372 - Annual Report on Home and Community-Based Services Waivers

State:	**NV**
Waiver Base:	**4150**
Report Status:	**ACCEPTED**
Begin Date:	01/01/2012
End Date:	12/31/2012
Initial Submission Date:	05/20/2014
Report Period Year:	2012
Waiver Year:	○ Year 1 ○ Year 2 ○ Year 3 ○ Year 4 ◉ Year 5
Report Type:	○ Initial Report ◉ Lag Report ○ TE Report
Unduplicated Participants:	583
Days of Waiver Enrollment:	190,564
Average Length of Stay:	326.9
Total Waiver Expenditures:	$3,354,271.00
APC Waiver Services (Factor D):	5,753
APC for State Plan Services (D'):	21,439
APC Total (D + D'):	$27,192
Factor G Value:	56,423
Factor G' Value:	10,621
APC Total if no waiver (G + G'):	$67,044
D + D' <= G + G':	**$27,192 <= $67,044**

Level/s of Care:

- ☐ **ICF/IID**
- ☑ **NF**
- ☐ **Hospital**

Additional Information (use if needed):

This waiver is legislatively funded for 579 slots. Additional slots were approved by the Nevada State Legislature and become effective July 1, 2013. Currently, the capacity is 649 with all slots filled.

Private case management was not utilized during this period due to lack of qualified providers enrolled with Nevada Medicaid.

Providers direct bill the Division of Health Care Financing and Policy's (DHCFP) QIO-like vendor for payment. DHCFP case managers perform service authorizations as an administrative function of the waiver. These authorizations include frequency and level of service which are billed using specific modifiers in order to determine the appropriate daily rate.

Direct service case management duties are separate from administrative case management duties and are tracked separately in the State's Time Tracking System.

All rates remained the same during this fiscal year.

The waiver costs associated with the number of recipients served were less than institutionalization. This waiver remains cost neutral.

Note: Average Per Capita (APC)

Annual Number of Section 1915c Waiver Recipients and Expenditures:
(Specify each service as in the approved waiver)

Service

Service Name (no longer a required field):	Level of Care	Expenses in $	Participants	Service Category Name
Assisted Living	NF	$461,475	14	

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (no longer a required field):	Level of Care	Expenses in $	Participants	Service Category Name
Attendant Care	NF	$1,597,419	143	

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (no longer a required field):	Level of Care	Expenses in $	Participants	Service Category Name
Chore / Home Maintenance	NF	$2,635	26	

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (no longer a required field):	Level of Care	Expenses in $	Participants	Service Category Name
Environmental Adaptations / Home Modifications	NF	$37,128	28	

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (no longer a required field):	Level of Care	Expenses in $	Participants	Service Category Name
Home Delivered Meals	NF	$594,960	395	

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (no longer a required field):	Level of Care	Expenses in $	Participants	Service Category Name
Homemaker	NF	$37,128	98	

HCBS Taxonomy:

Category 1: Subcategory 1:
Category 2: Subcategory 2:
Category 3: Subcategory 3:
Category 4: Subcategory 4:

Service Name (no longer a required field):	Level of Care	Expenses in $	Participants	Service Category Name

Service				
Personal Emergency Response System (PERS) If Other, specify: **This is the monthly service.**	**NF**	$131,786	395	

HCBS Taxonomy:

Category 1:	Subcategory 1:
Category 2:	Subcategory 2:
Category 3:	Subcategory 3:
Category 4:	Subcategory 4:

Service Name (no longer a required field):	Level of Care	Expenses in $	Participants	Service Category Name
Personalized Emergency Response Systems If Other, specify: **This is installation.**	**NF**	$1,710	37	

HCBS Taxonomy:

Category 1:	Subcategory 1:
Category 2:	Subcategory 2:
Category 3:	Subcategory 3:
Category 4:	Subcategory 4:

Service Name (no longer a required field):	Level of Care	Expenses in $	Participants	Service Category Name
Respite Care	**NF**	$83,484	76	

HCBS Taxonomy:

Category 1:	Subcategory 1:
Category 2:	Subcategory 2:
Category 3:	Subcategory 3:
Category 4:	Subcategory 4:

Service Name (no longer a required field):	Level of Care	Expenses in $	Participants	Service Category Name
Specialized Medical Equipment and Supplies	**NF**	$5,023	20	

HCBS Taxonomy:

Category 1:	Subcategory 1:
Category 2:	Subcategory 2:
Category 3:	Subcategory 3:
Category 4:	Subcategory 4:

Service Name (no longer a required field):	Level of Care	Expenses in $	Participants	Service Category Name
Case Management	**NF**	$401,523	583	

HCBS Taxonomy:

Category 1:	Subcategory 1:
Category 2:	Subcategory 2:
Category 3:	Subcategory 3:
Category 4:	Subcategory 4:

Assurances:

1. ☑ **Assurances were submitted with the initial report. (If you are submitting a lag report this item must be checked.)**
2. ☑ **All provider standards and health and welfare safeguards have been met and corrective actions have been taken where appropriate**
3. ☑ **All providers of waiver services were properly trained, supervised, and certified and/or licensed, and corrective actions have been taken where appropriate.**

Documentation:

4. **Provide a brief description of the process for monitoring the safeguards and standards under the waiver:**
Monitoring:

The DHCFP Central Office reviews 100% of all applications for waiver services for completeness and conducts a 25% content review. There were 98 applications submitted in 2012. Out of these 98 applications 26 were reviewed for content.

The only noted concerns were in the area of scope, frequency, and duration. This was discussed operationally and determined that this measure is to be removed from this particular review because the majority of these recipients will receive State Plan Personal Care, and case managers need the State Plan Functional Assessment before they determine scope, frequency and duration of waiver services. This area is included in the annual supervisory review and waiver review.

District Office supervisors review a representative sample of ongoing case file reviews annually. A total of 216 chart reviews were completed by supervisors in 2012. As noted the previous year, the lowest percentage was personalize goals identified on the Plan of Care which was noted at 83% compliance. In 2013, the corrective action was the creation of a new Plan of Care document which is more comprehensive and specifically includes an area for personalized goals, so case managers must address that area.

Hearings:

DHCFP monitors hearings and appeals for waiver services. In 2012, there were twelve (12) hearing requests. One (1) resulted in a no-show for the pre-hearing conference and was dropped. Eight (8) were withdrawn by the petitioner at the pre-hearing conference after discussion and clarification was provided by the State. Two (2) were settled at the pre-hearing conference in the State's favor. One (1) was not resolved at the pre-hearing conference and proceeded to fair hearing. This case was affirmed in the State's favor.

Claims:

Case managers complete a prior authorization for waiver services, based on the identified needs in the Plan of Care. Costs of waiver services are based on state payment for waiver services authorized. Those services are rendered to waiver recipients, and properly billed by qualified providers, in accordance with the approved waiver.

Waiver Review:

An annual review that includes a case file review, recipient surveys, provider reviews, and financial reviews was conducted in March of 2013 for waiver year 2012.

A random statistically significant sample of waiver recipients was selected from the population who were served during the waiver year. From a population of 600 unduplicated participants served during the 2012 waiver year; 80 recipient files were reviewed, 31 recipients were interviewed utilizing the Personal Experience Survey (PES), 17 providers were reviewed, and 32 financial reviews were completed.

Findings of Monitoring:

5. ☐ **No deficiencies were detected during the monitoring process;**
6. ☑ **Deficiencies were detected.**

Provide a summary of the significant areas where deficiencies were detected, (Note: Individual reports or assessment forms for waiver individuals and/or providers disclosing deficiencies and which document the summary are not necessary):
Chart Reviews

There were two areas that fell below 94% which were safety risks assessed on the POC (90%) and POC signed by recipient (93%).

Financial Reviews:

There was one area noted to be less than 94% compliance and that was Medicaid Payment to Provider

Correct (84%).

Recipient Surveys

A focus of HCBS is recipient satisfaction with their services and achievement of desired outcomes. Recipients were interviewed concerning their experiences with their waiver services and providers.

The review tool used for recipient interviews is the Participant Experience Survey (PES), developed by Medstat Group, Inc. This form has all of the elements required to determine if the desired outcomes are being achieved.

Key factors DHCFP is required to ensure are:

• Access to Care: What services is the participant receiving? Is he or she getting the help that is needed related to personal assistance, adaptive equipment, and case manager access?
• Choice and Control: Do program participants have input into the types of services they receive and who provides them?
• Respect/Dignity: Are program participants treated with respect by providers?
• Community Integration/Inclusion: Do program participants participate in activities and events of their choice outside their homes when they want to?

Recipient issues determined to be critical and in need of immediate attention were communicated to case management staff during the review. Recipients were found to be satisfied with services and receiving adequate services.

7. ☑ **Deficiencies have been, or are being corrected.**

Provide an explaination of how these deficiencies have been, or are being corrected as well as an explanation of what steps have been taken to ensure the deficiencies do not recur:
Chart Review Corrective Action:

The root cause of case managers deficiencies for not addressing goals (DHCFP Intake Chart Review Results) or safety risks on the POC (DHCFP Annual Review Results) was because the POC did not specifically request those items, nor was there room on the POC to hand-write those items. In 2013, a new POC was created and implemented which specifically addressed these two issues.

Financial Review Corrective Action:

Referrals are made directly to DHCFP's Surveillance and Utilization Review (SUR) Unit for follow up. Waiver QA reviewers send all relevant review information to the SUR Unit which is then responsible for the investigation, provider education, and the set-up and collection of any identified overpayments.

Certification:

I, do certify that the information shown on the Form CMS-372(S) is correct to the best of my knowledge and belief:

Signature: Jennifer Frischmann **Date:** 05/20/2014

Contact Information (optional):

Contact Person:

Phone Number: