ANNUAL STATEWIDE CONSOLIDATED HCBS FE/PD WAIVER REVIEW FINAL REPORT

FE/PD Waiver Review Period 2020

Home and Community Based Services (HCBS) Waivers for the Frail Elderly (FE) and People with Physical Disabilities (PD) Quality Assurance Consolidated Review to ensure the waiver continues to meet essential Federal statutory assurances and effectively meet the recipient's needs.

State of Nevada
Division of Health Care Financing and Policy
Managed Care & Quality Assurance Unit

August 2021

Review Year: FE (WY 1) & PD (WY 3)

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FE/PD Waiver Review Period 2020

Background/Introduction

The renewal of a waiver is contingent on the Centers for Medicare and Medicaid Services (CMS) determining that the State has effectively assured the health, safety, and welfare of waiver recipients during the period the waiver has been in effect.

Each State is expected to have, at a minimum, systems in place to measure and improve performance in meeting the waiver assurances that are set forth in 42 CFR §441.301 and §441.302. These assurances address important dimensions of waiver quality, including assuring that service plans are designed to meet the needs of waiver recipients and that the State has effective systems in place to monitor recipient health, safety, and welfare.

The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in the waiver application. Through an ongoing process of discovery, remediation, and improvement, the State assures the health, safety, and welfare of the recipients by monitoring: (a) level of care determinations; (b) individuals plans and services delivery; (c) provider qualifications; (d) recipient health, safety, and welfare; (e) financial oversight and (f) administrative oversight of the waiver.

Aims & Objectives

The annual review monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems and individual corrective actions. The results can be aggregated and analyzed to measure the overall system performance in meeting the waiver assurances.

Methodology

The CMS quality requirements are founded on an evidence-based approach. The CMS requests evidence from the State that it meets the assurances and applies a continuous quality improvement approach to the assurances. The Division of Health Care Financing and Policy (DHCFP) Quality Assurance (QA) staff has used a representative sample with a confidence interval equal to 95/5 for case files and 95/10 for financials and Participant Experience Surveys (PES) for this review.

The Annual Statewide Consolidated Review for the Home and Community Based Services (HCBS) Waivers for the Frail Elderly (FE) and Persons with Physical Disabilities (PD) for the State of Nevada is conducted monthly. Due to the limited population of waiver recipients in rural areas, recipients from regional offices in rural areas are reviewed bi-annually at one hundred percent (100%). This wavier review period included the bi-annual review of rural area, Elko, at one hundred percent (100%). A combined random sample of three hundred forty-eight (348) case files were reviewed, three hundred eighty-two (382) financial reviews were completed from one hundred seventy-seven (177) recipients and two hundred sixty-nine (269) recipients completed Participant Experience Surveys (PES) for the 2020 waiver year.

To avoid duplication of effort, reviews conducted by the Aging and Disability Services Division (ADSD) were obtained for a portion of the case file reviews and the PES for the 2020 review period. All provider reviews were completed by the ADSD.

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

Case File Review:

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

Financial Review:

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

Participant Experience Surveys (PES)

1. Access to Care
2. Choice and Control
3. Respect/Dignity
4. Community Integration/Inclusion

Listed below are the specific HCBS FE and PD Waivers, the Medicaid Services Manual (MSM) Chapters and Policy & Procedure (P&P) Transmittals that were used in the implementation of this annual review:

- Home and Community Based Services Waiver for the Frail Elderly (Effective 07/01/2015 and 07/01/2020)
- Home and Community Based Services Waiver for Persons with Physical Disabilities (Effective 01/01/2018)
- MSM Chapter 2200 Home and Community Based Waiver for the Frail Elderly (Effective 09/25/2019 and 02/01/2021)
- MSM Chapter 2300 Home and Community Based Waiver for Persons with Physical Disabilities (Effective 09/25/2019)
- MSM Chapter 3900 Home and Community Based Waiver for Assisted Living (Effective 07/13/2012 – Merged into MSM Chapter 2200 on 02/01/2021)
- P&P FE-PD-1-2016 - Interim and Finalized Service Plan Signature and Dates
- P&P FE-PD-1-2016 - Acknowledgment Form NMO-7075 (02/16)
- P&P FE-PD-3-2016 - Requirements for the Plan of Care (POC)
- P&P FE-PD-5-2016 - Designated Representative Attestation NMO-3581 (11/16)
- P&P FE-PD-2-2017 - Statement of Understanding (SOU) NMO-3580 (04/17)
- P&P FE-PD-21-001 - Direct Case Management ongoing contacts
- P&P FE-PD-21-002 - Annual Plan of Care Updates and Changes
- Appendix K: Emergency Preparedness and Response and COVID-19 Addendum (Issued 04/15/2020 and 01/19/2021)
- P&P FE-PD-1-2017 - Consumer Direct Timesheets (Obsoleted 04/21)
- P&P FE-PD-5/2017 – Suspension of Waiver Services (Obsoleted 04/21)

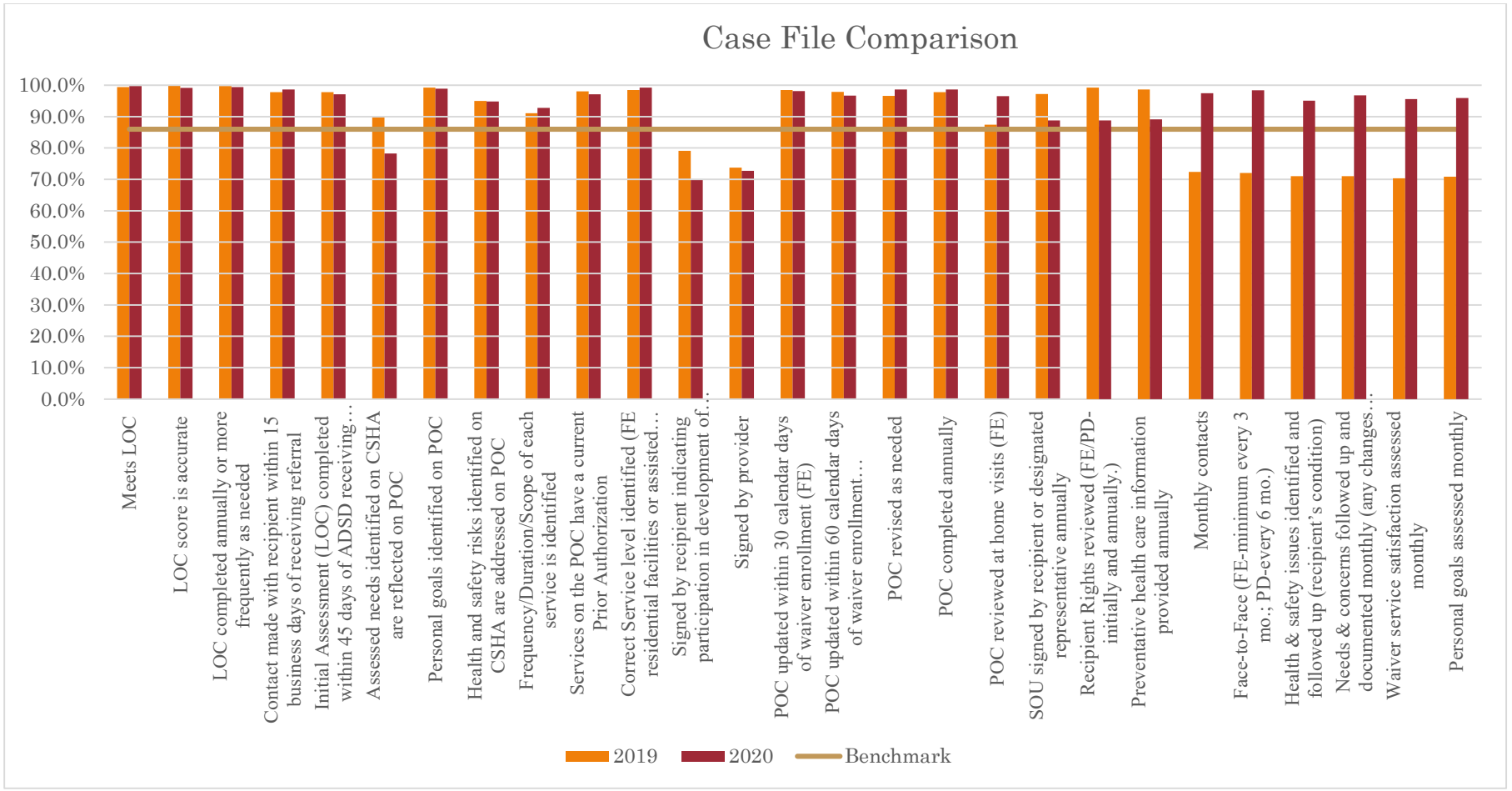
The following results identify the areas and percentages of compliance with performance measures which are required from the approved waivers and requirements outlined in the above documents.

Detailed statewide summaries can be found in Appendix A.

Results

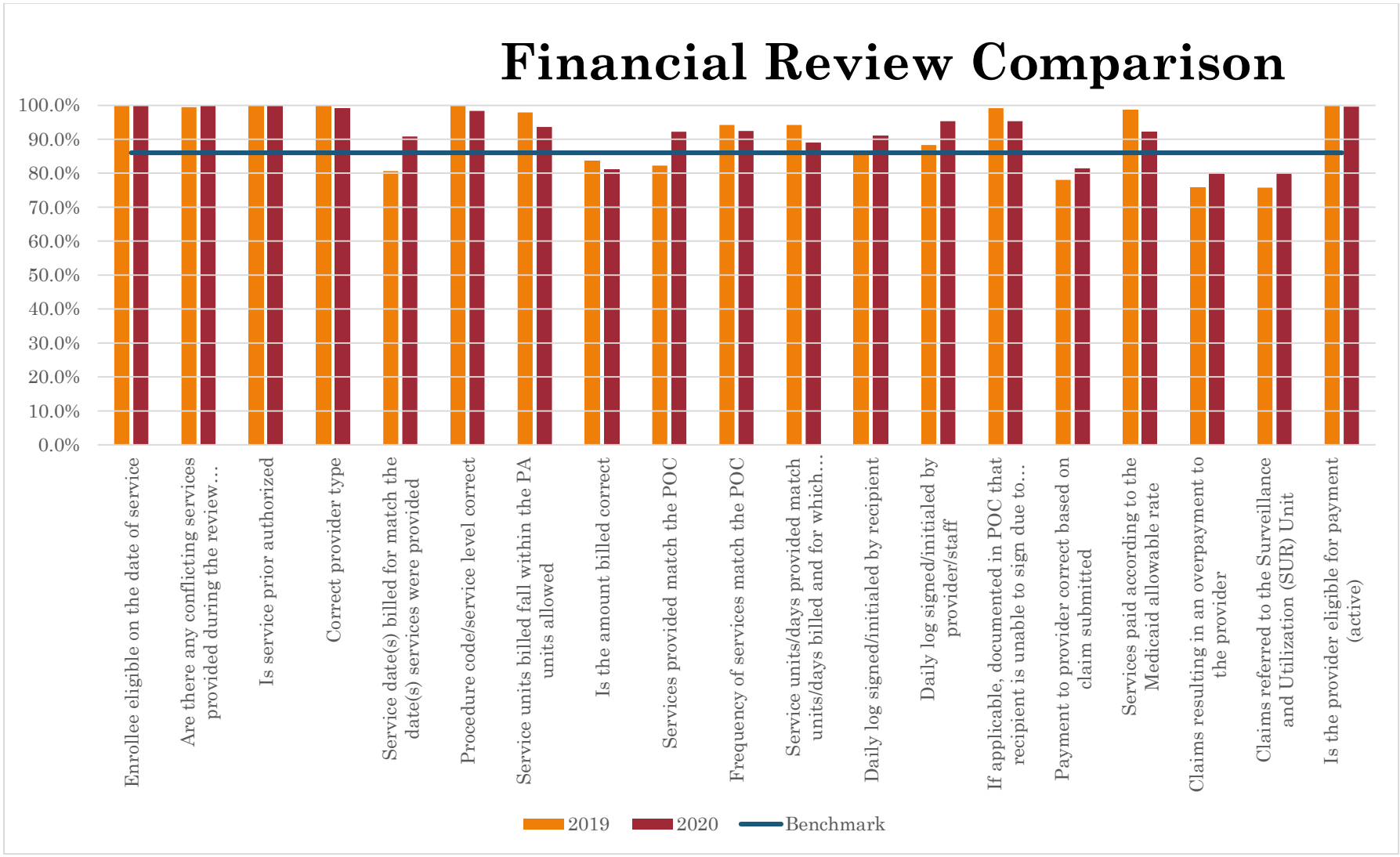
2020 Statewide Case File Results

LOC/CSHA					Plan of Care												Forms			Monthly Contacts and Documentation					
Meets LOC (at least 3 functional deficits)	LOC score is accurate	LOC completed annually or more frequently as needed	Contact made with recipient within 15 business days of receiving referral (New enrollees ONLY)	Initial Assessment (LOC) completed within 45 days of ADSD receiving referral (New enrollees ONLY)	Assessed needs identified on CSHA are reflected on POC	Personal goals identified on POC	Health and safety risks identified on CSHA are addressed on POC	Frequency/Duration/Scope of each service is identified	Services on the POC have a current Prior Authorization	Correct Service level identified (FE residential facilities or assisted living ONLY)	Signed by recipient indicating participation in development of POC (within 60 days of SOU date or waiver effective date)	Signed by provider (within 60 days of SOU date or waiver effective date, whichever is later)	POC updated within 30 calendar days of waiver enrollment (New FE enrollees ONLY)	POC updated within 60 calendar days of waiver enrollment (New PD enrollees ONLY)	POC revised as needed (when a significant change lasting more than 30 days occurs)	POC completed annually	POC reviewed at home visits (FE ONLY-at least annually and as outlined in the POC process)	SOU signed by recipient or designated representative annually	Recipient Rights reviewed (FE/PD-initially and annually.)	Preventative health care information provided annually	Monthly contacts	Face-to-Face (FE-minimum every 3 mo.; PD-every 6 mo.)	Health & safety issues identified and followed up (recipient's condition)	Needs & concerns followed up and documented monthly (any changes in services or providers)	Waiver service satisfaction assessed monthly	Personal goals assessed monthly
99.7%	99.1%	99.4%	98.9%	97.1%	78.2%	98.9%	94.8%	92.8%	97.1%	99.2%	70.1%	72.7%	98.1%	96.7%	98.6%	98.6%	96.5%	88.8%	88.8%	89.1%	97.4%	98.4%	95.1%	96.8%	95.6%	95.9%


Case File Comparison
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Meets LOC
LOC score is accurate
LOC completed annually or more frequently as needed
Contact made with recipient within 15 business days of receiving referral
Initial Assessment (LOC) completed within 45 days of ADSD receiving…
Assessed needs identified on CSHA are reflected on POC
Personal goals identified on POC
Health and safety risks identified on CSHA are addressed on POC
Frequency/Duration/Scope of each service is identified
Services on the POC have a current Prior Authorization
Correct Service level identified (FE residential facilities or assisted…
Signed by recipient indicating participation in development of…
Signed by provider
POC updated within 30 calendar days of waiver enrollment (FE)
POC updated within 60 calendar days of waiver enrollment…
POC revised as needed
POC completed annually
POC reviewed at home visits (FE)
SOU signed by recipient or designated representative annually
Recipient Rights reviewed (FE/PD-initially and annually.)
Preventative health care information provided annually
Monthly contacts
Face-to-Face (FE-minimum every 3 mo.; PD-every 6 mo.)
Health & safety issues identified and followed up (recipient's condition)
Needs & concerns followed up and documented monthly (any changes…
Waiver service satisfaction assessed monthly
Personal goals assessed monthly
2019
2020
Benchmark

2019 vs. 2020 Case File Review Comparison

For 2020, improvement is noted for twelve (12) components from the previous 2019 review period. The most notable improvements were the elements within the monthly contacts having all come into compliance since last review period. These six (6) elements were Monthly contacts (97%), Face-to-Face contacts (98%), Health & Safety issues identified and followed up (95%), Needs & concerns followed up and documented monthly (97%), Waiver service satisfaction assessed monthly (96%) and Personal goals assessed monthly (96%). Other areas of improvement include POC revised as needed (98%) and Frequency/Duration/Scope of each service is identified (93%), both seeing an increase of 2% to the prior reporting year.


Financial Review Comparison
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Enrollee eligible on the date of service
Are there any conflicting services provided during the review…
Is service prior authorized
Correct provider type
Service date(s) billed for match the date(s) services were provided
Procedure code/service level correct
Service units billed fall within the PA units allowed
Is the amount billed correct
Services provided match the POC
Frequency of services match the POC
Service units/days provided match units/days billed and for which…
Daily log signed/initialed by recipient
Daily log signed/initialed by provider/staff
If applicable, documented in POC that recipient is unable to sign due to…
Payment to provider correct based on claim submitted
Services paid according to the Medicaid allowable rate
Claims resulting in an overpayment to the provider
Claims referred to the Surveillance and Utilization (SUR) Unit
Is the provider eligible for payment (active)
2019
2020
Benchmark

2019 vs. 2020 Financial Review Comparison

Improvement is noted in eight (8) components from the previous 2019 review period to the current 2020 review period. The most notable being in Service date(s) billed for match the date(s) services were provided and Services provided match the POC, both showing a ten percent (10%) increase in compliance from the 2019 review period. Additional increases were noted in areas including Daily log signed/initialed by provider/staff six percent (6%) increase, Daily log signed/initialed by recipient five percent (5%) increase, Payment to provider correct based on claim submitted three percent (3%) increase, while both Claims resulting in an overpayment and Claims referred to the Surveillance and Utilization Review (SUR) unit both increased compliance by four percent (4%) each.

Please note:

The following elements reviewed are currently under compliance thresholds:

- *Is the amount billed correct*
- *Payment to provider correct based on claim submitted*

Findings and Recommendations

Findings identify areas of deficiency discovered through the completion of the Annual Statewide HCBS FE/PD Waiver Review. Recommendations are suggestions to help improve the effectiveness and quality of waiver operations. The following findings and recommendations are provided as guidance to develop best practices for continuing quality improvement:

Case File Review Results

ADSD Offices

The CMS requires quality improvement projects/remediation when the threshold of compliance is at or below eighty-six percent (86%). For the 2020 review period, three (3) elements have been identified as needing further analysis by the Quality Improvement (QI) committee.

- Assessed needs identified on CSHA are reflected on POC: 78%
- POC signed by recipient within 60 days: 70%
- POC signed by provider within 60 days: 73%

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

- **Assessed needs identified on CSHA are reflected on POC**: 22% of the files reviewed either had items identified on the CSHA that were not on the POC, or vice versa, identified on the POC that were not on the CSHA without documentation.

  Recommendation: Consistency meetings have been held with DHCFP QA, DHCFP LTSS and ADSD to review the CSHA and POC in depth and determine how case managers will notate needs and services for the recipient, as well as which sections are to be used to ensure those needs and services are addressed within the POC. The issues noted within this element's review cycle have been addressed and improvements should be seen for the upcoming review cycle.

- **POC signed by recipient within sixty (60) days:** 30% of the POCs reviewed were either not signed or not signed within the required timeframe by the recipient or their designated representative.

  Recommendation: This review period saw a reduction in compliance for this element due to the COVID-19 pandemic and inability to conduct face-to-face contacts to obtain timely signatures. Once restrictions lift, ADSD will reduce errors within this element by creating handwritten initial and updated POCs that can be

signed and dated at the face-to-face meetings. The ADSD case manager will then finalize this agreed upon POC within the SAMS system at their earliest convenience and will mail a copy of the signed handwritten POC along with the updated SAMS version to the recipient or designated representative.

- **POC signed by provider within sixty (60) days:** 27% of the POCs reviewed were either not signed or not signed within the required timeframe by the provider(s) or case manager.

  Recommendation: This review period saw a reduction in compliance for this element due to the COVID-19 pandemic and providers being short staffed, shortened hours or closures impacting the ability to obtain timely signatures. ADSD has been reviewing ways of obtaining digital signatures from providers.

Additional Recommendations

- Develop a standardized process for completing the Waiver Case File Review form for supervisor reviews:
  - Supervisors did not always include a comment when errors were cited.
  - Errors were not always marked during the review when an issue was noted.
- Ensure that Supervisor Reviews appropriately address questions specific to new enrollees. The DHCFP QA staff found that the following questions were answered as N/A, when a Yes or No answer was applicable:
  - Contact made with recipient within 15 business days of receiving referral.
  - Initial Assessment (LOC) completed within 45 days of the ADSD receiving referral.

Beginning April 2021 DCHFP LTSS, DCHFP QA and ADSD all worked together to review all policies, waiver, MSM, CFRs etc., to ensure all items reviewed are in accordance with policy. Within these meetings an in-depth review of the CSHA and POC was conducted for a better understanding of what should be noted and what should be included within the waiver and non-waiver services of the POC. As previously reported, in November 2019 all parties worked together for the wording and updates for the FE waiver that became effective 07/01/2020. In October 2020 all parties worked together to update MSM 2200 Home and Community Based Waiver for the Frail Elderly that became retroactively effective 07/01/2020.

Progress will continue to be monitored by the QI Committee, with the extensive collaboration efforts improvements should be seen throughout the next review period.

Financial Review Results

***The following elements showed an increase in errors from the previous review period*:**

- Correct provider type: 1%
- Procedure code/service level correct: 2%
- Service units billed for fall within the PA units allowed: 4%
- Is the amount billed correct: 3%
- Frequency of services match the POC: 2%
- Service units/days provided match units/days billed: 5%
- If applicable, documented in POC that recipient is unable to sign: 4%
- Services paid according to the Medicaid allowable rate: 7%

Elements with no change since last review period:

- Enrollee eligible on the date of service
- Are there any conflicting services provided
- Is service prior authorized
- Is the provider eligible for payment (active)

***The following elements showed a compliance increase from the previous review period*:**

- Service date(s) billed for match the date(s) services were provided: 10%
- Services provided match the POC: 10%
- Daily log signed/initialed by recipient: 5%
- Daily log signed/initialed by provider/staff: 7%
- Payment to provider correct based on claim submitted: 3%

Financial review results reflect compliance for the provider community. Five (5) elements of the review resulted in a one percent (1%) or more improvement when compared to the 2019 combined average results. Five (5) elements resulted in a three percent (3%) or more decrease in compliance when compared to the 2019 review period combined average results. Four (4) data elements remain below the eighty-six percent (86%) threshold, not meeting compliance. "Claims resulting in an overpayment" and "Claims referred to Surveillance and Utilization (SUR) Unit" showed an increase in compliance of four percent (4%) each. All elements with a decrease in compliance will be addressed in the forthcoming QI meetings to improve the overall operation of the HCBS FE/PD Waivers.

Comprehensive Provider Review

The ALiS provider database went live in March of 2018. This centralized database for provider reviews has provided ADSD and DHCFP LTSS Waiver Unit the ability to

download the entire review, capture and store notes from the review process, and maintain all required documentation in a centralized location. ADSD follows up on any deficiencies found during the provider reviews and DHCFP LTSS reports the findings.

DHCFP Central Office- LTSS Waiver Unit

The PD waiver renewal was approved 01/01/2018. The DHCFP LTSS Waiver Unit provided a P&P on 12/30/2020, effective 01/01/2021, providing guidance to the ADSD regarding due diligence of three (3) documented attempts on separate days within the month for both the PD and FE waiver combined reviews.

The HCBS Assisted Living (AL) Waiver expired 06/30/2014 and was combined with the HCBS FE Waiver effective 07/01/2015. LTSS held a public workshop on 11/30/2020 for updates made to MSM 2200 Home and Community Based Waiver for the Frail Elderly and the obsoletion of MSM Chapter 3900 Home and Community Based Waiver for Assisted Living. The updated FE waiver has been submitted, approved, and became effective 07/01/2020.

Participant Experience Surveys (PES)

A focus of the HCBS Waiver Program(s) is to ensure the recipient is satisfied with their services and achievement of desired outcomes. Recipients were interviewed regarding their experiences and satisfaction with their waiver services and providers. The interviews were conducted by the DHCFP QA staff and the ADSD staff using the Participant Experience Survey (PES) interview tool developed by The MEDSTAT Group, Inc. under a contract from the CMS. Indicators used for monitoring quality within the waiver program(s) are calculated using the data captured from these surveys. A copy of the PES interview tool can be found in Appendix B and a copy of the methodology for calculating the performance indicators in Appendix V.

A random sample of HCBS FE and PD Waiver recipients were selected to participate in the annual PES interviews for Carson City, Elko, Las Vegas, and Reno. PES interviews are conducted on a quarterly (ADSD) and biannually (DHCFP QA) basis. PES interviews included within this report, cover July 2019 through June 2021. Three hundred forty-eight (348) recipients were selected to meet a 95/5 sample size, wherein two hundred sixty-nine (269) PES interviews were completed. DCHFP QA staff mailed out one hundred forty-four (144) surveys to selected recipients due to the COVID-19 pandemic precautions. The cover letter requested the recipient to call to complete the survey together or return their completed survey. Of the one hundred forty-four (144) surveys mailed out, forty-one (41) were completed, eight (8) had returned mail with no forwarding address, nine (9) were deceased, two (2) moved out of state, one (1) closed and the remaining eighty-three (83) recipients did not participate either by choice, or due to circumstances such as hospitalization. ADSD staff completed two hundred and twenty-eight (228) PES interviews via telephone calls due to the COVID-19 pandemic.

Recipient issues determined to be critical and in need of immediate attention were promptly communicated to the appropriate ADSD office staff.

The top twelve (12) questions with the highest recipient satisfaction are:

- ✓ Changing Staff
- ✓ Contact for Reporting Staffing Problems
- ✓ Ability to Contact Case Manager
- ✓ Case Manager Helpfulness
- ✓ Overall Satisfaction with Case Manager
- ✓ Overall Satisfaction with Services
- ✓ POC Development
- ✓ Respect by Home Care Staff
- ✓ Careful Listening by Home Care Staff
- ✓ Careful Listening by Day Program Staff
- ✓ Community Involvement
- ✓ Case Manager Helpfulness

The seven (7) questions with the highest adverse responses indicating an unmet need are:

- ✓ Choice in Staff
- ✓ Directing Staff
- ✓ Respect by Day Program Staff
- ✓ Ability to Identify Case Manager
- ✓ Equipment or Modifications
- ✓ Transportation
- ✓ Employment

The DHCFP QA staff understands that due to the nature of the population interviewed, inconsistencies were noted in responses from the HCBS FE/PD Waiver recipients. A number of recipients indicated that they did not know who their case manager is; however, the person who calls every month or even more frequently is nice and helpful. This may contribute to why the "Ability to Identify Case Manager" is listed as an unmet need. In addition to the questions that were asked, the following positive feedback was provided by recipients and/or their family members or designated representative:

- Recipients clearly expressed their satisfaction with their case manager as well as with their providers.

- Recipients, family members and/or designated representatives reported that if there was something wrong with the help they were getting, they knew who could fix it.

- Recipients indicated that they actively participated in the development of their POC, allowing them to remain safely in their home of choice.

Best Practices

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:

- Waiver case file reviews completed by the ADSD supervisors demonstrated that positive guidance was given to the case manager. Specific examples were given indicating a job well done and encouraging staff to improve documentation and the quality of service.

- Some POCs identified the PA numbers with a start date and end date. This was often documented in the Desired Outcomes section for the corresponding service, demonstrating that the case manager complied with the PA requirement.

- Descriptive contacts make it easy to follow the recipient's progress and demonstrates the efforts the case manager makes to respond to the recipient's needs.

- It was noted among all the ADSD offices that a supportive and agreeable relationship between the case manager, providers and recipients is being established using a person-centered approach.

QI Project Performance

As part of the consolidated review process, the DHCFP QA staff and the ADSD waiver staff gather monthly for a Consolidated Waiver Quality Improvement (QI) Committee meeting. The CMS has mandated a threshold of less than eighty-six percent (86%) for any Performance Measure indicating a need for improvement. Assurances that are at or below eighty-six percent (86%) for the review period are assigned to a priority grid. The QI Committee members are assigned projects to analyze and identify the probable cause of deficiencies and develop plans to improve performance and track improvement.

The QI Committee is responsible for conducting the QI Projects for the Consolidated Waiver Review as issues are identified, 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 the 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?).

QI Committee

The QI Committee began addressing issues within Monthly Contacts and Documentation in January 2019 and had continued through the 2020 reviews. All elements within this area went from being in the seventy (70) percent range to ninety (90) percent range and came into compliance during this review year.

Monthly Contacts - As part of the waiver requirements, all recipients must have monthly contacts or if the recipient requests otherwise, quarterly contacts. If the recipients request quarterly contact, this must be narrated in the CSHA and/or POC.

Results:

- This waiver review period saw an increase in compliance from the prior year's reporting, showing a twenty-five percent (25%) increase in this area.

Face-to-Face Contacts (FE-minimum quarterly; PD every 6 mo.) - As part of the waiver requirements, all recipients must have face-to-face contacts, FE every quarter and PD recipients every six (6) months.

Results:

- This waiver review period saw an increase in compliance from the prior year's reporting, showing a twenty-six percent (26%) increase in this area.

Health & Safety issues identified and followed up (recipient's conditions) - As part of the waiver requirements, all recipients must have monthly contacts where the health and safety issues are identified by the recipient and the case manager. The case manager is to address and follow-up within the monthly contact narrative what items are needed and being addressed.

Results:

- This waiver review period saw an increase in compliance from the prior year's reporting, showing a twenty-four percent (24%) increase in this area.

Needs & concerns followed up and documented monthly (any changes in services or providers) - As part of the waiver requirements, all recipients must have monthly contacts, in which the needs & concerns of the recipient are followed up and documented by the case manager.

Results:

- This waiver review period saw an increase in compliance from the prior year's reporting, showing a twenty-six percent (26%) increase in this area.

Waiver service satisfaction assessed monthly - As part of the waiver requirements; all recipients must have monthly contacts in which the service satisfaction of the recipient is assessed monthly.

Results:

- This waiver review period saw an increase in compliance from the prior year's reporting, showing a twenty-five percent (25%) increase in this area.

Personal goals assessed monthly - As part of the waiver requirements; all recipients must have monthly contacts in which their personal goals are assessed in each monthly contact.

Results:

- This waiver review period saw an increase in compliance from the prior year's reporting, showing a twenty-five percent (25%) increase in this area.

ADSD credits these increases with their continuation of one-on-one trainings with their staff to ensure use of the monthly contact template, documentation within the contact is detailed and no copy/paste issues are being made, as well as, with whom and how the contact is being made.

The QI Committee has been monitoring issues directly relating to issues and limitations due to the COVID-19 pandemic:

Signed by recipient indicating participation in development of POC - As part of the waiver requirements, all recipients must sign their POCs within sixty (60) days of development.

Remediation Plan:

- Once restrictions lift, ADSD will reduce errors within this element by creating handwritten initial and updated POCs that can be signed and dated at the face-to-face meetings.

Signed by provider (within 60 days of SOU date, waiver effective date, or prior POC, whichever is later) - Every waiver service requires the provider signature.

Remediation Plan:

- ADSD has been reviewing ways of obtaining digital signatures from providers.

The QI Committee conducted Consistency meetings with staff from DCHFP LTSS, ADSD and DCHFP QA to address a new element that has fallen out of compliance:

Assessed needs identified on CSHA are reflected on POC – As part of the wavier requirements, 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.

Remediation Plan:

- Due to staff changes within both DHCFP QA and ADSD an in-depth review of the CSHA and POC was conducted. Determinations as to how case managers will notate needs and services on the CSHA for the recipient that will determine what will be contained on the POC were addressed to ensure all needs are addressed.

During the monthly QI meetings, the ADSD regional offices are given their year to date (YTD) and Quarterly reports so they can track how each office is doing and make improvements throughout the review period. Below are the following training dates that have occurred that were conducted by the ADSD:

- How to complete a case file review on 04/27/2021 and 04/29/2021.

- Troubleshooting of common scenarios on 04/27/2021 and 04/29/2021.

Requirements[1]

Case File Review Requirements

Level of Care (LOC)/Comprehensive Social Health Assessment (CSHA)

Assurance	Waiver Requirement	Waivers	MSM Requirement	MSM Chapter
Meets LOC (at least three (3) functional deficits)	FE- The assessment determines if the condition requires the level of services offered in a nursing facility with at least 3 functional deficits identified in sections 1-5 of the screening tool or a more integrated service which may be community based. PD- There are 13 total functional deficits identified on the LOC Assessment Tool. An eligible recipient or pending applicant must meet at least three deficits out of the 13 possible.	FE- Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (d) and (f) PD- Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (d)	FE- Each applicant/recipient must meet and maintain a level of care for admission into a nursing facility and would require imminent placement in a nursing facility (within 30 days or less) if HCBW services or other supports were not available. PD- The applicant must meet and maintain a LOC for admission into a Nursing Facility (NF) within 30 days if HCBW services or other supports were not available.	FE- MSM Chapter 2200, Section 2203.2A(5)(a)(1)(b) PD- MSM Chapter 2300, Section 2303.2A(5)(1)(b)
LOC score is accurate	FE/PD- Performance Measure: Number and percent of recipients whose Level of Care (LOC) eligibility was based on accurate application of policy resulting in accurate LOC determinations.	FE/PD- Appendix B: Evaluation/Revaluation of Level of Care. Quality Improvement: Level of Care, (d) and (f)	FE- Each applicant/recipient must meet and maintain a level of care for admission into a nursing facility…	FE- MSM Chapter 2200, Section 2203.2A(5)(a)(1)(b)
LOC completed annually or more frequently as needed	FE/PD- Clients must be assessed at minimum annually while receiving waiver services to reaffirm eligibility, including level of care. If there is a significant change in the client's condition that would affect the level of services or program eligibility, reassessment is made at that time.	FE/PD- Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (f) and (i)	FE/PD- The recipient's level of care, functional status and needs addressed by the POC must be reassessed annually or more often as needed.	FE- MSM Chapter 2200, Section 2203.1A(3)(b) PD- MSM Chapter 2300, Section 2303.1A(3)(b)

[1] The requirements in this grid are cited as written in the HCBS FE Waivers effective July 1, 2015 and July 1, 2020, the HCBS PD Waiver effective January 1, 2018, the MSM Chapter 100 effective May 1, 2019 and August 28, 2019, the MSM Chapter 2200 effective September 25, 2019 and February 1, 2021, the MSM Chapter 3900 effective July 13, 2012 (obsoleted), and the MSM Chapter 2300 effective September 25, 2019. Obsolete verbiage in this report will be updated upon revision of these documents.

Contact made with recipient within 15 business days of receiving referral (**New enrollees ONLY**)	FE/PD- When a referral is received and assigned; the Intake Specialist makes phone/verbal contact with the applicant or his or her representative within fifteen working days of receipt of the referral.	FE/PD- Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (f)	FE- The ADSD intake specialist will make phone/verbal contact with the applicant/ designated representative/LRI within 15 working days from the referral date.	FE- MSM Chapter 2200, Section 2203.12A(1)(b)
Initial assessment (LOC) completed within 45 days of ADSD receiving referral (**New enrollees ONLY**)	FE/PD- The face-to-face assessment to determine level of care and waiver service need must occur within 45 calendar days of the referral date to assure timely access to services.	FE/PD- Appendix B: Evaluation/Reevaluation of Level of Care. Quality Improvement: Level of Care (c) (ii)	If the applicant appears to be eligible, a face-to-face visit must be scheduled and completed within 45 calendar days from the referral date to assess eligibility including the NF LOC determination.	FE- MSM Chapter 2200, Section 2203.12A(1)(c)

Plan of Care (POC)

Assurance	Waiver Requirement	Waivers	MSM Requirement	MSM Chapter
Assessed needs identified on CSHA are reflected on POC	FE/PD- Performance Measure: Number and percent of recipients POCs that address the assessed needs identified in the social health assessment.	FE/PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, D-1.(c) and (d) and D-2(a)	FE/PD- The POC must reflect the recipient's service needs and include both waiver and non-waiver services in place at the time of POC completion, along with informal supports that are necessary to address those needs.	FE- MSM Chapter 2200, Section 2203.1A(3)(a) PD- MSM Chapter 2300, Section 2303.1A(3)(a)
Personal goals identified on CSHA are addressed on POC	FE/PD- Number and percent of recipients POCs that address personal goals identified in the social health assessment.	FE/PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, D-1.(c) and (d) and D-2(a)	FE/PD- 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.	FE- MSM Chapter 2200, Section 2203.4A(3) PD- MSM Chapter 2300, Section 2303.3E(3)
Health and safety risks identified on CSHA are addressed on POC	FE/PD- Performance Measure: Number and percent of recipients POCs that address health and safety risk factors identified in the social health assessment.	FE/PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, D-1.(e) and D-2(a)	FE- Monitoring the overall provision and quality of care of waiver services, in order to protect the health, welfare and safety of the recipient, and to determine that the POC goals are being met. PD- A written POC is developed in conjunction with the recipient by the DHCFP District Office Case Manager for each recipient under the waiver. The POC is based on the assessment of the recipient's health and welfare needs.	FE- MSM Chapter 2200, Section 2203.4A(3) PD- MSM Chapter 2300, Section 2303.3A
Frequency/Duration/Scope of each service is identified	FE/PD- Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.	FE/PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, D-1.(c) and (d) and D-2(a)	FE- In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC. PD- N/A	FE- MSM Chapter 2200, Section 2203.3B(1)(c-e), (h), (j-l) PD- N/A

Services on the POC have a current prior authorization	FE- The case manager ensures that the services on the POC are assigned the appropriate prior authorization. PD- All waiver services are prior authorized.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (b)(i) PD- Appendix I: Financial Accountability, Section I-2: Rates, Billing and Claims (1 of 3), (b)(2)	FE- Ensure completion of prior authorization form, if required, for all waiver services documented on the POC for submission into the Medicaid Management Information System (MMIS). PD- Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility: 11. Completion of prior authorization form in the Medicaid Management Information System (MMIS).	FE- MSM Chapter 2200, Section 2203.11 PD- MSM Chapter 2300, Section 2303.1A(10)
Service level identified ***(FE residential facilities or assisted living ONLY***)	FE- The service level provided is based on the recipient's functional needs to ensure his or her health, safety and welfare in the community. The case manager determines the service level.	FE- Appendix C: Participant Services, Section C-1/C-3: Service Specification	FE- There are three service levels of Augmented Personal Care. The service level provided is based on the recipient's functional needs to ensure his/her health, safety and welfare in the community.	FE- MSM Chapter 2200, Section 2203.10A
Signed by recipient indicating participation in development of POC (at next face-to-face home visit; FE every 3 mo.; PD-every 6 mo.)	FE- N/A PD- Performance Measure: Number and percent of recipients POCs that contain the recipient's signature indicating participation in POC development.	FE- N/A PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b)	FE- If services documented on a POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible. PD- All forms must be complete with signature and dates when required.	FE- MSM Chapter 2200, Section 2203.1A(3)(c) PD- MSM Chapter 2300, Section 2303.14A(4)(a)(6)
POC updated with waiver enrollment (**New enrollees ONLY**)	FE- Performance Measure: Number and percent of new applicants whose POC is completed within no more than 30 calendar days of waiver enrollment. PD- Performance Measure: Number and percent of new applicants whose POC is completed within no more than 60 calendar days of waiver enrollment.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b)	N/A	N/A

POC revised as needed (when a significant change lasting more than 30 days occurs)	FE/PD- Performance Measure: Number and percent of recipients' POCs that are updated when the recipient's needs changed.	FE/PD- Appendix D: Participant Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(c)	FE- The recipient's level of care, functional status and needs addressed by the POC must be reassessed annually or more often as needed. PD- The recipient's LOC, functional status and needs addressed by the POC must be reassessed annually or more often as needed.	FE- MSM Chapter 2200, Section 2203.3A(4)(c) PD- MSM Chapter 2300, Section 2303.1A(3)(b)
POC completed annually	FE/PD- Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.	FE/PD- Appendix D: Participant Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(c)		

Forms

Assurance	Waiver Requirement	Waivers	MSM Requirement	MSM Chapter
SOU signed by recipient or authorized representative	FE- Performance Measure: Number and percent of recipients whose SOU is signed indicating choice [of] providers and choice of services. PD- Performance Measure: Number and percent of recipients whose SOU is signed indicating choice of waiver services and institutional care, choice of providers and choice of services.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(e) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(e)	FE- ADSD will forward an initial assessment (IA) packet to the DHCFP Central Office Waiver Unit, which will include: ...the Statement of Understanding/Choice (SOU) must be complete with signature and dates. PD- All forms must be complete with signature and dates when required.	FE- MSM Chapter 2200, Section 2203.12A(5)(b) PD- MSM Chapter 2300, Section 2303. 14A(4)(a)(6)
Recipient Rights reviewed (initially and annually)	FE- The client Bill of Rights is reviewed during the initial application process and as needed thereafter. PD- Case managers provide a copy of the HCBW Recipient Rights to all individuals at the initial home visit and annual home visit so. In addition, case managers review the Recipient Rights at the six month home visit.	FE- Appendix G: (c)Participant Safeguards , Appendix G-1: Response to Critical Events or Incidents c. Participant Training and Education PD- Appendix B: Evaluation/Revaluation of Level of Care, Section Quality Improvement: Level of Care, (a)(i)(c)(ii)	FE- The HCBS Acknowledgement Form completed including initials, signature, and date. PD- All forms must be complete with signature and dates when required.	FE- MSM Chapter 2200, Section 2203.12A(5)(c) PD- MSM Chapter 2300, Section 2303. 14A(4)(a)(6)
Preventative health care information provided annually	FE/PD- Performance Measure: d) Number and percent of recipients who receive information annually regarding preventative health care.	FE/PD- Appendix G: Participant Safeguards, Quality Improvement: Health and Welfare, (a)(i)(a)(d)	FE- The HCBS Acknowledgement Form completed including initials, signature, and date. PD- All forms must be complete with signature and dates when required.	FE- MSM Chapter 2200, Section 2203.12A(5)(c) PD- MSM Chapter 2300, Section 2303. 14A(4)(a)(6)

Monthly Contacts and Documentation

Assurance	Waiver Requirement	Waivers	MSM Requirement	MSM Chapter
Contact with each recipient completed on a monthly basis	FE- Contacts may be by telephone, but there must be a home visit to each recipient at least every three months, or more often if the recipient has indicated a significant change in status or if there are reasons for concern about health and safety. PD- The direct service case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every six months. More contacts may be made if the recipient has indicated a significant change in his or her health care status or is concerned about his or her health and/or safety.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d)(f) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d)(f)	FE- The case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every three months…During the monthly contact, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. PD- The direct service case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every six months.	FE- MSM Chapter 2200, Section 2203.4A(4)(a)&(c) PD- MSM Chapter 2300, Section 2303.3E(4)(a)
Face-to-Face (minimum every 3 mo.-**FE**; every 6 mo.-**PD**)				
Health & safety issues identified and followed up (recipient's condition)	FE- Contacts may be by telephone, but there must be a home visit to each recipient at least every three months, or more often if the recipient has indicated a significant change in status or if there are reasons for concern about health and safety. PD- In addition to the [CSHA], individualized goals, risks, back-up plans, and follow-up on health and safety needs is addressed during the monthly contacts.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d)(f) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (5 of 8), (e)	FE- During the monthly contact, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. PD- During the monthly contact, the direct service case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and	FE- MSM Chapter 2200, Section 2203.4A(4)(c) PD- MSM Chapter 2300, Section 2303.3E(4)(c)

Needs & concerns followed up and documented monthly (any changes in services or providers)	FE- 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. PD- Contacts may be by telephone, but there must be a home visit to each participant at least every 6 months or more often if the participant has indicated a significant change in health care status or if there are reasons for concern about health, safety, and welfare.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section D-2: Service Plan Implementation and Monitoring (a) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d)(f)	follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC.	
Waiver service satisfaction assessed monthly	FE- Monthly contacts with the recipients are required to be initiated by the case manager to discuss the authorized services and evaluate the recipient's level of satisfaction. PD- Monthly contacts with the recipients are required and initiated by the case manager to discuss the authorized services and evaluate the recipient's level of satisfaction.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan (4 of 8), (d)(f) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d) Service Plan Development Process, (f)		
Personal goals assessed monthly	PD- In addition to the [CSHA], individualized goals, risks, back-up plans, and follow-up on health and safety needs is addressed during the monthly contacts.	PD- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (5 of 8), (e)		

Financial Claim Review Requirements

Eligibility

Assurance	Waiver Requirement	Waivers	MSM Requirement	MSM Chapter
Enrollee eligible on the date of service	FE/PD- The Medicaid Management Information System (MMIS) assures that all claims for payment are made when the recipient was eligible for Medicaid waiver payment on the date of service, that the service was included in the recipient's approved service plan, and that the services were provided. This is accomplished through several subsystems within MMIS.	FE/PD- Appendix I: Financial Accountability, Section I-2: Rates, Billing and Claims (3 of 3), (d)(a)	FE- The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service is included in the approved POC, and prior authorization is in place when required. PD- The DHCFP must assure CMS all claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service(s) are identified on the approved POC, and if the service(s) has been prior authorized.	FE- MSM Chapter 2200, Section 2203.14 PD- MSM Chapter 2300, Section 2303.15
Are there any conflicting services provided during the review month/service dates (*Institutional care*)	FE/PD- In accordance with 42 CFR 441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, an NF or ICF/IID.	FE/PD- 6. Additional Requirements, B. Inpatients.	FE- A recipient's case may be suspended, instead of closed if it is likely the recipient will be eligible again for waiver services within the next 60 days (for example, if a recipient is admitted to a hospital, nursing facility or ICF/MR). PD- Recipients must be suspended when they are admitted to a hospital or an NF.	FE- MSM Chapter 2200, Section 2204.1(a) PD- MSM Chapter 2300, Section 2304.1A(1)

Prior Authorization

Assurance	Waiver Requirement	Waivers	MSM Requirement	MSM Chapter
Is service prior authorized	FE/PD- Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization.	FE- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability (a)(i)(a) PD- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability (a)(i)	FE- All providers may only provide services that have been identified in the POC and that, if required, have a prior authorization. PD- Administrative case management activities include...Completion of prior authorization form in the Medicaid Management Information System (MMIS).	FE- MSM Chapter 2200, Section 2203.3B(1)(e) PD- MSM Chapter 2300, Section 2303.1A(11)

Correct provider type	N/A	N/A	FE- Must obtain and maintain a HCBW for the Frail Elderly provider number (Provider Type 48 or 57 as appropriate) through the DHCFP's QIO-like vendor. PD- Providers may also refer to the DHCFP's website for a complete list of codes/modifiers billable under Provider Type 58.	FE- MSM Chapter 2200, Section 2203.3B(1)(a) PD- MSM Chapter 2300, Section 2303.15B
Procedure code/service level correct	FE/PD- Performance Measure: Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization.	FE- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)(a) PD- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)	FE- The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service is included in the approved POC, and prior authorization is in place when required. PD- The DHCFP must assure CMS all claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service(s) are identified on the approved POC, and if the service(s) has been prior authorized.	FE- MSM Chapter 2200, Section 2203.14 PD- MSM Chapter 2300, Section 2303.15

Daily Record

Assurance	Waiver Requirement	Waivers	MSM Requirement	MSM Chapter
Services provided match the POC	FE- Number and percent of recipients services that are delivered in accordance with the approved POC. PD- The individual POC lists the services by scope, frequency, and duration. Case managers fax a copy of the appropriate POC to waiver providers and may go over the POC with waiver providers if requested. Providers are required to provide the services listed in the approved POC. The daily record verifies that services were provided in accordance with the approved POC.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(d) PD- Appendix I: Financial Accountability, Section I-2: Rates, Billing and Claims (3 of 3), (d)(b)	FE- All providers may only provide services that have been identified in the POC and that, if required, have a prior authorization. PD- All Providers...May only provide services that have been identified in the recipient POC and, if required, have prior authorization.	FE- MSM Chapter 2200, Section 2203.3B(1)(e) PD- MSM Chapter 2300, Section 2303.3B(1)(d)

Frequency of Services match the POC	FE/PD- Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(d) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b)		
Daily log signed by recipient	FE- The claims are compared to the prior authorizations, POC and daily logs or timesheet signatures for accuracy. PD- Waiver claims are pulled directly from the MMIS system and compared to the appropriate POC and daily records for verification of service delivery.	FE- Appendix I: Financial Accountability, Section I-1: Financial Integrity and Accountability, (b) PD- Appendix I: Financial Accountability, Section I-2: Rates, Billing and Claims (3 of 3), (d)(c)	FE- The daily record is documentation completed by a provider, indicating the scope and frequency of services provided. The documentation will include the recipient's initials daily with a full signature of the recipient on each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the recipient file. PD- Each provider agency must have a file for each recipient. In the recipient's file, the agency must maintain the daily records. Periodically, the DHCFP Central Office staff may request this documentation to compare to billings submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.	FE- MSM Chapter 2200, Section 2203.3B(1)(h) PD- MSM Chapter 2300, Section 2303.3B(2)(a)(10)
Service units billed fall within the PA units allowed	FE/PD- Performance Measure: Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization.	FE/PD- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)(a) FE/PD- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)	FE- May only provide services that have been identified in the recipient POC and, if required, have prior authorization. PD- All Providers...may only provide services that have been identified in the recipient POC and, if required, have prior authorization.	FE- MSM Chapter 2200, Section 2203.3B(1)(e) PD- MSM Chapter 2300, Section 2303.3B(1)(d)

Payment

Assurance	Waiver Requirement	Waivers	MSM Requirement	MSM Chapter
Is the provider eligible for payment (active)	N/A	N/A	FE-Must obtain and maintain a HCBW for the Frail Elderly provider number (Provider Type 48 or 57 as appropriate) through the DHCFP's QIO-like vendor. PD- Must enroll and maintain an active HCBW for Persons with Physical Disabilities provider number (type 58).	FE- MSM Chapter 2200, Section 2203.3B(1)(a) PD- MSM Chapter 2300, Section 2303.3B(1)(c)
Medicaid payment to the provider correct	FE/PD- 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 recipient files, Plans of Care, provider qualifications, waiver requirements and DHCFP policy.	FE/PD- Appendix I: Financial Accountability, Section I-1: Financial Integrity and Accountability, (b)	FE- Providers must meet and comply with all provider requirements as specified in MSM Chapter 100. PD- Providers must meet and comply with all provider requirements as specified in MSM Chapter 100.	FE- MSM Chapter 2200, Section 2203.3B(1)(b) PD- MSM Chapter 2300, Section 2303.3B(1)(b)
Services paid according to the Medicaid allowable rate				
Overpayment to provider	FE- If claims are found to be incorrect, a referral is made to DHCFP SURS unit to investigate under/over payments. PD- 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.	FE- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)(b)(i) PD- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (b)(i)		
Referral to Surveillance and Utilization Review (SURS)				

Acronyms & Definitions

ADC/ADHC - (ADULT DAY CARE/ADULT DAY HEALTH CARE)

An organized program of services during the day in a group setting for the purpose of supporting the personal independence of older adults and promoting their social, physical, and emotional well-being.

ADL - (ACTIVITIES OF DAILY LIVING)

Self-care activities routinely performed on a daily basis, such as bathing, dressing, grooming, toileting, transferring, mobility, continence and eating.

ADSD - (AGING AND DISABILITY SERVICES DIVISION)

A State agency in Nevada's Department of Health and Human Services (DHHS) responsible for operating the Home and Community Based Services (HCBS) Waivers for the Frail Elderly, Physically Disabled, and Individuals with Intellectual Disabilities.

AL - (HCBS WAIVER FOR ASSISTED LIVING)

A 1915(c) Waiver Program that provides assisted living services to individuals who are age 65 and older who, but for the provision of such services, would require a Nursing Facility (NF) level of care (LOC). This waiver was merged with the Waiver for the Frail Elderly (FE) effective July 1, 2015.

APC – (AUGMENTED PERSONAL CARE)

CFR - (CODE OF FEDERAL REGULATIONS)

The CFR is a codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal government. The Code is divided into 50 titles which represent broad areas subject to federal regulation.

CM – (CASE MANAGER)

CMT - (CASE MANAGEMENT)

Case management is a process by which an individual's needs are identified and social and medical services to meet those needs are located, coordinated, and monitored. Case management may be targeted to certain populations in certain areas of the state under the authority of Section 1905(a)(19) of the Social Security Act.

CMS - (CENTERS FOR MEDICAIRE & MEDICAID SERVICES)

The Federal government entity that monitors state programs to assure minimum levels of public health service are provided, as mandated in CFR Title 42.

CSHA/SHA - (COMPREHENSIVE SOCIAL HEALTH ASSESSMENT)

An assessment that addresses 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 assessment includes information regarding the recipient's medical history and social needs. The assessment includes risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs.

CPAP – (CONTINOUS POSITIVE AIRWAY PRESSURE)

CPR - (CARDIOPULMONARY RESUSCITATION)

Cardiopulmonary resuscitation is a lifesaving technique useful in many emergencies, including heart attack or near drowning, in which someone's breathing or heartbeat has stopped. The American Heart Association recommends that everyone, untrained bystanders, and medical personnel alike, begin CPR with chest compressions.

DHCFP - (DIVISION OF HEALTH CARE FINANCING AND POLICY)

A State agency in Nevada's Department of Health and Human Services (DHHS) that works in partnership with the Centers for Medicare & Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources.

DHHS - (DEPARTMENT OF HEALTH AND HUMAN SERVICES)

The Department of Health and Human Services (DHHS) is an office of the Executive Branch of State Government and is led by a Director appointed by the Governor. DHHS is one of the largest departments in State government comprised of five Divisions including: Aging and Disability Services, Child and Family Services, Health Care Financing and Policy (Medicaid), Public and Behavioral Health, and Welfare and Supportive Services.

DME - (DURABLE MEDICAL EQUIPMENT)

Medically necessary durable medical equipment that a doctor prescribes for use in the home.

EVCC – (EAGLE VALLEY CARE CENTER)

FBI - (FEDERAL BUREAU OF INVESTIGATION)

The mission of the FBI—as a national security and intelligence organization—is to protect and defend the United States against terrorist and foreign intelligence threats, to uphold and enforce the criminal laws of the United States, and to provide leadership and criminal justice services to federal, state, municipal, and international agencies and partners.

FE - (HCBS WAIVER FOR THE FRAIL ELDERLY)

A 1915(c) Waiver Program (formerly Community Home Base Initiative Program) that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for the frail elderly who would otherwise need institutional nursing facility services.

GH – (GROUP HOME)

HCBS/HCBW - (HOME & COMMUNITY-BASED SERVICES/HOME & COMMUNITY BASED WAIVER)

Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as the frail elderly, people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

HCQC - (HEALTH CARE QUALITY AND COMPLIANCE)

The Bureau of Health Care Quality and Compliance (HCQC) protects the safety and welfare of the public through the promotion and advocacy of quality health care through licensing, regulation enforcement, and education.

HDM – (HOME DELIVERED MEALS)

HFA – (HEALTH FUNCTIONAL ASSESSMENT)

HIPAA - (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

The HIPAA of 1996 is a law to improve the efficiency and effectiveness of the health care system. HIPAA included a series of "administrative simplification: procedures that establish national standards for electronic health care transactions, and requires health plans (i.e., Medicaid and Nevada Check Up) and health care providers that process claims and other transactions electronically to adopt security and privacy standards in order to protect personal health information.

HMKR – (HOMEMAKER)

HUD – (DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT)

HV – (HOME VISIT)

IA - (INITIAL ASSESSMENT)

This assessment is conducted as an administrative function of the waiver program and evaluates service needs based on functional deficits, support systems, and imminent risk of institutionalization.

IADL - (INSTRUMENTAL ACTIVITIES OF DAILY LIVING)

Activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication and money management.

LOC - (LEVEL OF CARE)

The specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the State Plan and home and community-based services waiver. LOCs are based on current assessments showing level of functional skills and support needs. The assessments include psychological evaluation, medical records, nursing, and social assessments completed by professionals.

LRI - (LEGALLY RESPONSIBLE INDIVIDUAL)

Individuals who are legally responsible to provide medical support including: spouses of recipients, legal guardians, and parents of minor recipients, including: stepparents, foster parents, and adoptive parents.

LTSS - (LONG TERM SERVICES AND SUPPORTS)

A unit within the Division of Health Care Financing and Policy that provides services specifically to Medicaid eligible recipients. This includes services for a diverse group of Nevadans including the elderly and people living with disabilities and special health care needs. LTSS provides both institutional and home and community-based care.

MC – (MONTHLY CONTACT)

MD - (MEDICAL DOCTOR)

A licensed medical practitioner.

MFCU - (MEDICAID FRAUD CONTROL UNIT)

Statewide program that investigates and prosecutes Medicaid providers that obtain Medicaid funds through fraudulent means.

MMIS - (MEDICAID MANAGEMENT INFORMATION SYSTEM)

A computer system designed to help managers plan and direct business and organizational operations.

MSM - (MEDICAID SERVICES MANUAL)

The policies that govern Medicaid services.

MTM – (MEDICATION THERAPY MANAGEMENT)

NF - (NURSING FACILITY)

NF is a general Nursing Facility, free-standing or hospital-based, which is licensed and certified by the Division of Public and Behavioral Health, Health Care Quality and Compliance, and provides both skilled and intermediate nursing services.

NMO - (NEVADA MEDICAID OFFICE)

The Nevada Medicaid Office is responsible for policy, planning and administration of the Nevada Medicaid program; also known as the Division of Health Care Financing and Policy.

NOD - (NOTICE OF DECISION)

A Notice of Decision is sent to a waiver recipient for the following reasons: denial, suspension, reduction, and termination. The Notice of Decision outlines the recipient's right to a Fair Hearing.

OT – (OCCUPATIONAL THERAPY)

P&P TRANSMITTAL - (POLICY & PROCEDURE TRANSMITTAL)

The Policy and Procedure Transmittals are designed to provide a consistent format for communicating policy clarification within the Division of Health Care Financing and Policy and among sister agencies.

PA - (PRIOR AUTHORIZATION)

A review conducted to evaluate medical necessity, appropriateness, location of service and compliance with Medicaid's policy, prior to the delivery of service.

PCA - (PERSONAL CARE ASSISTANT)

Personal care assistants, also known as caregivers, home health or personal care aides, give assistance to people who are sick, injured, mentally or physically disabled, or the elderly and fragile.

PCS - (PERSONAL CARE SERVICES)

Hands-on assistance with activities of daily living (ADLs) (such as eating, bathing, dressing, and bladder and bowel requirements) or instrumental activities of daily living (IADLs) (such as taking medications and shopping for groceries).

PD - (HCBS WAIVER SERVING PEOPLE WITH PHYSICAL DISABILITIES)

A 1915(c) Waiver Program that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for persons with physical disabilities who would otherwise need institutional nursing facility services.

PERS - (PERSONAL EMERGENCY RESPONSE SYSTEM)

An electronic device which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a landline and programmed to signal a response center once the "help" button is activated.

PES - (PARTICIPANT EXPERIENCE SURVEY)

An interview tool developed by Medstat Group, Inc. under a contract from the Centers for Medicare and Medicaid Services. The surveys capture data that can be used to calculate indicators for monitoring quality within the waiver programs.

POA – (POWER OF ATTORNEY)

POC - (PLAN OF CARE)

A written document identifying the recipient's health and welfare needs, along with goals and interventions to meet the identified needs. It specifies the level of assistance, type, amount, scope, duration and frequency for all services, as well as other ongoing community support services that may meet the assessed needs of the recipient, regardless of the funding source.

PT – (PHSICAL THERAPY)

QA - (QUALITY ASSURANCE)

A structured, internal monitoring and evaluation process designed to improve quality of care. QA involves the identification of quality-of-care criteria, which establishes the indicators for program measurements and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

QI - (QUALITY IMPROVEMENT)

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.

QIO - (QUALITY IMPROVEMENT ORGANIZATION)

The QIO program focuses on three aims: better patient care, better population health, and lower health care costs through improvement.

SAMS - (SOCIAL ASSISTANCE MANAGEMENT SOFTWARE)

Social Assistance Management Software or SAMS® manages consumer (recipient) and service data for social assistance organizations.

SOR - (SERIOUS OCCURRENCE REPORT)

A report of any actual or alleged event or situation involving either the provider/employee or recipient that relates a substantial or serious harm to the safety or well-being of the provider/employee or recipient. Serious occurrences may include, but are not limited to the following: suspected physical or verbal abuse, unplanned hospitalization, neglect of the recipient, exploitation, sexual harassment or sexual abuse, injuries requiring medical intervention, an unsafe working environment, any event which is reported to Child or Elder Protective Services or law enforcement agencies, death of the recipient during the provision of Waiver Services, or loss of contact with the recipient for three consecutive scheduled days.

SOU - (STATEMENT OF UNDERSTANDING) / **SOC** (STATEMENT OF CHOICE)

A form given to all applicants describing the services offered under the waiver during the intake process and as required by each waiver. The assigned case manager informs the applicant of their choice between waiver services and placement in a long-term care facility, in addition to their choice of qualified providers.

SUR - (SURVEILLANCE AND UTILIZATION REVIEW)

A statewide program that safeguards against unnecessary or inappropriate use of services by preventing excess payments in the Nevada Medicaid and Nevada Check Up programs. The SUR unit 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.

ST – (SPEECH THERAPY)

SW – (SOCIAL WORKER)

TB - (TUBERCULOSIS)

Tuberculosis is a potentially serious infectious disease that mainly affects the lungs. The bacteria that cause tuberculosis are spread from one person to another through tiny droplets released into the air via coughs and sneezes.

Appendices

See attached appendices:

Appendix A – Detailed Statewide Summaries

Appendix B – Participant Experience Survey Interview Tool

Appendix V – Calculating the FE/PD PES Performance Indicators