TITLE 480 HOME AND COMMUNITY-BASED SERVICES

CHAPTER 4 PROVIDER REQUIREMENTS

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statutes (Neb. Rev. Stat.) §§ 68-901 et seq. (the Medical Assistance Act).

002. GENERAL PROVIDER REQUIREMENTS.

002.01 COMPLIANCE WITH MEDICAID PROVIDER REQUIREMENTS. To participate in Nebraska Medicaid, providers of Home and Community-Based Waiver services must comply with all applicable provider participation requirements identified in 471 Nebraska Administrative Code (NAC) Chapters 1-000, 2-000 and 3-000. In the event that provider participation requirements in 471 NAC Chapters 1-000, 2-000 or 3-000 conflict with requirements outlined in this Chapter, the individual provider participation requirements in this chapter will govern.

002.02 SERVICE AUTHORIZATION. Waiver services will be authorized for each participant up to a 12 month period. All authorized services are based on needs identified in the person-centered plan (PCP) and the results of ongoing monitoring activities. A copy of the authorization is supplied to both the participant and the provider identifying which tasks the provider is authorized to perform. Providers are responsible for knowing and understanding the tasks they are authorized to perform for each participant they serve. The service authorization must be complete before services are performed.

002.03 PROVIDER CAPABILITIES. Providers must have the knowledge and skills to respond to emergency situations. Additionally, providers must have the physical and mental abilities to safely perform all requirements of the service that has been authorized. Failure to meet these standards will be grounds for termination or denial.

002.04 REASONABLE CAUTION. Providers must exercise reasonable caution and care in the use and storage of participants' property, resources, equipment, appliances, tools, and supplies.

002.05 PROVIDER OWNED AND OPERATED SETTINGS. If services are provided in a provider owned and operated setting, the provider must comply with the following requirements. Failure to meet these standards will be grounds for termination or denial of a Medicaid provider agreement.

(A) Ensure that the facility or home is architecturally designed to accommodate the needs of the participants being served;
(B) Have available an operable telephone;
(C) Post emergency phone numbers by the telephone;
(D) Ensure that the home or facility is accessible to the participant, clean, in good repair, free from hazards, and free of rodents and insects;
(E) Ensure that the facility or home is equipped to provide comfortable temperature and ventilation conditions;
(F) Ensure that toilet facilities are clean and in working order;
(G) Ensure that the eating areas and equipment are clean and in good repair;
(H) Ensure that the home or facility is free from fire hazards;
(I) Ensure that the furnace, water heater, any firearms, medications, and poisons are inaccessible to the participant;
(J) Ensure that any household pets have all necessary vaccinations;
(K) The unit or dwelling in which the participant resides must be a specific place owned, rented, or occupied under a legally enforceable residency agreement; and
(L) The provider must cooperate with the Department in completing any assessments regarding the community-based nature of the property.

002.06 PARTICIPATION STANDARDS. All Home and Community-Based Services (HCBS) Waiver providers must meet the standards outlined in 471 NAC 2-000. Additional standards including but not limited to the following apply for providers of Home and Community-Based Waiver services:

(A) Follow all applicable Department policies and procedures found in NAC Titles 465, 471, 473, 474, and 480;
(i) Bill only for services which are authorized and actually provided;
(B) Accept payment as payment in full for the agreed upon service(s) unless the participant has been assigned a portion of the cost by the Department. Provider will not charge participants any difference between the agreed upon rate and private pay rate;
(C) No one may provide services for a spouse, minor child, or any participant that the provider has an obligation to support;
(D) Not engage in any activity that influences service approval or utilization if they are an employee of the Department, the relative of a Department staff person;
(E) Retain all records related to provider enrollment and service provision, including financial records. Records must be maintained for retention periods in compliance with federal and state law, but no record may be destroyed prior to expiration of a six year retention period;
(F) Allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 42 CFR 431.107. Inspections, reviews, and audits may be conducted on site;
(G) Provide services as an independent contractor, if the provider is an individual, recognizing that they are not an employee of the Department or of the State;
(H) Understand that any false claims, including claims submitted electronically, statements, documents, or concealment of material fact may be prosecuted under applicable state or federal laws per 42 CFR 455.18;
(I) Respect every participant's right to confidentiality and safeguard confidential information;

(J) Understand and accept responsibility for the participant's safety and property;
(K) Not transfer this agreement to any other entity or person;
(L) Not use any federal funds received to influence agency or congressional staff;
(M) Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom they provide services. This may include a listing on the child or adult central registries of abuse and neglect, a listing on sex offender registries, or a history of criminal convictions;
(N) Agency providers agree to allow Department staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place. The agency provider must allow the Department access to records in order to establish compliance with this requirement;
(O) Have the knowledge, experience, and skills necessary to perform the tasks;
(P) Be capable of recognizing signs of distress in a participant and know how to access available emergency resources if a crisis situation occurs;
(Q) Report changes to appropriate Department staff including but not limited to no longer being able or willing to provide the service, or changes in participant function;
(R) Report all incidents in which there is reasonable cause to believe the participant has been subjected to abuse, neglect, or exploitation. All such incidents will be reported to law enforcement and to the Department;
(S) Be age 19 or older if an individual provider; or assure that agency staff who assume the following roles are age 19 or older: director, administrator, agency representative for signing legal documents, or provider of in-home participant services;
(T) Persons may not be eligible to provide services if they are also a recipient of Chore, Personal Assistance Services (PAS), or similar assistance services; and
(U) Providers entering the participant’s home to provide services may not be accompanied in the participant’s home by any individuals, including the provider’s minor children, whose presence is unnecessary to the provision of services to the participant, or who are not authorized to provide services to the participant.

002.07 DENIAL, TERMINATION AND SANCTION OF HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER PROVIDERS. In addition to the reasons for denial, termination, and sanction listed in 471 NAC Chapter 2-000, Waiver Providers are subject to sanction, termination or denial of service approvals and service provider agreements when charges are pending, or a conviction has occurred. No service provider agreement will be issued or remain in effect if there is a conviction for, admission of, or substantial evidence of crimes against a child or vulnerable adult, crimes involving intentional bodily harm, or crimes involving the illegal use of a controlled substance on the part of the provider or any other household members when services are provided in the same location the provider lists as their home address. The provider and household members must not engage in or have a history of behavior injurious to, or which may endanger the health or safety of the participant. Agency providers are responsible for screening their employees for the listed provider standards. Agency providers approved to provide Home and Community-Based Waiver services may not employ persons that have such charges in their history if that person will be providing direct care services.

002.08 REPORTS OF ABUSE OR NEGLECT. Agency providers must ensure they have policies that strictly comply with this chapter to ensure that appropriate procedures regarding abuse or neglect are in place.

002.08(A) REGISTRY CHECKS. Medicaid providers must be cross-referenced with the Adult Protective Services and Child Protective Services Central Registries. For services being provided in the same location the provider lists as their home, members of the household must also be checked in the Central Registries.

002.08(B) REPORTED ABUSE OR NEGLECT. If a report of abuse or neglect concerning a provider, or a household member when service is provided in the same location that the provider lists as their home address is made Department staff will immediately terminate the service provider agreement. If a report of abuse or neglect is indicated, the Department will not enroll the provider.

002.09 ONGOING PARTICIPATION REQUIREMENTS. Annually, the Department will conduct an in-person review with each provider to ensure the provider continues to meet general and service specific provider standards. This review will also include a screening of the sex offender, Adult Protective Services, and Child Protective Services Central Registries, and may include an additional criminal background check.

002.10 CLAIMS SUBMISSION. Refer to 471 NAC 3-000. Services must be delivered before they can be billed. Providers are responsible for verifying that the information is accurate and complete prior to submission.

002.11 SOCIAL SECURITY TAX WITHHOLDING. When required by law, the Department withholds Social Security taxes, also known as Federal Insurance Contribution Act, (FICA) from provider payments. The employee's share of Social Security tax is withheld from provider payments only when in-home service is provided by an individual not affiliated with an agency. The Department, upon receiving a signed "Employer Appointment of Agent," acts on behalf of participants who receive in-home services to withhold mandatory Federal Insurance Contribution Act (FICA) taxes from individual providers and pays the participant's matching tax share to the Internal Revenue Service (IRS).

002.11(A) EARNINGS TAXED FOR SOCIAL SECURITY. Affected providers are subject to Social Security tax payment for each calendar year in which they are paid a federally determined amount or more for services provided to one participant. The Department will withhold this tax from all payments to affected providers. If a provider's earnings do not reach this annual amount for Federal Insurance Contribution Act (FICA) services per participant, the amount withheld for that year is refunded.

002.11(B) SOCIAL SECURITY TAX RATES. The Department remits to the IRS an amount equal to the current Social Security tax rate for specified "in-home" services. Half of this amount is withheld from the provider as the employee's share; the other half is provided by the Department on behalf of the participant employer.

002.12 RECORD REQUIREMENTS. Providers of Waiver services must retain for six years the following material:

(A) Documentation which supports provision of services to each participant served under the Waiver;
(B) Any other documentation determined necessary by the Department to support selection and provision of services under a person-centered plan (PCP);

(C) Financial information necessary to allow for an independent audit under the Waiver;
(D) Documentation which supports requests for payment under the Waiver; and
(E) Provider agreements with the Department.

003. SERVICE SPECIFIC PROVIDER REQUIREMENTS.

003.01 ADULT DAY HEALTH SERVICES (ADHS). The Department enrolls providers of Adult Day Health Services (ADHS) ensuring all applicable federal, state, and local laws and regulations are met. These standards include but are not limited to, regulations located in Title 175 NAC 5-000. Providers are subject to the additional standards that follow.

003.01(A) PROVIDER STANDARDS. Providers of Adult Day Health Services (ADHS) must obtain adequate information on the medical and personal needs of each participant, if applicable; and observe and report all changes to the services coordinator.

003.01(B) FACILITY STANDARDS. Each Adult Day Health Service (ADHS) facility must meet all applicable federal, state, and local fire, health, and other standards prescribed in law or regulation. The provider is responsible for ensuring that services are provided in an integrated, community-based setting. This includes the following standards:

(i) ATMOSPHERE AND DESIGN.
  (1) The facility must be architecturally designed to accommodate the needs of the participants being served;
  (2) Furniture and equipment used by participants must be adequate;
  (3) Toilets must be in working order and easily accessible from all program areas; and
  (4) A telephone must be available for participant use.

(ii) LOCATION AND SPACE. The provider must ensure that the facility has sufficient space to accommodate the full range of program activities and services including:
  (1) Flexibility for large and small group and individual activities and services;
  (2) Storage space for program and operating supplies;
  (3) A rest area, adequate space for special therapies, and designated areas to permit privacy and isolate participants who become ill;
  (4) Adequate table and seating space for dining;
  (5) Outside space available for outdoor activities and accessible to participants; and
  (6) Adequate space for outer garments and private possessions of the participants.

(iii) SAFETY AND SANITATION. The facility must ensure that:
  (1) The facility is maintained in compliance with all applicable local, state, and federal health and safety regulations. See 175 NAC 5-000, Nebraska Revised Statute § 81-2,257.01 and 81-2,244.01, and the Nebraska Food Code as published by the Nebraska Department of Agriculture;
  (2) If food is prepared at the center, the food preparation area must comply with all applicable federal, state, and local laws. See 175 NAC 5-000, Nebraska Revised Statute § 81-2,257.01 and 81-2,244.01, and the Nebraska Food Code as published by the Nebraska Department of Agriculture;
  (3) At least two well-identified exits are available;
  (4) Stairs, ramps, and interior floor have non-slip surfaces or carpet;

(5) The facility is free of hazards including but not limited to, exposed electrical cords, improper storage of combustible material;
(6) All stairs, ramps, and barrier-free bathrooms are equipped with usable handrails; and
(7) A written plan for emergency care and transportation is documented in the participant's file.

003.01(C) STAFFING. Each center must be staffed at all times by at least one full-time trained staff person during operating hours. The center must maintain an appropriate ratio of direct care staff to participants sufficient to ensure that participant needs are met. The center must develop written job descriptions and qualifications for each professional, direct care, and non-direct care position.

003.01(D) PROVIDER SKILLS AND KNOWLEDGE. Direct care staff members must:
(i) Have training or, one or more years of experience in working with adults in a health care or social service setting;
(ii) Have training or knowledge of cardiopulmonary resuscitation (CPR) and first aid;
(iii) Be able to recognize distress or signs of illness in participants;
(iv) Have knowledge of available medical resources, including emergency resources;
(v) Have access to information on each participant's address, telephone number, and means of transportation; and
(vi) Know reasonable safety precautions to exercise when dealing with participants and their property.

003.01(E) LICENSED NURSE. The provider must have a licensed nurse on staff, or contract with a licensed nurse, who will provide the health assessment and nursing service component of Adult Day Health Service (ADHS) and supervise activities of daily living (ADLs) as well as activities of daily living (ADL) training components.

003.01(F) ADULT DAY HEALTH SERVICE (ADHS) RATES AND FREQUENCY. The frequency of service is a calendar day of at least four hours. In the event that a Waiver participant must leave the Adult Day Health Services (ADHS) facility due to an unplanned need and has been there less than four hours, this is considered a full day for reimbursement purposes. The Department establishes a statewide rate for Adult Day Health Services (ADHS).

003.02 ASSISTED LIVING STANDARDS. The Department enrolls providers of assisted living services ensuring all applicable federal, state, and local laws and regulations are met. Each year the Department will perform an in-person site visit with enrolled Waiver providers of assisted living services to ensure that all applicable federal, state, and local laws and regulations are met.

003.02(A) PROVIDER OWNED AND OPERATED SETTING STANDARDS. The following minimum standards apply to assisted living providers that serve Waiver individuals. These standards are in addition to standards required by the Department’s licensure unit:

(i) Each assisted living (AL) provider must be licensed as an assisted living facility and certified as an assisted living (AL) provider of Waiver services;
(ii) The assisted living (AL) providers must provide a private room with bathroom consisting of a toilet and sink for each participant receiving Waiver assisted living service. Semi-private rooms will be considered on a case-by-case basis, and require prior approval of the Department;
(iii) An assisted living facility that is adjacent to a mutually-owned nursing facility must be separately licensed and be in accordance with the requirements in 175 NAC 4-000. The assisted living (AL) provider must have policies, procedures, activities, dining and common areas that are specifically for individuals residing the in the assisted living facility. Direct care staff do not include administrative, laundry, housekeeping, dietary, or maintenance staff;
(iv) The assisted living (AL) provider must provide essential furniture, at a minimum, a bed, dresser, nightstand or table, and chair, if a participant does not have those items;
(v) The assisted living (AL) provider must provide normal, daily personal hygiene items including, at a minimum, soap, shampoo, toilet paper, facial tissue, laundry soap, and dental hygiene products. Other personal products or brand choices are the responsibility of the participant;
(vi) The assisted living (AL) provider must provide privacy in the unit including lockable doors, and access by the participant to the facility and to the individual apartment; and
(vii) The assisted living (AL) provider must provide a grievance process for review of denials of individualized participant requests. Denials of individualized participant requests must be documented in the person-centered plan (PCP) including the outcome of any grievances filed.

003.02(B) ASSISTED LIVING RATES. Medicaid provides payment for assisted living services in monthly increments through rates established by the Department. Variable rates may be utilized and may change annually. Assisted living (AL) provider rates have the following characteristics:

(i) OCCUPANCY. Rates differentiate between the single occupancy of an assisted living unit and the multiple occupancy of one unit;
(ii) RATE ELEMENTS. Each rate consists of three parts:
  (1) The amount the facility must collect for room and board from the participant;
  (2) The participant’s share of cost (SOC) that must be obligated before the Department will assume financial responsibility; and
  (3) The Medicaid responsibility for services provided.

003.02(C) ASSISTED LIVING RECORD KEEPING. The provider must maintain at least the following in each participant's file:

(i) The current Resident Service Agreement (RSA); and
(ii) Phone numbers of persons to contact in case of an emergency and the participant's physician's name and phone number.

003.02(D) DEPOSIT. Assisted living (AL) providers and specialized assisted living providers (SALP) cannot charge a deposit to Waiver participants, with the exception of a pet deposit. Assisted living (AL) providers and specialized assisted living (SAL) providers must refund any deposit previously paid by a participant when in private pay status, if the amount is considered a resource for Medicaid eligibility. The provider is allowed to evaluate the living unit at the time the participant's payment status changes from private pay to Medicaid Waiver. If there are repairs to be made, the facility may make the necessary repairs, deduct the amount from the deposit and refund the balance, if any, to the participant.

003.02(E) ASSISTED LIVING FREQUENCY. Units of service for assisted living are daily or monthly. A monthly rate is used for ongoing months. A daily rate is used for the months of admission and discharge if the participant resides in the assisted living for less than the full month.

003.02(F) ABSENCE NOTIFICATION. Assisted living (AL) provider and specialized assisted living (SAL) provider staff must notify the Services Coordinator within five calendar days when the resident is out of the facility more than 24 hours for a medical absence. The Department has the authority to impose a fiscal sanction if an absence is not reported.

003.03 ASSISTIVE TECHNOLOGY SUPPORTS, HOME AND VEHICLE MODIFICATIONS (ATS, H/VM).

003.03(A) ASSISTIVE TECHNOLOGY SUPPORTS, HOME AND VEHICLE MODIFICATIONS (ATS, H/VM) RATES. The Department does not have an annual maximum for each of the two components. This allows flexibility for the participant's needs to be met if a modification is necessary to remain or return home.

003.04 CHORE. The Department enrolls providers of Chore ensuring all applicable federal, state, and local laws and regulations are met.

003.04(A) CHORE RATES. Chore rates are established by the Department. Negotiated and established rates may change annually. Services may be authorized in frequencies of hourly, daily, or occurrence. Providers must bill for the quarter of the hour if the participant is not in attendance for a full hour.

003.04(B) OVERNIGHT CARE. In order for a Chore provider to be eligible to bill for care during overnight sleeping hours, the participant's person-centered plan (PCP) must outline care needs that require a caregiver's attention and the care tasks from the plan will be outlined in the service authorization. These tasks can include, but are not limited to: re-positioning and turning, attending to participant's incontinence issues, or tracheostomy suctioning.

003.05 EXTRA CHILD CARE FOR CHILDREN WITH DISABILITIES. Waiver providers of Extra Child Care for Children with Disabilities must be approved or licensed through the Department. Waiver providers of Extra Child Care for Children with Disabilities must obtain

adequate information on the medical and personal needs of each child and observe and report all changes to the services coordinator.

003.05(A) EXTRA CHILD CARE FOR CHILDREN WITH DISABILITIES. Rates for Extra Child Care for Children with Disabilities are set by the Department. The parent or primary caregiver of the child is responsible for the cost of routine child care. That amount is determined by the provider rates published by the Child Care Subsidy Program in Title 392 for care provided in the provider's home or a center. For care provided in the child's home, the license-exempt family child care home rate chart applies to individual providers and the child care center chart applies to agency providers. The Department is responsible for payment of the approved cost of the service above the basic cost of routine child care.

003.05(B) FREQUENCY. Frequency of service is hourly or daily rate dependent upon the setting in which the services are provided. Participants may have authorization for both hours and days if services are provided outside the participant's home. For hourly billing, providers must bill for the quarter of the hour if the participant is not in attendance for a full hour. Six or more hours of care provided outside the child's home must be paid at a day rate, if that option is offered by the provider to private pay families.

003.06 HOME AGAIN SERVICES.

003.06(A) HOME AGAIN RATES. The Home Again rate consists of payment for the actual cost of items and services necessary for the participant's move and any payment to the sponsor. The maximum amount allowed for the Home Again service is determined annually by the Department. Payment for the Home Again service is not counted in the participant's monthly cost for Waiver services.

003.06(B) HOME AGAIN PROVIDER BILLING. Home Again Sponsors must bill for services by:

(i) Totaling and submitting dated receipts for purchases made on behalf of the participant;
(ii) Totaling and submitting receipts or other written documentation of the financial obligation incurred by the sponsor on behalf of the participant for security deposits, utility installation, and fees;
(iii) Providing a detailed listing of the dates and activities performed if payment for the sponsor's time is authorized; and
(iv) Submitting a billing request for the total amount of expenses incurred.

003.07 HOME-DELIVERED MEALS.

003.07(A) PROVISION OF SERVICES. The need for home-delivered meals is jointly determined by the services coordinator and the participant. Any changes should be reported to the services coordinator.

003.07(B) HOME-DELIVERED MEAL STANDARDS. The Department enrolls providers of Home-Delivered Meals ensuring all applicable federal, state, and local laws and regulations are met. See Neb. Rev. Stat. §§ 81-2,257.01 and 81-2,244.01, and the Nebraska Food Code as published by the Nebraska Department of Agriculture.

(i) Providers must ensure that food preparation facilities and areas conform to all established local, state, or federal fire prevention, sanitation, zoning, and facility maintenance standards.
(ii) Food preparation personnel must be in good health and free from contagious disease and skilled and instructed in sanitary food handling, preparation, and serving practices.

003.07(C) HOME-DELIVERED MEALS RATES. Home-Delivered Meals rates are established by the Department. This established rate may change annually. A frequency is one meal.

003.08 INDEPENDENCE SKILLS BUILDING. The Department enrolls providers of Independence Skills Building ensuring that all applicable federal, state, and local laws and regulations are met. Each provider must have experience in the components of Independence Skills Building or be directly supervised by a person with experience. In addition, experience with formalized teaching methods is preferred.

003.08(A) FACILITY STANDARDS. Any facility used in connection with the provision of Independence Skills Building must meet at least the following environmental and fire and safety standards:
(i) Be architecturally designed to accommodate the needs of the clients being served;
(ii) Have adequate equipment and furniture for use by the participant;
(iii) Have toilets in working order;
(iv) Have a telephone available for participants to use;
(v) Have at least two well-identified exits;
(vi) Have non-slip surfaces or carpets on stairs, ramps, and interior floors;
(vii) Be free of hazards, including but not limited to: exposed electrical cords, or improper storage of combustible materials; and
(viii) Have usable handrails for all stairs, ramps, and barrier-free bathrooms.

003.08(B) INDEPENDENCE SKILLS BUILDING (ISB) RATES. Independence Skills Building (ISB) rates are set by the Department. Frequency of service may be hourly or occurrence.

003.08(C) INDEPENDENCE SKILLS BUILDING (ISB) RECORD KEEPING. The provider must maintain at least the following in each participant's file:
(i) The Independence Skills Building (ISB) plan and any recommended changes;
(ii) The monthly progress reports;
(iii) The name of the participant's physician; and
(iv) Pertinent medical information such as, activity restrictions, medications and administration schedule, or special diets.

003.09 NON-MEDICAL TRANSPORTATION.

003.09(A) NON-MEDICAL TRANSPORTATION RATES. Transportation rates are set by the Department according to statutory limits in Neb. Rev. Stat. § 75-304.01. Frequency of service is by mileage or trip or hourly for escort service.

003.10 PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS).

003.10(A) PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) PROVIDER SPECIFIC STANDARDS. Providers of Personal Emergency Response Systems (PERS) must:

(i) Instruct the participant about how to use the Personal Emergency Response System (PERS) device;
(ii) Obtain a participant signature verifying receipt of the Personal Emergency Response Systems (PERS) unit;
(iii) Ensure that response to device signals (where appropriate to the device) will be provided 24 hours per day, seven days a week;
(iv) Furnish a replacement Personal Emergency Response Systems (PERS) unit to the participant within 24 hours of notification of malfunction of the original unit while it is being repaired;
(v) Update list of responder and contact names at a minimum of semi-annually to ensure accurate and current information;
(vi) Ensure monthly testing of the Personal Emergency Response Systems (PERS) unit; and
(vii) Furnish ongoing assistance when needed to evaluate and adjust the Personal Emergency Response Systems (PERS) device or to instruct participants in the use of Personal Emergency Response Systems (PERS) devices, as well as to provide for system performance checks.

003.10(B) PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) RATES. Frequency of service is a monthly rental fee. Installation and removal fees will be authorized separately.

003.10(C) PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) RECORD KEEPING. Providers of Personal Emergency Response Systems (PERS) must maintain at least the following in each participant's file:

(i) Documentation of service delivery including client orientation to the system and installation of Personal Emergency Response Systems (PERS) device;
(ii) List of responder and contact names;
(iii) Case log documenting participant and responder contacts; and
(iv) Record of monthly testing of the Personal Emergency Response Systems (PERS) unit.

003.11 RESPITE CARE. A provider may be an individual or agency. The Department enrolls providers of respite care ensuring that all applicable federal, state, and local laws and regulations are met. Respite providers must obtain adequate information on the medical and personal needs of each participant. The provider must observe and report all changes to the services coordinator.

003.11(A) AGENCY PROVIDER STANDARDS. Each agency provider must:

(i) Employ respite care staff based upon their qualifications, experience, and demonstrated abilities;
(ii) Provide training to ensure that respite staff are qualified to provide the necessary level of care. Agree to make training plans available to the Department; and

(iii) Ensure adequate availability and quality of service.

003.11(B) RESPITE CARE RATES. Respite care rates are established by the Department. This established rate may change annually. Frequency of service is hourly or daily rate dependent upon the setting in which the services are provided. Participants may have authorization for both hours and days if services are provided outside the participant's home. For hourly billing, providers must bill for the quarter of the hour if the participant is not in attendance for a full hour. The rate for respite care may include the cost of three full meals per day only when respite care is provided on a 24 hour basis in a facility that is not a private residence.

004. PROVIDER ENROLLMENT. Refer to 471 NAC 2-000 for guidance regarding provider enrollment. Additional standards applicable to providers of Medicaid Home and Community-Based Waiver services follow.

004.01 PROVIDER SCREENING. In addition to requirements for provider screening found in 471 NAC 2-000, Department staff, or a designee of the Department, must conduct an in-person interview with each potential provider upon initial application and annually to review compliance with current service specific program standards. Monitoring visits will occur if a potential provider is approved. If the provider does not meet service specific standards at the time of the interview, but is willing to correct the deficiency within 30 days, staff will continue the interview when proof of compliance is received. If the provider is not willing to correct deficiencies within 30 days the provider will be denied or terminated.

004.02(A) DEPARTMENT STAFF RELATIVES AS PROVIDERS. In situations where a Department staff person's relative is the only resource, staff will obtain administrative approval. Department staff cannot approve, reapprove, evaluate, or negotiate provider agreements with, or authorize service provision from, providers to whom they are related.

004.02(B) PARTICIPANT RELATIVES AS PROVIDERS. A provider may not provide services for a relative participant that the provider has a legal responsibility to support.

004.03 DENIAL OR TERMINATION OF ENROLLMENT. Refer to 471 NAC 2-000.

004.03(A) DENIAL OR TERMINATION OF ENROLLMENT. Refer to 471 NAC 2-000. The Department, in its discretion, may deny or terminate a provider's enrollment for good cause.

004.03(B) VOLUNTARY WITHDRAWAL. Written notice to the potential provider is not required if the potential provider voluntarily withdraws from the evaluation process.

004.04 SERVICE PROVIDER AGREEMENT. Refer to 471 NAC 2-000.

004.04(A) AGREEMENT POLICIES. The following standard applies as found in 471 NAC 2-000:

(i) Service provider agreements are effective up to five years. Service provider agreements must be agreed upon and signed by all parties on or before the effective date.

004.05 APPEAL RIGHTS. Refer to 471 NAC 2-000. A provider of Waiver services has the right to appeal decisions or actions related to their enrollment as a Medicaid provider, including but not limited to:

(A) Reductions in rates;
(B) Sanctions; and
(C) Termination or denial of enrollment as a provider of Medicaid services.