelines established for Food and Drink Establishments in NAC, Chapter 446, or local health code regulations.

   b. All kitchen staff must hold a valid health certificate if required by local health ordinances.

   c. Report all incidents of suspected food borne illness to the affected recipients and local health authority within 24 hours and to the DHCFP District Office case manager by the next business day.

3. All employees must pass State/FBI background checks.

4. Provide documentation of taxpayer identification number.

5. The service must be prior authorized.

2303.12 ATTENDANT CARE

2303.12A COVERAGE AND LIMITATIONS

Extended State plan personal care attendant service may include assistance with eating, bathing, dressing, personal hygiene, ADLs, shopping, laundry, meal preparation and accompanying the recipient to appointments as necessary to enable the individual to remain in the community. The service may include hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled services to the extent permitted by State law. This service may include an extension of task completion time allowed under the state plan with documented medical necessity.

1. Where possible and preferred by the recipient, he/she will direct his/her own service through an Intermediary Services Organization (ISO). Refer to MSM Chapter 2600. When the recipient recruits and selects a caregiver, the individual is referred to the ISO for hire. The recipient may also terminate the assistant. When utilizing this option, the recipient will work with his/her case manager to identify an appropriate back up plan. If this option is not used, the recipient will choose a provider agency that will otherwise recruit, screen, schedule assistants, provide backup and assurance of emergency assistance.

2. Extended personal care attendant services in the recipient's plan of care may include assistance with:

   a. eating;

   b. bathing;

   c. dressing;

   d. personal hygiene;

   e. ADLs;

   f. hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or

cognitive function.

3. Flexibility of Services

Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization. Reference 2303.3B.1.e of this chapter.

2303.12B ATTENDANT CARE PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, reference Section 2303.3B of this Chapter regarding Individual Provider Responsibilities.

1. Personal care attendants may be members of the individual's family. However, payment will not be made for services furnished by legally responsible individuals.

2. When the provision of services includes an unskilled provider completing skilled care, qualifications and requirements must be followed as in NRS 629.091, and MSM Chapter 2600.

3. Providers must demonstrate the ability to:

   a. perform the care tasks as prescribed;

   b. identify emergency situations and to act accordingly, including CPR certification which may be obtained outside the agency;

   c. maintain confidentiality in regard to the details of case circumstances; and

   d. document in writing the services provided.

4. Provider Agencies must arrange training in:

   a. procedures for arranging backup when not available, agency contact person(s), and other information as appropriate. (Note: This material may be provided separate from a training program as part of the provider's orientation to the agency.)

   b. personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.

   c. home making and household care, including good nutrition, special diets, meal planning and preparation, essential shopping, housekeeping techniques and maintenance of a clean, safe and healthy environment.

5. Service must be prior authorized and documented in an approved EVV System.

6. Provider is responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV System.

2303.13 PROVIDER ENROLLMENT/TERMINATION

All providers must comply with all the DHCFP provider enrollment requirements, provider responsibilities/qualifications, and the DHCFP provider agreement limitations. Provider non-compliance with all or any of these stipulations may result in Nevada Medicaid's decision to exercise its right to terminate the provider's contract. Refer to MSM Chapter 100 for general enrollment policies.

2303.14 INTAKE PROCEDURES

The DHCFP developed procedures to ensure fair and adequate access to services covered under the HCBW for Persons with Physical Disabilities.

2303.14A COVERAGE AND LIMITATIONS

1. Slot Provisions

a. The allocation of waiver slots is maintained statewide based on priority and referral date. Slots are allocated by priority based on the earliest referral date.

b. Recipients must be terminated from the waiver when they move out of state, fail to cooperate with program requirements, or request termination; their slot may be given to the next person on the waitlist.

c. When a recipient is placed in an NF or hospital, they must be sent a NOD terminating them from the waiver 45 days from admit date. Their waiver slot must be held for 90 days from the NOD date. They may be placed back in that slot if they are released within 90 days of the NOD date and request reinstatement. They must continue to meet program eligibility criteria. After 90 days, their slot may be given to the next individual on the waitlist.

2. Referral Pre-Screening

A. A referral or inquiry for the waiver may be made by the potential applicant or by another party on behalf of the potential applicant by contacting the local DHCFP District Office. The DHCFP District Office staff will discuss waiver services,