Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
•Changes to this waiver will include updates to provider qualifications for all services and the inclusion of a consolidated review process. The State will consolidate the reviews of this waiver with The Waiver for Persons with Physical Disabilities 1915 (c) waiver, State Plan Personal Care Services, and 1915 (i) services. This consolidated review will streamline the provider review processes within the State and across multiple state agencies. The consolidated review methodology is included in in the optional information section.

The State will revise language regarding monthly contacts to be more person centered and be directed by the recipient. At a minimum, the State will require one face-to-face contact annually, with ongoing contact determined by the recipient, which may include other forms of contact such as email or text. It must be noted that most recipients on this waiver will still require monthly contact due to their level of need and cognitive impairments, but the waiver will include the option to be less frequent, and to include additional methods of contact. This does not remove the responsibility of the providers to report serious occurrences or the recipients from contacting their case manager when there are issues. This allows the recipient to direct ongoing contact; not the State.

The State will revise language regarding signatures on service records and other forms of programmatic documentation. The State will allow for different methods of signature. The State will permit verbal acknowledgement or written signature, and allow designated family members or friends to sign as appropriate. Case managers will be required to document who is designated to sign on behalf of the recipient and why the recipient is unable to sign. In addition, an acknowledgement form will be available to condense signatures on one document.

The State has made many improvements to its case management system and has made improvement to existing processes. One such improvement is a revision to the Social Health Assessment, now titled the Comprehensive Social Health Assessment (CSHA). This assessment tool includes the nursing facility level of care questions, which were taken verbatim, from the existing Nursing Facility Level of Care Tool. Secondly, an in depth risk assessment was added. This has streamlined processes and consolidated three separate forms into one; which is completed initially and annually. The CSHA is a function within the automated case management system.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Nevada** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):

Waiver for the Frail Elderly

C. **Type of Request: renewal**

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NV.0152
Waiver Number:NV.0152.R06.00
Draft ID: NV.016.06.00

D. **Type of Waiver** *(select only one):*

Regular Waiver

E. **Proposed Effective Date:** *(mm/dd/yy)*

07/01/15

1. Request Information (2 of 3)

F. **Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The DHCFP currently administers the Home and Community Based Waiver for the Frail Elderly, a Medicaid Home and Community-Based Services waiver under the authority of Section 1915(c) of the Social Security Act. The provision of waiver services is based on the identified needs of the waiver recipient. DHCFP is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization, with the ultimate goals of self sufficiency and independence. This waiver has been in existence since July of 1992.

Aging and Disability Services Division (ADSD) operates the waiver, which includes data collection for eligibility verification, evaluation of level of care (LOC), plan of care (POC) development, and annual reassessments. DHCFP exercises administrative authority over the operation of the waiver and issues policies, rules, and regulations related to the waiver.

The purpose of this waiver is to offer the option of Home and Community Based Services (HCBS) as an alternative to nursing facility care. Access to the services available in the waiver is voluntary. No individual is required to leave a nursing facility. The target population is those individuals who are age 65 and older who are eligible for waiver services, have a Nursing Facility (NF) level of care (LOC), meet financial income criteria, and meet the criteria for home and community based services.

Eligible applicants may be placed from an institution, another waiver program, or the community. An evaluation will be made to support that there is a reasonable indication that recipient would need nursing home services in the near future (30 days or less) unless he or she receives home and community based services, the cost of which would be reimbursed under the approved waiver.

The following services are included in this waiver: Case management, Homemaker, Respite care, Chore services, Personal Emergency Response Systems, Companion services, Adult Day Care, and Augmented Personal Care. Services will be provided in accordance with this waiver and by qualified Medicaid providers who have enrolled through DHCFP's fiscal agent.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:

ADSD employs Community Ombudsmen who share information at community events. There is private provider participation on the Quality Management Committee meetings with plans to identify a public representative to participate in these as well. The Commission on Aging, Fair Hearings, Strategic Health Plan Accountability Committee, Legislative subcommittees on health care and disability are a variety of other venues used to secure public input. There have been several presentations to Community Advocates, Medical Care Advisory Committee (MCAC),Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs,Senior Coalition Meeting, Home and Community Based Services Conference; Mission Possible (2), and Public Workshops for program and policy initiatives.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Frischmann

First Name: Jennifer

Title: Chief, Long Term Services and Supports

Agency: Division of Health Care Financing and Policy

Address: 1100 E. William Street, Suite 222

Address 2:

City: Carson City

State: Nevada

Zip: 89701

Phone: (775) 684-3747 **Ext:** ☐ **TTY**

Fax: (775) 687-8724

E-mail: Jennifer.Frischmann@dhcfp.nv.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Ritter

First Name: Tammy

Title: Chief, Community Based Care

Agency: Aging and Disability Services Division

Address: 3416 Goni Rd., Bldg. D, #132

Address 2:

City: Carson City

State: Nevada

Zip: 89706

Phone: (775) 687-0556 **Ext:** **TTY**

Fax: (775) 687-0581

E-mail: tlritter@adsd.nv.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Jennifer Frischmann

State Medicaid Director or Designee

Submission Date: Mar 31, 2015

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Whitley

First Name: Richard

Title: Director of the Department of Health and Human Services

Agency: Department of Health and Human Services

Address: 4126 Technology Way, Suite 100

Address 2:

City: Carson City

State: Nevada

Zip: 89706-2009

Phone: (775) 684-4000 **Ext:** ☐ **TTY**

Fax: (775) 684-4010

E-mail: rwhitley@dhhs.nv.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The State submitted its transition plan to CMS on February 24, 2015 as required by CMS in response to the new rule which was published in January 2014 and became effective March 17, 2014. States had until March 17, 2015 to provide a transition plan which includes an assessment of the state's current settings, proposed changes to settings, and public comment.

The State determined through the process of completing the transition plan that there were no issues with the following HCBS in regards to the new rules: Case Management, Homemaker, Chore, Respite, Personal Emergency Response Systems, Social Adult Day Care, or Adult Companion.

The renewed waiver and the state policy will be amended to state that any provider of HCBS meets the criteria set forth in the new regulations. Further, the State will work with the provider community to ensure network adequacy while maintaining compliance.

All providers who provide Augmented Personal Care are located in residential group homes that allow full choice and integration within the community. The renewed waiver and the state policy will be amended to state any augmented personal care provider, in the future, who is located in the same building, or on the same campus, as an institution will not be approved as

a waiver provider.

As part of the transition plan, the State must evaluate and amend current state regulations regarding "aging in place". The State has until 2019 to review and revise regulations. It is anticipated that individuals will remain in their chosen home settings, without any break in service, unless it is determined that an individual diagnosis or need for skilled service is something that cannot be provided in a home and community based setting. The DHCFP is working with the regulatory oversight agency to evaluate current regulations to encourage aging in place.

The State has a mechanism in place to assist individuals who must move from one group home to another, for a variety of reasons. If a current group home chooses to end their provider agreement with Medicaid, or Medicaid chooses to terminate their agreement with a provider, because they do not comply with some or all of the requirements of the new regulations, the State will assist the recipient by providing a list of Medicaid enrolled group homes, and assisting with the transition to their new home.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Guidance from CMS received March 16, 2015: "In the section Transition Plan #2, DHCFP can describe the settings of the FE waiver and how they comport with the newly passed regs of March 17, 2014. Describe the target group, how and where they receive their services. Describe any comments the state has received as a result of public noticing in which there might be concern about the settings and what steps will be taken to adjudicate the settings and a timeline if applicable. Any information provided in this section must pertain to the FE elderly waiver. If the settings are in compliance, the state can indicate there is no need for a transition plan, but still provide information regarding target group/services. If the state is in the process of conducting an assessment of settings/providers, please inform what the assessment will cover and will it will conclude, providing a timeline."

The State submitted it's transition plan to CMS on February 24, 2015. This Plan outlined the work the State has already completed which included a provider self assessment and recipient assessment. This particular waiver serves individuals aged 65 and older in two types of residential settings: their own home and in residential group homes, as well as providing adult social day care of the recipient's choice in a community setting.

The following services within this waiver are compliant with the HCBS rule requirements: Case Management, Respite Services, Homemaker Services, Personal Emergency Response System, Adult Companion, and Chore Services. The services are compliant as evidenced by the plan of care developed with the recipient utilizing the person centered planning process and delivered in the recipients home in which individuals are allowed full access to the community and choice of all services and supports. Most of the individuals on this waiver do not wish to seek employment.

Social Adult Day Care is compliant with the HCBS requirements. Services are provided in a community setting of the recipient's choice during the day. The State believes that the current Adult Day Health Care facilities are community based and allow for access to the greater community as they are not associated with, or located on, a campus like setting, a nursing facility, or an inpatient setting. The State is actively recruiting new providers of Social Adult Day Care. The State will ensure that all newly enrolled providers are compliant with the new regulations.

Augmented Personal Care is provided in residential group homes. The state is currently in the process of completing in-person reviews of these providers to verify they are compliant with the new HCBS rules. Based on partial completion of the reviews, the state has identified a potential issue one residential group home located in a rural community is on the same campus as a

nursing facility. This is the only residential group home available within this community and serves many HCBS waiver recipients. The State is considering requesting an exception for this setting due to the remote, rural location and the potential displacement of the individuals to a community that is not their own.

As noted, the State is evaluating the current regulations regarding "aging in place". The State has regulations in place that prohibit individuals with certain "diagnosis" from living in residential group homes because they need some skilled care. The State Medicaid Agency is working with the State Regulatory Agency on this. Regulatory changes require legislative approval and the next legislative session is in 2017.

Prior to submittal of the Transition Plan, the State held four public workshops and completed a recipient survey, via mail, on 100% of affected recipients. The State received valuable feedback from the provider community and the recipient community which was incorporated within the Plan. The State has been transparent throughout the process of creating the transition plan, to include publishing all materials on the DHCFP website. One such document is recipient comments from the recipient survey. This document alone is 29 pages in length and is located, along with all documents related to the Plan, at https://dhcfp.nv.gov/hcbs.htm.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Annual Home and Community Based Combined Frail Elderly (FE) and Persons with Physical Disabilities Consolidated Review Introduction:

A Quality Assurance Annual Review Report will be completed annually utilizing documented information from monthly waiver reviews conducted by the State Medicaid Agency (DHCFP) and the state operating agencies.

It is DHCFP's responsibility to ensure that the waivers are implemented by the state operating agencies in accordance with Medicaid statute and regulations, program policy, and waiver requirements. Currently the State of Nevada's Home and Community Based Waivers (HCBW) for the Frail Elderly and the Waiver for Persons with Physical Disabilities are managed and monitored almost identically. By consolidating the waiver reviews and reporting of waiver operations, the state will achieve administrative efficiencies, a natural process of current continuous quality improvement, prevent duplication of efforts, and assure continuous consistencies among waiver programs where applicable.

The Persons with Physical Disabilities & Frail Elderly waivers currently meet the 5 conditions outlined by CMS to consolidate reviews and reporting across multiple waivers.

1. Design of waivers is the same or similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver applications appendices:
   Participant Services
   Participant-Centered Planning and Service Delivery
   Participant Safeguards
   Quality Management
3. The quality management approach is the same or very similar across waivers, including:
   Methodology for discovering information (e.g., data systems, sample selection)
   Manner in which individual issues are remedied
   Process for identifying and analyzing patterns/trends
   Majority of the performance indicators are the same
   The provider network is the same or very similar
   Provider oversight is the same or very similar

A report of the annual review findings will be prepared by the State of Nevada, Department of Healthcare Financing and Policy, Grants Management & Quality Assurance, QA Staff and distributed annually to the appropriate managers and staff of DHCFP and the waiver operating agencies. The report will include a cumulative total percent of compliance for all performance measures as well as a breakdown by regional office and/or waiver upon request by the operating agency or State Administrative staff.

Methodology:

The Nevada Division of Health Care Financing and Policy (DHCFP) Grants Management & Quality Assurance unit will utilize the following stratified approach for the combined Annual Waiver Review for the Frail Elderly and the Persons with Physical Disabilities waivers.

Each year, QA will run a query in Decision Support System (DSS) Advantage Suite to determine the cumulative number of the statewide population of recipients in receipt of services under waivers during the preceding 12 month period. This consolidated list of recipients will be used to determine the stratified sample size for the annual review.

A random sample of the consolidated list will be selected striving for a probability of a 95 percent confidence level with a +/- 5 confidence interval (95/5) determining the statewide total of recipient files to be reviewed by designated staff based on available resources. A second sample striving for a probability of a 95 percent confidence level with a +/- 10 confidence interval (95/10) will be generated using the same consolidated list to determine the required number of recipient cases.

The annual consolidated report will cover July 1 to June 30 of each year. The consolidated evidence report will be submitted in accordance with each waiver's reporting schedule.

Chart Reviews:

Each year DHCFP QA will provide a list to all operating agency's regional offices identifying the number of recipient file reviews they will conduct each month and the minimum number of supervisor reviews that must be submitted to the DHCFP QA Office on a monthly basis.

All charts will be reviewed to ensure assurances, sub-assurances and performance measures are being met. The DHCFP QA unit verifies the following elements when reviewing case files: a) Level of care criteria is met, b) level of care agrees with social health assessment, c) health and safety risks are identified in the social health assessment, d) plan of care includes an individualized goal/s, e) includes amount, scope, frequency and duration, and type of provider; but allows for flexibility of service (ex: 20 units/wk for 1 year) f) the plan of care is signed by recipient, g) the Statement of Understanding/Choice is signed by the recipient, and h) the plan of care is updated annually or when a recipient's needs change.

All charts will be reviewed using the 12 months immediately preceding the review utilizing the approved waiver for that time period.
DHCFP QA staff will utilize the SAMS operating system currently in use by both waiver operating agencies to complete as much of the review as possible. Additional documentation will be requested as necessary.

Provider Reviews:

The LTSS Provider Quality Assurance Committee is currently in the development stages of creating a comprehensive stratified provider review process. This process will be piloted April 2015. This stratified review will cover all providers currently providing services. The provider reviews will be completed by DHCFP staff and sister agencies under the Department of Health and Human Services (DHHS) which currently includes our waiver operating agencies.

Financial Reviews:

Financial reviews will be completed on paid claims for waiver recipients selected in the sample for case file reviews. Claims for the selected review month for the recipient are examined, together with the information in the recipient's case file. The DHCFP QA Unit or operating agency will request the daily logs, the prior authorization, and the provider rates as well as any other backup documentation necessary for the selected month from the specified provider.

All financial claims will be reviewed to ensure assurances, sub-assurances and performance measures are being met. The DHCFP QA Unit verifies the following elements when reviewing financials: a) recipient eligibility, b) services are prior authorized using the correct procedure code and/or service level, c) daily records document frequency, scope and duration of services provided in accordance with the plan of care, and d) provider payment is correct and in accordance with the rate methodology in the approved waiver(s).

Recipient Personal Experience Surveys (PES):

Participant Experience Surveys will be conducted with the recipients to ensure health and welfare, as well as waiver satisfaction. Interviews will be grouped by location and completed throughout the year. Participant interviews will be completed on all recipients selected for case file reviews. If a recipient is no longer on the waiver, an alternate will not need to be selected since a case file review and a financial will be completed.

The review tool currently being utilized for the recipient PES interviews was developed by Medstat, Group, Inc. This form has all of the elements required to determine if required outcomes are being achieved.

Operating Agency Rebuttals:

DHCFP QA staff will provide the operating agencies with a draft copy of the current results. The operating agency can seek clarification of the results during a mutually agreed upon meeting with QA staff. The operating agency will then have an opportunity to submit a formal rebuttal at that time.

Quality Improvement Strategy:

DHCFP QA staff will continue with the monthly waiver Quality Improvement (QI) meetings. The two meetings will be merged into one Consolidated Waiver Quality Improvement Meeting to be known as the Consolidated Waiver Review Quality Improvement Committee. New sub-assurances have set the threshold of less than 86% on any Performance Measure as indicating a need for improvement. Any assurances that are at or below 86% for the review year will be assigned to one of the two priority grids. The Consolidated Waiver Quality Improvement Committee members will be assigned to analyze and identify the probable cause of the deficiency and develop a plan to improve performance.

The QI Committee will be responsible for conducting the QI Projects for the consolidated waiver review as problems arise as well as at the time of the final Consolidated Annual Waiver Review Report. The committee will conduct all QI Projects related to the waiver reviews using the following CMS guidance:

1. Identify probable cause(s) of problem
2. Develop intervention(s) designed to improve performance
3. Allow enough time for intervention to have effect
4. Measure impact (does performance increase, decrease, remain the same?)

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:
   Aging and Disability Services Division (ADSD)

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   1. DHCFP monitors the unduplicated count of recipients being served year to date, including current open and closed cases.
   2. DHCFP staff reviews all eligibility packets to ensure waiver criteria is met.
   3. DHCFP staff participates in quarterly Quality Management Committee meetings.
   4. DHCFP staff completes an annual review to assess compliance of established policies and procedures and samples of provider billings. Findings are reported annually to CMS via the 372 report, including any necessary plans for improvement.
   5. An Interlocal Agreement between DHCFP and ADSD delineates responsibilities and expectations of each entity and is monitored at Quality Management meetings. The interlocal was updated in 2014.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   The Division of Health Care Financing and Policy (DHCFP) is contracted with a fiscal agent. One of the responsibilities of the fiscal agent is Medicaid provider enrollment, including waiver service providers. The fiscal agent is responsible for the verification of provider qualifications and enrollment of providers.

   All provider agreements with DHCFP terminate three years from the enrollment date. Providers must reapply through the fiscal agent who verifies provider qualifications and re-enroll providers.

   The fiscal agent prepares a monthly report of all provider enrollments by provider type for DHCFP review.

   ○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
DHCFP is responsible for assessing the performance of the fiscal agent.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The DHCFP Provider Enrollment Unit collaborates with DHCFP Long Term Support Services Unit to ensure that qualified waiver providers are enrolled by the fiscal agent, both at initial enrollment and every three years thereafter.

The fiscal agent provides reports monthly on new enrollments and re-enrollments.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☑	☑	☐
Waiver enrollment managed against approved limits	☑	☑	☐
Waiver expenditures managed against approved levels	☑	☑	☐
Level of care evaluation	☑	☑	☐
Review of Participant service plans			

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
	☑	☑	☐
Prior authorization of waiver services	☑	☑	☐
Utilization management	☑	☑	☐
Qualified provider enrollment	☑	☑	☑
Execution of Medicaid provider agreements	☑	☐	☑
Establishment of a statewide rate methodology	☑	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐
Quality assurance and quality improvement activities	☑	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of providers who have executed Medicaid agreements prior to providing services to waiver recipients. N: Total number of providers who have executed Medicaid agreements. D: Total number of providers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent intake packets that are accurately completed, including assessment, level of care and waiver service need which is subject to Administrative/Medicaid approval. N: Number of intake packets that are accurately completed. D: Total number of packets submitted.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

		Sampling Approach*(check each that applies):*

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of recipients who were enrolled according to waiver and/or state policy. N: Number of recipients enrolled according to waiver and/or state policy. D: Number of recipient packets reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of Medicaid expenditures of waiver recipients which are demonstrated and validated with the cost neutrality formula and compared to nursing

facility costs of care. N: Total expenditures for waiver recipients. D: Total number of recipients reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DHCFP monitors hearings and appeals for waiver services.

DHCFP Central Office Quality Assurance Unit conducts annual programmatic and financial review of this waiver which is structured as a look back review of delegated functions. DHCFP has the ability to break out the review findings by geographical office or Statewideness to identify trends that may be applicable to a specific regional office or generalized program issues.

The State strives for a sample size producing a probability of a 95% and a confidence level of 5%. The State accomplishes this in the following ways:

A 95/5 sample of chart reviews is completed by combining annual supervisory chart reviews with annual QA reviews, utilizing the same review tool;

A 95/5 sample of participant satisfaction is completed by combining ADSD PES reviews with the annual QA PES reviews, utilizing the same tool;

A 95/10 sample of recipient financials is completed annually be QA staff. The state is unable to complete a 95/5 sample of financials due to lack of resources; however, there are other reviews completed by PERM, Fiscal Integrity, and the DHCFP Surveillance Utilization Unit that cover waiver financials.

100% of providers are reviewed annually for compliance with provider requirements by a combination of DHCFP and ADSD staff.

A management report of the annual review is prepared and distributed as applicable, which includes the review findings listed above. An important goal of the annual review is to address and document broad issues and outcome measures, incorporating methods and criteria for prioritizing findings, and to improve documentation of remediation efforts and successes. The priority for these improvements is balanced by available staff and other necessary resources.

This annual report is used to identify any problems or issues with the waiver, to include training for case managers or providers, systems issues, or policy clarifications that both DHCFP and ADSD will work to resolve over the next year.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Deficiencies are remediated through corrective strategies discussed in the quarterly quality management meetings to assure coordination of processes across the state and based on findings in the annual review and subsequent plan of improvement. The ADSD quality management specialist is responsible for monitoring progress based on established timelines and for reporting progress to DHCFP.

The monthly unduplicated list of waiver participants, ongoing caseload and wait list is used to check accuracy of information on waiver status. ADSD management analysts research discrepancies in the report between data from ADSD and DHCFP. ADSD management analysts and fiscal staff work with DHCFP, DWSS, and our fiscal agent to assure accuracy of information on waiver eligibility status whenever claims are denied. If needed, corrections are sent to the DHCFP Long Term Services and Support (LTSS) staff who corrects the data for the monthly report. Continued discrepancies are reported to ADSD Community Based Care Chief, who resolves the issue with DHCFP.

As issues arise, ADSD and DHCFP have meetings to discuss and solve problem. The issue is prioritized and incorporated into a priority spreadsheet, and monitored, until resolution occurs.

ADSD staff participates in the review and revision of Medicaid Service Manual policy updates to ensure that waiver requirements are met.

DHCFP has a contractual agreement with the fiscal agent to enroll qualified providers. The contract identifies the responsibilities of the fiscal agent. The fiscal agent is required to enroll only qualified providers and prepare a monthly report by provider type on enrolled providers and providers who did not meet qualifications. DHCFP staff reviews these reports annually.

Additionally, ADSD supervisory staff intervenes and counsels case managers to resolve individual client problems or documentation issues. If an issue has the potential to recur, it is reviewed with all supervisors during the monthly supervisors meeting to ensure that they are aware and can take steps to prevent recurrence.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					
	☑	Aged	65		☑
	☐	Disabled (Physical)			
	☐	Disabled (Other)			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

1. Individuals may be placed from a nursing facility, an acute care hospital, another Home and Community Based Waiver, or the community.

2. Individuals who, but for provision of services, would require a Nursing Facility Level of Care that would require imminent placement in a nursing facility within 30 days.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

- ( ) **A level higher than 100% of the institutional average.**

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2524
Year 2	2600
Year 3	2683
Year 4	2763
Year 5	2846

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	1906
Year 2	1994
Year 3	1994
Year 4	1994
Year 5	1994

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Eligibility for the Home and Community-Based Waiver for the Frail Elderly is determined by the combined efforts of the DHCFP, ADSD, and the DWSS. These three State agencies work collaboratively to determine eligibility. This is the same process as with Nevada's other Home and Community Based Waivers.

ADSD case managers gather data and evaluate applicants or recipients to ensure they are 65 years of age or older, meet and maintain a level of care for admission into a nursing facility, have a waiver service need and would require placement in a nursing facility in the near future (30 days or less) if HCBS or other supports were not available.

DHCFP monitors the unduplicated count of recipients being served year to date, including current open and closed cases using monthly reports sent to DHCFP Central Office by ADSD. DHCFP Health Care Coordinators (HCC) review a retrospective sample, about 25%, of initial packets to ensure the packet is complete for entrance onto the waiver. This review includes: a) nursing facility level of care criteria is met; b) there is a waiver service need; c) financial eligibility established or pending with DWSS; and the applicant has been informed of their right to participate in the development of the plan of care (POC) using the person centered approach with the support systems, friends, family of their choice involved.

Findings of these packet reviews are prepared quarterly and sent to ADSD quality assurance specialist for inclusion in the quarterly quality management meeting. DHCFP staff attends the quality management meeting and provide feedback to ADSD regarding packet review findings. Data gathered is incorporated into the evidentiary report and corrective action plans as appropriate.

DWSS validates that the applicant/recipient is eligible for Medicaid waiver services using institutional income and resource guidelines.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ◉ **SSI Criteria State**
   - ○ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ○ **No**
   - ◉ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- [x] **A special income level equal to:**

Select one:

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ○ **100% of FPL**
- ○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the State plan**

Select one:

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**

(*select one*):

- **300% of the SSI Federal Benefit Rate (FBR)**
- **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- **A dollar amount which is less than 300%.**

Specify dollar amount:

- **A percentage of the Federal poverty level**

Specify percentage:

- **Other standard included under the State Plan**

Specify:

- **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- **The following formula is used to determine the needs allowance:**

Specify:

- **Other**

Specify:

The maintenance needs allowance is equal to the individuals total income as determined under the post-eligibility process which includes income that is placed in a Miller Trust.

ii. Allowance for the spouse only (*select one*):

- **Not Applicable**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

Specify:

- **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage: [ ]

- ○ **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

  [ ]

- ◉ **Other**

  Specify:

  The maintenance needs allowance is equal to the individuals total income as determined under the post-eligibility process which includes income that is placed in a Miller Trust.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

[ ]

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing initial evaluation must have the following educational or professional qualifications: licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse by the State of Nevada Board of Nursing, or have a professional license or certificate in a medical specialty applicable to the assignment; one year of professional experience providing case management services in a social or health related field is preferred but can be obtained through on the job training; or have an equivalent combination of education and experience.

Additional criteria:
* Has a valid driver's license to enable home visits.
* Follows Health Insurance Portability and Accountability Act (HIPAA) requirements.
* FBI Criminal History Background check - A criminal history background check is to be completed on all individuals providing direct service to program recipients to ensure those with a previous history of abuse or other violent crimes are not placed in a recipient's home.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The name of the LOC tool is: NEVADA MEDICAID LEVEL OF CARE (LOC). This tool is used for all programs requiring determination of nursing facility level of care.

The Level of Care Tool consists of five categories which include: ability to self administer medication, treatments and special needs, activities of daily living, need for supervision, and instrumental activities of daily living.

The total numeric score from the assessment tool determines whether an applicant meets nursing facility LOC. There are 13 total functional deficits identified on the Level of Care Assessment Tool. An eligible recipient or pending applicant must meet at least 3 deficits out of the 13 possible.

The five categories are broken down as follows:

Ability to self-administer medication: the inability to safely administer one's own medication counts as one functional deficit - (1);

Treatments and special needs: may include suctioning, ventilator dependent, feeding tube, wound care, glucose monitoring, IV lines, oxygen dependent, and pediatric specialty care among others. Treatments or conditions that an individual performs as self-care aren't included as a functional deficit. A recipient/applicant is only required to have one treatment or special need for this category to be counted - (1);

Activities of daily living: a total of eight functional deficits are possible in the areas of bathing, dressing, grooming, eating, mobility, transferring, ambulation, and continence - (8)

In this category, there are four (4) identifiable levels of assistance. 1) Independent (I) which means the recipient can independently perform this activity or requires no assistance to perform the activity with use of an adaptive device. 2) Supervision (S) which means to the recipient's safety, a caregiver must oversee this activity. 3) Assistance (A) which means the recipient requires help. 4) Dependent (D) which means the recipient is totally dependent upon caregivers to complete this activity for him or her. If any of the areas is determined S, A or D, it counts as a deficit. An area determined as an "I" does not count as a deficit;

Need for supervision: a total of one functional deficit is possible for the areas of wandering, resists care, behavior problem, safety risk, socially inappropriate, verbally abusive, and physically abusive - (1);

Instrumental activities of daily living in the areas of meal preparation and homemaking services - (2);

Total Possible - 13

Total Needed to Meet Level of Care - 3

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The LOC assessment tool is used to screen, assess and reassess that a nursing facility level of care exists to establish eligibility criteria for the waiver. These assessments are completed and reimbursed as an administrative function by the operating agency qualified staff with the initial screening visit, annually, and if there is a significant change in condition or circumstances that may affect eligibility. These duties are separate and distinct from case management services covered in the waiver. When a referral is received and assigned, the Intake Specialist makes phone/verbal contact with the applicant or his or her representative within 15 working days of receipt of the referral. Subsequently, there is a face to face visit with the recipient to process the referral, complete the necessary forms, and gather the required documentation necessary to establish program eligibility. The face to face assessment to determine level of care and

waiver service need should occur within 45 calendar days of the referral date to assure timely access to services. A screening assessment for level of care is completed to determine if the individual has functional deficits and requires the level of services offered in a nursing facility or a more integrated service that may be community based. The screening tool and the process to assess the level of care is the same for assessments and reassessments. Clients must be assessed at minimum annually while receiving waiver services to reaffirm eligibility, including level of care. If there is a significant change in the client's condition that would affect program eligibility, reassessment is made at that time. The same screening tool is used that nursing facilities utilize.

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

Specify the other schedule:

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The level of care assessment is an integral part of case management services. Evaluation and annual reevaluation of eligibility, assessments, level of care, and POC development are performed and reimbursed as an administrative function by qualified staff of the operating agency. DWSS NOMADS system identifies individuals requiring financial eligibility redetermination which occurs annually. ADSD maintains a social services database, which provides notification when a reassessment is due. Staff also utilize a tickler system and/or calendar to ensure reassessments are completed as required. Waiver eligibility must be reassessed annually. The case managers schedule the reassessment visits up to a month prior to the annual anniversary. Supervisory staff review assessments and reassessments to assure levels of care are determined accurately. ADSD supervisory staff review case records at least annually to assure accurate determinations and as part of Quality Assurance.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

An individual record is established for each waiver recipient in both written and electronic formats.Records of assessments and reassessments of level of care are maintained in the following location(s): by the agency designated in Appendix A as having primary authority for the daily operation of the waiver program; at the office for the geographic area in which the recipient resides; by the persons or agencies designated as responsible for the performance of assessments and reassessments. Copies of plans of care are given to the recipient or his/her designated representatives and waiver service providers. Written or electronically retrievable documentation of all assessments and reassessments are maintained for a minimum period of 6 years after the date the last claim was paid for waiver services for each recipient.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new applicants who meet Level of Care prior to receiving services. Numerator: Number of new applicants who meet Level of Care prior to receiving services. Denominator: Number of new applicants who meet a level of care.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percentage of enrolled recipients whose Level of Care was reevaluated annually. Numerator: Number of enrolled recipients whose Level of Care was reevaluated annually. Denominator: Number of enrolled recipients reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients who's Level of Care (LOC) eligibility was based on accurate application of policy resulting in accurate LOC determinations. N: number

of recipients who's LOC eligibility was based on accurate application of policy resulting in accurate LOC determinations, D: number of recipients reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
After a referral for services is received, a qualified licensed case manager (intake specialist) contacts the recipient within fifteen business days to arrange a face-to face meeting within 45 days to complete a LOC screening to determine program eligibility. The same instrument is used in determining the Level of Care for the waiver and for institutional care under the State plan.

If the recipient meets LOC and has a waiver service need, they are placed on a wait list while financial eligibility is determined and for a waiver slot to become available. Once a waiver slot becomes available, a qualified ADSD case manager conducts a face-to-face meeting to complete the initial assessment. This assessment is conducted as an administrative function of the waiver program and evaluates service needs based on functional deficits, support systems, and imminent risk of institutionalization.

ADSD supervisory staff reviews initial assessments to assure accurate LOC determination based on the recipients' functional deficits and appropriateness for program eligibility using the Case File Review Form.

At the quarterly quality management meetings between ADSD and DHCFP, DHCFP reports on the review findings of a sampling of 25% of the intake packets submitted for approval.

ADSD supervisory staff reviews LOC reevaluations to help ensure accurate LOC determinations. Case Managers track redetermination dates as an activity/referral in Social Assistance Management Software(SAMS), which notifies case managers when reassessments are due. After the LOC reassessment is completed, the supervisor reviews the LOC reassessments for timeliness and accuracy. At the time of review, any errors or concerns the supervisor identifies are addressed with the individual case manager for correction or clarification. The LOC reevaluation has been incorporated into the social health assessment. These reviews are submitted to ADSD QM staff monthly, entered into a database, and tracked for timely reassessments, issues, or concerns. The data is reported at the quarterly quality management meetings for recommendations, remedial action, and improvement strategies.

Other monitoring by DHCFP is accomplished using an annual review approach. The DHCFP annual review is designed as a look-back review to confirm the operating agency data. If issues are discovered during the annual review, the review is expanded to determine the extent of the problem, which will be addressed in the Plan of Improvement response to the annual review.

ADSD managers and supervisors have monthly meetings to bring issues to the group so that trends can be identified and addressed statewide.

Identified training needs are incorporated into planning educational offerings for ADSD staff.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
ADSD supervisory staff addresses concerns or issues as they are identified with the case manager. The supervisor reviews the assessment to assure the individual meets the required LOC score, has a waiver service need, and meets all eligibility criteria. When the supervisor identifies errors, omissions, or concerns they are addressed with the social worker for correction at that time.

Deficiencies are remediated through corrective strategies discussed in the quarterly quality management meetings to assure coordination of processes across the state. The ADSD quality management specialist is responsible for monitoring progress based on established timelines and for reporting progress to DHCFP.

Monthly manager/supervisor meetings are held to discuss issues so statewide trends among the ADSD District

Offices can be identified. Issues addressed at these meetings are discussed and remediation is completed through feedback and discussion of additional training needs at team meetings with ADSD staff. Training is provideed to staff by a Health Care Coordinator III, who is also responsible for updating policies and forms. Procedures and processes are reviewed to ensure consistency and effectiveness.

Deficiencies are remediated through corrective strategies discussed in the quarterly quality management meetings to assure coordination of statewide processes. If an issue is identified to be widespread, a workgroup will be formed to develop and implement a corrective action plan and identify additional training needs. The ADSD quality management specialist is responsible for monitoring progress based on established timelines and follow-up to DHCFP.

ADSD participates with DHCFP in updating policy changes to the Medicaid Services Manual. In working together, policy changes are identified based on Quality Management meetings, deficiencies noted in annual reviews, and trending reports.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Applicants are given a description of services available through the waiver during the intake process. The case manager informs the applicant of their choice between waiver services and institutional care, in addition to their choice of qualified providers.

Service providers are required to be an agency employee for billing, oversight, and or training purposes. For Augmented Personal Care, the applicant will be notified of group care homes that are contracted to provide Medicaid services to eligible individuals and other service options.

The person centered planning process is driven by the individual, personal representative, legal guardian or other supports chosen by the individual and includes necessary information and support to ensure that the individual directs the process to the maximum extent possible.

The Statement of Understanding/Choice form is used to inform applicants of their rights and the right to choose home and community based waiver services as opposed to placement in a nursing facility and is signed by the recipient/personal representative.

The information reviewed with the recipient/personal representative include: process for development of the plan of care, services to be provided, and choice of service provider. The recipient may request a change in services or service provider at any time.

Case managers will assist the recipient in gaining access to necessary state plan and waiver services as well as needed medical, social, educational, and other services, regardless of funding sources.

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

A record is established for each recipient. One copy of the Statement of Choice is filed in the recipient"s case record in the office of the geographic region that the recipient resides and a copy is provided to the recipient. The recipient's permanent case file will be located at the office for the geographic area in which the recipient resides. Case files (hard copy or electronic) are maintained for as long as an individual is on the waiver, or for six (6) years after waiver services end.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Nevada State Purchasing Division has awarded contracts for telephone based interpreter services to CTS Language Link, Language Line Services, Pacific Interpreters and Transcend for document translation services. ADSD employs bilingual staff. For those languages where bilingual staff are not available, translation services are utilized through the contracted state vendors. Vendors, rates, and contract expiration dates are posted on the State of Nevada Department of Administration Purchasing Division website.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Case Management		
Statutory Service	Homemaker		
Statutory Service	Respite		
Other Service	Adult Companion		
Other Service	Adult Day Care		
Other Service	Augmented Personal Care (APC)		
Other Service	Chore		

Service Type	Service
Other Service	Personal Emergency Response System (PERS)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers are responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case Management services can be provided by ADSD or provider agencies.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management (Private)
Agency	Case Management (Public)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency

Provider Type:
Case Management (Private)

Provider Qualifications

License *(specify)*:
Employees of the case management provider agencies who provide direct service case management must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers; licensure as a Registered Nurse by the Nevada State Board of Nursing; or have a professional license or certificate in a medical specialty applicable to the assignment.

Certificate *(specify)*:

Other Standard *(specify)*:
Case Management providers must be enrolled as a Waiver Case Management Provider Agency through DHCFP's fiscal agent. The following requirements are verified upon enrollment:

- Documentation of taxpayer ID
- Business license as required by city, county, or state government
- Proof of Workers Compensation Insurance
- Proof of Unemployment Insurance Account
- Proof of Commercial General Liability
- Proof of Business Automobile Liability Coverage
- Proof of Commercial Crime Insurance
- Fixed business landline telephone number published in a public telephone directory
- Business office that is accessible to the public during established and posted business hours

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Agent for DHCFP.

Division of Health Care Financing and Policy and Aging and Disability Services Division.

Frequency of Verification:
Upon enrollment with DHCFP's Fiscal Agent and every three years at re-enrollment. Annually as part of Quality Assurance activities and waiver review. State Licensing Agency Requirements.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management (Public)

Provider Qualifications

License *(specify):*

Employees of ADSD who provide direct service case management must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers; licensure as a Registered Nurse by the Nevada State Board of Nursing; or have a professional license or certificate in a medical specialty applicable to the assignment.

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as a waiver case management provider agency through DHCFP's fiscal agent.
Employees who provide case managment must have licensure as required above and:
1. A valid driver's license and means of transportation to enable home visits.
2. Adheres to Health Insurance Portability and Accountability Act (HIPAA) requirements.
3. FBI criminal history background check

Verification of Provider Qualifications

Entity Responsible for Verification:

The DHCFP fiscal agent and Aging and Disability Services Division.

Frequency of Verification:

Upon initial enrollment and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services consisting of light housekeeping, meal preparation, shopping, and laundry. These services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homemaker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Homemaker
Provider Qualifications

License *(specify):*
Licensure as a Personal Care Agency or ISO issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH).
Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card).
Proof of Worker's Compensation Insurance.
Proof of Commercial General Liability Insurance
Proof of Commercial Crime Insurance
Proof of Business Automobile Insurance
Signed Business Associate Addendum

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCFP's fiscal agent.

Frequency of Verification:
Upon initial enrollment and every three years for re-enrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite providers provide general assistance with ADLs and IADLs, as well as provide supervision for recipients with functional impairments in their home or place of residence (community setting). Services may be for 24-hour periods, and the goal is relief of the primary caregiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

336 hours per waiver year (July 1 - June 30).

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite, waiver

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Respite, waiver

Provider Qualifications

License *(specify)*:
Licensure as a Personal Care Agency or ISO issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH).
Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card).
Proof of Worker's Compensation Insurance.
Proof of Commercial General Liability Insurance
Proof of Commercial Crime Insurance
Proof of Business Automobile Insurance
Signed Business Associate Addendum

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCFP's fiscal agent.

Frequency of Verification:
Initially and every three years for reenrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Companion

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Non-medical care, supervision and socialization, provided to a functionally impaired adult in his/her own home, which are furnished on a short-term basis or to meet a need for relief of those persons normally providing the care. Adult companions may assist or supervise the individual with such tasks as meal preparation and clean up, light housekeeping, shopping and facilitate transportation, and escort, but do not perform these activities as distinct services. The provision of adult companion services does not entail hands-on medical care. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the recipient. This service is provided in accordance with a goal in the plan of care, and is not purely diversional in nature.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Companion

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion

Provider Category:
Agency
Provider Type:
Adult Companion
Provider Qualifications
License *(specify):*
Licensure as a Personal Care Agency or ISO issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH).
Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card).
Proof of Worker's Compensation Insurance.
Proof of Commercial General Liability Insurance
Proof of Commercial Crime Insurance
Proof of Business Automobile Insurance
Signed Business Associate Addendum
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DHCFP's fiscal agent.
Frequency of Verification:
Initially and every three years at reenrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Adult Day Care

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

04 Day Services | 04060 adult day services (social model)

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Adult day care is a service provided 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing social services needed to ensure the optimal functions of the recipient. Meals provided as part of these services shall not constitute a "full nutritional regime" (three meals per day). This service is provided in accordance with the goals in a plan of care and is not merely diversional in nature. Services are provided in a non-residential Adult Day Care facility setting, where recipients receive Adult Day Care services during the day.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Day Care

Provider Category:
Agency

Provider Type:
Adult Day Care Facility

Provider Qualifications

License *(specify):*
Must be licensed as an Adult Day Care Facility by BHCQC.
Must have a state required business license.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DHCFP's fiscal agent.
Frequency of Verification:
Initially and every three years at reenrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Augmented Personal Care (APC)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Assistance and/or supervision with ADL's and IADL's is inherent to the services provided in a group home or assisted living by licensure.

Augmented personal care provided in a licensed residential facility for groups or assisted living is a 24-hour in home service that provides assistance with basic self care and activities of daily living that are included as part of the service: homemaker; personal care; chore, companion; therapeutic social and recreational programming; medication oversight; services to ensure safety, security and adequate supervision. Augmented personal care is over and above the mandatory service provision required by regulation, which includes the provision of transportation to and from the residential facility for groups to the hospital, a nursing facility, routine medical appointments and social outings organized by the facility. This service includes 24-hour in home supervision to meet scheduled or unpredictable needs.

Other individuals or agencies may also furnish care directly, or under arrangement with the group home or assisted living, but the care provided by these other entities supplements that provided by the home and does not supplant it.

Nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of group care and assisted living services. Payment will not be made for 24-hour skilled care or supervision.

FFP is not available in the cost of room and board furnished.

There are three levels of augmented personal care covered in this waiver. The service level provided is based on the recipient's functional needs to ensure his or her health, safety and welfare in the community. The case manager determines the service level. If the case manager is an employee of ADSD, they also complete the prior authorization for services. If the case manager is from a provider agency, that case manager must comunicate the service level to ADSD for completion of the prior authorization for services.

Level One Daily (minimum assistance)
Requires supervision and cueing to complete basic self care and ADLs with minimum hands on care; in home supervision when direct care tasks are not being completed. Minimum assistance with
laundry; housekeeping; meal preparation and eating; bed mobility and transfers; bathing, dressing and grooming; mobility and ambulation.

Level Two Daily (moderate assistance)
Requires physical assistance to complete ADLs with moderate hands on care; in home supervision with regularly scheduled checks as needed. Moderate assistance with increased laundry needs; housekeeping; special meal prep and eating; bed mobility and transfers; bathing, dressing and grooming; mobility and ambulation.

Level Three Daily (maximum assistance)
Requires physical assistance to complete ADLs with maximum hands on care; direct 24 hour supervision and/or safety system (alarm) to ensure safety when supervision is not direct. Maximum assistance with increased laundry needs; housekeeping; special meal prep and eating; bed mobility and transfers; bathing, dressing and grooming; mobility and ambulation.

*Documentation on the daily log is required to justify amount and types of care for service level determination and verification of proper billing.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The only limit is licensure by the Bureau of Health Care Quality and Compliance (HCQC). HCQC licenses residential facilities for group based on the level of service as identified under the service specifications.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Facility for Groups
Agency	Assisted Living

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Augmented Personal Care (APC)

Provider Category:
Agency

Provider Type:
Residential Facility for Groups

Provider Qualifications

License *(specify):*
Licensed by the Health Division, Bureau of Health Care Quality & Compliance as a residential facility for groups.
Business license issued by the city, county or state.

Certificate *(specify):*

Other Standard *(specify):*
Group home staff will be trained in the functional care skills that are needed to care for each unique recipient. Training will include but not be limited to techniques such as transfers, mobility, positioning, use of special equipment, identification of signs of distress, First Aid and CPR.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCFP's Fiscal Agent

Frequency of Verification:
Initially and every three years at reenrollment.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Augmented Personal Care (APC)

Provider Category:
Agency

Provider Type:
Assisted Living

Provider Qualifications

License *(specify):*
Licensed by the Health Division, Bureau of Health Care Quality & Compliance as a residential facility for groups and may have an assisted living endorsement.
Business license issued by the city, county or state.

Certificate *(specify):*

Other Standard *(specify):*

Additional Qualifications for Assisted Living Providers include:
Assisted Living staff will be trained in the functional care skills that are needed to care for each unique recipient. Training will include but not be limited to techniques such as transfers, mobility, positioning, use of special equipment, identification of signs of distress, First Aid and CPR.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCFP's Fiscal Agent

Frequency of Verification:
Initially and every three years at reenrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Chore

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Services needed to maintain a clean, sanitary and safe home environment. This service includes heavy household chores such as cleaning windows and walls, shampooing carpets, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress, minor home repairs and removing trash and debris from the yard.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chore

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:
Agency
Provider Type:
Chore
Provider Qualifications
License *(specify)*:
Licensure as a Personal Care Agency or ISO issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH).
Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card).
Proof of Worker's Compensation Insurance.
Proof of Commercial General Liability Insurance
Proof of Commercial Crime Insurance
Proof of Business Automobile Insurance
Signed Business Associate Addendum
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
DHCFP's fiscal agent.
Frequency of Verification:
Initially and every three years at reenrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service components include both the installation of the unit and monthly monitoring. Two separate authorizations are required for payment; the initial installation fee for the device and a monthly fee for continuous monitoring.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Agency	Personal Emergency Response System (PERS)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:
Agency

Provider Type:
Personal Emergency Response System (PERS)

Provider Qualifications

License *(specify):*
Documentation showing Taxpayer Identification Number
Copy of business license from the Nevada Secretary of State or a copy of the Secretary of State business license in the provider's home state
National Provider Identifier

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCFP's fiscal agent.

Frequency of Verification:
Initially and every three years at reenrollment.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management is offered as a waiver service that may be offered by any qualified provider. Case Management services can be provided by ADSD, or provider agencies.

No administrative services will be permitted to be claimed as waiver case management services.

Case management services will fully comply with Section 1902(a)(23) of the Social Security Act to include all qualified providers who undertake to provide the services.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

AGING AND DISABILTIY SERVICES DIVISION (ADSD) EMPLOYEES:

ADSD, in compliance with the Department of Health and Human Services (DHHS), requires a criminal background check of any person appointed to a position in the classified or unclassified service whose duties include regular or potential contact with clients of the Division or access to client records. State agencies use NRS 239B.010 "request by agency of State or political subdivision for information on certain persons from Federal Bureau of Investigation" as the citation to request background checks. A criminal background check is required as a condition of employment for any person accepting employment with the agency, to include appointment as a new hire, reinstatement, reemployment, reappointment or transfer.
Employees are fingerprinted within five working days of their date of hire or appointment.

It is the responsibility of an employee's supervisor to ensure fingerprint cards are completed and submitted to the designated Division Personnel Staff who has the responsibility of submitting the fingerprint cards to Central Repository for Nevada Records of Criminal History, an agency of the Nevada Department of Public Safety, Records and Technology Division. The results of the state and national FBI criminal history search are transmitted back to Personnel, who notify the ADSD Administrator or Deputy Administrator of any positive results. The ADSD Administrator or Deputy Administrator takes any action necessary as a result of the background check.

WAIVER PROVIDERS:
DHCFP policy requires all waiver providers to have State and Federal criminal history background checks completed. Based on the results of the background check, the DHCFP fiscal agent will not enroll any provider agency whose operator has been convicted of a felony under Federal or State law for any offense which DHCFP determines is inconsistent with the best interest of recipients.

Unlimited convictions

You may not employ any individual who has ever been convicted of any of the following:

•Murder, voluntary manslaughter or mayhem.
•Assault with intent to kill or to commit sexual assault or mayhem.
•Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime.
•Abuse or neglect of a child or contributory delinquency.
•Abuse, neglect exploitation or isolation of any older persons or vulnerable persons, including, a violation of any provision of NRS 200.50955 or 200.5099, inclusive, or a law of any other jurisdiction that prohibits the same or similar conduct.
•A violation of any provision of NRS 422.450 to 422.590, inclusive, relating to Nevada's State Plan for Medicaid.

Seven-year convictions

You may not employ any individual who has been convicted within the past seven years of any of the following:

•Any violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in
•Chapter 454 of NRS, within the immediately preceding 7 years.
•Misdemeanor Prostitution, solicitation, lewdness or indecent exposure, or any other sexually related crime that is punished as a misdemeanor, within the immediately preceding 7 years.
•A crime involving domestic violence that is punished as a felony.
•A crime involving domestic violence hat is punished as a misdemeanor, within the immediately preceding 7 years.
•A violation of any provision of law relating to the State Plan for Medicaid or a law of any other jurisdiction that prohibits the same or similar conduct.
•A criminal offense under the laws governing Medicaid or Medicare.
•Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property.
•Any other felony involving the use or threatened use of force or violence against the victim or the use of a firearm or other deadly weapon.
•An attempt or conspiracy to commit any of the offenses listed in this paragraph, within the immediately preceding 7 years.

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 the individual believes that the information provided by the Central Repository is incorrect and immediately notifies you, then NRS 449.125 requires that you give the individual a reasonable amount of time of not less than 30 days to correct that information with the Central Repository before you terminate the individual on the basis of being disqualified under NRS 449.174.

Agencies that provide personal care or nursing services in the home are required to conduct FBI background checks on all employees. Within 10 days after hiring an employee, the provider agency must:
(a)Obtain a written statement from the employee stating whether he has been convicted of any crime listed in NRS 449.188;
(b)Obtain an oral and written confirmation of the information contained in the written statement obtained pursuant to paragraph (a);
(c)Obtain from the employee two sets of fingerprints and a written authorization to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the FBI for its report; and
(d)Submit to the Central Repository for Nevada Records of Criminal History the fingerprints obtained pursuant to paragraph
ADSD and DHCFP verifies background checks on service providers/employees using a representative sample during annual provider reviews.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- (●) **No. The State does not conduct abuse registry screening.**
- ( ) **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living	
Residential Facility for Groups	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Residential Facilities for Groups and Assisted Living:

Personalized care is furnished to individuals who choose to reside in a group home or assisted living based on their individualized service plan that is developed with the recipient, people chosen by the recipient, caregivers and the case manager. The recipient has a right to privacy. This service includes 24 hour on site staff to meet scheduled or unpredictable needs and to provide supervision, safety, and security. Care must be furnished in a way that fosters the independence of each recipient. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect. All waiver recipients will receive augmented personal care by the servicing provider of their choice.

Assisted Living homes:

Service will be provided in individual apartment/studio units that include kitchenette, sleeping area or bedroom, and contain private toilet facilities. These units can be dually occupied when both residents consent to the arrangement.
If the recipient requests a change of provider or a specific living arrangement, the case manager will assist in remediation, relocation or assistance in locating a residence that meets the recipient's preferences.

(i)Residents have access to a variety of social, religious and community activities of their choice. Planned activities suited to the interest and capacities of the residents are scheduled and posted such as bingo, school group visits, singing groups, karaoke, exercise classes, arts and crafts, and special events. There are areas sufficient in size to conduct both indoor and outdoor activities that are easily accessible and safe. Community integration activities provide access to shopping (Wal-Mart, Target, Grocery, and Pharmacy) or regularly scheduled outings. Residents may choose to enjoy their privacy, participate in physical activities, relax or associate with other residents. Aging in place is supported with services and supports. Recipients do not typically seek outside employment or work in competitive integrated settings but will be assisted in achieving that goal by the case manager if desired. Some recipients do participate in volunteer type activities. Participation in activities within the home is optional and based on the individual's choice. Individuals can fully access the community at their will, control personal resources and receive services in the community in the same manner as individuals without disabilities. At the time of admission, a comprehensive assessment is made by the staff and together with the individual and any family or personal representatives they choose develop a personalized plan of care which identifies supports or services that are tailored to the individual. Events and activities are routinely scheduled and participation is at the sole discretion of the individual. Both of the assisted living facilities are fully ADA compliant.

(ii)Once a waiver applicant expresses an interest in a group home setting, they are provided with a list of qualified providers. A social worker is available to provide additional information and guidance relative to specific needs of the individual. The individual, family members and/or personal representative are encouraged to visit multiple homes to get a feel for how their lifestyle and preferences will best fit in the various settings. Many homes will pick the individual up and bring them in for a tour over lunch. Considerations may include size of home, geographic location, proximity of friends and family, available supports, available activities, food, staff, other residents, likes and dislikes, medical or mental health concerns, whether or not pets are allowed, if recipient is more comfortable in small or larger settings, level

of independence that they still have, proximity to health care, the home's reputation in the community, and a variety of other individualized preferences. The recipient, family and/or personal representative make the final decision, freedom of choice. If none of the homes are a good fit, they are encouraged to visit more sites or given referral and resource options. In addition to site visits there are brochures, websites and community Ombudsmen that can provide information on homes.

(iii)Both assisted living facilities provide services based on recipient choice, direction and preferences. Privacy and confidentiality are maintained during the provision of services. Living units are not entered without permission. Staff knocks on doors and waits for a response before entering. Services are scheduled and provided based on recipient preferences as able. Staff receives training during orientation and annually to ensure awareness of rights and freedom of coercion. Religious and cultural considerations are incorporated into the person centered plan for service delivery.

(iv)A variety of daily activities are offered and posted in the residence. A residential home must have at least one centrally located common area in which residents may socialize and participate in recreational activities. A common area may include, without limitation, a living room, dining room, enclosed porch or solarium. The congregate dining room must be of sufficient size to accommodate all the residents comfortably and conveniently located near the kitchen to ensure the rapid and efficient serving of food. Participation in activities and interaction with other residents is at the discretion and choice of the individual. Scheduled activities that are suited to the interest and capacity of the residents to encourage mental and physical stimulation as well as social interaction are a requirement of licensure by HCQC.

(v)The recipient makes the choice on living arrangements and specific home in which they want to live. If at anytime they are not satisfied with their living arrangements or services being provided, their case manager will work with the recipient, group home/assisted living staff and caregivers to resolve any areas of dissatisfaction. If the recipient makes the decision to relocate to another home then the case manager will provide information and facilitate visits to other contracted homes. Augmented personal care is provided by employees of the residential facility for groups (RFG). Services provided by providers outside the RFG are based on the individual's choice and the case manager facilitates care coordination for these services.

(vi)Service specifications are assessed by the case manager. There are 3 levels of augmented personal care base on the amount of hands on care and supervision the individual requires meeting their needs. Additional training is required for caregivers of residents with dementia. A home must have authorization from HCQC for Category 2 residents which is defined as a home with more than 10 residents, that have a resident who, without the assistance of any other person, is not physically or mentally capable of moving himself or herself from the room in which the resident sleeps to the other side of a smoke or fire barrier or outside the facility, whichever is nearest, in 4 minutes or less.

(A)The 2 assisted living facilities both have a rental application that is completed as part of the application to facility process and a lease agreement that is signed on the day of admission. There is an eviction policy at the facilities where the Executive Director will compose a formal letter citing the Nevada Revised Statutes (NRS), Nevada Administrative Code (NAC) or policy that has been violated or the reason for the eviction. Generally, there is a 30 day notice unless safety is involved. Additionally, Medicaid policy requires facilities to provide ADSD with at least a 30-day notice before discharging a recipient unless the recipient's condition deteriorates and warrants immediate discharge. When a case manager is notified, they assist in relocation and working with staff on transfers/discharges. Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC) cite state law and regulations. Both assisted living homes have admission and rental agreements that comply with state law that outlines requirements for individuals with or without disabilities and prohibits discrimination, allows for reasonable accommodation and requires housing providers to allow persons with disabilities to make reasonable modifications.

(B)(1) Individual units or rooms have locking doors. Residents have a right to privacy. A bedroom or bathroom door in a residential facility which is equipped with a lock must open with a single motion from the inside unless the lock provides security for the facility and can be operated without a key or any special knowledge. If a key is required to open a lock from outside, the key must be readily available at all times. Staff must knock before entering and the resident has the right to choose who enters the home.

(B)(2)Residents are encouraged to utilize personal furniture, furnishings, photos and decorative items to personalize their living space.

(C) Food and snacks are available at all times. Dietary restrictions or modifications are included in the

person centered planning. There are optional meal choices outside of the regular menu for routine meals. Recipients can also store and access food in their private kitchenette.

(D)State licensure requires a policy on visiting hours. Homes must allow unrestricted visitation by family/friends at the recipients will. The assisted living homes have suites for visitors to stay overnight. They request visitors sign in/out for safety.

(E)Services and supports are allowed by qualified individuals that are based on medical necessity but not a requirement for living in the home. The only limitations are licensure restrictions for certain medical conditions or treatments.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Homemaker	☐
Chore	☐
Adult Companion	☐
Adult Day Care	☐
Personal Emergency Response System (PERS)	☐
Respite	☐
Case Management	☑
Augmented Personal Care (APC)	☑

Facility Capacity Limit:

This is based on Bureau of Health Care Quality and Compliance review by facility,

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Facility for Groups

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Homemaker	☐
Chore	☐
Adult Companion	☐
Adult Day Care	☐
Personal Emergency Response System (PERS)	☐
Respite	☐
Case Management	☐
Augmented Personal Care (APC)	☑

Facility Capacity Limit:

This is based on Bureau of Health Care Quality and Compliance review by facility,

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- (●) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ( ) **Other policy.**

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any willing provider that meets the established criteria for a specific provider type may enroll with DHCFP through their fiscal agent. Enrollment is continuously open for all potential waiver providers.

The fiscal agent website www.medicaid.nv.gov lists required documentation for applications to enroll in Medicaid as a waiver provider by specific service type. Supporting information is also available in the Medicaid Services Manuals on the DHCFP website dhcfp.nv.gov

The fiscal agent possesses and monitors provider qualifications, provider agreements, skill requisite, and licensure requirements for this waiver. The fiscal agent enrolls providers initially, and every three (3) years thereafter. The fiscal agent will not enroll any provider who does not meet the qualifications.

The fiscal agent has a provider enrollment hotline from 8:00 am to 5:00 pm Monday through Friday, staffed with customer service representatives to assist with provider enrollment, claims, and general provider questions. The fiscal agent processes claims through the MMIS system, makes payments to providers, and tracks payment via remittance advices.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of currently enrolled providers, by type, initially and continue to meet licensure/certification qualifications. N: Number of currently enrolled providers, by type, initially and continue to meet licensure/certification qualifications; D: Total number of currently enrolled providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☑ Other Specify: Fiscal Agent	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☑ Other Specify: Provider Enrollment Report	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of provider applicants that meet licensure/certification qualifications prior to delivering services. N: Number of provider applicants that meet licensure/certification qualifications prior to delivering services; D: Total number of provider applicants.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Agent	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Provider Re-enrollment report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. *Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of currently enrolled non-licensed/non-certified providers that continue to meet qualifications. N: Number of currently enrolled non-licensed/non-certified providers that continue to meet qualifications; D: Total number of currently enrolled non-licensed/non-certified providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Agent	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☑ Other Specify: Provider Re-enrollment Report	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of non-licensed/non-certified provider applicants that meet qualifications prior to delivering services. N: Number of non-licensed/non-certified provider applicants that meet qualifications prior to delivering services; D: Total number of non-licensed/non-certified provider applicants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☑ Other Specify: Fiscal Agent	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Provider Re-enrollment Report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of agencies whose employees receive required training prior to delivering services. N: Number of agencies whose employees receive training prior to delivering services; D: Number of agencies reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of agencies who employees receive annual training as specified in policy and procedure. N: Number of agencies whose employees receive annual training as specified by policy and procedure; D: Number of agencies reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The fiscal agent will not enroll any provider that does not meet Medicaid or waiver provider qualifications.

All providers under this waiver are licensed or certified with the State except PERS providers.

DHCFP conducts annual program and fiscal reviews of services provided under this waiver. The annual review is structured as a look-back and includes review of provider qualifications and compliance to policy. ADSD also performs annual provider reviews on all waiver providers. If problems are discovered during the review, staff takes appropriate action and provides education and training to the provider. An Alert Memo is forwarded to DHCFP and HCQC as indicated based on the identified issue or deficiency noted. A Corrective Action Plan (CAP) may be required for remediation or the provider may be suspended or terminated. The action taken depends on the nature of the problem and the action of the provider to correct and prevent recurrence of the problem.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

During monthly contacts, a case manager may identify a situation where providers are not meeting requirements. The case manager will then address the concern with the provider and/or ADSD staff. If a resolution cannot be reached, the recipient will be given the option of choosing a different provider of services. If resolution is achieved, the case manager will follow up at the time of next contact. Additionally, the issue can be reported up the supervisory chain of command for evaluation and problem solving. Deficiencies are remediated through corrective strategies discussed in the quarterly QM committee meetings to assure coordination of processes across the state. The ADSD quality assurance specialist is responsible for monitoring progress based on established timelines and for reporting progress to DHCFP. The quality management specialist may change processes to provide more efficiency.

Deficiencies are remediated through corrective strategies discussed in the quarterly QM committee meetings to assure coordination of processes across the state. The ADSD quality assurance specialist is responsible for monitoring progress based on established timelines and for reporting progress to DHCFP.

The results of DHCFP waiver reviews are used as the basis for discussion between DHCFP and ADSD to create a joint Plan of Improvement (POI) and monitored for progress at subsequent reviews by DHCFP. The ADSD quality management specialist monitors progress on the POI quarterly.

ADSD reviews a sampling of employee files during their annual visit as well. If a provider does not meet criteria, then a letter is sent documenting the deficiencies and a plan of improvement is required. A follow up review is scheduled to validate that the plan is being followed. DHCFP monitors progress on plans of improvement.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- [ ] **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Residential settings meet federal HCBS settings requirements as services are provided within a private residence.

Adult Day Care facilities meet HCBS settings requirements at this time. The state will update policy to reflect that any potential or future Adult Day Care must be located in the community and not located on the campus as an institution, or within the same building as an institution.

Services are provided using an integrated, person centered planning process to identify the individuals preferences, needs, and choice. The planning process will allow for the individuals highest level of independence and self sufficiency, while still ensuring health, safety, and welfare.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care (POC) - developed, completed, and reimbursed as an administrative function of the waiver program.

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- ☐ **Social Worker**

  Specify qualifications:

- ☐ **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Qualified case managers develop the Plan of Care (POC) as an administrative activity of the waiver program.

The applicant, applicants family and/or applicants representative are encouraged to participate in the planning process. Information about the range of services and supports offered through the waiver is provided to the applicant during the initial assessment. The applicant, applicant's family, an applicant's representative, and/or an applicant's circle of support are encouraged to participate in this process. The Plan of Care is developed based on this assessment.

The POC form must be used for all applicants. The POC includes, at a minimum, the individual's needs, goals to meet those needs, identified risks, services to be provided, case management hours, and services provided by others.

All waiver clients will receive case management by the servicing provider of their choice (a list is provided).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a) Qualified case managers develop the Plan of Care (POC) as an administrative activity of the waiver program. ADSD has identified national experts to provide specialized training in person centered thinking. All agency staff and designated DHCFP staff will receive this training which will also include concurrent train the trainer certifications for ongoing continuity.

Information about the range of services and supports offered through the waiver is provided to the applicant during the initial assessment. The applicant, family, support systems, and/or personal representatives are encouraged to participate in the development of the plan of care and to direct the process to the maximum extent possible. Planning includes convenience to the recipient, cultural considerations, use of plain language, strategies for solving any disagreements, identification of what is important to and for the individual, personal preferences, choice of caregivers, strategies to facilitate health and welfare and remediate identified risks, identified goals, outcomes, preferences related to relationships, community integration and opportunities to participate in integrated settings/seek employment or volunteer activities, control over personal resources.

A POC form must be established for all applicants. The POC includes, at a minimum, the individual's needs, goals to meet those needs,identified risks, services to be provided, case management hours, and services provided by others.

All waiver clients will receive case management by the servicing provider of their choice (a list is provided)and can request a change of providers at any time. Training is provided to ADSD staff to facilitate an understanding of client choice and how this affects care planning.

Case management is an as needed services and directed by the recipient and/or personal representative. The POC will identify the recipient's and/or personal representatives desired mode and frequency of ongoing contact. Contacts must be made to sufficiently verify that services are being provided appropriately or as outlined in the POC, and identify changes in condition or service needs. Contact may be by telephone, fax, or email, and a in-person visit will be conducted annually and as outlined in the POC development process.

b) The applicant, family, support systems, and/or personal representatives of the individuals choosing are encouraged to participate in the planning process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Plan of Care (POC) development is completed and reimbursed as an administrative function of the waiver program.

(a) Initial development of the POC and annual updates are completed as an administrative activity. Ongoing POCs are updated and revised when there is a change indicated that occurs outside of the annual review. The POC is person centered based on individualized goals and developed with participation from the recipient, family, and/or designated representative.

(b) The assessment process includes addressing the recipient''s needs identified by the Social Health Assessment and individualized goals. This assessment process includes addressing activities of daily living (ADLs), instrumental activities of daily living (IADLs), service needs and support systems. In addition, this process includes gathering information regarding the medical history and social needs. The POC process considers risk factors, equipment needs, behavioral status, current support system, and unmet service needs. A list of available waiver services is provided to the recipient and/or his or her representatives. Development of the POC considers location, availability of transportation, and necessary or desired activities. Personal goals are identified by the recipient and documented on the service plan initially and each time the POC is updated.

(c) At the applicant''s initial contact with the Division, the applicant is informed of services available through the waiver. An informational brochure is provided to the applicants describing these services. The information is provided to the applicant at the time of the initial assessment. Once on the waiver, the recipient receives a copy of the initial POC and annually.

(d) The recipient is an active participant in developing the POC that identifies desired outcomes, needs and preferences. The POC development process ensures that participant goals, needs, and preferences are addressed through the inclusion of the recipient, involved family members, personal representatives, and providers. Choice of service and providers are integrated in the planning process. A registered nurse is also available for consultation as medical concerns are identified for recipients.

(e) The POC identifies the services required, including type, amount, scope and frequency of services. Specific tasks, risk factors or direction are noted. The service providers are contacted by phone to establish availability and given a copy of the recipient's POC prior to initiation of services via fax. The assigned case manager reviews the document with the recipient. Once the recipient is deemed eligible, the case manager coordinates the initiation of services with the chosen provider.

(f) Contact with the recipients are required to be initiated by the case manager to discuss the authorized services and evaluate the recipient''s level of satisfaction. Contacts must be made to sufficiently verify that services are being provided appropriately or as outlined in the POC, and identify changes in condition or service needs. Contact may be by telephone, fax, or email, and a in-person visit will be conducted annually and as outlined in the POC development process. During contact or home visits, case managers are responsible for reviewing the POC and daily logs (for those residing in group homes)for feedback from the participant to help ensure services are delivered as authorized in the POC.

(g) The POC is reviewed and updated at a minimum annually, but more often if changing conditions require an update. The case manager is responsible for ensuring the POC is being followed and facilitating revisions of the POC. ADSD supervisory staff conducts reviews of POCs on initial, annual updates, and ongoing cases. DHCFP reviews a sample of POCs during the annual review process. ADSD reviews the provider''s compliance with POCs during annual site visits.

The case manager faxes all new and updated POCs and authorizations to the service provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to recipients are assessed during the initial assessment process by addressing ADL and IADL needs and identifying the amount of assistance needed to safely complete these activities. Factors addressed to assess risk include the recipient''s ability to manage medication, potential to wander, resist care, or exhibit cognitive and behavioral

problems. The level of assistance required is identified along with equipment needs and methods of safely providing the services on the plan. As safety concerns are identified, referrals are made to appropriate resources to address and mitigate those concerns. Additional at risk criteria used and incorporated, as applicable, into the social health assessment, plan of care development, and service needs identification includes:

Access to medical services
Aggression/Behavioral problems
Aspiration/choking
Bedbound
Change in support/inconsistent
Chronic Health problems
communication deficit
crisis/emergency situation
dementia/Alz/Cognitive Deficit
Difficulty/obtaining meals
Endagering self/self neglect
Endurance Deficit
Environmental(cluttered/hoarding/maintenance/infestation/Sanitation)
Fall Risk/Hx of falls/unsteady gait
Finances
Illegal activities in home
Incontinent
Isolation
Lives alone
Loss of Medicaid
Mental health issues
Multiple ER/Hospitalizations
Multiple Prescriptions
Non-compliance to medication/treatment
Non-cooperation
Nutritional/special diet
Other-specify in notes
Oxygen
Physically/verbally abusive
Requires minimal essential PCS/NRS 426.723
Resistive to care
Rural area with limited resources
Safety Risk
Seizures
Sensory deficits
Service needs exceed available resources
Service Refusal
Sexual Behavior
Shopping Difficulty/food/prescriptions
Skin breakdown/wounds
Smoking
Socially inappropriate
Substance Abuse
Terminal Illness
Unavailable LRI/Caregiver
Victim of abuse/neglect/isolation/exploitation-
Wandering

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The Statement of Understanding/Choice form is used to inform new waiver applicants of their right to choice. The applicant is notified of their right to choose HCBS in their home or in a group home setting instead of a nursing facility and the provider of their choice. A brochure is provided to the applicant describing these services. Applicants are informed of services available through the waivers. The recipient also has the right to choice of service providers. The case manager works with the recipient to ensure that recipient preferences are maintained. If a service provider change is requested or a new service need identified, the case manager will coordinate and update the POC and authorizations as indicated.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DHCFP reviews a representative sample of POCs retrospectively during the annual review of this waiver program or more frequently if necessary (in response to complaints or quality management concerns). POCS are reviewed in conjunction with recipient satisfaction data collected by ADSD, participant experience survey data, a review of ADSD quality assurance studies, interviews with recipients and providers, and chart reviews of a representative of waiver recipients. These activities are designed to assure that POCs are appropriate to the assessed needs of the recipient ensure recipient health, safety, welfare, and ensure recipient choice of provider. During the initial packet review by DHCFP the anticipated services are identified and included in the packet for review.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

ADSD case managers are responsible for implementation of the POC for each individual that includes at a minimum, the amount, frequency, and type of provider of services. This is accomplished through the initial assessment, contacts and face to face visits. Information obtained during these contacts is used to update and revise the POC, which occurs at minimum, annually. During the contacts, information such as: changes since last contact, medical appointments, new medications or treatments, hospitalizations, falls, waiver services meeting needs, any new or unmet needs, satisfaction with services, any equipment or supplies needed, or other information is gathered based on interview. Service authorizations are reviewed and updated to facilitate payment. If the recipient requires increased or additional services, the case manager will discuss with the recipient and/or personal representative. If a new service need is identified, the POC will be updated and the recipient and/or personal representative is given a choice of providers.

Case managers encourage family members, a personal representative, or members of the recipient's circle of support to attend face-to-face visits with the recipient. Family members, a personal representative, or a member of the recipient's circle of support can assist recipients who have cognitive or communication difficulties.
In order to assure the health, safety and welfare of recipients and assess on a continual basis recipients' satisfaction with services, the following quality assurance tools are used: Quality Assurance Questionnaire-Participant Experience Survey (PES) is completed during a visit to the client's home. ADSD supervisory staff monitor cases annually, at a minimum.

Private case management agencies are required to conduct a sample of cases each quarter for every case manager employed by that agency and providing case management services to waiver recipients. They must report to ADSD the findings of their reviews, the actions taken, and the effectiveness of those actions. Provider case management agencies are required to participate in DHCFP's annual audit. Private agencies will be required to report to the operating agency on 10% of open cases quarterly, for quality management and oversight. Currently there are no private providers providing case management services to waiver recipients.

The POC is reviewed for the following:
a. Objectives;
b. Personal/individualized goals (if the client is unable to provide personal goals, a statement about why client cannot provide goals must be included);
c. Specific waiver services client is currently receiving;
d. Specific services to be provided by ADSD and additional services provided by other agencies;
e. The proposed amount, frequency, and type of provider for each service;
f. Signature by the client or personal representative that they participated in POC development (SOU/Addendum);
g. The provider of services is identified; and
h. Client's risks are identified.
i. Service level for augmented personal care

The Plan of Care must be reviewed and revised annually or when the client's need for services changes. Any improprieties found during the residential facility visits must be reported to the appropriate oversight agency (HCQC, EPS) for investigation and follow-up.

b. Monitoring Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

ADSD supervisory staff monitors cases annually, at minimum. ADSD staff conducts sample reviews of the cases at least annually. ADSD performs agency site visits to all active waiver providers annually, to ensure that provider qualifications are met and POCs are being followed. In addition, DHCFP completes a representative sample of agency site visits during the annual program review.

Any improprieties identified are reported to the appropriate oversight agency (BHCQC, EPS) for investigation and follow-up.

ADSD Quality Management staff track and trend the reviewing of plans of care to verify that they specify services by amount, duration, frequency, and type of provider. Another area of review is to verify that POCs are updated every 365 days, or as needed.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients POCs that address personal goals identified in the social/health assessment. N: Number of recipients POCs that address personal goals identified in the social health assessment; D: Number of recipient POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95/5
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of recipients POCs that address health and safety risk factors identified in the social health assessment. N: Number of recipients POCs that address health and safety risk factors identified in the social health assessment; D: Number of recipient POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95/5
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of recipients POCs that address the assessed needs identified in the social health assessment (SHA). N: Number of recipients POCs that address te assessed needs identified in the SHA; D: Number of recipients POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95/5
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients POCs that are revised annually. N: Number of recipients POCs that are revised annually. D: Number of recipients POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95/5
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of recipients POCs that are updated when the participants needs changed. N: Number of recipients POCs that are updated when the participants needs changed. D: Number of recipients POCs reviewed where there was a documented change in need.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample Confidence Interval = 95/5
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients who indicate during monthly contacts that they are receiving the services they need. N: Number of recipients who indicate they are receiving the services they need. D: Number of recipients records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95/5
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of recipients services that are delivered in accordance with the approved POC. N: Number of recipients whose services are delivered in accordance with the approved POC. D: Number of recipients records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		95/5
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients whose SOU is signed indicating choice providers and choice of services. N: Number of recipients whose SOU is signed indicating choice of providers and choice of services. D: Number of recipient records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95/5
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
ADSD supervisory staff reviews intake packets for eligibility prior to submission to DHCFP for approval. Supervisors address any concerns or deficiencies with the case manager as they occur.

DHCFP reviews intake packets for eligibility and approves the packets. DHCFP reviews a 25% sample of all intake packets and reports findings to ADSD at the quarterly Quality Management meetings. Improvement activies are discussed at these quarterly meetings. The following are included in the findings to ADSD. a) Level of care criteria is met, b) at risk for institutionalization , c) monthly waiver service need d) the Statement of Understanding/Choice is signed by the recipient.

ADSD supervisors review a sample size of ongoing case files producing a probability of 95% confidence level with a +/- 5 confidence interval.

DHCFP conducts annual program and fiscal reviews of services provided under this waiver. A sample size producing a probability of a 95/5 percent confidence level is utilized. The annual review is structured as a look-back review of all delegated functions and confirmation of quarterly data on performance measures provided by ADSD. DHCFP has the ability to break out the findings by the specific policy area. During the review, DHCFP staff evaluates compliance with policies related to the operation of the waiver and assure such policies are administered correctly. Policies are available on DHCFP's website, https:\\dhcfp.nv.gov, and it is the responsibility of ADSD staff to refer to policy when operating the waiver.

The State has a serious occurrence reporting system in place for provider to report occurrences that happen during the provision of service delivery. The State is currently working on a database for serious occurrence reporting which will be accessible by providers, state case management staff, and state supervisory/management staff. The anticipated completion date is 10/01/15.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
ADSD supervisory staff reviews the POC to assure that service needs, health and safety risk factors, and personal goals are identified and incorporated into the plan. If areas are omitted or incorrect, supervisors address this individually with case managers and corrections are made immediately.

POC reviews are documented on the Case File Review Form at the time of initial assessment or reassessment. Case file reviews are submitted to quality management as they are completed for entry into a database which will identify areas needing improvement. The results are reported at the quarterly quality management meetings for recommendations, remedial action, and improvement strategies.

The case manager ensures that the services on the POC are assigned the appropriate prior authorization. The authorization number and a copy of the plan of care are given to the servicing provider. The case manager provides care instructions to the servicing provider. The servicing provider must bill and receive payment through MMIS.

ADSD uses a Statement of Understanding/Choice form to indicate the recipient's knowledge of their right to choose home and community based services in their home, as opposed to placement in a nursing facility and the provider of their choice. Case managers inform recipients of their right to choice at the time of initial assessment and at during any contacts.

Review of the Statement of Understanding/Choice is captured on the case file review form for initial assessments and at the time of annual reassessments. Reviews are submitted to quality management to track and trend. The findings are reported at the quarterly quality management meetings for recommendations, remedial action, and improvement strategies.

Trained ADSD staff complete participant experience surveys (PES) with 20%, based on available resources, of ongoing waiver recipients which include questions on choice and satisfaction. Participant surveys are submitted to quality management as they are completed to be analyzed for trends and areas of improvement. The information is discussed at the quarterly quality management meetings to identify areas for improvement and develop improvement strategies.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one)*:

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

When a potential waiver applicant is referred for service, a LOC determination is completed. If the applicant meets the criteria for nursing facility placement, home and community-based services as an alternative to institutional care are discussed with the applicant and/or his or her designated legal representative. If the applicant prefers institutionalization, the applicant may remain in or be placed in a nursing facility.

After the choices have been explained and prior to enrollment in the waiver, all waiver applicants read (or have read to them) and sign a Statement of Understanding/Choice that includes the following statements:

• I may choose and have chosen to receive Home and Community-Based Services in lieu of placement in a long-term-care facility (nursing facility).
• I may select the provider of my choice from those who meet Medicaid provider requirements and are willing to contract with the Division of Health Care Financing and Policy.
• I may request a hearing from the Division of Health Care Financing and Policy (DHCFP) if I have not been given a choice of Home and Community-Based Services as an alternative to a long-term-care facility placement, if I am denied this service, or if services are reduced or terminated. A written request for a hearing must be sent to Nevada Medicaid, 1100 E. William Street, Suite 102, Carson City, NV 89701, within 90 days of the date of the decision.

This Statement of Understanding/Choice must be in the recipient's case management file and in the file at the ADSD office for the geographic area in which the participant resides. During the annual review, the DHCFP Quality Assurance Unit verifies that this form has been signed and is in the file.

The DHCFP Medicaid Services Manual (MSM) Chapter 3100 sets forth Medicaid policy regarding Fair Hearings. "Pursuant to 42 CFR 431 Subpart E, Nevada Medicaid will provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly."

In Section 3104 of the Medicaid Services Manual, Nevada Medicaid provides the Fair Hearing process and describes each step of the process and timelines as appropriate, from the beginning of the process to the rendering of a decision. The Medicaid Services Manual Chapter 3100 further describes the process of the disposition of the hearing request; the notification, scheduling, and location of the hearing; program participation upon recipient request pending fair hearing outcome; hearing participation; and hearing preparation and presentation.

Medicaid Services Manual Chapter (MSM) 2200 identifies the following circumstances under which notice must be made to a waiver applicant or participant of an adverse action:

• Denial of specific waiver services
• Termination of specific waiver services
• Reduction of specific waiver Services
Termination of the waiver program

Further situations which a notice must be made to the recipient:

Denied entrance to the waiver due to not meeting the level of care requirement or failure to show a need for one ongoing waiver service
Termination of the wait list due to various circumstances

All Notices of Decision contain a statement of the person's hearing rights and how to access the hearing process. Notices of Denial, Suspension, or Termination are generated in DHCFP's Central Office and the recipient is notified.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the

types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Nevada Revised Statutes (NRS) reads as follows: NRS 200.5091 Policy of State. It is the policy of this State to provide for the cooperation of law enforcement officials, courts of competent jurisdiction and all appropriate state agencies providing human services in identifying the abuse, neglect, exploitation and isolation of older persons and vulnerable persons through the complete reporting of abuse, neglect, exploitation and isolation of older persons and vulnerable persons.

The statute includes an extensive list of persons required to report incidences of abuse, neglect, exploitation or isolation, which includes persons who provide medical or social services or supports.

The report must be made to a law enforcement agency as soon as reasonably practicable, but not later than 24 hours after the person knows or has reasonable cause to believe that the vulnerable person has been abused, neglected, exploited or isolated. Because of these timeframes, telephone or facsimile reports are accepted by most law enforcement agencies.

Additionally, DHCFP and ADSD require all direct care providers for the waiver to report all serious occurrences, including those required to be reported to the Aging and Disability Services Elder Rights Unit and/or law enforcement (abuse, neglect, exploitation and isolation) as well as injuries, unplanned hospital visits, and theft. The Serious Occurrence Form is available to providers to facilitate the report, which is faxed by providers to the ADSD within 24 hours of discovery. ADSD quality assurance staff tracks and trends all serious occurrences by type. These findings are presented at the quarterly Quality Management meetings. ADSD has a serious occurrence database that reports are entered into for tracking and trending. A report on all Serious Occurrence Reports is made to the Quality Management Committee quarterly. ADSD staff monitor timely remediation of any serious occurrences. DHCFP is currently working on developing a centralized database, funded by BIPP monies, of collecting SOR to track and trend the occurrences by type, provider and follow up.

The State of Nevada has established mandatory reporting requirements of suspected incidents of Elder Abuse. ADSD and local Law Enforcement are the receivers of such reports. Reports must be made within 24 hours of identification/suspicion. ADSD, waiver service case managers, and waiver service providers are mandatory reporters.

Recipient safeguards include initiation of investigation by local law enforcement and/or Elder Protective Services agency, and provision of protective services to the older person if they are able and willing to accept them. If the person who is reported to have abused, neglected, exploited or isolated an older person or a vulnerable person is the holder of a license or certificate issued pursuant to NRS Chapters 449, 630 to 641B, inclusive, or 654, information contained in the report must be submitted to the Board that issued the license.

The BHCQC receives complaints regarding the facilities they license. ADSD staff receives training regarding the role of the BHCQC and how to make appropriate referrals for investigation when events occur that may be considered licensing infractions.

ADSD has a Serious Occurrence Database and reporting system. Current waiver providers are expected to report concerns with care supervision and delivery to the case manager under their current contracting language. Reporting includes:

1. Suspected physical or verbal abuse;
2. Unplanned hospitalization;
3. Neglect, exploitation or isolation of the recipient;
4. Theft;
5. Sexual harassment or sexual abuse;
6. Injuries requiring medical intervention;
7. An unsafe working environment;
8. Any event which is reported to Elder Protective Services or law enforcement agencies;
9. Death of the recipient during the provision of waiver services;
10. Loss of contact with the recipient for three (3) consecutive scheduled days or;
11. Medication errors resulting in injury, hospitalization, medical treatment or death.

ADSD will be notified of any serious occurrence within 24 hours of discovery. Case managers must follow up within 5 working days. Action as appropriate, including supervisory review, will be taken. Based on the outcome of the analysis, the occurrence will be reported to the oversight agency or law enforcement and the recipient will be offered protective services as appropriate. Serious occurrences will be forwarded to ADSD quality management. The trends of the reports will be reviewed at the Quarterly Management Meetings and program/policy modifications will be recommended if possible.

BHCQC also receives complaints regarding the facilities they license. ADSD staff receives training regarding the role of the BHCQC and how to make appropriate referrals for investigation when events occur that may be considered licensing infractions.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Case managers educate clients regarding reporting requirements and available agency contacts during their regular monthly contacts and annual reassessment visits. The client Bill of Rights is reviewed during the initial application process and as needed thereafter. The Bill of Rights information covers the Elder Abuse Statutes and the right to adequate treatment by all waiver providers. The Bill of Rights delineates ADSD staff that can be contacted to report violation of client rights. Providers are also trained on the Elder Abuse Statutes of the State during the provider enrollment process.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reports of abuse, neglect, exploitation or isolation of persons over age 60 are made to ADSD, Elder Protective Services (EPS) Unit, during normal working hours. Reports are investigated by the local office and shall commence within three working days of receiving the report. EPS conducts evaluations, including the following:

1. Determining confidentiality required;
2. Attempting to verify the reported or suspected abuse;
3. Gathering information and discussing options for resolving problems;
4. Conducting face-to-face contact;
5. Completing assessment and evaluation;
6. Determining the need for protective services;
7. Developing a plan of action.

For adult populations under the age of 60 that are vulnerable and for reports outside normal working hours, reports are made to law enforcement. Law enforcement agencies are required to investigate reports of abuse, neglect, exploitation and isolation immediately.

To specifically help ensure the health and welfare of waiver participants, direct care providers for the waiver are also required to report all serious occurrences to ADSD. If the report is related to any waiver participant, the supervisor reviews it and provides it to the case manager. The case manager reviews the report and determines whether immediate response is called for and, if so, responds immediately. The case manager contacts the recipient, determines confidentiality, required attempts to verify the report and takes appropriate action. If it is determined that immediate response is not necessary, the case manager follows up at the next monthly contact (such as a report of a minor injury or an unplanned hospital visit about which the case manager already received adequate information to determine that it was not a threat to the recipient). ADSD Supervisory staff reviews the adequacy and effectiveness of the case manager's response to reports as a normal part of their supervisory reviews. If requested by the participant or representative, results of investigation are provided.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Providers must provide the local ADSD office with written notification of serious occurrences involving the recipient, the provider''s staff, or anything affecting the provider's ability to deliver services. ADSD must be notified of serious occurrences by fax within 24 hours of discovery.

A summary report of serious occurrences must be submitted in January and July of each year to ADSD. These reports are to be submitted to the Carson City ADSD, Quality Management staff.

Providers are responsible for submitting serious occurrence reports (SORs) to ADSD for the incidents identified in the chapter. If a case manager becomes aware of an incident from the client or a family member, they are required to complete a SOR. 100% of SORs received by providers are followed up on by case managers and forwarded to ADSD quality assurance staff. SORs received from providers are given to the client''s assigned case manager. The case manager will verify client, waiver program and Medicaid number. The case manager will provide follow up comments on all SORs received. Case managers will either initial or sign the SOR. The case manager will complete a SOR for any

reportable incident that they become aware of through monthly contact or quarterly home visit that has not been previously reported. The case manager will give 100% of SORs to the supervisor for review. Supervisors are responsible for forwarding SORs to QM. ADSD is responsible for overseeing the reporting of and response to critical incidents or events as well as timely follow up and remediation if indicated. Currently, the number and type of reports received by providers are entered into a database and summary reports are produced by type and by provider for review of trends and issues. The data is reported at the quarterly QM committee meetings for review and recommendations.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

ADSD is responsible for detecting the unauthorized use of restraints or seclusion. This is accomplished through the Serious Occurrence Process and through ongoing contacts with waiver recipients.

If any occurrence of unauthorized use of restraints or seclusion were to be detected, a report is made to the appropriate entity and the situation would be remedied.

Additionally, the annual program reviews of a representative sample help to detect and remediate any systemic issues regarding restraints and seclusions.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

ADSD is responsible for detecting the unauthorized use of restraints and restrictive interventions. This is accomplished through the Serious Occurrence Process and through ongoing contacts with waiver recipients.

If any occurrence of unauthorized use of restraints and restrictive interventions are detected, a report is made to the appropriate entity and the situation would be remedied.

Additionally, the annual program reviews of a representative sample help to detect and remediate any systemic issues regarding restraints and restrictive interventions.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

ADSD is responsible for detecting the unauthorized use of seclusion. This is accomplished through the Serious Occurrence Process and through ongoing contacts with waiver recipients.

If any occurrence of unauthorized use of seclusion are detected, a report is made to the appropriate entity and the situation would be remedied. Reports of inappropriate seclusion are made to BHCQC and EPS as indicated. For residents living in group home environments there are also Ombudsmen that make visits and provide advocacy. Visits can be made more often as indicated and can be announced/unannounced. Any other provider of waiver services is required to report inappropriate seclusion to EPS as indicated and a Serious Occurence Report to ADSD.

Additionally, the annual program reviews of a representative sample help to detect and remediate any systemic issues regarding use of seclusion.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

BHCQC monitors medication management activities for residential facilities for groups as described in the following Nevada Administrative Code:

NAC 449.2744 Administration of medication: Maintenance and contents of logs and records.

1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain:

(a) A log for each medication received by the facility for use by a resident of the facility. The log must include:

(1) The type and quantity of medication received by the facility;
(2) The date of its delivery;
(3) The name of the person who accepted the delivery;
(4) The name of the resident for whom the medication is prescribed; and
(5) The date on which any unused medication is removed from the facility or destroyed.

(b) A record of the medication administered to each resident. The record must include:

(1) The type of medication administered;
(2) The date and time that the medication was administered;
(3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and
(4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician.

2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication

NAC 449.2742 Administration of medication: Responsibilities of administrator, caregivers and employees of facility. (NRS 449.0302)

1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall:

(a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility:

(1) Reviews for accuracy and appropriateness, at least once every 6 months, the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and

(2) Provides a written report of that review to the administrator of the facility.

(b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file

maintained pursuant to NAC 449.2749 for the resident who is the subject of the report.

(c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a).

(d) Develop and maintain a plan for managing the administration of medications at the residential facility, including, without limitation:

(1) Preventing the use of outdated, damaged or contaminated medications;

(2) Managing the medications for each resident in a manner which ensures that any prescription medications, over-the-counter medications and nutritional supplements are ordered, filled and refilled in a timely manner to avoid missed dosages;

(3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744;

(4) Monitoring the administration of medications and the effective use of the records of the medication administered to each resident;

(5) Ensuring that each caregiver who administers a medication is in compliance with the requirements of subsection 6 of NRS 449.0302 and NAC 449.196;

(6) Ensuring that each caregiver who administers a medication is adequately supervised;

(7) Communicating routinely with the prescribing physician or other physician of the resident concerning issues or observations relating to the administration of the medication; and

(8) Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access to websites on the Internet which provide reliable information concerning medications.

(e) Develop and maintain a training program for caregivers of the residential facility who administer medication to residents, including, without limitation, an initial orientation on the plan for managing medications at the facility for each new caregiver and an annual training update on the plan. The administrator shall maintain documentation concerning the provision of the training program and the attendance of caregivers.

(f) In his or her first year of employment as an administrator of the residential facility, receive, from a program approved by the Bureau, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and obtain a certificate acknowledging completion of such training.

(g) After receiving the initial training required by paragraph (f), receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training.

(h) Annually pass an examination relating to the management of medication approved by the Bureau.

2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator.

3. Before assisting a resident in the administration of any medication, including, without limitation, any over-the-counter medication or dietary supplement, a caregiver must obtain written information describing the side effects, possible adverse reactions, contraindications and toxicity of the medication.

4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met.

5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744.

6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident:

(a) The caregiver responsible for assisting in the administration of the medication shall:

(1) Comply with the order;

(2) Indicate on the container of the medication that a change has occurred; and

(3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744;

(b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and

(c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744.

7. If a resident refuses, or otherwise misses, an administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.

8. An employee of a residential facility shall not draw medication into a syringe or administer an injection unless authorized by law to do so.

9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744.

10. The administrator of a facility is responsible for any assistance provided to a resident of the residential facility in the administration of medication, including, without limitation, ensuring that all medication is administered in accordance with the provisions of this section.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

a and b) NAC 449.2738 Review of medical condition of resident; relocation or transfer of resident having certain medical needs or conditions. (NRS 449.037)

1. If, after conducting an inspection or investigation of a residential facility, the Bureau determines that it is necessary to review the medical condition of a resident, the Bureau shall inform the administrator of the facility of the need for the review and the information the facility is required to submit to the Bureau to assist in the performance of the review. The administrator shall, within a period prescribed by the Bureau, provide to the Bureau:

(a) The assessments made by physicians concerning the physical and mental condition of the resident; and

(b) Copies of prescriptions for medication or orders of physicians for services or equipment necessary to provide care for the resident.

2. If the Bureau or the resident"s physician determines that the facility is prohibited from caring for the resident pursuant to NAC 449.271 to 449.2734, inclusive, or is unable to care for the resident in the proper manner, the administrator of the facility must be notified of that determination. Upon receipt of such a notification, the administrator shall, within a period prescribed by the Bureau, submit a plan to the Bureau for the safe and appropriate relocation of the resident pursuant to NRS 449.700 to a place where the proper care will be provided.

3. If an inspection or investigation reveals that the conditions at a residential facility may immediately jeopardize the health and safety of a resident, the administrator of the facility shall, as soon as practicable, ensure that the resident is transferred to a facility which is capable of properly providing for his care.

NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302)

1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident's medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key.

2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room.

3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be:

(a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and

(b) Kept in its original container until it is administered.

4. Except as otherwise provided in subsection 5, when a resident is discharged or transferred from a residential facility, all medications prescribed for the resident must be provided to the resident or to the facility to which he or she is transferred.

5. If a resident is transferred to a hospital or skilled nursing facility, the residential facility shall hold the resident's medications until the resident returns or for 30 days after the transfer, whichever is less, unless the hospital or skilled nursing facility requests the residential facility to provide the hospital or skilled nursing facility with the medications. If the resident does not return within 30 days after the transfer, the residential facility shall promptly dispose of any remaining medications. Upon the return of the resident from the hospital or skilled nursing facility, the residential facility shall, if there has been any change in the resident's medication

regimen:

(a) Contact a physician, within 24 hours after the resident returns, to clarify the change; and

(b) Document the physician contact in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744.

c) Medication administration is regulated by HCQC. If a resident refuses, or otherwise misses, an administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.

Each facility shall have and implement policies and procedures that minimize errors in the administration of drugs. The medical director of the facility and the pharmacist who is responsible for the pharmacy service shall approve the policies and procedures.

Errors in administering a drug, adverse reactions by a client to a drug and incompatibilities between a drug and a client must be immediately reported to the attending physician of the client.

If an accident or incident occurs at a facility, including, without limitation, any error in providing medication to a patient of the facility or any adverse reaction of a patient to a drug administered to the patient at the facility, the facility shall immediately prepare a written record of the accident or incident. A written record prepared pursuant to this subsection must be maintained by the facility and be made available for review by the HCQC.

Additionally, medication errors resulting in injury, hospitalization, medical treatment or death would require that a serious occurrence report be submitted to the ADSD case manager by telephone/fax within 24 hours of discovery. A completed SOR form report must be made within five (5) working days and maintained in the agency's recipient record. The case manager will follow up as indicated and the supervisor will review for appropriateness.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

See answers above. All residential group homes who are waiver providers must be licensed by BHCQC and must follow the Nevada Administrative Code as noted.

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

Missed dosages based on client refusal or staff error. Medication errors resulting in injury, hospitalization, medical treatment or death must be reported as a serious occurrence within 24 hours to ADSD.

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The annual waiver review covers compliance with the POC and does not include medication management as it is not part of the covered Medicaid Service package included on the service plan. Oversight is made by the state licensing authority that reviews this information during the initial and ongoing review of the facility.

Group home staff that meet qualifications to provide oversight and have had the training required to participate in medication administration provide medication management.

Training requirements are part of the NAC:

Administrators and caregivers of the residential facility, receive, from a program approved by the Bureau, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training and obtain a certificate acknowledging completion of such training.

After receiving the initial training required they must receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training.

Annually pass an examination relating to the management of medication approved by the Bureau.

Administrators have to complete initial training within the first year, and caregivers must complete initial training prior to assisting any recipient with medication administration.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
c) Number and percent of recipients who were free from restrictive interventions. N: Number of recipients free from restrictive interventions. D: Number of recipients reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a 2.) Number and percent of unexplained death, as reported through the Serious Occurrence Report process that receives appropriate follow-up. N: Total number of unexplained deaths, as reported through the SOR process that received proper follow up. Total number of unexplained deaths reported through the SOR process.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
b.) Number and percent of recipients serious occurrence reports that include appropriate follow-up. N: Number of serious occurrences that received follow-up. D: Number of serious occurrences requiring follow up.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
a.)Number and percent of recipients who received information about how to report abuse/neglect/expoitation/isolation initially and annually thereafter. N: Total number of recipient who receive information on how to report abuse/neglect/expoitation/isolation . D: Total number of recipients.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

	☐ **Continuously and Ongoing**	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
d)Number and percent of recipients who receive information annually regarding preventative health care. N: Total number of recipients who receive information annually regarding preventative health care. D: Total number of recipients.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☑ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Per NRS 200.5093, it is ADSD policy that every employee adheres to reporting instances of abuse, neglect, exploitation, and isolation to the Elder Rights unit. Each ADSD employee signs a Policy for Reporting Elder Abuse form indicating their responsibility to report elder abuse.

Case managers seek to prevent instances of abuse, neglect, exploitation, isolation and ensure the health, welfare and safety via monthly contacts with participants.

Supervisory staff reviews a sample size of ongoing case files producing a probability of 95/5 confidence level which identifies monthly contact, concerns, needs, follow-up action, and waiver satisfaction. These reviews are captured on the Case File Review Form and submitted to QM as they are completed. QM reports this data at quarterly QM committee meetings for review and recommendations.

Case managers report concerns of abuse, neglect, exploitation, or isolation to the Elder Rights unit. Case managers and providers are also responsible for completing DHCFP's Serious Occurrence Report (SOR) form. As case managers receive SORs from providers they take appropriate follow-up action regarding the occurrence. QM receives SOR forms from case managers and providers. The form identifies the type of occurrence and documentation of the case manager's follow-up action. ADSD QM has developed and utilizes a database to track/trend SORs. The data is reported at the quarterly QM committee meetings for review and recommendations.

ADSD quality management staff tracks all EPS referrals received by ADSD. ADSD waiver staff coordinate and consult with Elder Rights staff on cases with suspected abuse, neglect, exploitation, or isolation.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
ADSD waiver staff coordinate and consult with Elder Rights staff on cases with suspected abuse, neglect, exploitation, or isolation. Elder Rights staff perform provider and staff training on mandated reporting and elder issues. If trends are identified, they will be reported to QM for resolution/remediation.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Responsible Party(*check each that applies*):	Frequency of data aggregation and analysis(*check each that applies*):
☐ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State of Nevada is a large rural state that consists of two major urban areas that are over 400 miles apart. They are Las Vegas located in the southern Clark County and Reno located in the northern Washoe County. Rural Nevada covers over 90,000 square miles. Aging and Disability Services Division (ADSD) is responsible for operating the Waiver for the Frail Elderly.

The ADSD offices are located in Carson City, Reno, Las Vegas and Elko. The Quality Assurance Specialist is located in the Carson City office and reports to the Chief of Community Based Care who oversees all waiver operations.

ADSD is committed to improving its quality management system and has allocated a full time quality assurance position to this waiver program which has been filled since 2006. There is also special projects staff in the Carson City office and Las Vegas office dedicated to quality initiatives. ADSD has participated in and operated a Quality Management Committee since January 2004 in order to specifically address CMS quality assurance components and improve program performance. ADSD quality management system continues to evolve and refine monitoring tools and processes to better reflect CMS assurance components.

Statewide Quality Management Committee:

At the center of the ADSD's quality management system is the Statewide Quality Management Committee (QM) which meets quarterly. This team is composed of ADSD's quality assurance specialist, the Chief of Community Based Care, district managers, supervisors, and case managers. The QM committee has provider representatives. DHCFP participates in the QM meetings with members of the Quality Assurance Unit and the Waiver Operations Unit. The purpose of the QM committee is to coordinate quality assurance and quality improvement activities across the state. The committee monitors performance statewide by reviewing performance measures based on the data gathered in the previous quarter for the six quality assurances, which ensures that discovery processes for the waiver program are carried out consistently and reliably. In its analysis of statewide data, the committee identifies strategies for improvement or remediation to be implemented statewide.

Quality improvement goals are identified in the QM committee as well and progress is discussed at each

meeting. In some cases, work group meet in between quarterly meetings and progress is reported at each meeting.

ADSD's Quality Management Unit is made up of one quality assurance specialist, a social worker allocated part time in the north and south, a Health Care Coordinator 3, a management analyst 1 and one administrative assistant. They are responsible for developing reports on performance measures that are shared with the QM committee quarterly.QM staff also work with the special projects team to track and trend data and ensure QM initiatives are implemented. Data and trends are discussed as well as remediation strategies and future plans. DHCFP quality assurance representatives use this opportunity to provide program oversight, make inquiries, or ask for additional information.

ADSD Supervisor Meetings

ADSD supervisors meet monthly to discuss program operations to include policy and procedure. The quality assurance specialist presents an update on quality management functions having to do with reporting requirements for the District Offices to newly implemented processes. Supervisors have that opportunity to seek clarification on data collection methods and processes for quality management purposes.

QM Newsletter

QM has developed an internal newsletter which is used to inform staff of the purpose and function of quality management. It is also used to provide updates on processes and procedures. The first newsletter went out December of 2008 and is scheduled to go out quarterly.

DHCFP Annual Reviews

DHCFP will conduct a consolidated review process beginning 07/01/15. The State will consolidate the reviews of this waiver with The Waiver for Persons with Physical Disabilities 1915 (c) waiver, State Plan Personal Care Services, and 1915 (i) services. This consolidated review will streamline the provider review processes within the State and across multiple state agencies. The consolidated review methodology is included in in the optional information section. This process is described in Main: B - Optional.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The QM committee is the main body for evaluating information statewide. It is also the committee that develops new data collection tools and processes. The team has begun to develop integrated data systems that draw information from a number of data sources.

Data is collected in a variety of ways. It is collected from Initial Assessment Reviews, Ongoing Case File Reviews, Level of Care Reviews, Serious Occurrence Reporting and Participant Experience Survey's. Reports

are created and shared quarterly at the QM committee meetings. Going forward, QM plans to place more emphasis on analysis of trends. The QM Committee minutes document the data reviewed, improvement strategies developed, and the entity responsible for implementation statewide.

ADSD utilizes a web-based case management system called Social Assistance Management Software (SAMS). This system has reporting capabilities that are under development with the current database. There are numerous reporting capabilities in SAMS system which include: QM Open Cases – Quarterly for sampling, QM Level of Care Compare Report – Monthly to evaluate timelines, QM Plan of Care Compare Report - Monthly to evaluate timeliness, QM Level Of Care Timeliness Report – Monthly to evaluate timelines amount of time for a new referral to obtain a Level of Care screening, QM Case Processing Timeliness Report – Monthly to evaluate case processing time from pending to approved, QM EPS Report – Quarterly – to review waiver clients who have received an EPS referral and if it was substantiated or unsubstantiated, and QM Annual Provider Review Report – Quarterly to evaluate timeliness of ADSD contracted providers' site visits.

DHCFP participates in the quarterly QM meetings, which is the forum for the state to share information on improvement strategies that are being implemented based on the analysis of the data shown in the reports.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Quality management is a system that changes and improves over time. The process of data analysis, setting goals, monitoring outcomes and identifying problem areas leads to continual adjustment of the quality management strategy. The QM specialist is responsible for updating the quality management strategy. The process is to review and update the strategy annually. The quality management strategy is posted for every employee of ADSD to view. The strategy is shared with DHCFP.

The Quarterly Quality Management Meetings are used to evaluate the quality management strategy on an ongoing basis. The quality manager uses feedback from the quarterly meetings, as well as information from the current processes to evaluate the effectiveness, efficiency and appropriateness of the quality management system and update the system on an as needed basis. Evidentiary reports, annual review findings, and Plans of Improvement are utilized to evaluate and set priorities.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

FINANCIAL INTEGRITY

The MMIS claims processing system identifies the provider, authorized services, and units of service for each recipient. MMIS is linked to DWSS NOMADS eligibility system. MMIS checks each claim to assure recipients were eligible on the dates of service. MMIS maintains records on both the recipient and the provider and provides data for the CMS 64 and 372 reports.

a. Waiver provider agencies are not required to secure an independent review of financial statements.

b. A financial review is completed during the annual waiver review by the DHCFP Quality Assurance Unit. The objective of this review is to confirm the accuracy of provider payments made by examining claims paid and comparing those claims with participant files, Plans of Care, provider qualifications, waiver requirements, and DHCFP/ADSD policy.

The financial review utilizes the statewide random sample of recipients selected for program review. A list of claims paid is produced from the MMIS for each sample case for all waiver services for one chosen month. A sample month is randomly selected for each recipient who is part of the sample. All waiver claims for that sample month for that recipient are examined, in conjunction with the POC and daily record documentation.

In addition, ADSD completes an annual financial review on 10% of recipients during the year.

The results of the financial review are included in the annual waiver review report. The final report is presented to the ADSD Chief of Community Based Care; Chief, Long Term Services and Supports; DHCFP and ADSD administration; and to CMS.

The State has in place a Quality Improvement Committee which analyzes any noted areas and works on improvement for those areas during the year, and up to the next review. This committee includes DHCFP waiver administrative staff, DHCFP quality assurance staff, and ADSD staff. This committee assesses the seriousess and pervasiveness of the problems, identifies goals to remediate issues and problems through policy development, policy clarification, system and program changes, staff training and other remedies, and follows up on remediation progress. If necessary, the results of the finacial review are provided to DHCFP Surveillance and Utilization Review Unit (SURS) or the Medicaid Fraud Control Unit.

Waiver quality assurance staff analyzes findings from the financial review to determine whether the MMIS payment edits are functioning as expected or whether modifications to the MMIS system would prevent future occurrences of erroneous payments. Based on the results of these audits and other analyses, changes to the MMIS system are considered by DHCFP.

c. DHCFP and ADSD staff are responsible for conducting the financial review. DHCFP conducts a financial review annually as part of the annual waiver review. Additionally, ADSD quality review staff review financial records for a designated month during the year.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization. N: Number of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization. D: Number of claims reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
The State provides evidence that rates remain consistent with the approved rate methodology through the five year waiver cycle. Number and percent of provider payment rates which are consistent with the rate methodology in the approved waiver. N: Total number of payment rates which are consistent with the rate

methodology in the approved waiver. D: Total number provider payment rates reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS verification that rates paid to providers are in line with approved rate methodology

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. **Methods for Remediation/Fixing Individual Problems**

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
ADSD internally validates billing and reviews billing workbooks for case management. Factors reviewed include recipients, dates of service, authorization, procedure codes, provider number, eligibility effective date, modifier, and rates. The review is based on claims history reports generated from Nevada's MMIS. DHCFP staff also completes an annual review which includes financial integrity.

ADSD supervisor staff reviews a sample of ongoing case files for appropriateness of administrative claiming versus direct service case management and to verify the correct units are billed. If this area is found to be deficient, supervisors address this individually with case managers to identify areas in needing improvement and ensure corrections are made.

DHCFP and ADSD annually reviews a random sample of claims paid through the MMIS system for a months of waiver services. The purpose of the financial review is to evaluate waiver payments. DHCFP evaluates the services received by the recipients to ensure they are appropriate for the waiver. If providers have billing issues identified during the review they will be required to correct the issue and outline a corrective action plan going forward.

If claims are found to be incorrect, a referral is made to DHCFP SURS unit to investigate under/over payments. This unit provides education to providers who have trouble understanding the claiming process, to include service records needed to compare to claims. In addition, SUR will recoup funds providers are not entitled to, or have a provider rebill for funds they were not paid, if applicable. ADSD staff will provide training to providers on billing procedures , and providers may contact DHCFP's fiscal agent for training on billing procedures at any time. If provider training efforts fail, DHCFP may suspend the provider from accepting new Medicaid recipients and request a corrective action plan.

If there are errors found within MMIS during the annual review, there is a mechanism in place to correct the issues by submitting a Production Discrepancy Report (PDR)to the fiscal agent to obtain an estimation for time and cost of fix. DHCFP Information Technology staff approves any and all work related to MMIS.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The new rules added a subassurance that requires the State to provide evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle. Historically we had projected market increases that never occurred so the projections were in the waiver but the rate never changed from 2002 when a study was conducted by the Provider Rates Task Force which established base rates for waivers.

The rate methodology has remained unchanged since 2002 and is as follows: Take the waiver base rate established by the Task Force in 2002 and increase it by the CPI in each year of the waiver. However, the state does utilize actual expenditures to estimate the number of users of each service, as that has grown over time.

Rate Determination Methods: The Division of Health Care Financing and Policy (DHCFP) determine all rates.

Case Management - Public Providers:
The rate for case management for public entities is based on a study conducted by the Provider Rates Task Force in 2002. The model included obtaining costs from public entities providing case management and targeted case management services at the time the survey was conducted. The methodology mirrors that of the Private case management rate methodology allowing for actual costs (i.e. salary, and associated salary costs, direct costs as identified and a 10% indirect rate was allowed for indirect costs.) The rate was rebased in 2005 and has not been rebased since;

however, it does allow for inflation (CPI) if approved by the Legislature through the biennial budget process. To date, the rate has not been increased for inflation. Aging and Disability Services is the only governmental provider that is reimbursed under the œpublic case management rate for medical case management services. DHCFP pays out the total computable amount for these services; there is no IGT or CPE funding mechanism.

DHCFP also pays ADSD for case management services as an administrative function assisting recipients through the Medicaid eligibility application process. These expenditures are based on actual expenditures and an approved cost allocation plan. DHCFP approves the CAP. Since these services are billed quarterly after ADSD incurs or pays the cost, there is no interim rate established through a cost report nor are these costs trued up or settled at the end of each year. The rates for public case management are the same for all providers which are state employees and are posted on DHCFP's website under Rates and Cost Containment, Provider Type 48.

Case Management - Private Providers:
There are no private case management providers enrolled to provide waiver services at this time. The rate for case management for private entities is based on a market basket model and consistent with the rates established for same provider type in other Home and Community Based Waivers with the most current percentage increase from the Consumer Price Index for Medical Services. The major component of the market rate is a wage assumption for the case manager. The wage scale for a licensed clinical social worker in State service was used for this component. Average benefits are also applied as a percentage of the hourly wage. This percentage is based on analysis of the average benefits of a licensed clinical social worker in State service. Productivity assumptions are then applied to take into account wage costs, which would not be billable, e.g. no show appointment, phone calls, paperwork. Then a factor for a portion of a supervisor' s wage is added into the formula. Then a percentage of 10% for indirect costs and overhead is applied. The final rate is then expressed in ¼ hour increments.

This model is designed to approximate the costs of a private provider to render this service. It is not a cost based rate.

Waiver Service Rates:
The rates for Homemaker, Respite, Chore, Personal Emergency Response System (PERS) installation and ongoing, Adult Companion, and Adult Day Care remained flat throughout the waiver period. The number of recipients is based on the percent of unduplicated recipients that have historically utilized services and the service units are based on projections and actuals from SFY 2014. Waiver rates were set in 2002 the Nevada Provider Rates Task Force, which was contracted by a DHCFP to conduct an analysis of provider rates and make recommendations on rate setting. Rates for waiver providers were recommended by the Provider Rates Task Force and adopted by DHCFP. It must be noted that waiver rates have not increased in the last five years so for the purpose of this amendment, the current rates are the same as in year 1 of the waiver. Any recommended provider rate increase would have to be approved by the state legislature which meets biannually.

Augmented Personal Care:
The rates for these services are the existing, long established rates in the Waiver for the Elderly Adult in Residential Care and Home and Community Based Waiver for Assisted Living. These are not cost based rates. States experience with these services indicates these rates are appropriate for the services provided. These rates are sufficient to enlist enough providers so that these services are available to recipients while still being consistent with efficiency, economy and quality of service.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers direct bill DHCFP's fiscal agent by submitting an electronic bill through Nevada's Medicaid Management Information System (MMIS). This is true of both public and private providers. Billings do not flow through any intermediary other than the DHCFP's fiscal agent.

The MMIS adjudicates claims by:
1. Verifying recipient eligibility.
2. Verification of prior authorization.

The provider is expected to:
1. Verify eligibility monthly.
2. Submit claims weekly or monthly.
3. Submit claims directly through the MMIS system.

MMIS has a series of edits which verifies name, Medicaid number, prior authorization, and the number of units of service authorized. If the claim fails just one of these areas, the claim will deny. The provider must resubmit claims with the correct information. There is an edit in the system which verifies providers do not receive reimbursement over what is authorized. Provider claims are stored in a data warehouse and can be accessed through reports.

Case management is the exception. It is not prior authorized and it is provided on an as needed basis. DHCFP has a Time Tracking System in place which allows case managers to track administrative activities as Waiver Administration and direct services activities as Medical Case Management. Each case manager has a billing work book and these workbooks must match time tracking. Supervisors review a representative sample of case file reviews monthly in which this area is included.

Administrative activities and direct service activities are split up as follows:

Administrative activities are time tracked based on the approved cost allocation plan. Those activities include:
1. Intake referral;
2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance for the Aged, Blind and Disabled (MAABD) application and obtaining documents required for eligibility determination;
3. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility:
4. Request form for a Notice of Decision (NOD) when a waiver application is denied;
5. Coordination of care and services to collaborate in discharge planning to transition applicants from facilities;
6. Documentation for case files prior to eligibility;
7. Case closure activities upon termination of service eligibility;
8. Outreach activities to educate recipients or potential recipients on how to enter into care through a Medicaid Program;
9. Communication of the POC to all affected providers;
10. Completion of prior authorization form prior to submission into the Medicaid Management Information System (MMIS).
11. Travel time for all home visits

ADSD bills administrative activities based on the approved cost allocation plan through DHCFP fiscal unit.

Direct Services:
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 contacts with recipients;
5. Ensuring that the recipient retains freedom of choice in the provision of services;
6. Notifying all affected providers of changes in the recipient's ,medical status, service needs, address, and location, or of changes of the status of legally responsible individuals or authorized representative;
7. Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient;
8. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;
9. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency; and
10. Case Managers must provide recipients with appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case management is an as needed service. Case managers must, at a minimum, have an annual face-to-face visit and ongoing contact that is sufficient to meet the needs of the recipient. The amount of case management services must be adequately documented and substantiated by the case manager's notes.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a) The Medicaid Management Information System (MMIS) assures that all claims for payment are made when the recipient was eligible for Medicaid waiver payment on the date of service, that the service was included in the recipient's approved service plan, and that the services were provided. This is accomplished through several subsystems within MMIS.

The recipient and provider subsystems enroll members in the various benefit plans, and maintain and reports enrollee eligibility data while also supplying demographic and other data used to adjudicate payment requests.

The reference subsystem and the claims processing subsystem identify the covered services for the benefit plan as well as the associated edits and pricing.

The claims processing subsystem then produces fully adjudicated payment requests which are then selected by the financial subsystem for check writing and other financial processing.

b) ADSD also maintains a corresponding record for each recipient documenting the recipient's waiver eligibility and services provided. The record includes recipient demographics, assessments, POCs, level of care screenings, ongoing levels of care, and documentation of waiver service authorizations. These records are reviewed during supervisory reviews and the DHCFP annual review to assure accurate payment. Waiver providers keep a daily record or signed timesheet to verify that services were provided in accordance with the POC.

c) As part of the DHCFP annual review, samplings of provider billings are compared to the claims paid system for determination of accuracy. ADSD staff also verifies services were provided and billed as authorized on the POC during the annual provider reviews.

When a recipient's eligibility for the waiver is terminated, the benefit plan is updated to indicate the date of termination. As claims are processed for payment, an edit is performed to ensure the date on the claim is within the eligibility dates identified in the benefit plan and the services billed are included in the benefit plan.

For medical services in this waiver, the non-federal share of payments is appropriated directly to the DHCFP Medicaid budget. Therefore, Certified Public Expenditures with ADSD are not applicable to these services.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

ADSD for case management services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of

providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [x] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

  During the 76th Legislative Session, SB 485 was passed which amended the counties responsibility to pay the State's Share of expenditures for indigents who are institutionalized with income at 156% to 300% of the Federal Benefit Rate (FBR). The bill amended this population lowering the FBR to an amount prescribed annually by the Director and included the waiver population within the same income limits. The FBR was lowered to 142%.

  The counties reimburse these expenditures through property taxes collected. This is not a CPE mechanism as the counties are not providing the services to these recipients. This is a reimbursement of expenditures in which the

counties are responsible to pay through property taxes collected. The expenditures include waiver and state plan services provided by private community providers.

DHCFP obtains those funds from the counties by invoicing each county, monthly, based on projected costs for the recipients the county is responsible for. A reconciliation is completed each quarter.

DHCFP updated the contracts of all 17 Nevada counties in 2013 to state "payments made by the County shall be derived from general county tax revenues or other general revenues of the County".

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

○ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

◉ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☑ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

SB 485 passed during the 2011 Legislative Session imposed responsibility upon the counties to reimburse the non-federal share of expenditures for waiver recipients whose income is at 142% to 300% of the FBR. These amounts are capped at the amount approved through the biennial budget process.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Medicaid does not pay the cost of room and board furnished to an individual under the waiver. For all services room and board costs are excluded from payment. Individual resources such as SSI, Social Security, Pensions or Savings cover room and board. Rates are based on service delivery, not room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**

- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	6445.80	13841.00	20286.80	59327.10	12323.85	71650.95	51364.15
2	6896.70	14533.00	21429.70	60237.50	12940.20	73177.70	51748.00
3	7454.95	15260.00	22714.95	61555.00	13587.00	75142.00	52427.05
4	8071.56	16023.00	24094.56	64017.19	14266.35	78283.54	54188.98
5	8733.67	16826.00	25559.67	66577.88	14980.00	81557.88	55998.21

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	2524	2524
Year 2	2600	2600
Year 3	2683	2683
Year 4	2763	2763
Year 5	2846	2846

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay is based on the total number of days of waiver coverage of all recipients enrolled in the Waiver for the Frail Elderly divided by the unduplicated number of recipients in the waiver. Actual average length of stay was calculated based on the CMS-372 (3c) data for the period of July 01, 2012--June 30, 2013.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Users per waiver service:

For each waiver service, the number using the service is estimated using the ratio of users to unduplicated counts of recipients for SFY 2013. The same ratio is applied to the forecasted number of participants for each year.

Units per user:
For each waiver service, the number of units was estimated based on the average units by service for SFY 2013. The same ratio is applied to the forecasted number of participants for each year.

Average cost per unit:
Rates were established in 2002. Waiver rates are anticipated to remain unchanged throughout this waiver period and there are no plans for rate increases prior to the end of this waiver. Rates increases are subject to legislative approval.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

State plan service estimates for this waiver renewal were based on data for SFY 2013. The cost of prescription medication furnished to dual eligible€™s is not included in factor D'.

The average cost for all other services provided to individuals in the waiver program is based on data for SFY 2013. The Consumer Price Index indicates a 3.3% growth in medical care, however, the State utilizes a 5% increase to account for institutional costs, so 5% is added in years 2 through 5 to account for growth in state plan services for waiver recipients in order to mirror anticipated growth of institutional services.

Waiver rates have remained unchanged throughout this waiver period and there are no plans for rate increases prior to the end of this waiver.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The nursing facility costs are estimated based on the statewide average nursing facility cost per patient for SFY 2013. Nursing facility rates fluctuate based on MDS reviews and are adjusted quarterly. The base average cost is increased by 5% annually to account for a cost increase in each year of the waiver.

Waiver rates have remained unchanged throughout this waiver period and there are no plans for rate increases prior to the end of this waiver.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

State plan service estimates for this waiver renewal were based on data for SFY 2013. The cost of prescription medication furnished to dual eligible€™s is not included in factor G'.

The Medicaid costs per person for all services other than Nursing Facility cost for persons in a nursing facility was estimated based on the statewide average costs for these services for SFY 2013. The base average cost is increased by 5% annually to account for a cost increase in each year of the waiver.

Waiver rates have remained unchanged throughout this waiver period and there are no plans for rate increases prior to the end of this waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Case Management	
Homemaker	
Respite	
Adult Companion	

Waiver Services	
Adult Day Care	
Augmented Personal Care (APC)	
Chore	
Personal Emergency Response System (PERS)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**4427352.00**
Case Management (Public)	1/4 hour	2388	72.00	25.75	**4427352.00**	
Case Management (Private)	1/4 hour	0	0.01	15.84	**0.00**	
Homemaker Total:						**1019531.25**
Homemaker	1/4 hour	725	375.00	3.75	**1019531.25**	
Respite Total:						**248555.00**
Respite per diem	per diem	3	9.00	65.00	**1755.00**	
Respite per unit	1/4 hour	160	617.00	2.50	**246800.00**	
Adult Companion Total:						**58624.00**
Adult Companion	1/4 hour	64	458.00	2.00	**58624.00**	
Adult Day Care Total:						**1554999.40**
Adult Day Care per unit (1/4 hour)	1/4 hour	10	982.00	1.67	**16399.40**	
Adult Day Care per diem	per diem	245	157.00	40.00	**1538600.00**	
Augmented Personal Care (APC) Total:						**8555540.00**
APC Level of Service 3 (U3)	per diem	286	235.00	60.00	**4032600.00**	
APC Level of Service 1 (U1)	per diem	173	227.00	20.00	**785420.00**	
				GRAND TOTAL:		**16269204.15**
				Total Estimated Unduplicated Participants:		**2524**
				Factor D (Divide total by number of participants):		**6445.80**
				Average Length of Stay on the Waiver:		283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
APC Level of Service 2 (U2)	per diem	358	232.00	45.00	3737520.00	
Chore Total:						7687.50
Chore	1/4 hour	50	41.00	3.75	7687.50	
Personal Emergency Response System (PERS) Total:						396915.00
PERS (monthly)	per month	1200	8.00	40.00	384000.00	
PERS Installation	1 system	287	1.00	45.00	12915.00	
				GRAND TOTAL:		16269204.15
				Total Estimated Unduplicated Participants:		2524
				Factor D (Divide total by number of participants):		6445.80
				Average Length of Stay on the Waiver:		283

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						4558986.00
Case Management (Public)	1/4 hour	2459	72.00	25.75	4558986.00	
Case Management (Private)	1/4 hour	0	0.00	15.84	0.00	
Homemaker Total:						1082812.50
Homemaker	1/4 hour	750	385.00	3.75	1082812.50	
Respite Total:						263280.00
Respite per diem	per diem	3	9.00	65.00	1755.00	
Respite per unit	1/4 hour	165	634.00	2.50	261525.00	
Adult Companion Total:						75520.00
Adult Companion	1/4 hour	80	472.00	2.00	75520.00	
				GRAND TOTAL:		17931409.55
				Total Estimated Unduplicated Participants:		2600
				Factor D (Divide total by number of participants):		6896.70
				Average Length of Stay on the Waiver:		283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**1704818.55**
Adult Day Care per unit (1/4 hour)	1/4 hour	13	1005.00	1.67	**21818.55**	
Adult Day Care per diem	per diem	255	165.00	40.00	**1683000.00**	
Augmented Personal Care (APC) Total:						**9824520.00**
APC Level of Service 3 (U3)	per diem	346	235.00	60.00	**4878600.00**	
APC Level of Service 1 (U1)	per diem	178	228.00	20.00	**811680.00**	
APC Level of Service 2 (U2)	per diem	396	232.00	45.00	**4134240.00**	
Chore Total:						**9112.50**
Chore	1/4 hour	54	45.00	3.75	**9112.50**	
Personal Emergency Response System (PERS) Total:						**412360.00**
PERS (monthly)	per month	1247	8.00	40.00	**399040.00**	
PERS Installation	1 system	296	1.00	45.00	**13320.00**	
				GRAND TOTAL:		**17931409.55**
				Total Estimated Unduplicated Participants:		**2600**
				Factor D (Divide total by number of participants):		**6896.70**
				Average Length of Stay on the Waiver:		283

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**5483205.00**
Case Management (Public)	1/4 hour	2535	84.00	25.75	**5483205.00**	
Case Management (Private)	1/4 hour	0	0.00	15.84	**0.00**	
Homemaker Total:						**1108650.00**
				GRAND TOTAL:		**20001623.08**
				Total Estimated Unduplicated Participants:		**2683**
				Factor D (Divide total by number of participants):		**7454.95**
				Average Length of Stay on the Waiver:		283

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker	1/4 hour	760	389.00	3.75	1108650.00	
Respite Total:						278590.00
Respite per diem	per diem	4	9.00	65.00	2340.00	
Respite per unit	1/4 hour	170	650.00	2.50	276250.00	
Adult Companion Total:						79704.00
Adult Companion	1/4 hour	82	486.00	2.00	79704.00	
Adult Day Care Total:						1300854.08
Adult Day Care per unit (1/4 hour)	1/4 hour	8	1028.00	1.67	13734.08	
Adult Day Care per diem	per diem	186	173.00	40.00	1287120.00	
Augmented Personal Care (APC) Total:						11310345.00
APC Level of Service 3 (U3)	per diem	419	235.00	60.00	5907900.00	
APC Level of Service 1 (U1)	per diem	184	228.00	20.00	839040.00	
APC Level of Service 2 (U2)	per diem	439	231.00	45.00	4563405.00	
Chore Total:						12150.00
Chore	1/4 hour	60	54.00	3.75	12150.00	
Personal Emergency Response System (PERS) Total:						428125.00
PERS (monthly)	per month	1295	8.00	40.00	414400.00	
PERS Installation	1 system	305	1.00	45.00	13725.00	
				GRAND TOTAL:		20001623.08
				Total Estimated Unduplicated Participants:		2683
				Factor D (Divide total by number of participants):		7454.95
				Average Length of Stay on the Waiver:		283

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**5911994.00**
Case Management (Public)	1/4 hour	2609	88.00	25.75	**5911994.00**	
Case Management (Private)	1/4 hour	0	0.00	15.75	**0.00**	
Homemaker Total:						**1128960.00**
Homemaker	1/4 hour	768	392.00	3.75	**1128960.00**	
Respite Total:						**294412.50**
Respite per diem	per diem	4	10.00	65.00	**2600.00**	
Respite per unit	1/4 hour	175	667.00	2.50	**291812.50**	
Adult Companion Total:						**86000.00**
Adult Companion	1/4 hour	86	500.00	2.00	**86000.00**	
Adult Day Care Total:						**1411801.36**
Adult Day Care per unit (1/4 hour)	1/4 hour	8	1051.00	1.67	**14041.36**	
Adult Day Care per diem	per diem	192	182.00	40.00	**1397760.00**	
Augmented Personal Care (APC) Total:						**13010220.00**
APC Level of Service 3 (U3)	per diem	507	234.00	60.00	**7118280.00**	
APC Level of Service 1 (U1)	per diem	189	228.00	20.00	**861840.00**	
APC Level of Service 2 (U2)	per diem	486	230.00	45.00	**5030100.00**	
Chore Total:						**13485.00**
Chore	1/4 hour	62	58.00	3.75	**13485.00**	
Personal Emergency Response System (PERS) Total:						**444850.00**
PERS (monthly)	per month	1346	8.00	40.00	**430720.00**	
PERS Installation	1 system	314	1.00	45.00	**14130.00**	
				GRAND TOTAL:		**22301722.86**
				Total Estimated Unduplicated Participants:		**2763**
				Factor D (Divide total by number of participants):		**8071.56**
				Average Length of Stay on the Waiver:		283

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						6222487.50
Case Management (Public)	1/4 hour	2685	90.00	25.75	6222487.50	
Case Management (Private)	1/4 hour	0	0.00	15.75	0.00	
Homemaker Total:						1161000.00
Homemaker	1/4 hour	774	400.00	3.75	1161000.00	
Respite Total:						311050.00
Respite per diem	per diem	5	10.00	65.00	3250.00	
Respite per unit	1/4 hour	180	684.00	2.50	307800.00	
Adult Companion Total:						88580.00
Adult Companion	1/4 hour	86	515.00	2.00	88580.00	
Adult Day Care Total:						1519455.36
Adult Day Care per unit (1/4 hour)	1/4 hour	8	1076.00	1.67	14375.36	
Adult Day Care per diem	per diem	197	191.00	40.00	1505080.00	
Augmented Personal Care (APC) Total:						15078060.00
APC Level of Service 3 (U3)	per diem	614	234.00	60.00	8620560.00	
APC Level of Service 1 (U1)	per diem	195	228.00	20.00	889200.00	
APC Level of Service 2 (U2)	per diem	538	230.00	45.00	5568300.00	
Chore Total:						13485.00
Chore	1/4hour	62	58.00	3.75	13485.00	
Personal Emergency Response System (PERS) Total:						461895.00
PERS (monthly)	per month	1398	8.00	40.00	447360.00	
PERS Installation	1 system	323	1.00	45.00	14535.00	
				GRAND TOTAL:		24856012.86
				Total Estimated Unduplicated Participants:		2846
				Factor D (Divide total by number of participants):		8733.67
				Average Length of Stay on the Waiver:		283