

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

**State:** NV  
**Waiver Base:** 0152  
**Report Status:** ACCEPTED  
**Begin Date:** 07/01/2012  
**End Date:** 06/30/2013  
**Initial Submission Date:** 12/24/2014  
**Report Period Year:** 2013  
**Waiver Year:** 2013  
**Report Type:** ☐ Year 1 ☐ Year 2 ☐ Year 3 ☒ Year 4 ☐ Year 5  
**Unduplicated Participants:** ☐ Initial Report ☒ Lag Report ☐ TE Report  
**Days of Waiver Enrollment:** 2,236  
**Average Length of Stay:** 591,123  
**Total Waiver Expenditures:** 264.4  
**APC Waiver Services (Factor D):** \$9,339,958.00  
**APC for State Plan Services (D'):** 4,177  
**APC Total (D + D'):** 9,803  
**Factor G Value:** \$13,980  
**Factor G' Value:** 60,969  
**APC Total if no waiver (G + G'):** 13,587  
**D + D' <= G + G':** \$74,556  
**\$13,980 <= \$74,556**

**Level/s of Care:****Additional Information (use if needed):**

Providers direct bill DHCFP's QIO-like vendor for payment. Aging and Disability Services Division (ADSD) performs

service authorizations as an administrative function of the waiver. These authorizations include scope, frequency and duration of services. ADSD internally validates billing and reviews billing workbooks.

Private case management was not utilized during the waiver period due to lack of qualified providers enrolled as Medicaid providers.

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
Companion Services	NF	\$25,144	42	
<b>HCBS Taxonomy:</b>				
Category 1:	Subcategory 1:			
Category 2:	Subcategory 2:			

Service				
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	\$960,532	2,204	
<b>HCBS Taxonomy:</b>				
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	\$2,842	36	
<b>HCBS Taxonomy:</b>				
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
Adult Day Care (social model)	NF	\$865,042	189	
<b>HCBS Taxonomy:</b>				
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	\$741,878	589	
<b>HCBS Taxonomy:</b>				
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
Personal Emergency Response System (PERS)	NF	\$312,597	888	
<b>HCBS Taxonomy:</b>				
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: Installation	NF	\$8,550	188	
<b>HCBS Taxonomy:</b>				
Category 1:		Subcategory 1:		
Category 2:		Subcategory 2:		
Category 3:		Subcategory 3:		
Category 4:		Subcategory 4:		

Service				
Service Name (no longer a required field):	Level of Care	Expenses in \$	Participants	Service Category Name
Respite Care	NF	\$127,388	93	
<b>HCBS Taxonomy:</b>				
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
Adult Residential Care	NF	\$6,295,984	693	
<b>HCBS Taxonomy:</b>				
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:**  
ADSD and the Division of Health Care Financing and Policy (DHCFCP) meet quarterly to discuss quality and program operations. In addition, ADSD tracks serious occurrences on an ongoing basis and provides a quarterly report to DHCFCP. Serious occurrences are reviewed and followed up on by ADSD case managers and/or supervisory staff.

ADSD tracks the number of persons on the wait list and time from referral to program eligibility. ADSD also tracks waiver slot allocation. DHCFCP monitors the wait list and the unduplicated count monthly and waiver expenditure data quarterly.

DHCFCP receives 100% of all intake packets for approval. 75% are approved as long as all required forms are present and signed as appropriate. 25% are reviewed content prior to approval.

DHCFCP sends Notices of Decision (NODS) on all waiver denials, suspensions, and terminations.

DHCFCP monitors hearings and appeals for waiver services. DHCFCP received 12 hearing requests in waiver year 2013 in which 10 requests were withdrawn by petitioner prior to hearing, one was resolved in the State's favor, and one request was incomplete and was not processed.

The State verifies that costs of waiver services are based on state payments for waiver services that have been authorized in the plan of care, rendered to waiver participants, and properly billed by qualified providers in accordance with the approved waiver.

ADSD is responsible for prior authorizing services and verifying provider records match billing statements.

All participants are ultimately responsible for their services and verifying providers perform services in accordance with the plan of care by signing the daily record.

Direct service case management and administrative case management are billed and tracked separately. Social workers, supervisors and administrative assistants currently review case management billing workbooks prior to submitting claims for case management expenditures.

The MMIS claims processing system identifies the provider, authorized services, rate, and units of service for each recipient. The system is linked to the Medicaid eligibility system, which checks each claim to assure recipients were eligible on the dates of service. The system maintains records on both the recipient and the provider. MMIS provides data for the CMS 64 and 372 reports.

ADSD maintains a record on each recipient documenting the recipient's waiver eligibility and services provided. The record includes recipient demographics, assessments, level of care screenings, plans of care, and documentation of all case management services provided. These records are reviewed during supervisory reviews and DHCFP's annual reviews.

#### 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):

The annual review for the Home and Community Based Waiver (HCBW) for the Frail Elderly was conducted in August 2014. A combined random sample of one hundred and thirty-seven (137) recipients were selected for Participant Experience Survey (PES) interviews, ninety-one (91) case files were reviewed, one-hundred and eighty-two (182) financial reviews were 4 completed from ninety-two (92) recipients for the 2013-2014 waiver year. Additionally, a total of forty-four (44) service providers were selected for review.

To avoid duplication of efforts, reviews conducted by the Aging and Disability Services Division (ADSD) were obtained for a portion of the Case File Review, Provider Review, and Participant Experience Survey for the 2013-2014 review year.

The following areas were evaluated during this year's annual review:

Case File Review:

1. Social Health Assessment (SHA)
2. Level of Care (LOC)
3. Plan of Care (POC)
4. Service Level
5. Forms
6. Monthly Contacts and Documentation

Financial Review:

1. Eligibility
2. Prior Authorization
3. Daily Record
4. Payment

Provider Review

1. Qualifications
2. Recipient POC
3. Documentation of Services on Daily Logs
4. Records Retention
5. Provider Background Check
6. Testing for Tuberculosis
7. Completion and Documentation of Training

All program areas reviewed were at 100%, except the following:

- Initial Assessment completed within 28 days of referral: 98%

- Social Health Assessment Agrees with POC: 98%
- POC is signed by recipient: 89%
- All waiver forms signed and dated: 98%
- Monthly Contacts: 99%
- Face to Face Contacts: 99%
- Health and Safety concerns addressed: 99%
- Needs and concerns followed up: 99%
- Waiver service satisfaction: 99%

All financial areas reviewed were at 100%, except the following:

- Procedure Code and service level were correct: 99%
- Services provided matched POC: 95%
- Frequency and duration were accurately identified on the POC: 92%
- Service units were billed correctly: 99%
- Medicaid payment to provider was correct: 87%
- Overpayment to provider: 86%

Best practices are methods or techniques that represent the most efficient or prudent course of action. The following practices were observed contributing to the quality of health, safety, and welfare of waiver recipients:

SHAs were completed timely and consistently addressed medical needs and available support systems.

LOCs were assessed timely and met the minimum of three functional deficits.

POCs regularly identified goals, safety risks, and services needed.

Monthly telephone and quarterly face to face contacts often occurred more often than the minimum requirement due to recipient need.

Recipient's health and safety, needs and concerns, and waiver service satisfaction were consistently addressed each month.

Goals on the POC were consistently assessed.

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

Provide an explanation 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:

A perfect score of 100% compliance was earned in thirteen components. Improvement is noted in eight components from the previous 2012/2013 review year to the current 2013/2014 review year. The most notable improvements were obtaining recipient signatures on the Plan of Care and Forms Acknowledgement documents as well as waiver satisfaction assessed and documented on a monthly basis. There was an improvement of 4-5% for each of these components.

There was minimal shift in the financial results between the 2012/2013 review and the 2013/2014 review years. The most notable improvement was in services provided matching the POC, which showed a marked increase of 6%.

The following findings and recommendations are provided as guidance to develop best practices for continuing quality improvement:

- Complete all initial assessments within 28 days of receiving a referral. There were two recipients whose initial assessments were completed more than 28 days after ADSD received the referral. (This is an improvement from the prior review and due a high level of turnover and vacancies within ADSD).
- Although the POCs were created in a timely manner, not all POCs were signed within three months. Ensure the POCs are not only created, but signed in the required timeframe. There were ten instances of the POCs not being signed by the recipient at the next face to face visit or within three months. (Some of these are case manager errors, which have been addressed individually, and some are due to the fact that the recipient is unable to sign. DHCFP and ADSD are working on specific guidance for case managers to document when a recipient is unable to sign).
- Ensure that quarterly face to face home visits are being conducted timely. There were two recipients that did not receive a face to face visit within the required three month timeframe. (These were addressed individually with case managers).

- The frequency identified on the POC should be appropriate for the service. For example, the frequency of homemaker services should be allocated on a weekly basis as opposed to every care plan. This will clarify the units allocated to be four units per week as opposed to 191 units per care plan. (This was a segmented occurrence that has been addressed on an individual case manager basis).
- Diagnosis of dementia or other cognitive impairment on its own is not sufficient indication that a recipient cannot sign. Per policy, if a recipient is unable to sign due to cognitive and/or physical limitations, it must be clearly documented on the POC. (This was addressed under POC signature).
- If a recipient selects a personal representative to sign on their behalf, at a minimum it must be documented that the personal representative has permission to sign if the appropriate authorization and consent forms have not yet been completed. Indication that a recipient has given permission for the case manager to speak with a personal representative during a monthly contact is not sufficient documentation to allow that person to sign on their behalf.

Provider payment discrepancies are sent the DHCPF's Surveillance and Utilization Review (SUR) Unit which analyzes claims data to identify potential fraud, waste, overutilization, and abuse; collects provider overpayments and refers appropriate cases to the Medicaid Fraud Control Unit (MFCU) for criminal investigation and prosecution. However, in most cases, provider billings errors are due to problems in the billing process or records keeping process and SUR regularly sends provider education letters in these instances.

**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:**  
**Contact Information**  
**(optional):**

Jennifer Frischmann

**Date:** 12/24/2014

Contact Person:

Phone Number: