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 waivers 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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. Program Title:
Home and Community Based Waiver for Persons with Physical Disabilities

C. Waiver Number:NV.4150
Original Base Waiver Number: NV.4150.90 R3

D. Amendment Number:NV.4150.R06.01

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

01/01/18

Approved Effective Date: 01/01/18
Approved Effective Date of Waiver being Amended: 01/01/18

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The Division of Health Care Financing and Policy received feedback from Physically Disabled Waiver (PD Waiver) recipients and relative providers regarding relatives no longer able to provide the waiver services. As a result, the amendment is to add the "Relative" back, so that relatives under Intermediary Services Organizations (ISO)can continue to provide waiver services to PD Waiver recipients without interruption.

The "Relative" will be added to the following services: Homemaker, Respite, Attendant Care Services

For adding Relative - see Appendix C-1/C3

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	C1/C-3
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

Adding Relative to - "Service may be provided by:"

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*):

Home and Community Based Waiver for Persons with Physical Disabilities

C. Type of Request: amendment

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.4150
Waiver Number:NV.4150.R06.01
Draft ID: NV.003.06.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/18
Approved Effective Date of Waiver being Amended: 01/01/18

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 Physically Disabled, 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 physically disabled with the opportunity to remain in a community setting in lieu of institutionalization, with the ultimate goals of self sufficiency and independence.

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. The DHCFP exercises administrative authority over the operation of the waiver and issues policies, rules, and regulations related to the waiver. The DHCFP also completes disability determinations for waiver applicants.

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 determined to be physically disabled, have a Nursing Facility (NF) level of care (LOC), meet financial income criteria, and meet the criteria for home and community based services. Applicants must meet all eligibility factors to receive waiver services or to be added to the waiver waitlist pending slot allocation. There are no age restrictions.

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, Chore, Respite, Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, Personal Emergency Response System (PERS), Assisted Living Services, Home Delivered Meals, and Attendant Care Services. 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:

Since this is a technical amendment, public input was not necessary per CMS.

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: Coulombe

First Name: Kirsten

Title: Chief, Long Term Services and Support

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: kirsten.coulombe@dhcfp.nv.gov

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

Last Name: Wren

First Name: Crystal

Title: Chief, Community-Based Care

Agency: Aging and Disability Services Division

Address: 3416 Goni Road, Building D-132

Address 2:

City: Carson City

State: Nevada

Zip: 89706

Phone: (775) 684-0969 **Ext:** ☐ **TTY**

Fax: (775) 687-0581

E-mail: cwren@adsd.nv.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Kirsten Coulombe

State Medicaid Director or Designee

Submission Date: Feb 8, 2019

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 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:

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.

"The state assures that this waiver amendment and renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan."

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Annual Home and Community Based Services (HCBS) Waivers Combined Frail Elderly (FE) and Persons with Physical Disabilities (PD) Consolidated Review Process

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

It is the responsibility of the DHCFP to ensure that the waivers are implemented by the state operating agency in accordance with Medicaid statute and regulations, program policy, and waiver requirements. Currently the State of Nevada's Home and Community Based Services (HCBS) Waiver for the Frail Elderly (FE) and our waiver for Persons with Physical Disabilities (PD) are managed and monitored almost identically. By consolidating the waiver reviews and reporting of the FE and PD 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 FE and PD waivers currently meet the 5 conditions outlined by Centers for Medicare & Medicaid Services (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;
3. The quality management approach is the same or very similar across waivers;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar

A report of the annual review findings will be prepared by the DHCFP, Managed Care and Quality, Quality Assurance (QA) staff and distributed annually to the appropriate managers and staff of the DHCFP and the waiver operating agency. The report will include a cumulative total percent of compliance for 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 DHCFP Managed Care & Quality unit will utilize the following stratified approach for the combined Annual Waiver Review for the FE and PD waivers. Each year, QA will determine the cumulative number of the statewide population of recipients in receipt of services under the FE and PD 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 producing 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 the operating agency supervisors and the DHCFP QA staff. A second sample producing 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 files [to include recipient files and Personal Experience Surveys (PES)] that the DHCFP QA staff will evaluate throughout the review year.

The Consolidated Evidence Report will be submitted in accordance with the approved waivers. Any "outlier" performance measures, measures that are not exactly the same for both waivers, will be reported with the Consolidated Evidence Report.

Chart and Financial Reviews:

Charts and financial claims will be reviewed to ensure assurances, sub-assurances and performance measures are being met. The DHCFP QA unit verifies elements in the following assurance categories: a) Waiver Administration and Operation, b) Recipient Access and Eligibility c) Recipient Services, d) Person Centered Planning and Service Delivery, e) Recipient Safeguards, and f) Financial Accountability.
Charts will be reviewed using the 12 months immediately preceding the month the review is conducted, utilizing the approved waiver for that time period.

All waiver claims for a randomly chosen review month for each selected recipient are examined, together with the information in the recipient's case file.

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 completed on recipients selected for case file reviews. 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:

The DHCFP QA staff will provide the operating agency with a draft copy of the monthly results. The operating agency can seek clarification of the results from the QA staff. The operating agency will then have the opportunity to submit a formal rebuttal.

Quality Improvement Strategy:

The DHCFP QA staff will conduct consolidated monthly waiver Quality Improvement (QI) meetings. 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 below 86% for the review year will be assigned to a priority grid. The QI 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. All QI projects related to the waiver review will be conducted 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?)

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:

All charts will be reviewed to ensure assurances, sub-assurances and performance measures are being met. The following elements will be reviewed: 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) the plan of care includes amount, scope, frequency and duration, and type of provider; but allows for flexibility of service, 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.
The 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 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 HCBW 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 following elements will be reviewed: 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 waiver recipients to ensure health and welfare, as well as waiver satisfaction. Interviews will be completed throughout the year and include those recipients who were selected for case file reviews. 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

The 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:

The 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?)

Additional Information on Cost Study from Appendix I-2-a section:

The State will identify the services which require a cost study, the State will begin this process in June 2018. Due to budget constraints the DHCFP will not use a contractor for the cost study.

o The cost survey will entail:
- Determination of time frame to be studied, i.e. most recent full Fiscal Year, calendar year, etc.
- Determination of provider population for survey, i.e. all providers or statistical random sampling of providers.
- Development of a survey with clear, concise instructions and questions carefully crafted to identify unallowable costs and identify gaps in provider understanding. The survey will allow for provider comments and questions.
- Administration of the survey.
- Analysis and compilation of survey data.

o Cost Study will be approved by Administration and be sent to providers via mail, email or fax blasts through coordination with our fiscal agent. Best method will be determined by DHCFP staff.
o Providers will be given 8 weeks to complete the cost study.
o Follow up phone calls by DHCFP staff will be conducted during response time.
o Once surveys are received from providers, DHCFP will compile and analyze the results.
o Public comment period will be given after review and analysis of data has occurred.

Timeline for cost study:
- Begin process July 2018
- Survey to providers by October 2018
- Survey returned to DHCFP by December 2018
- Analysis and compilation of data January – April 2019

- Public Workshop for Waiver amendment May 2019
- Finalized cost Study to CMS by June 30, 2019

The State cannot make any change to rates without Legislative approval to do so.

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. The DHCFP monitors the unduplicated count of recipients being served year to date, including current open and closed cases.
2. The DHCFP staff reviews all eligibility packets to ensure waiver criteria are met.
3. The DHCFP staff participates in LTSS quarterly Quality Management Committee meetings.
4. The 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. The DHCFP conducts monthly quality improvement meetings.
6. The DHCFP issues Notices of Decision to the recipient for denials, terminations, and reductions, of waiver services in accordance with policy.
7. The DHCFP Disability Determination Team performs disability determinations for waiver applicants.
8. An Interlocal Agreement between the DHCFP and ADSD delineates responsibilities and expectations of each entity and is monitored at Quality Management meetings. The Interlocal was updated in 2015.

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 also responsible for the verification of provider qualifications.

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:

The DHCFP assesses the performance of the fiscal agent in enrolling qualified waiver service providers.

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 Program Integrity Unit collaborates with the Long Term Services and Support Unit to ensure that qualified waiver providers are enrolled by the fiscal agent, both at initial enrollment and every three years thereafter. The DHCFP maintains oversight of waiver administrative and operational functions listed in Appendix A-7.

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 States quality improvement strategy, provide information in the following fields to detail the States 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 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):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data	Frequency of data	Sampling Approach*(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*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:

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 prior to providing services to waiver recipients. D: Total number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reviews are conducted both onsite and offsite depending on the provider type and location.

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 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 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:

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**

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:

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 DHCFP monitors hearings and appeals for waiver services. Nevada Medicaid Services Manual Chapter 100 is located on the DHCFP website and outlines provider requirements and administrative sanctions. The DHCFP has a Program Integrity Unit that tracks providers who are on sanction periods.

The DHCFP Managed Care and Quality Assurance Unit conduct annual programmatic and financial review of this waiver which is structured as a look back review of delegated functions. The DHCFP has the ability to break out the review findings by geographical office or Statewide, 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 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 by 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 the DHCFP and the ADSD staff.

25% of intake packets are fully reviewed by the DHCFP for completeness.

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 the DHCFP and ADSD will work to resolve over the next year.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 quality improvement 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 the DHCFP.

The DHCFP informs ADSD of the legislatively approved caseload. ADSD reports waiver caseload and waitlist statistics monthly to the DHCFP. Management analysts at DHCFP and ADSD monitor these statistics to track actual caseload against legislatively approved caseloads and for trends that may affect caseload and the waitlist. The ADSD management analysts and fiscal staff work with the DHCFP, the 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 the ADSD Community Based Care Chief, who resolves the issue with the DHCFP.

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

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

The 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. The DHCFP staff reviews these reports on an ongoing basis.

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)**	0	64	
	☐	**Disabled (Other)**			
☐ **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:

This waiver has no minimum or maximum age limits.

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

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.

Individuals must be determined to be physically disabled. The disability determination for this waiver are conducted by DHCFP staff.

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:

There is no minimum/maximum age limit for this waiver. Attempts to select the N/A button resulted in an error message that did not allow for submission of this application.

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	875
Year 2	966
Year 3	1114
Year 4	1318
Year 5	1579

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	869

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 2	960
Year 3	1108
Year 4	1312
Year 5	1573

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 Physically Disabled is determined by the combined efforts of the DHCFP, ADSD, and the DWSS (Division of Welfare and Supportive Services). 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 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. The DHCFP performs a disability determination.

Referrals come from many different means to include family members, providers, hospitals, nursing facilities, non-profit organizations, and recipients themselves. They are all evaluated and placed on the waitlist by priority. The waitlist priority is as follows:

1. Applicants currently in a nursing facility and desiring discharge.
2. Applicants who require assistance or are dependent or some combination of both in all three areas of eating, bathing, and toileting as identified on the LOC screening.
3. Applicants who require assistance or are dependent or some combination of both in 5 or more of the following ADLs as identified on the LOC screening:

Medication Administration
Special Needs
Bed Mobility
Transferring
Dressing
Eating and Feeding
Hygiene
Bathing
Toileting
Locomotion

4. Applicants who are not in priority 1, 2, or 3.

The operating agency is responsible for management of the wait list and allocation of available slots.

The DHCFP monitors the unduplicated count of recipients being served year to date, including current open and closed cases using monthly reports sent to the DHCFP Central Office by the ADSD.

The 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:

The Home and Community Based Services Waiver Eligibility Status Form is complete;

A Nursing Facility Level of Care (LOC) screening indicating the applicant meets a minimum of 3 functional deficits;

There is agreement between the LOC, Plan of Care (POC), and the Comprehensive Social Health Assessment (CSHA);

Individualized goals are identified on the POC;

Health and Safety risks are identified on the POC;

At least 1 ongoing waiver service is identified on the POC;

All needs (Waiver and State Plan) are identified on the POC;

The Forms Acknowledgement is signed, initialed, and dated by the recipient or designated representative;

The Statement of Understanding (SOU) is signed, initialed, and dated by the recipient or designated representative;

A disability determination has been completed by the DHCFP.

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

The 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:

42 CFR 435.135, 435.137, 435.138 (Groups deemed to be receiving SSI for Medical purposes)

Other caretaker relatives specified at 435.110, pregnant women specified at 435.116 and children specified at 435.118.

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:

☒ **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 spend down 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 period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), 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 September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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 individual's 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 the selections in B-5-b also apply to B-5-e.

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-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 (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 the selections in B-5-d also apply to B-5-g.

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 a government agency 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 evaluations 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 Nursing Facility Level of Care (LOC) tool has been embedded into the Social Assistance Management Software (SAMS) electronic case management system.

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 determines whether an applicant meets a nursing facility LOC. There are 13 total functional deficits identified and an eligible recipient or pending applicant must meet at least 3 deficits out of the 13 possible. This is the same numeric score required to meet nursing facility placement.

The State uses the same Level of Care criteria for participants in the waiver as eligibility requirements for members outside of the waiver under all institutional setting types as outlined in the waiver and State Plan.

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, amongst 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 functional deficits possible.

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 (ADSD case manager) makes phone/verbal contact with the applicant or his or her representative within 15 working days of receipt of the referral. The Intake Specialist is an ADSD case manager assigned to assess and determine an individual's level of care at initial application of waiver services. The LOC assessment will determine the applicants eligibility for waiver services and placement on the waitlist, if appropriate. At the initial phone/verbal contact the applicant is advised to gather medical records.

Within 45 days of the referral a face to face visit is made to assess the LOC, complete forms and gather the medical records.

At the face to face visit if the applicant does not have medical records they are given a form advising them that they have 30 days to submit their medical records to the Intake Specialist.

If a waiver slot is not available the LOC and medical records are submitted to the DHCFP for a disability determination. If the recipient meets a LOC and is determined to be physically disabled ADSD is notified and the applicant is added to the waiver waitlist by priority and referral date.

When a waiver slot is available an entire waiver application which includes the LOC is submitted to the DHCFP.

DWSS determines financial eligibility.

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, 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 case management 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 and least annually to assure accurate determinations and as a 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 electronic and/or written format. 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. A copy of the plan of care is provided to the recipient or his/her designated representative and waiver service provider(s). 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 States quality improvement strategy, provide information in the following fields to detail the States 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 receive a Level of Care evaluation for whom there is reasonable indication that services are needed. Numerator: Number of new applicants for whom there is reasonable indication services are needed as a result of the LOC. 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**

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:

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 whose Level of Care eligibility determinations were based on accurate application of policy resulting in accurate LOC determinations.
Numerator: Number of recipients whose Level of Care eligibility determinations were based on accurate application of policy resulting in accurate LOC determinations;
Denominator: 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:

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 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 ADSD quarterly quality management meetings, the 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.

Additional monitoring by the 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 quality improvement meetings.

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 States 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 the DHCFP.

Monthly manager/supervisor meetings are held to discuss issues and identify statewide trends between offices. 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 provided to staff by a Health Care Coordinator III or Social Services Program Specialist 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).

Waiver applicants are given a description of services offered under the Waiver for Persons with Physical Disabilities 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 enrolled providers.

The person centered planning process is driven by the individual, designated 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.

Prior to entrance to the waiver, all waiver applicants must read, or have the form read to them, and the applicant must sign the Statement of Understanding in which the applicant acknowledges a selection of either waiver services or institutional care.

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 State makes every effort to inform recipients of waiver information in their language. The Nevada State Purchasing Division has awarded contracts for telephone based interpreter 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**		
Extended State Plan Service	**Attendant Care Services**		
Other Service	**Assisted Living Services**		
Other Service	**Chore Services**		
Other Service	**Environmental Accessibility Adaptations**		

Service Type	Service		
Other Service	**Home Delivered Meals**		
Other Service	**Personal Emergency Response Systems (PERS)**		
Other Service	**Specialized Medical Equipment and Supplies**		

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:**

Service Definition *(Scope):*

Case Management Services 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:

Public Case Management does not require an authorization. Private Case Management must be prior authorized by ADSD for billing purposes.

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	Case Management Provider Agency (Private)
Agency	Aging and Disability Services Division (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 Provider Agency (Private)

Provider Qualifications

License *(specify):*

Employees of the case management provider agencies who provide direct service case management services must be 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.

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 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;
National Provider Identifier (NPI) validation;
Signed Business Associate Addendum.
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 the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent and every three years at re-enrollment.

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:

Aging and Disability Services Division (Public)

Provider Qualifications

License *(specify):*

Employees of ADSD who provide direct services case management services must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse (RN) 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.

Certificate *(specify):*

Other Standard *(specify):*

Employees of ADSD must pass a State and FBI criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

The ADSD personnel staff will verify licensure and results of background checks as part of the hiring process.

Frequency of Verification:

Licensure is verified annually.

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:**

Service Definition *(Scope):*

Homemaker Services consist of general household tasks such as mopping floors, vacuuming, dusting, cleaning the stove, changing and making beds, washing dishes, defrosting and cleaning the refrigerator, cleaning bathrooms and kitchens, and washing windows as high as the homemaker can reach while standing on the floor. Additional services include shopping for food and needed supplies, planning and preparing meals, laundry activities, and doing routine clean-up for up to two (2) household pets. (Walking pets is not included unless it is a service animal). Additional homemaker activities may be approved on a case by case basis.

The homemaker may accompany the recipient on tasks such as shopping or the Laundromat. Transportation for those activities is not reimbursable as a Medicaid expense.

The homemaker services allowed under the PD waiver are provided only when the individual regularly responsible for the above activities is temporarily absent or unable to manage the home or care for him/herself or others in the home.

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

Homemaker services are provided by agencies who meet provider qualifications and are enrolled as a Medicaid provider through the DHCFP's fiscal agent.

Service must be prior authorized by ADSD.

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	Personal Care Services Agency
Agency	Intermediary Services Organization

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Personal Care Services Agency

Provider Qualifications

License *(specify):*

Licensure as a Personal Care Agency 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;
National Provider Identifier (NPI) validation;
Signed Business Associate Addendum.

Certificate *(specify):*

None

Other Standard *(specify):*

Must be enrolled as a provider agency through the DHCFP's fiscal agent.

Agency providers must arrange for employees to receive training required by the licensing agency which is the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH) and any additional training required by the DHCFP. In order to avoid multiple agencies monitoring the same training requirements, the DHCFP and the operating agency ADSD will only monitor requirements specific to DHCFP policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent for the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Intermediary Services Organization

Provider Qualifications

License *(specify):*

Licensure as a Personal Care Agency issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH)and/or an endorsement as an ISO;
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;
National Provider Identifier (NPI)validation;
Signed Business Associate Addendum.

Certificate *(specify):*

None.

Other Standard *(specify):*

Must be enrolled as a provider agency through the DHCFP's fiscal agent.

Agency providers must arrange for employees to receive training required by the licensing agency which is the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH) and any additional training required by the DHCFP. In order to avoid multiple agencies monitoring the same training requirements, the DHCFP and the operating agency ADSD will only monitor requirements specific to DHCFP policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent for the Division of Health Care Financing and Policy

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at 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:**

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:

Respite care is limited to 120 hours per recipient per year.

Service must be prior authorized by ADSD.

Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

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	Personal Care Services Agency
Agency	Intermediary Service Organization (ISO)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Care Services Agency

Provider Qualifications

License *(specify):*

Licensure as a Personal Care Agency 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;
National Provider Identifier (NPI)validation;
Signed Business Associate Addendum.

Certificate *(specify):*

None

Other Standard *(specify):*

Must be enrolled as a provider agency through the DHCFP's fiscal agent.

Agency providers must arrange for employees to receive training required by the licensing agency which is the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH) and any additional training required by the DHCFP. In order to avoid multiple agencies monitoring the same training requirements, the DHCFP and the operating agency ADSD will only monitor requirements specific to DHCFP policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal agent for the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Provider Type:

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

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:

Extended State Plan Service

Service Title:

Attendant Care Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that are only provided to individuals age twenty-one (21) and over when the limits of State plan Personal Care Services (PCS) under the approved State plan are exhausted. All medically necessary attendant care services for children under age twenty-one (21) are covered in the State plan pursuant to the EPSDT benefit. The scope and nature of these services do not otherwise differ from State plan PCS services furnished under the State plan. The provider qualifications specified in the State plan apply.
Waiver Case Managers assess the recipient's need for attendant care based upon functional deficits.

A recipient may direct his/her own service using the Intermediary Service Organization (ISO) model or choose a Personal Care Services (PCS) provider agency for service delivery.

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

Attendant care services cannot, on an ongoing basis, exceed what the State would pay for the recipient in a nursing facility.

Service must be prior authorized by ADSD.

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	Personal Care Services (PCS) Provider Agency
Agency	Intermediary Service Organization (ISO)

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Attendant Care Services

Provider Category:

Agency

Provider Type:

Personal Care Services (PCS) Provider Agency

Provider Qualifications

License *(specify):*

Licensure as a Personal Care Agency 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;
National Provider Identifier (NPI)validation;
Signed Business Associate Addendum.

Certificate *(specify):*

None

Other Standard *(specify):*

Must be enrolled as a provider agency through the DHCFP's fiscal agent.

Agency providers must arrange for employees to receive training required by the licensing agency which is the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH) and any additional training required by the DHCFP. In order to avoid multiple agencies monitoring the same training requirements, the DHCFP and the operating agency ADSD will only monitor requirements specific to DHCFP policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal agent for the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Attendant Care Services

Provider Category:

Agency

Provider Type:

Intermediary Service Organization (ISO)

Provider Qualifications

License *(specify):*

Licensure as a Personal Care Agency issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH)and/or an endorsement as an ISO;
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;
National Provider Identifier (NPI)validation;
Signed Business Associate Addendum.

Certificate *(specify):*

Other Standard *(specify):*

Must be enrolled as a provider agency through the DHCFP's fiscal agent.

Skilled services must be performed in accordance with NRS 629.091.

Agency providers must arrange for employees to receive training required by the licensing agency which is the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH) and any additional training required by the DHCFP. In order to avoid multiple agencies monitoring the same training requirements, the DHCFP and the operating agency ADSD will only monitor requirements specific to DHCFP policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal agent for the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at 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:

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:

Assisted Living Services

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:**

Service Definition *(Scope):*

Assisted living services are all-inclusive services furnished by an assisted living services provider that meets the HCB setting requirements. Assisted living services are intended to provide all support services needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/ transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, provided in a home-like environment in a licensed (where applicable) community care facility. Services provided by a third party must be coordinated with the assisted living facility. This service may include skilled or nursing care to the extent permitted by state law. Nursing and skilled therapy services are incidental, rather than integral to the provision of assisted living services. Payment is not made for 24 hour skilled care. If a recipient chooses assisted living services, no other waiver services may be provided, except case management services.

The service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way promoting maximum dignity and independence, and to provide supervision, safety and security.

Recipients are responsible for room and board and personal items of comfort.

Federal financial participation is not available for the costs of facility maintenance, upkeep and improvement.

The methodology by which the costs of room and board are excluded from payments for assisted living services is described in Appendix I-5.

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

Service must be prior authorized by ADSD.

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	Assisted Living Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living Services

Provider Category:

Agency

Provider Type:

Assisted Living Provider

Provider Qualifications

License *(specify):*

Licensure as a Residential Facilities for Groups 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 CP 575 or W-9 or Social Security Card;

Proof of Worker's Compensation Insurance;

National Provider Identifier (NPI) validation;

Signed Business Associate Addendum.

Certificate *(specify):*

None

Other Standard *(specify):*

If the attendant is providing attendant care services that include skilled services, he or she must meet the requirement of NRS 629.091.

Agency providers must arrange for employees to receive training required by the licensing agency which is the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH) and any additional training required by the DHCFP. In order to avoid multiple agencies monitoring the same training requirements, the DHCFP and the operating agency ADSD will only monitor requirements specific to DHCFP policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent of the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at 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:

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 Services

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:**

Service Definition *(Scope):*

Services needed to maintain a clean, sanitary and safe home environment. This service includes heavy household chores such as washing floors, 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, packing and unpacking boxes, and removing trash and debris from the yard. These services are provided only when neither the recipient nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.

In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service.

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

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

Service must be prior authorized by ADSD.

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	Personal Care Services (PCS) Provider Agency
Agency	Intermediary Service Organization

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Personal Care Services (PCS) Provider Agency

Provider Qualifications

License *(specify):*

Licensure as a Personal Care Agency 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;
National Provider Identifier (NPI) validation;
Signed Business Associate Addendum.

Certificate *(specify):*

None

Other Standard *(specify):*

Must be enrolled as a provider agency through the DHCFP's fiscal agent.

Agency providers must arrange for employees to receive training required by the licensing agency which is the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH) and any additional training required by the DHCFP. In order to avoid multiple agencies monitoring the same training requirements, the DHCFP and the operating agency ADSD will only monitor requirements specific to DHCFP policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent of the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Intermediary Service Organization

Provider Qualifications

License *(specify):*

Licensure as a Personal Care Agency issued by the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH)and/or an endorsement as an ISO;
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;
National Provider Identifier (NPI) validation;
Signed Business Associate Addendum.

Certificate *(specify):*

None

Other Standard *(specify):*

Must be enrolled as a provider agency through the DHCFP's fiscal agent.

Agency providers must arrange for employees to receive training required by the licensing agency which is the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH) and any additional training required by the DHCFP. In order to avoid multiple agencies monitoring the same training requirements, the DHCFP and the operating agency ADSD will only monitor requirements specific to DHCFP policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal agent for the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at 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:

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:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Environmental Accessibility Adaptations are physical adaptations to the residence of the recipient or the recipient's family, identified in the recipient's person centered plan, that are necessary to ensure the health, welfare and safety of the recipient or that enable the recipient to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the recipient.

Environmental Accessibility Adaptation under this waiver are limited to additional services not otherwise covered under the State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the recipient.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

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

Service must be prior authorized by ADSD. Documentation from the recipient's physician or health care provider may be required.

Must receive landlord's written approval prior to authorizing services.

There is an annual limit of $3230.00 per recipient.

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	Environmental Accessibility Adaptations Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptations Provider

Provider Qualifications

License *(specify):*

Must have a business license from the Nevada Secretary of State (for in state providers) or a business license from the Secretary of State in the provider's home state (for out of state providers).

Certificate *(specify):*

None

Other Standard *(specify):*

Environmental Accessibility Adaptations Providers must have:

Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Number;

Contractor's license (if completing installation);

Proof that provider is an authorized vehicle adaptation dealer (for providers who provide vehicle adaptation services only);

National Provider Identifier (NPI) validation;

Signed Business Associate Addendum.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent of the Division of Health Care Financing and Policy.

Frequency of Verification:

Initially and every three years at 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:

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:

Home Delivered Meals

HCBS Taxonomy:

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

06 Home Delivered Meals	06010 home delivered meals

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

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

Service Definition *(Scope):*

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

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

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

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

Home Delivered Meals are limited to two meals per day.

Service must be prior authorized by ADSD.

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	Agency for Home Delivered Meals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Agency for Home Delivered Meals

Provider Qualifications

License *(specify):*

Business license form the Secretary of State (for in-state providers) or a copy of the Secretary of State business license in the provider's home state (for out -of-state provider).

Certificate *(specify):*

None

Other Standard *(specify):*

Documentation showing taxpayer identification number (SS-4 or CP575 or W-9 or Social Security Card).

A food service establishment permit pursuant to NRS 446.

National Provider Identifier (NPI) validation.

Signed Business Associate Addendum.

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

All providers must comply with applicable federal, state and local code and regulations relating to the public health, safety, and welfare, and to food preparation as required in all stages of food service operation.

Copies of all current inspection reports by health department staff, registered sanitarian, or fire officials should be kept on file by the provider and posted at the meal preparation site.

All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services and the U. S. Department of Agriculture and provide a minimum of one-third of the current daily Recommended Dietary Allowances as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent of the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at 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:

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 Systems (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:**

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:

PERS services are limited to those recipients who live alone, who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision.

Service must be prior authorized by ADSD.

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	PERS Provider Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

PERS Provider Agency

Provider Qualifications

License *(specify):*

Must have a business license from the Nevada Secretary of State (for in state providers) or a business license from the Secretary of State in the provider's home state (for out of state providers).

Certificate *(specify):*

None

Other Standard *(specify):*

Documentation showing Taxpayer Identification Number (SS-4 or CP575 or W-9 or Social Security Card);

National Provider Identifier (NPI) validation;

Signed Business Associate Addendum.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent of the Division of Health Care Financing and Policy.

Frequency of Verification:

At enrollment with DHCFP's fiscal agent and every three years at 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:

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:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology

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

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

Service Definition *(Scope):*

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

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and nondurable equipment not available under the State Plan that is necessary to address participant functional limitations; and (e) necessary medical supplies not available under the State Plan.

NOTE: Products must have received approval from the federal Food and Drug Administration (FDA) and be consistent with the approved use. Products or usage considered experimental or investigational are not covered services. Consideration may be made on a case-by-case basis for items approved by the FDA as a Humanitarian Device Exemption (HDE) under the Safe Medical Device Act of 1990 and as defined by FDA. That is, a device that is intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 4,000 individuals in the United States per year.

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

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan, including EPSDT shall exclude those items that are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation and where indicated, will be purchased from and installed by authorized dealers.

Service must be prior authorized by ADSD. Documentation from the recipient's physician or health care provider may be required.

There is an annual limit of $565.00 per recipient.

The specialized medical equipment is billed directly to Medicaid. There are occasions in which a community organization will contribute to the cost of equipment if the maximum allowable limit is reached. When this occurs the recipient's case manager through ADSD will work with the organization to arrange for the supplement payment. The specialized medical equipment is provided only to those in a private home environment.

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	Durable Medical Equipment, Prosthetic Devises, Orthotic Devices, and Disposable Medical Supplies (DMEPOS) Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment, Prosthetic Devises, Orthotic Devices, and Disposable Medical Supplies (DMEPOS) Provider Agency

Provider Qualifications

License *(specify):*

All providers must be licensed through the Nevada State Board of Pharmacy (BOP) as a Medical Device, Equipment, and Gases (MDEG) supplier, with the exception of a pharmacy that has a Nevada State Board of Pharmacy license and provides Durable Medical Equipment, Prosthetic Devices, Orthotic Devices, and Disposable Medical Supplies (DMEPOS). Once licensed, providers must maintain compliance with all Nevada BOP licensing requirements OR be enrolled with DHCFP as a DME provider for State Plan DME.

Certificate *(specify):*

None

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent for the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

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.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *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:

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

State Staff includes employees of ADSD who are qualified Medicaid case managers for the Waiver for Persons with Physical Disabilities.

Employees of the case management provider agency who provide direct service case management services must be 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 and must have a valid driver's license. 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.

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):

For the purpose of this amendment, relative means non-LRI (Legally Responsible Individual). Relatives, who want to be personal caregivers of waiver recipients must adhere to the same requirements as non-relative personal caregivers. Relatives must be enrolled with an ISO (Intermediary Service Organization) prior to providing waiver services to recipients in order to get paid. ISO is an entity acting as an intermediary between Medicaid recipients, who elect the Self-Directed Model and the Personal Care Assistants (PCAs) who provide the services; and is an employer of record for the caregivers (relatives) providing services to a Medicaid waiver recipient, who serves as the managing employer of the caregiver. All Medicaid providers including ISO entities and their respective caregivers are subject to criminal background check.

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:

The 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.

A fingerprint based criminal background check is required for all employees who provide direct care to recipients, as well as owners and administrators. Internet based background checks are not acceptable.

The DHCFP policy requires all providers have a fingerprint based criminal history completed prior to service initiation, and every five years thereafter. The DHCFP fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100, Section 102.2, which outlines a list of crimes which are inconsistent with the best interests of the recipients, and MSM Chapter 2600 Section 2603.8(1)for ISO requirements for caregivers including relatives.

Criminal background checks must be conducted through the Nevada Department of Public Safety (DPS). Agencies do not have to have a DPS account. Individuals may request their own personal criminal history directly from DPS and the FBI and must have the results sent directly to the employer. Information and instructions may be found on the DPS website at: http://nvrepository.state.nv.us/criminal/forms/PersonalNevadaCriminalHistory.pdf

The employer is responsible for reviewing the results of employee criminal background checks and maintaining the results within the employee’s personnel records. Continued employment is at the sole discretion of the servicing agency. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing employment and have this documented in the employee’s personnel file. These convictions include (not all inclusive):

1. murder, voluntary manslaughter or mayhem;

2. assault with intent to kill or to commit sexual assault or mayhem;
3. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
4. abuse or neglect of a child or contributory delinquency;
5. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in NRS 454;
6. a violation of any provision of NRS 200.700 through 200.760;
7. criminal neglect of a patient as defined in NRS 200.495;
8. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
9. any felony involving the use of a firearm or other deadly weapon;
10. abuse, neglect, exploitation or isolation of older persons;
11. kidnapping, false imprisonment or involuntary servitude;
12. any offense involving assault or battery, domestic or otherwise;
13. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;
14. conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; or
15. any other offense that may be inconsistent with the best interests of all recipients.

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

Residential Facilities for Groups:

Additional requirements for Residential Facilities for Groups under Nevada Revised Statute 449.

Employers of residential facilities for groups are required to conduct FBI background checks on all employees within 10 days after hiring an employee and 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 the 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).**

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.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

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.

Relatives, who are NOT legal guardians, may be paid for providing waiver services. Nevada's Legally Responsible Individual include spouses, legal guardians, and parent(s), stepparent(s), foster parent(s), and adoptive parent(s) of minor children.

Relatives must adhere to all waiver providers' requirements as stated in the PD Waiver MSM Chapter 2300 Section 2303.3B Provider Responsibilities and ISO MSM Chapter 2600 Section 2603.8 Provider Responsibilities. All relative caregivers are responsible to ensure they are in compliance with required training as a PD waiver provider, only provide services in accordance with the waiver recipient's service plan, Plan of Care must be developed and signed by all applicable participants: recipient, relative caregiver and case manager. Additionally, all waiver services must be prior authorized prior to providing services; and, ISO entities are subject to DHCFP and ADSD Quality Assurance (QA) units' review, which is reported to CMS. Relative caregivers also has individual case file kept in the ISO agency and are reviewed annually. The case file must contain result of criminal background check, training certificate, plan of care, daily logs signed by recipient and caregiver (NOTE: if recipient is unable to sign daily logs and documented in the POC, the log must be signed by another relative, who is not the caregiver). When during the QA review, it was determined that caregiver was non-compliant, the case is also referred to DHCFP Surveillance and Utilization Review (SUR), for further investigation and possible recoupment.

○ **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 the DHCFP through its 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 at the Medicaid Services Manual on the DHCFP website which is www.dhcfp.nv.gov.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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, that continue to meet licensure/certification qualifications. Numerator: Number of currently enrolled providers, by type, that continue to meet licensure/certification qualifications; Denominator: Total number of currently enrolled 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):*
☒ **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 qualification prior to delivery of services. Numerator: Number of provider applicants that meet licensure/certification qualifications prior to delivering services. Denominator: 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:

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

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 non-licensed/non-certified provider applicants that meet qualifications prior to delivering services. Numerator: Number of non-licensed/non-certified provider applicants that meet qualifications prior to delivering services; Denominator: 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:

Performance Measure:
Number and percent of currently enrolled non-licensed/non-certified providers that continue to meet qualifications. Numerator: Number of currently enrolled non-licensed/non-certified providers that continue to meet qualifications; Denominator: 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Provider Re-enrollment report	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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 licensed provider agencies whose employees receive required training prior to delivering services. Numerator: Number of agencies whose employees receive training prior to delivering services; Denominator: Number of agencies reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider On Site Review

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:

Division of Public and Behavioral Health, Health Care Quality and Compliance		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Every 24 months, or more often if indicated.	

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: Division of Public and Behavioral Health, Health Care Quality and Compliance	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every 24 months, or more often if indicated.

Performance Measure:
Number and percent of agencies whose 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):
Other

If 'Other' is selected, specify:
Provider reviews on site

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: Division of Public and Behavioral Health, Health Care Quality and Compliance	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Every 24 months, or more often if indicated.	

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Division of Public and Behavioral Health, Health Care Quality and Compliance	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every 24 months, or more often if indicated.

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.

In order to prevent Personal Care Service Agencies and Intermediary Service Organizations from being surveyed by multiple state agencies on employee training, the DHCFP will accept the training required by the licensing agency and the monitoring performed by the licensing agency as sufficient. Agency providers must arrange for employees to receive training required by the licensing agency which is the State of Nevada Department of Health and Human Services Division of Public and Behavioral Health (DPBH), Health Care Quality and Compliance (HCQC). The DHCFP does not actively track provider compliance with the required DPBH and HCQC required trainings. The DHCFP relies on HCQC or DPBH to follow up with the providers and notify DHCFP of non-compliance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 QM staff serve as a resource for providers by providing on-site technical assistance during reviews and provider education on an as-needed or as-requested basis year-round.

If problems are discovered during reviews of providers by any agency, the DHCFP and ADSD staff will take appropriate action which may include requiring a Plan of Improvement (POI) for remediation, provider suspension, or provider termination. The action taken depends on the nature of the problem and the action of the provider to correct and prevent recurrence of the problem.

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**

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

For information regarding the Waiver specific transition plan, please refer to Attachment #2 in this application.

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)

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:*

Once an applicant is determined eligible for Medicaid, entities or individuals that have responsibility for service plan development may provide direct case management services to the recipient. These entities or individuals do not provide services other then direct case management services to the recipient.

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 designated 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 developed 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. Private case managers would be required to receive the same training as ADSD staff.

Case management is an as needed service and directed by the recipient and/or personal representative. The POC will identify the recipient's and/or designated 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, or email, and an in-person visit will be conducted annually and as outlined in the POC development process.

b) The applicant, family, support systems, and/or designated 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):

a) The POC is developed as an administrative function of the waiver. Qualified case managers are responsible for the development of the plan of care. The POC is developed by the case manager using a person centered process. The qualified case manager implements the plan once developed. The case manager contacts all service providers to arrange for the agreed upon services.

The recipient has the authority to determine who is involved in the development of the POC.

This process involves the recipient, parents/guardians, other family members, friends, health care professionals, and anyone else who has a personal interest in the recipient. The plan is completed no more than 60 calendar days from waiver enrollment. The finalized service plan must be signed and dated by both the recipient and provider(s). This is to account for the assessment of implementation of State Plan Personal Care Services prior to waiver services so waiver services can complement those State Plan Services. The POC is revised annually, or when a significant change occurs that lasts greater than 30 days.

b) The case manager completes a Comprehensive Social Health Assessment (CSHA). The assessment process includes addressing the recipient's activities of daily living (ADLs), which are self care activities, such as bathing, dressing, grooming, transferring, toileting, ambulation, and eating. Instrumental activities of daily living (IADLs), which capture more complex life activities, are also assessed, including meal preparation, light housework, laundry, and essential shopping. In addition, this process includes gathering information regarding the recipient's disability, medical history and social needs. The assessment process considers risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs. Development of the POC considers location, availability of transportation and necessary and desired activities. Personal goals are identified by the recipient and documented on the POC initially and each time the POC is updated.

c) At the initial contact with ADSD, the recipient is informed of services available through the waivers. If the person has any interest in applying for services, a brochure is provided. The information is again provided to the recipient at the time of the initial POC development and reviewed during ongoing contacts thereafter by the waiver case manager.

d) The recipient always receives a copy of the POC each time it is revised. The POC documents all services available through the waiver. The recipient plays an active role in developing the POC that identifies desired outcomes, needs and preferences. The POC development process ensures that the service plan addresses recipient goals, needs (including health care needs) and preferences through the inclusion of the recipient, involved family members, designated representatives and health care professionals.

e) The POC identifies the level of assistance required, the type, amount, scope and frequency of services, and the method by which the assistance is to be provided. Service providers are given a copy of the recipient's POC and the assigned case manager reviews the document with the recipient. The case manager is responsible for authorizing all waiver services. Authorizations are updated as needs change.

f) Ongoing contact with a recipient is required by the case manager to discuss authorized services and evaluate the recipient's level of satisfaction. The frequency of ongoing contact is driven by the needs of the recipient, and may occur as frequently as monthly, or as minimally as annually. However, when case management is the only waiver service identified on the POC, case managers shall continue to have monthly contact with the recipient and/or designated representative. Ongoing contacts may be by telephone, or email. The recipient will be informed that contact must be made with the case manager if there are any instances of health, safety, or welfare concerns, or when a significant change in their health status has occurred. There must be a home visit with the recipient annually, at which time, the case manager will complete a new LOC assessment of the recipient and develop a new POC. ADSD supervisors review plans of care developed by case managers. The DHCFP QA Unit is responsible for conducting annual program reviews, including reviews of the Plan of Care, using a representative sample.

g) The POC is reviewed on an as needed basis as directed by the recipient, and updated annually, or when a significant change lasting greater than 30 days occurs. The case manager is responsible for facilitating the revision of the plan of care.

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. 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
Endangering 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

Risks are identified by the Social Health Assessment. Some risks are mitigated by the implementation of services through State Plan and/or waiver services. Some risks are addressed by not necessarily mitigated due to recipient choice.

For example, smoking is a risk, but a recipient has that choice. Case manager's document identified risks and how they are addressed within the recipient chart, to include formal and informal supports in place for risk mitigation. Recipients have a choice of providers. Providers are required to provide a backup plan. In addition, recipients utilize formal and informal supports as needed.

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.

Prior to enrollment in the waiver, all waiver recipients read (or have read to them) and sign a Statement of Understanding that includes language that informs the recipient that they are choosing a community placement and that the waiver case manager will assist in finding needed services in that community based setting. Recipients are then informed of the services that they are authorized to receive and are provided with a list of enrolled waiver providers for the authorized services. Waiver recipients are informed of their choice of providers at all face to face visits and have ongoing accessibility upon request. 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):

The 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). The representative sample size used is based on generally accepted probabilities and confidence levels. The DHCFP QA unit pulls a 95/10 sample size for review and used additional reviews from the operating agency to review a total sample size of 95/10. 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 the 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.

The assigned case manager is responsible for implementation of the Plan of Care (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 designated representative. If a new service need is identified, the POC will be updated and the recipient and/or designated representative is given a choice of providers.

Case managers encourage family members, a designated representative, or members of the recipient's support system to attend face-to-face visits with the recipient. Family members, a designated representative, or a member of the recipient's support system 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 (QA) Questionnaire-Participant Experience Survey (PES) is completed during a visit to the client's home or by telephone. ADSD supervisory staff conducts a review of the recipient's Level of Care (LOC) and Plan of Care (POC) annually, at a minimum. The ADSD QA unit complies this data for tracking and trends purposes. The information collected is shared with supervisory staff and DHCFP at the quarterly QA meetings for remediation and educational opportunities.

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.

The Plan of Care must be reviewed and revised annually or when the client's need for services changes for greater than 30 days.

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:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
PM: Number and percent of recipients POCs that address health and safety risk factors. N: Number of recipients POCs that address health and safety risk factors; 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:
PM: Number and percent of recipients POCs that address personal goals. N: Number of recipients POCs that include personal goals; D: Number of recipient POCs reviewed.

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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:
PM: Number and percent of recipients POCs that address the assessed needs identified in the social health assessment. N: Number of recipients POCs that address the assessed needs 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:

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 participants 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:
PM: 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**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM: 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**
	☐ **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:
PM: Number and percent of recipients services that are delivered in accordance with the approved Plan of Care N: Number of recipients whose services are delivered in accordance with all criteria to include type, scope, amount, duration and frequency specified in the current Plan of Care 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 who indicate during 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:

e. ***Sub-assurance: Participants are afforded choice: 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:
PM: Number and percent of recipients whose SOU is signed indicating choice of waiver services and institutional care, choice of providers and choice of services. N: Number of recipients whose SOU is signed indicating choice of waiver services and institutional care, 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 the DHCFP for approval. Supervisors address any concerns or deficiencies with the case manager as they occur.

The DHCFP reviews intake packets for eligibility and approves the packets. The DHCFP reviews a 25% sample of all intake packets and reports findings to ADSD at the quarterly Quality Management meetings. Improvement activities are discussed at these quarterly meetings. The following are included in the findings to ADSD:

The Home and Community Based Services Waiver Eligibility Status Form is complete;

A Nursing Facility Level of Care (LOC) screening indicating the applicant meets a minimum of 3 functional deficits;

There is agreement between the LOC, Plan of Care (POC), and the Comprehensive Social Health Assessment (CSHA);

Individualized goals are identified on the POC;

Health and Safety risks are identified on the POC;

At least 1 ongoing waiver service is identified on the POC;

All needs (Waiver and State Plan) are identified on the POC;

The Forms Acknowledgement is signed, initialed, and dated by the recipient or designated representative;

The Statement of Understanding (SOU) is signed, initialed, and dated by the recipient or designated representative;

A disability determination has been completed by the DHCFP.

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

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

ADSD supervisors review a sample size of ongoing case files producing a probability of 95% confidence level with a +/- 5 confidence interval.

The DHCFP conducts a consolidated review of program and fiscal services available under this waiver. A stratified sample size producing a probability of a 95/5 percent confidence level is utilized. An annual report is completed utilizing documented information from monthly reviews of all delegated functions and confirmation of quarterly data on performance measures provided by ADSD. The DHCFP has the ability break out the findings by the specific policy area. During the review, the DHCFP staff evaluates compliance with policies related to the operation of the waiver and assure such policies are administered correctly. Policies are available on the DHCFP's website, https:\\dhcfp.nv.gov, and it is the responsibility of ADSD staff to refer to policy when operating the waiver. Any assurances that fall below the CMS benchmark for compliance will be addressed during regularly scheduled Quality Improvement meetings. Identified areas of concern will be assigned a priority and a plan developed to improve performance.

The State has implemented a new Serious Occurrence Reporting (SOR) system that captures all reports submitted from Providers, the Public or reported to the Case managers. The paper form has been turned into an electronic format that is accessible to all Providers, Public and State staff via the DHCFP public facing website, the DHCFP’s Fiscal Agent’s website, and the ADSD’s public Facing website. Once the SOR is completed and

submitted electronically it will populate the internal system which is used as both a database and a SOR management system. Specific identified staff will be notified when a SOR is received so they can review, distribute as needed, and work as appropriate. This system will allow an assurance that the SOR's are being reported, recorded and responded to on a timely basis. This system will also allow the State to collect data more easily for reporting requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 these areas are omitted or incorrect, supervisors address this individually with case managers and corrections are made immediately.

The POC is included in the packet of information submitted to the DHCFP for approval and processing. 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 during ongoing recipient 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) 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**

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

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a) The recipient is offered the opportunity to self direct utilizing employer authority, known as Nevada's Intermediary Services Organization (ISO) Model.

b) Case managers provide information to recipients advising them of their options for service delivery. If the recipient selects the ISO Model, they are referred to a Nevada Medicaid enrolled ISO.

c) ISO's are used to support individuals who choose to self direct. With guidance and support from an ISO, which provides fiscal and supportive services, the recipient or their Personal Care Representative (PCR) develops a care delivery and back up plan, then arranges and directs their own care and services as referenced in NRS 449.4304.

d) Skilled services provided by an unskilled caregiver must be in compliance with NRS 629.091.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ◉ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery**

methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Recipients have the choice to self direct the following services: Attendant Care, Chore, Respite, or Homemaker. In order to participate in self directed care, the recipient must have the ability and desire to direct, manage and take responsibility to direct his/her care. They must be capable to select the provider, the personal care assistance and arrange for delivery of authorized services. The recipient must be capable of making choices about service needs, understand his/her choices, assume responsibility of those choices and direct all tasks related to services. The self direction available to recipients is strictly for non-skilled services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) The recipient is offered the opportunity to self direct utilizing employer authority, known as Nevada's Intermediary Services Organization (ISO) Model.

b) Case managers provide information (in written form) to recipients advising them of their options for service delivery. If the recipient selects the ISO Model, they are referred to a Nevada Medicaid enrolled ISO. Recipients that select self directed service model are provided their responsibilities in writing prior to the start of services.

c) ISO's are used to support individuals who choose to self direct. With guidance and support from an ISO, which provides fiscal and supportive services, the recipient or their Personal Care Representative (PCR) develops a care delivery and back up plan, then arranges and directs their own care and services as referenced in NRS 449.4304.

d) Skilled services provided by an unskilled caregiver must be in compliance with NRS 629.091.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The recipient or their designated representative may direct waiver services as designated through signed consent. The selection of the designated representative is strictly the choice of the recipient. The designated representative is advised of their responsibilities by the case manager. The designated representative may direct services in place of the recipient. The designated representative's authority does not extend into legal matters. Case Managers ensure they receive a copy of any documents indicating an appointed legal representative.

In addition, the recipient or their designated representative can select a Personal Care Representative (PCR) who can be anyone of their choosing. The PCR is responsible for directing the recipient's care, if the recipient is unable to. They have all of the responsibilities the recipient has, to include signing delivery records, and verifying back up plans.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Respite	☒	☐
Homemaker	☒	☐
Attendant Care Services	☒	☐
Chore Services	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The ISO, as the employer of record, furnishes FMS. These services include: verification of worker citizenship status, processing time sheets of workers, processing payroll, withholding, filing and payment of applicable Federal, State, and Local employment taxes and insurance.

The entities that furnish the FMS are the ISO who are private entities enrolled as Medicaid providers. The ISO enroll with the QIO-like vendor and are licensed by BHCQC. There is no procurement process. ADSD and BHCQC are the entities responsible for surveying the ISOs.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Costs are calculated within the ISO rate methodology.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

☐ **Maintain a separate account for each participant's participant-directed budget**

☐ **Track and report participant funds, disbursements and the balance of participant funds**

☐ **Process and pay invoices for goods and services approved in the service plan**

☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement**

with the Medicaid agency or operating agency

☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

a)Provider reviews are completed annually. A copy of the completed review is available to the DHCFP's Surveillance and Utilization Review (SUR) Unit.

In addition, the Medicaid Management Information System (MMIS) system includes system edits to ensure services are reimbursed in accordance with approved services.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Case Management	☐
Personal Emergency Response Systems (PERS)	☐
Respite	☐
Specialized Medical Equipment and Supplies	☐
Homemaker	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Attendant Care Services	☐
Environmental Accessibility Adaptations	☐
Chore Services	☐
Home Delivered Meals	☐
Assisted Living Services	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

a) The assigned case manager provide information to recipients advising them of their options for service delivery. If the recipient selects the ISO Model, they are referred to a Nevada Medicaid enrolled ISO.

b) The recipient, LRI, or Personal Care Representative (PCR) have the opportunity to self-direct either unskilled or skilled personal care services. An agreement between the recipient or the recipient's representative is signed specific to the provision of unskilled or skilled personal care services.

c) The assigned case manager will provide the same levels of recipient contact and ongoing monitoring to recipients that choose the ISO model as those recipients who choose the agency model.

d)The DHCFP and ADSD conduct an annual review of this waiver. The sample includes individuals who utilize the self-directed option.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Recipients may change their provider or delivery model at any time throughout the year. They should notify the case manager of the termination and their desire to change providers or delivery model. The case manager will assist with alternate delivery models as chosen by the recipient.

Service authorizations from one provider to another are such that there is no break in service delivery. The MMIS system allows for retroactive authorizations which means one provider can be closed one day, and the new provider can begin the next day and may be completed retroactively.

If a recipient becomes unable to direct their care due to age or disease progression, an alternative delivery model will be facilitated by the case manager, if no Personal Care Representative (PCR) has been designated.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The State is committed to ensuring self direction and choice. All efforts to support health, safety, and welfare will be afforded.

If the identified caregiver does not fulfill the responsibilities and functions required; or the health and welfare needs of the recipient are not met, ADSD case managers will counsel the recipient about terminating the use of participant direction and subsequently accessing provider managed care. If participant direction is terminated, the case manager will ensure services are arranged and in placed prior to the termination. The assigned case manager is responsible to make reports to the appropriate authorities, based upon the recipient's age, if there is suspected abuse, neglect, or exploitation.

Recipients are required to have a documented back up plan, which can be an identified caregiver under the participant directed, or the agency model; therefore, there should not be any break in service delivery. If the back-up plan is no longer viable, the case manager will provide a list of qualified and enrolled providers for the recipient to choose from. Prior authorizations can be retro-active if needed to ensure no break in service delivery.

If a recipient becomes unable to direct their care due to age or disease progression, an alternative delivery model will be facilitated by the case manager, if no Personal Care Representative (PCR) has been designated.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	167	
Year 2	182	
Year 3	197	
Year 4	212	
Year 5	227	

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The DHCFP contracts with a fiscal agent who pays all claims. Enrolled providers bill MMIS directly.

A recipient may hire, fire, and train a caregiver who is referred to an Intermediary Services Organization (ISO) who acts as the fiscal intermediary.

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The cost is absorbed by the employee.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Background checks are administered by the state's licensing agency.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how

the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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.

Medicaid Services Manual(MSM) Chapters 2300, Waiver for Persons with Physical Disabilities, 3100, Hearings, identifies the following circumstances under which Notice of Decision (NOD) must be made to a waiver participant or participant of an adverse action:

- Denial of waiver participation
- Termination of waiver services
- Reduction of waiver services
- Suspension of waiver services

The following language is included on the NOD:

If you disagree with Medicaid's denial, reduction, suspension or termination of service, you may request a Fair Hearing. A Fair Hearing allows you and Medicaid to give information about your situation to a Hearing Officer. The Hearing Officer is a neutral party who makes a decision on your appeal. There is no charge for a Fair Hearing.

Medicaid must receive your request within 90 calendar days from the Notice Date.

You may represent yourself or have the help of another adult. The adult can be a friend, family member, or lawyer. Medicaid has provided the names of some agencies that may be able to help you. (See below).

The request for a Fair Hearing must include: (1) your name, address, telephone number (2) Medicaid number; and (3) if someone is helping you, the name, telephone number and address of the adult who will help you (the "authorized representative"). You must sign the request unless you are unable to do so because of your disability. You may use the enclosed form to request a Fair Hearing.

If you want your services to stay the same during the Fair Hearing process, you must: 1) ask for a hearing not more than 10 calendar days after the Date of Action (shown on the Notice of Decision); and 2) you must ask that your services stay the same. (During the Fair Hearing process, your services will be continued). You may use the enclosed form to do this.

Medicaid may ask you to pay back the cost of the continued services if you lose your appeal.
After you have requested a Fair Hearing, Medicaid will contact you within 10 days to arrange a Hearing Preparation Meeting (HPM). The meeting will be by telephone. The goal of this meeting is to try to resolve your appeal. Medicaid will explain its decision and give you the chance to provide more information. If you and Medicaid cannot agree, you may go to a Fair Hearing. A Hearing Preparation Meeting (HPM) is optional. You do not have to take part in a HPM. You can let Medicaid know you want to go directly to a Fair Hearing and have a Hearing Officer decide your appeal.

To find out more about Medicaid appeals, you may go to the Nevada Department of Health and Human Services, Division of Health Care Financing & Policy's Medicaid Service Manual Chapter 3100 – Hearings at: https://dhcfp.nv.gov

DHCFP has a separate hearings unit located at Central Office. All waiver hearing requests are directed to that unit and are assigned out to a hearings representative. All hearing requests and outcomes are kept within a hearings database.

In addition, the Statement of Understanding, which is signed prior to service delivery, includes the following statements:

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 DHCFP, 1100 E. William Street, Suite 102, Carson City, NV 89701, within 90 calendar days from the Notice of Decision date.

I may obtain representation by legal counsel, or a friend, relative or other person, or I may represent myself.

The assigned case manager provides this information (in written form) with the recipient at the time of initial assessment. The recipient and/or designated representative is provided this information in the event that a hearing is requested. The ongoing ADSD case manager will maintain a copy of adverse actions that result in a hearings request. All documentation related to a hearing and/or hearing request is maintained by the DHCFP Hearings Unit.

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).

Alleged abuse, neglect and exploitation is addressed in the Nevada Revised Statutes (NRS) 200.5091, NRS 200.5092, and NRS 200.5093. NRS 200.5091 addresses the policy of the state surrounding identification of abuse, neglect, exploitation and isolation of older and vulnerable persons (60 and older) through reporting. It includes an extensive list of persons required to report these incidents. NRS 200.5092 defines abuse, exploitation, isolation and neglect, and self neglect while NRS 200.5093 defines certain occupations or employees as mandatory reporters of abuse, exploitation, isolation, neglect and self neglect. ADSD expects all providers to be in compliance with all applicable statutes. Reports of abuse, exploitation, isolation, neglect, and self neglect must be reported to the appropriate state oversight agency and the specified law enforcement agency.

Additionally, ADSD requires all waiver service providers to report all serious occurrences, including occurrences of suspected abuse, neglect, exploitation and isolation, as well as falls and injuries requiring medical attention, deaths, unplanned hospital visits, loss of contact, and theft or exploitation. The State has implemented a new Serious Occurrence Reporting (SOR) system that captures all reports submitted from Providers, the Public or reported to the Case managers. The paper form has been turned into an electronic format that is accessible to all Providers, Public and State staff via the DHCFP public facing website, the DHCFP's Fiscal Agent's website, and the ADSD's public Facing website. Once the SOR is completed and submitted electronically it will populate the internal system which is used as both a database and a SOR management system. Specific identified staff will be notified when a SOR is received so they can review, distribute as needed, and work as appropriate. This system will allow an assurance that the SOR's are being reported, recorded and responded to on a timely basis. This system will also allow the State to collect data more easily for reporting requirements.

Providers are required to report incidents or issues related the recipient's health, safety and welfare to the ADSD case manager with in twenty four (24) hours of discovery. A completed Serious Occurrence report/incident report must be made within five (5) working days and maintained in the case file. ADSD case managers have three (3) business days to follow up with the recipient and/or provider on the critical event.

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.

Case managers give each recipient an information page at the initial home visit which provides information to them if they suspect they are a victim of abuse, neglect, exploitation, or isolation. The informational page includes phone numbers of various agencies and other additional resources on how to report abuse, neglect, and exploitation. The information page is reviewed annually during the reassessment process/annual face-to-face home visit. This information page also includes the names and phone numbers of both the assigned case manager and the case manager supervisor.

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.

Providers are required to report incidents or issues related to the recipient's health, safety and welfare to ADSD within 24 hours of discovery. A completed Serious Occurrence Report (SOR) must be made within five (5) working days and maintained on file. The assigned case manager has three (3) business days to follow up with the recipient and/or provider on the SOR.

The case manager reviews the SOR to determine what follow up action is required. Supervisory staff reviews the adequacy and effectiveness of the case manager's response to all reports as a normal part of their supervisory reviews.

ADSD does not investigate allegations of abuse, neglect, or exploitation for individuals under the age of 60. For adults aged 60 and over, the Aging and Disability Services Division Elder Protective Services accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

For children under age 18, the Division of Child and Family Services and other county child protective service agencies accept reports of suspected abuse or neglect.

For all other individuals or vulnerable persons defined as a person 18 years of age or older who: (1) suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or (2) has one or more physical or mental limitations that restrict the ability of the person to perform the normal activities of daily living; local law enforcement agencies accept reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

Participant safeguards include initiation of investigation by local law enforcement, Elder Protective Services, or Child Protective Services. If the person who is reported to have abused, neglected, exploited or isolated an older person, child, or a vulnerable person is the holder of a license or certificate, the information contained in the final report must be submitted to the Board that issued the license.

The Department of Public and Behavioral Health (DPBH) is responsible for investigating complaints for state licensed facilities. ADSD staff is trained regarding the role of the DPBH and how to make appropriate referrals for investigation when events occur that may be considered licensing infractions.

The case manager review 100% of cases of death and evaluate if the death was of a suspicious nature, and if so, the case manager would gather any available facts, from family members, providers, and medical facilities, and refer to the appropriate agency for investigation and follow up, if applicable.

Trending reports of serious occurrences are reviewed quarterly during the quality management meetings which may identify areas needing change or system improvements.

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.

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. The number and type of events received by providers are entered into a database and summary reports are produced by type and by provider for review of trends and issues on a monthly basis. The State has implemented a new Serious Occurrence Reporting system that captures all reports submitted from Providers, the Public or reported to the case managers. The paper form has been turned into an electronic format that is accessible to all Providers, Public and State staff via the DHCFP public facing website, the DHCFP's Fiscal Agent's website, and the ADSD's public Facing website. Once the SOR is completed and submitted electronically it will populate the internal system which is used as both a database and a SOR management system. Specific identified staff will be notified when a SOR is received so they can review, distribute as needed, and work as appropriate. This system will allow an assurance that the SOR's are being reported, recorded and responded to on a timely basis. This system will also allow the State to collect data more easily for reporting requirements.

There is limited communication with Elder Protective Services (EPS) and Child Protective Services (CPS) with regards to critical events. EPS staff routinely provide informal status updates to ADSD QA staff on shared recipients. However, there not a formal oversight or process by which EPS/CPS regularly furnish the DHCFP or ADSD with information about critical incidents.

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 use of restraints or seclusion. Waiver case managers discuss the rights of recipients to be free from restraints or seclusion initially and annually. The recipient has the phone number of the case manager, and case manager supervisor, and is told to call if there are any problems or concerns. The case manager or supervisor will assess the situation and call the appropriate authorities, if applicable. The recipient also has numbers to Elder Protective Services (EPS) and local law enforcement.

If any occurrence of restraints or seclusion is discovered by case management staff, a report will be made to law enforcement immediately. The State will also report to the DPBH if the provider is licensed.

Additionally, the annual program reviews of a representative sample help to detect and remediate any systemic issues regarding restraints and seclusion.

○ **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 reporting process and through ongoing contacts with waiver recipients.

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.

The Assisted Living Service provider for this waiver is licensed as a residential facility for groups. The Bureau of Health Care Quality and Compliance (BHCQC) monitors medication management activities for residential facilities for groups as described in the following Nevada Administrative Code (NAC):

NAC449.2744Administration 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

NAC449.2742Administration 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.

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 BHCQC.

Additionally, medication errors resulting in injury, hospitalization, medical treatment or death would require that a serious occurrence report be submitted electronically to the Serious Occurrence Reporting system within 24 hours of discovery. The ADSD case manager will follow up as indicated and the supervisor will review for appropriateness.

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.

The Bureau of Health Care Quality and Compliance is responsible for oversight and follow up of medication management for providers licensed as a residential facility for groups. ADSD staff review medication logs and notify HCQC in the form of an Alert Memorandum if issues are identified.

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.

NAC449.2748Medication: 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 BHCQC.

Additionally, medication errors resulting in injury, hospitalization, medical treatment or death would require that a serious occurrence report be submitted electronically to the Serious Occurrence Reporting system within 24 hours of discovery. The ADSD 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).

Providers licensed as a residential facility for groups must follow the Nevada Administrative Code as noted.

Individuals who utilize the Assisted Living Service live in their own apartments or in a group home setting with lockable doors and have the choice to keep medications in their own living environment or have the provider keep the medication for them. In both instances, medications must be locked and not available to anyone other than the recipient or provider. If the provider keeps the medication, the provider is responsible for administering the medication per Nevada Administrative Code.

NAC449.2742Administration 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.

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:

Providers are responsible to report medication errors to the State of Nevada, Bureau of Health Care Quality and Compliance (HCQC).

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 BHCQC.

Additionally, medication errors resulting in injury, hospitalization, medical treatment or death would require that a serious occurrence report be submitted electronically to the Serious Occurrence Reporting system within 24 hours of discovery. The ADSD case manager will follow up as indicated and the supervisor will review for appropriateness.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are responsible to record all medication errors.

(c) Specify the types of medication errors that providers must *report* to the state:

Provider are responsible to self report all errors to HCQC.

○ **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:

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. The Bureau of Health Care Quality and Compliance is responsible to identify problems with provider performance and institute any necessary remediation activity as well as tracking and trending patterns for improvement.

Providers licensed as a residential facility for groups must ensure that staff who are administering medication are trained under the NAC.

Training requirements are:

Administrators and caregivers of assisted living receive, from a program approved by the BHCQC, 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 BHCQC.

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 States quality improvement strategy, provide information in the following fields to detail the States 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:
PM: 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. D: Total number of unexplained deaths reported through the SOR process.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Serious Occurrence Report

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**

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

Performance Measure:
Number and percent of recipients who received information about how to report A/N/E initially and annually thereafter. N: Total number of recipients who receive information on how to report A/N/E. D: Total number of recipients.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Recipient rights form.

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 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.

Performance Measure:
Number and percent of recipient serious occurrence reports that include appropriate follow up. N: Number of serious occurrence reports that received appropriate follow up.D: Number of serious occurrence reports requiring follow up.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Serious Occurrence Reports

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 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.

Performance Measure:
Number and percent of recipients who were free from restrictive interventions. N: Number of recipients free from restrictive interventions. D: Total number of recipients reviews.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Serious Occurrence Report

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**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **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**

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

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.

Performance Measure:
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):
Other
If 'Other' is selected, specify:
Recipient rights form

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.

Per NRS 200.5093, every employee adheres to reporting instances of abuse, neglect, and exploitation to the proper authorities. In Nevada, Aging and Disabilities Services Division Elder Protective Services is available for individuals age 60 and older. The Division of Child and Family Services (DCFS) for children up to age 18, and for those individuals between 19 years of age and 59, the police must be contacted.

Case managers seek to prevent instances of abuse, neglect, exploitation, isolation and ensure the health, welfare and safety via ongoing contacts with the recipients.

ADSD supervisors review a representative sample of ongoing case files which includes ongoing contacts, concerns, needs, follow-up action, and waiver services satisfaction. These reviews are captured on the Case File Review form and submitted to the QM committee as they are completed. QM committee reports this data at quarterly meetings.

Case managers report concerns of abuse, neglect, exploitation, or isolation to the appropriate state agency. Case managers and providers are also responsible for completing Serious Occurrence Report (SOR) forms. As case managers receive SORs from providers, they take appropriate follow-up action regarding the occurrence. The form identifies the type of occurrence and documentation of the case manager's follow-up action. These reports are sent to the Quality Assurrance Specialist for review.

Issues are discussed and prioritized at the QM meetings.

The DHCFP QA staff review a sample of ongoing case files during the annual waiver review. These reviews identify contacts, concerns, needs, follow-up action, and waiver satisfaction. If a Serious Occurrence was reported, the follow up action is reviewed as well as the monthly contact documentation. This is the verification of follow up to the Serious Occurrence and verification of addressing needs and concerns.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Case managers provide a copy of the HCBW Recipient Rights to all individuals at the initial home visit and annual home visits. The Recipient Rights includes the following statements: the right to not to be physically, sexually, or otherwise abused, not to be neglected, not to be exploited, and not to be isolated. In addition, this form provides contact information for who to contact, if they suspect they are being abused, neglected, or exploited. This form also includes the name and contact number for the case manager and the case manager supervisor so recipients can call if there are issues. Case managers are responsible for addressing issues and providing referrals if applicable. In some cases, a referral to another state agency, provider agency, or law enforcement is the appropriate action.

When abuse, neglect, and exploitation are identified on a Serious Occurrence Report, action is taken to protect the health and welfare of the recipient by verifying appropriate follow up is completed. Appropriate follow-up could mean a referral to the DPBH which is the state licensing agency. Appropriate follow-up could be a report to Division and Child and Family Services or Aging and Disability Services Division. Lastly, if the individual is between 19 and 59, appropriate follow-up is state or local law enforcement. These entities are tasked with investigation of reported incidents.

Education is completed to verify that providers are aware of the serious occurrence policy and that they have the information on how to submit an electronic SOR through the link provided on the DHCFP public facing webpage, the ADSD webpage and/or the DHCFP’s Fiscal Agents webpage. Reviewers also verify that serious occurrences are being completed, followed up on, and kept on file. Supervisors or QA staff review time frames for reporting serious occurrences. If a provider is not in compliance, education is offered and provided to the provider by case managers or supervisory staff.

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 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 3)

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; and
- 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 3)

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, through a benchmark in our Money Follows the Person (MFP) Grant, is working to build efficiencies and system wide improvement. Through this benchmark, a Multi-Agency Team called the Long Term Support Services Quality Management Team has been created. This group includes supervisory and administrative staff from the licensing agency, the operating agencies, and the State Medicaid Agency. The purpose of this high level group is to discuss systematic issues and make decisions on the best approach to provide improvement. The objective of this group is continuous improvement and open communication across multiple state agencies. This group is also functioning as a special projects committee, and has developed the consolidated review process.

Waiver 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 DHCFP participates in the QM meetings with members of the Managed Care and 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 groups meet in between quarterly meetings and progress is reported at each meeting.

Systematic problems are discussed and may be elevated to the Long Term Support Services Quality Management Team for discussion and recommendations if needed.

The purpose of the Committee is to:

- Identify waiver goals;
- Remediate issues and problems through policy development and clarification;
- Review program data for trending;
- Identify staff training needs and program changes;
- Discuss and identify program improvements; and
- Set priorities for system improvement.

The Committee is responsible for:

- Updating of waiver processes to specifically address CMS assurance components;
- Standardizing education, training and quality systems;
- Monitoring the results of supervisory level monitoring and designing statewide reports;
- Improving program performance and ensuring efficiency; and
- Implementation of waiver assurance monitoring for the health and welfare of recipients.
- In some cases, a work group may be established to identify possible solutions to needed improvements.

Documentation of meeting minutes, decisions, and agreements are maintained.

The DHCFP will conduct a consolidated review process beginning 07/01/15. The State will consolidate the reviews of this waiver with The Waiver for the Frail Elderly 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 the optional information section. This process is described in Main: B - Optional.

The DCHFP has several units. Those units include: Managed Care and Quality, which includes the Quality Assurance Unit, and Long Term Support Services, which includes Waiver Operations.

The separation of waiver operations and QA within two different units removes conflict of interest.

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.

ADSD and the DHCFP are responsible for monitoring and analyzing the effectiveness of system design changes and for reporting the results to each division's administration. Results are shared across waiver programs in order to promote best practices and system design improvements.

Results of quality improvement activities are shared with stakeholders and providers by using both the fiscal agent and DHCFP websites.

The DHCFP and ADSD utilize a variety of resources to prioritize HCBW quality improvement activities. Results from annual waiver reviews and analysis of performance measure data guides the DHCFP and ADSD in assessing problem areas and prioritizing program improvements. Timelines, resource allocation and project planning are used to accompany each system improvement so that progress towards implementation can be tracked and measured for impact.

Clients, advocates and other stakeholders are encouraged to provide feedback regarding the care and services received. This feedback is evaluated to determine if system design changes will result in improvement in waiver service provision.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The DHCFP has developed a system wide Home and Community Based Service (HCBS) Long Term Support Services (LTSS) quality improvement system which includes members from all waiver operational areas as well as members from the state licensing division. This group meets quarterly and discusses and recommends high level system improvements. The LTSS committee uses feedback from the quarterly Quality Management meetings, as well as information from the current processes to evaluate the effectiveness, efficiency and appropriateness of the quality activities and updates these activities on an as needed basis.

The ADSD Quality Management Committee meets quarterly and is responsible for: data analysis, goal setting, monitoring outcomes and identifying problem areas. Identified issues that cannot be resolved in this committee and forwarded to the LTSS for direction.

The Quality Improvement Strategy is reviewed and update annually, based on information gathered from all of the activities completed throughout the year, and the annual waiver review. If there were no serious concerns, the Strategy may not change. If additional items need to be monitored, DHCFP and ADSD will modify the Strategy to include this additional monitoring.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

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).*

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. 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 policy.

The financial review utilizes the statewide random sample selected for the program review. The random sample is selected from the total population of active participants. A list of claims paid is produced from the Medicaid Management Information System (MMIS) for each sample case for all waiver services for one chosen month. A sample month is randomly selected for each recipient in the sample. All waiver claims for that sample month for that participant are examined, in conjunction with the POC and daily record documentation.

The results of the financial review are included in the final waiver review report. The final report is presented to the QM committee, District Office managers, the Chief, Long Term Support Services, DHCFP administration and to CMS. The QM Committee assesses the seriousness and pervasiveness of 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 financial review are provided to DHCFP Surveillance and Utilization Review (SUR) Unit. The DHCFP SUR unit has a protocol in place to recoup payment when a provider is fraudulently or inappropriately billing the State.

Additionally, 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) The Division of Health Care Financing and Policy Quality Assurance Unit is responsible for conducting the financial review, during the annual review process. The Legislative Counsel Bureau (LCB) is responsible for Single Audit Act reviews.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(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:
PM: 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):*
Financial records (including expenditures)
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***

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:*

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.

Performance Measure:
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 of provider payment rated 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***
	☐ ***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.*

The DHCFP's Quality Assurance Unit reviews all financial claims for a randomly selected month on a random sample of total recipients. This includes any and all waiver services received during that selected month.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States 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 QM staff serve as a resource for providers by providing on-site technical assistance during reviews and provider education on an as-needed or as-requested basis year-round.

ADSD supervisors and the DHCFP QA staff review a random sample of ongoing cases annually. If an error is noted with eligibility or with the identification of time spent doing activities associated with direct service case management, this is remediated on a case by case basis immediately by the case manager. ADSD supervisors indicate the needed corrections and verify that corrections were made. This is documented on the Case File Review Tool.

If errors are made by a provider, the provider may receive an education letter notifying them of the error and how to correct it. Ongoing errors of the same nature are referred for recoupment and/or suspension/termination as a Medicaid provider.

If claims are discovered to be incorrect, a referral is made to the Surveillance and Utilization Recovery Unit (SURS) within DHCFP. This Unit investigates overpayments and underpayments. This unit will recoup funds providers are not entitled to. In addition, DHCFP's fiscal agent will provide training to providers on billing procedures. 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 the MMIS system during the annual review, there is a mechanism in place to correct these issues. The errors that have been noted in the past include incorrect rates, payments edits that are not functioning, or payment edits that need to be included so claims pay appropriately. When these types of errors are noted, a form called the Production Discrepancy Report (PDR) is completed which identifies the nature of the problem. The PDR is submitted to DHCFP's fiscal agent for a Scope of Work which outlines the amount of time and cost to fix the system. Once that is approved by DHCFP IT staff, the work is prioritized.

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***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☐ ***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 Division of Health Care Financing and Policy (DHCFP) determines all rates. All rates are listed by provider type and rates for this waiver and are located on the DHCFP internet website. The specific rates address is: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

State Plan Services Rate Methodology:
The rate methodology for State Plan Medicaid Services is outlined in Nevada's State Plan. All State Plan Amendments regarding Rate Methodology creation or changes are subject to Public Hearing. The public comments are solicited through the Public Hearing process. Some rate determination methodologies are also presented at Public Workshops.

Waiver Rates: Date of last rate review: January 2017
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. The DHCFP does not have access to the full documentation provided by that vendor, either due to employee attrition or state record retention codes. The DHCPF does use a general methodology state regarding the initial rate setting: Rates for waiver providers were recommended by the Provider Rates Task Force and adopted by DHCFP. The task force provided the following recommendations for rates setting in the future: 1) Require providers to submit cost information annually to the State so the State can develop a baseline of information on the industry, 2) The State shall rebase rates no less frequently than every 5 years, and 3) For years that rates are not rebased, rates shall be increased by an independent inflation index. It must be noted that waiver rates have not increased in the last five years.

Beginning January 2018, Nevada has in place a statue requiring cost model rate reviews of all rates on a four year cycle. This plan is currently under review for publication prior to the January 2018 implementation.

The rates for all services are increased by the 2006 Consumer Price Index (CPI) for medical care to allow a rate increase of 4.10% for each year; however, the rates will not be adjusted without legislative approval. The inflation factor is from the U.S. Department of Labor, Bureau of Labor Statistics, 2006 Consumer Price Index -All Urban Consumers (not seasonally adjusted), 12 months percent change, U.S. City average for Medical Care Services. However, the rate will not be adjusted without legislative approval.

These activities are required by both CMS regulation and as of January 1 2018, Nevada statute. DHCFP rate staff uses DSS Reporting and periodically analyze number of claims paid, net payments to billing providers, service count, the number of patients, total expenditures and estimated cost per patient. If the report indicates a drop in the number of claims, patients or billing providers by 25%, the DHCFP will first verify that it is not due to a seasonal phenomenon, and if it is a local or statewide impact. If it is not related to a seasonal phenomenon, the DHCFP will query the District Offices and the Fiscal Agent staff to determine if access issues are being reported. If no access issues are being reported, the DHCFP will continue to track the data and make ongoing public inquiries through public forums, workshops, council meetings which also address provider issues/concerns.
In addition, Medicaid Management Information System (MMIS), which tracks all Medicaid providers, including Waiver providers, from initial enrollment to revalidation and tracks the adequacy of qualified providers. As of 4/2018, of the 180 NV PT 58 providers, 19 closed, which is 11% of the total providers. Based on MMIS provider information screen, some of these providers have been NV Medicaid PT 58 providers since early 2000. In addition to being PT 58 providers, 16 are also PT 83 providers – Intermediary Services Organization (ISO). ISO providers act as billing providers and geared towards a Self-Directed Model, which allows Waiver recipients to direct their own care and recruit their own qualified providers. PD Waiver recipients, who are living in the rural areas, are able to receive waiver services through an ISO agency. Because of the geographical location of some of the waiver recipients, mileage reimbursement is also available for caregivers that travel long distance to provide personal care services to waiver recipients in their homes.
The state also monitors billed claims for fluctuations in utilization of waiver services through reports obtained from MMIS and financial reviews conducted by DHCFP Quality Assurance (QA) unit annually. Further, ADSD's QA unit reviews waiver providers annually to ensure providers are in-compliance with the approved waiver, Medicaid policies and licensure requirements. Recipients are surveyed annually utilizing the Participant Experience Survey (PES) to ensure their health, safety and welfare. Any discrepancies found are reported to the the state's licensure agency, or DHCFP Surveillance Utilization Review unit or LTSS unit.

Waiver Service Rates:
Rates will not be adjusted without legislative budget approval. The rates submitted in the renewal have been established and utilized since 2000 in previously submitted waiver renewals and amendments.

Case Management – Public Providers:
The rates for public providers are expected to be higher than those described for private providers. This is due in part to the generally higher administrative costs of public providers and also due to the productivity based on the clientele served. Geographically, Nevada is composed primarily of rural and frontier areas. Experience has been that private providers will not render many services in these areas. The State invariably is the sole provider of case management services for many of these rural and frontier communities. Travel then becomes a large factor in the productivity of public providers serving these areas.
The case management rate for DHCFP employees is based on the Allocap Case Management cost pool in time tracking for each quarter. Case managers indicate the amount of time they spend doing direct services case management by pay period. That information is gathered quarterly and averaged. The rate is a blended rate among all case managers and is increased for years 2, 3, 4, and 5 by 3.4 percent.

Case Management – Private Providers:
Any willing and qualified provider may enroll as a Medicaid provider and provide Direct Service case management. The rate for case management for private providers is based on a market basket model and consistent with the rates established for the 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 1 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 and is increased for years 2, 3, 4, and 5 by 3.4 percent.
The State believes these rates are sufficient to ensure access to services for recipients while still being consistent with efficiency, economy, and quality of services. The State will review the appropriateness of this rate based on future experience with this waiver. To date, no private providers have participated in service delivery.

Assisted Living Services
The rates for these services are comparable to similar services available in the Home and Community Based Waiver for the Frail Elderly. The rates for these services are existing, long established rates for Assisted Living Services. The existing rates are appropriate for services provided and 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.
Applicable Nevada waiver rate structures and applicable regulations were reviewed. Stakeholder input was obtained from Public Workshops and Public Hearings. Cost surveys of appropriate and interested providers were conducted and well as other state Medicaid programs. The resulting cost models were market based and competitive. Subsequent rate reviews have been conducted on an as needed basis responding to both provider inquiry and access to care concerns; the latter due to both access complaints as well as utilization reviews.

Personal Emergency Response System (PERS) and Installation
The rate calculation for PERS is based on the actual cost of the provider in 2000 which assumes a 10 month life average per year. The installation rate is based on the actual installation costs equal the cost of one month of service.
http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/Rates/PT%2058%20WIN%20Waiver%20-%2004042017.pdf

Respite Care, Chore Service, Home Delivered Meals and Home Modifications
These rates are based on actual costs charged by the provider to Aging and Disability Services Division (ADSD). These rates have not been increased since the previous waiver renewal. There is a maximum allowable rate for these services.

Applicable Nevada waiver rate structures and applicable regulations were reviewed. Stakeholder input was obtained from Public Workshops and Public Hearings. Cost surveys of appropriate and interested providers were conducted and as well as other state Medicaid programs. The resulting cost models were market based and competitive. Subsequent rate reviews have been conducted on an as needed basis responding to both provider inquiry and access to care concerns; the latter due to both access complaints as well as utilization reviews.

Per CMS request, the state conducted a survey of 2 neighboring states (Idaho and Utah) with similar waiver services was

undertaken to compare rates for the current renewal period. Along with their geographic proximity to Nevada, both were selected for their similarity in offered waiver services and fee-for-service reimbursement structure. Utah's Physical Disability Waiver and Idaho's Aged and Disabled Waiver allowed for rate comparison of all direct care services including Chore, Attendant Care, Homemaker, Respite, Case-Management and Home-Delivered Meals. Direct rate comparison was also possible for Emergency Response System across both states. Comparisons of Utah's Home Modifications and Assisted Living services with Nevada's rates were made; however, no suitable comparison with Nevada's Personal Care/Specialized Equipment was realized. Where rates were comparable across all 3 states, Nevada's rates were within -1% from the average.

For Cost Study: please see "B. Optional" under the "Main" section for details.

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 the 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. Submit claims weekly or monthly.
2. 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. Case managers have a system in place to track administrative activities and direct service activities. Each case manager has a billing work book. 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 case managers bill the above listed administrative activities based on the approved cost allocation plan through DHCFP fiscal unit. Case managers use a time tracking system to account for their time. This is done on a daily basis and submitted for supervisor approval bi-weekly and forward to the ADSD 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 and that there was an active prior authorization for the service in question.

The recipient and provider subsystems within MMIS record various benefit plans, reflects 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 rates of the service.

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 record or signed timesheet to verify that services were provided in accordance with the POC.

c) As part of the provider review, samplings of provider billings are compared to the claims paid system for determination of accuracy. These reviews verify that services were provided and billed as authorized on the POC during the annual provider reviews. The billing validation process also includes comparing ADL logs with prior authorizations, the Plan of Care and MMIS records.

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 of service on the claim is within the eligibility dates identified in the benefit plan and the services billed are included in the benefit plan.

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.***

☒ ***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 staff provides case management as a waiver service. Case management is broken up into Administrative and Direct Service. (Reference I-2.b for a breakdown of Administrative and Direct Services). The type of case management provided is tracked in an electronic time sheet. Only Direct Service case management is billed as a waiver service.

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.

- ◉ ***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.***

○ ***This waiver is a part of a concurrent ?1115/?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 ?1115 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:*

☒ ***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:

☒ ***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.

The 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.

The DHCFP updated the contracts of all 17 Nevada counties which will take effect on July 1, 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:

a) Nevada counties are responsible for a portion of waiver costs. b) The sources of revenue are local or county tax revenues. c) Funds are transferred to the state by the counties.

☐ ***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:

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:*

Assisted Living Services are provided as a waiver service, in a residential setting, under this waiver. The DHCFP policy clearly states reimbursement cannot include room and board or the cost of the building maintenance, upkeep, or improvement. A daily rate has been established which covers the cost of services included in the Assisted Living Services definition. The MMIS payment system ensures the payments do not exceed the allowable daily rate.

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	9328.33	24815.00	34143.33	60715.00	25686.00	86401.00	52257.67
2	8750.90	25750.00	34500.90	62633.00	32051.00	94684.00	60183.10
3	7875.86	26721.00	34596.86	64613.00	39993.00	104606.00	70009.14
4	6959.08	27728.00	34687.08	66654.00	49903.00	116557.00	81869.92
5	6103.00	28774.00	34877.00	68761.00	62270.00	131031.00	96154.00

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	875	875
Year 2	966	966

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 3	1114	1114
Year 4	1318	1318
Year 5	1579	1579

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.*

Average length of stay is based on the total days of waiver coverage divided by the unduplicated number of recipients served based on the CMS 372 (3c) data for the period of January 1, 2014 through December 31, 2014. The average length of stay in waiver year 2014was 313.8 days (rounded up to 314). The same number of days is used to project average length of stay for all 5 years of the renewal period.

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 and methodology for these estimates is as follows:*

Users per waiver service:

For each waiver service, the number using the service is estimated using the average percentage of users to unduplicated counts of recipients for calendar years 2010-2014. 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 calendar years 2010-2014. The same ratio is applied to the forecasted number of participants for each year.

Average cost per unit:
For years one - five, the current payment rates are used. There are no changes expected to current waiver rates.

The state demonstrates cost neutrality as the waiver costs (D+D')are less than the cost of institutional care (G+G'). The State completes the 372 report annually to demonstrate the costs for factor D' are less than the costs for factor G'. The State used a five (5) year average from the previously approved waiver and projected forward. The State expects costs for factor G' to continue to be higher than factor D' as the cost for G' are for costs of institutional care incurred by individuals with a skilled need and higher level of care need.

The state currently does not have a rate methodology explanation available for this existing fee schedule and the detailed plan to establish a new rate methodology is described in Main/Optional

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 calendar years 2010 - 2014. The cost of prescription medication furnished to dual eligible's is not included in factor D'.

The average cost of Medicaid costs for all other services provided to individuals in the waiver program are from calendar years 2010 - 2014. The average cost is increase by the medical care services CPI of 1.9% for each year of the waiver. The inflation factor is from the U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index-All Urban Consumers, 12 months percent change, U.S. City cy expenditure category. The Consumer Price Index indicates a 1.9% growth in medical care.

Each year of the waiver is increased based on the average of the calendar years 2010 - 2014. There are no changes expected to current waiver rates.

D' is an estimated annual average per capita Medicaid cost for all services that are furnished under the waiver. The data provided shows the utilization rather consistent for services with an average increase of 3.77%.

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 calendar years 2010 - 2014.

Each year of the waiver is increased based on the average of the calendar years 2010-2014. There are no changes expected to current waiver rates.

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 from calendar years 2010-2014. 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 calendar years 2010-2014. The average cost is increase by the medical care services CPI of 1.9% for each year of the waiver. The inflation factor is from the U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index-All Urban Consumers, 12 months percent change, U.S. City cy expenditure category. The Consumer Price Index indicates a 1.9% growth in medical care.

Each year of the waiver is increased based on the average of the calendar years 2010-2014. There are no changes expected to current waiver rates.

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	
Attendant Care Services	
Assisted Living Services	
Chore Services	
Environmental Accessibility Adaptations	

Waiver Services	
Home Delivered Meals	
Personal Emergency Response Systems (PERS)	
Specialized Medical Equipment and Supplies	

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:						**4091288.75**
Case Management Public	15 minutes	739	215.00	25.75	**4091288.75**	
Case Management Private	15 minutes	0	0.00	15.84	**0.00**	
Homemaker Total:						**320542.50**
Homemaker	15 minutes	158	541.00	3.75	**320542.50**	
Respite Total:						**135268.32**
Respite	15 minutes	136	274.00	3.63	**135268.32**	
Attendant Care Services Total:						**2115655.35**
Non-Agency	15 minutes	0	0.00	4.63	**0.00**	
Agency	15 minutes	205	2229.00	4.63	**2115655.35**	
Assisted Living Services Total:						**426615.00**
Assisted Living Services	Day	17	239.00	105.00	**426615.00**	
Chore Services Total:						**4612.50**
Chore Services	15 minutes	41	30.00	3.75	**4612.50**	
Environmental Accessibility Adaptations Total:						**93670.00**
Environmental Accessibility Adaptations	Annual	29	1.00	3230.00	**93670.00**	

GRAND TOTAL:	**8162292.42**
Total Estimated Unduplicated Participants:	**875**
Factor D (Divide total by number of participants):	**9328.33**
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:						**762375.00**
Home Delivered Meals	per meal	535	285.00	5.00	**762375.00**	
Personal Emergency Response Systems (PERS) Total:						**186840.00**
PERS Installation	install	168	1.00	45.00	**7560.00**	
PERS Monthly Fee	monthly	498	9.00	40.00	**179280.00**	
Specialized Medical Equipment and Supplies Total:						**25425.00**
Specialized Medical Equipment and Supplies	Annual	45	1.00	565.00	**25425.00**	
				GRAND TOTAL:		**8162292.42**
				Total Estimated Unduplicated Participants:		**875**
				Factor D (Divide total by number of participants):		**9328.33**
				Average Length of Stay on the Waiver:		314

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:						**4061573.25**
Case Management Public	15 minutes	777	203.00	25.75	**4061573.25**	
Case Management Private	15 minutes	0	0.00	15.84	**0.00**	
Homemaker Total:						**422295.00**
Homemaker	15 minutes	188	599.00	3.75	**422295.00**	
Respite Total:						**139304.88**
Respite	15 minutes	164	234.00	3.63	**139304.88**	
Attendant Care Services						**2280821.34**
				GRAND TOTAL:		**8453371.97**
				Total Estimated Unduplicated Participants:		**966**
				Factor D (Divide total by number of participants):		**8750.90**
				Average Length of Stay on the Waiver:		314

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Non-Agency	15 minutes	0	0.00	4.63	**0.00**	
Agency	15 minutes	222	2219.00	4.63	**2280821.34**	
Assisted Living Services Total:						**430920.00**
Assisted Living Services	Day	18	228.00	105.00	**430920.00**	
Chore Services Total:						**5512.50**
Chore Services	15 minutes	49	30.00	3.75	**5512.50**	
Environmental Accessibility Adaptations Total:						**96900.00**
Environmental Accessibility Adaptations	Annual	30	1.00	3230.00	**96900.00**	
Home Delivered Meals Total:						**788175.00**
Home Delivered Meals	per meal	565	279.00	5.00	**788175.00**	
Personal Emergency Response Systems (PERS) Total:						**199620.00**
PERS Installation	install	188	1.00	45.00	**8460.00**	
PERS Monthly Fee	monthly	531	9.00	40.00	**191160.00**	
Specialized Medical Equipment and Supplies Total:						**28250.00**
Specialized Medical Equipment and Supplies	Annual	50	1.00	565.00	**28250.00**	

GRAND TOTAL:	**8453371.97**
Total Estimated Unduplicated Participants:	**966**
Factor D (Divide total by number of participants):	**8750.90**
Average Length of Stay on the Waiver:	314

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:						**4044192.00**
Case Management Public	15 minutes	818	192.00	25.75	**4044192.00**	
Case Management Private	15 minutes	0	0.00	15.84	**0.00**	
Homemaker Total:						**557760.00**
Homemaker	15 minutes	224	664.00	3.75	**557760.00**	
Respite Total:						**143029.26**
Respite	15 minutes	198	199.00	3.63	**143029.26**	
Attendant Care Services Total:						**2455752.00**
Non-Agency	15 minutes	0	0.00	4.63	**0.00**	
Agency	15 minutes	240	2210.00	4.63	**2455752.00**	
Assisted Living Services Total:						**410130.00**
Assisted Living Services	Day	18	217.00	105.00	**410130.00**	
Chore Services Total:						**6750.00**
Chore Services	15 minutes	60	30.00	3.75	**6750.00**	
Environmental Accessibility Adaptations Total:						**96900.00**
Environmental Accessibility Adaptations	Annual	30	1.00	3230.00	**96900.00**	
Home Delivered Meals Total:						**814905.00**
Home Delivered Meals	per meal	597	273.00	5.00	**814905.00**	
Personal Emergency Response Systems (PERS) Total:						**213210.00**
PERS Installation	install	210	1.00	45.00	**9450.00**	
PERS Monthly Fee	monthly	566	9.00	40.00	**203760.00**	
Specialized Medical Equipment and Supplies Total:						**31075.00**
Specialized Medical Equipment and Supplies	Annual	55	1.00	565.00	**31075.00**	

GRAND TOTAL:	**8773703.26**
Total Estimated Unduplicated Participants:	**1114**
Factor D (Divide total by number of participants):	**7875.86**
Average Length of Stay on the Waiver:	314

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:						***4035076.50***
Case Management Public	*15 minutes*	*861*	*182.00*	*25.75*	***4035076.50***	
Case Management Private	*15 minutes*	*0*	*0.00*	*15.84*	***0.00***	
Homemaker Total:						***733162.50***
Homemaker	*15 minutes*	*266*	*735.00*	*3.75*	***733162.50***	
Respite Total:						***147486.90***
Respite	*15 minutes*	*239*	*170.00*	*3.63*	***147486.90***	
Attendant Care Services Total:						***2648360.00***
Non-Agency	*15 minutes*	*0*	*0.00*	*4.63*	***0.00***	
Agency	*15 minutes*	*260*	*2200.00*	*4.63*	***2648360.00***	
Assisted Living Services Total:						***393120.00***
Assisted Living Services	*Day*	*18*	*208.00*	*105.00*	***393120.00***	
Chore Services Total:						***8100.00***
Chore Services	*15 minutes*	*72*	*30.00*	*3.75*	***8100.00***	
Environmental Accessibility Adaptations Total:						***100130.00***
Environmental Accessibility Adaptations	*Annual*	*31*	*1.00*	*3230.00*	***100130.00***	
Home Delivered Meals Total:						***844200.00***
Home Delivered Meals	*per meal*	*630*	*268.00*	*5.00*	***844200.00***	
Personal Emergency						***227970.00***

GRAND TOTAL:	***9172070.90***
Total Estimated Unduplicated Participants:	***1318***
Factor D (Divide total by number of participants):	***6959.08***
Average Length of Stay on the Waiver:	*314*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response Systems (PERS) Total:						
PERS Installation	install	234	1.00	45.00	**10530.00**	
PERS Monthly Fee	monthly	604	9.00	40.00	**217440.00**	
Specialized Medical Equipment and Supplies Total:						**34465.00**
Specialized Medical Equipment and Supplies	Annual	61	1.00	565.00	**34465.00**	
				GRAND TOTAL:		**9172070.90**
				Total Estimated Unduplicated Participants:		**1318**
				Factor D (Divide total by number of participants):		**6959.08**
				Average Length of Stay on the Waiver:		314

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:						**4012674.00**
Case Management Public	15 minutes	906	172.00	25.75	**4012674.00**	
Case Management Private	15 minutes	0	0.00	15.84	**0.00**	
Homemaker Total:						**965775.00**
Homemaker	15 minutes	316	815.00	3.75	**965775.00**	
Respite Total:						**151588.80**
Respite	15 minutes	288	145.00	3.63	**151588.80**	
Attendant Care Services Total:						**2849255.70**
Non-Agency	15 minutes	0	0.00	4.63	**0.00**	
Agency	15 minutes		2190.00	4.63	**2849255.70**	
				GRAND TOTAL:		**9637421.00**
				Total Estimated Unduplicated Participants:		**1579**
				Factor D (Divide total by number of participants):		**6103.00**
				Average Length of Stay on the Waiver:		314

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		281				
Assisted Living Services Total:						**395010.00**
Assisted Living Services	Day	19	198.00	105.00	**395010.00**	
Chore Services Total:						**9787.50**
Chore Services	15 minutes	87	30.00	3.75	**9787.50**	
Environmental Accessibility Adaptations Total:						**100130.00**
Environmental Accessibility Adaptations	Annual	31	1.00	3230.00	**100130.00**	
Home Delivered Meals Total:						**871150.00**
Home Delivered Meals	per meal	665	262.00	5.00	**871150.00**	
Personal Emergency Response Systems (PERS) Total:						**243630.00**
PERS Installation	install	262	1.00	45.00	**11790.00**	
PERS Monthly Fee	monthly	644	9.00	40.00	**231840.00**	
Specialized Medical Equipment and Supplies Total:						**38420.00**
Specialized Medical Equipment and Supplies	Annual	68	1.00	565.00	**38420.00**	

GRAND TOTAL:	**9637421.00**
Total Estimated Unduplicated Participants:	**1579**
Factor D (Divide total by number of participants):	**6103.00**
Average Length of Stay on the Waiver:	314