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

State:	**NV**
Waiver Base:	**0125**
Report Status:	**ACCEPTED**
Begin Date:	10/01/2016
End Date:	09/30/2017
Initial Submission Date:	03/29/2019
Report Period Year:	2017
Waiver Year:	○ **Year 1** ○ **Year 2** ○ **Year 3** ◉ **Year 4** ○ **Year 5**
Report Type:	○ **Initial Report** ◉ **Lag Report** ○ **TE Report**
Unduplicated Participants:	2,184
Days of Waiver Enrollment:	753,638
Average Length of Stay:	345.1
Total Waiver Expenditures:	$104,745,630.00
APC Waiver Services (Factor D):	47,960
APC for State Plan Services (D'):	11,799
APC Total (D + D'):	$59,759
Factor G Value:	161,950
Factor G' Value:	14,574
APC Total if no waiver (G + G'):	$176,524
D + D' <= G + G':	**$59,759 <= $176,524**
Level/s of Care:	☒ **ICF/IID** ☐ **NF** ☐ **Hospital**

Additional Information (use if needed):

The Aging and Disability Services Division (ADSD) Development Services (DS) is responsible for the operation of this waiver. There are three Regional Centers: Reno, Carson City and Las Vegas.

Additionally, ADSD is the regulatory agency responsible for provider certification of 100% waiver providers. Providers under this waiver are not licensed through the Bureau of Health Care Quality and Compliance (HCQC). Once the certification process is complete, provider enroll through the DHCFP's fiscal agent. Provider must re-enroll every three (3) years. In addition, ADSD conducts recertification reviews approximately every eighteen (18) months.

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

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 (required field):	Level of Care	Participants	Service Category Name
Day Habilitation	ICF/IID	891	

(●) Expenses in $ ( ) Expenses in %

$12,167,509

HCBS Taxonomy:

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

Service Name (required field):	Level of Care	Participants	Service Category Name
Prevocational Services	ICF/IID	970	

(●) Expenses in $ ( ) Expenses in %

$7,570,748

HCBS Taxonomy:

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

Service Name (required field):	Level of Care	Participants	Service Category Name
Residential Support Services	ICF/IID	1,705	

(●) Expenses in $ ( ) Expenses in %

$76,360,884

HCBS Taxonomy:

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

Service Name (required field):	Level of Care	Participants	Service Category Name
Supported Employment	ICF/IID	325	

(●) Expenses in $ ( ) Expenses in %

$2,575,135

HCBS Taxonomy:

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

Service Name (required field):	Level of Care	Participants	Service Category Name
Behavioral Consultation Training & Intervention	ICF/IID	535	

(●) Expenses in $ ( ) Expenses in %

$1,117,960

HCBS Taxonomy:

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

Service Name (required field):	Level of Care	Participants	Service Category Name
	ICF/IID	223	

Service

Counseling Service			
◉ Expenses in $ ○ Expenses in % $78,018			

HCBS Taxonomy:

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

Service Name (required field):	Level of Care	Participants	Service Category Name
Non-Medical Transportation ◉ Expenses in $ ○ Expenses in % $1,224,746	ICF/IID	1,457	

HCBS Taxonomy:

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

Service Name (required field):	Level of Care	Participants	Service Category Name
Nursing Services ◉ Expenses in $ ○ Expenses in % $315,238	ICF/IID	610	

HCBS Taxonomy:

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

Service Name (required field):	Level of Care	Participants	Service Category Name
Nutritional Counseling Services ◉ Expenses in $ ○ Expenses in % $85,127	ICF/IID	157	

HCBS Taxonomy:

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

Service Name (required field):	Level of Care	Participants	Service Category Name
Residential Support Management ◉ Expenses in $ ○ Expenses in % $3,250,265	ICF/IID	1,689	

HCBS Taxonomy:

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

Service Name (required field):	Level of Care	Participants	Service Category Name
Career Planning	ICF/IID	0	

Service			
◉ Expenses in $ ○ Expenses in % $0			

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:**

The Division of Health Care Financing and Policy (DHCFP) reviews 100% of all applications for waiver services for completeness and conducts a 25% review for packet content. There were 198 applications submitted in waiver year 2017. Of those submitted in 2017, 49 intake packets were reviewed for content.

Findings:

Form 3010 (routing log) complete: 100% correct
Level of Care (LOC) correct: 100% accurate
Agreement between LOC, Person Centered Plan (PCP) and assessment: 100% accurate
Individualized goals identified: 100% accurate
Safety risks identified: 100% accurate
At least one (1) ongoing waiver service: 100% accurate
All needs identified on PCP: 100% identified
PCP or forms acknowledgement signed by recipient or representative: 100% accurate
Statement of Choice (SOC) signed by recipient or representative: 100% accurate

The overall findings for waiver year 2017 indicate 100% compliance in areas reported. Training continues to be available to staff and more specifically to individual case manager when errors are identified.

Hearings:

The DHCFP Compliance Unit monitors hearing and appeals for waiver services. During waiver year 2017, there were eight (8) hearing requests. The majority of hearings requested were denied for insufficient information. Below are the results of the hearing requests that proceeded to the Hearing Preparation Meeting.

2 Resolved HPM (State's Favor) – The matter was resolved during the Hearing Preparation Meeting (HPM). The DHCFP's decision was upheld and the recipient withdrew.

2 Dismissed with Prejudice – One request was withdrawn after re-assessment of the applicant. Another was withdrawn by the Authorized Representative prior to the Hearing date.

1 Dismissed – The recipient began attending the day program and the waiver was reinstated prior to Hearing.

Claims:

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

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 Division of Health Care Financing and Policy (DHCFP) has a Quality Assurance (QA) Unit assigned specifically to review waiver programs. During waiver year 2017, this review process was conducted annually with the operating agency staff. The review includes a case file review, financial review, provider review, and Participant Experience Survey (PES) directly with the waiver recipient.

Case File Review – There were three hundred fifty (350) charts reviewed.

The review focused on six (6) key areas:

1. Waiver Eligibility
2. Waiver Service Received
3. Social Assessment (SA)
4. Person Centered Plan (PCP)
5. Current Contracts/Service Agreements
6. Monthly Contracts and Documentation

Statewide Case File Review Results:

Documentation of ID or RC in file – 94.6%
Meets LOC for admission into ICF/ID – 95.7%
SA completed annually or more frequently as needed - 87.1%
Certification of LOC for admission into ICF/ID completed annually or more frequently as needed – 85.7%
Assessed needs identified on the SA and LOC are reflected in the Support Plan – 82.3%
PCP completed annually or more frequently as needed – 89.4%
Service type specified – 74.9%
Frequency/Duration/Scope of services identified – 72.3%
Recipient health and safety risks identified – 96.0%
Preventative healthcare information provided annually – 96.6%
Recipient individualized goal(s) identified – 95.1%
PCP signed by recipient or designated representative (within 60 days) – 56.6%
PCP signed by Service Coordinator – 91.1%
PCP signed by Service Provider (within 60 days) – 42.3%
Statement of Choice signed by recipient or designated representative – 89.1%
Recipient informed of rights (prior to initiation of services and annually thereafter) – 77.7%
Person-Centered Planning – 94.6%
Habilitation plan in place for services listed on the Support Plan – 61.7%
Supported Living Arrangement – 96.3%
Jobs & Day Training Authorization – 94.6%
Other Waiver Services – 93.7%
Monthly Contact – 87.9%
Face-to-Face Contacts (minimum every 3 months) – 94.0%
Quarterly PCP Review – 86.2%
Health/Safety issues identified and followed up – 86.4%
Needs/Concerns followed up and documented monthly – 85.6%
Waiver Service Satisfaction assessed/addressed – 86.1%
Goals identified in the PCP assessed/addressed monthly – 86.6%

Financial Review:

There were three-hundred ninety (390) financial reviews completed. The review focused on six (6) key areas:

1. Waiver Eligibility
2. Service Authorization
3. Claim
4. Daily Record

5. Payment
6. Provider

Statewide Financial Review Results:

Enrollee is eligible on the date of service 99.7%
No conflicting services during the month 99.2%
Service is prior authorized 97.4%
Service date(s) billed for match the date(s) services were provided 84.6%
Procedure code/procedure modifier is correct 96.6%
Service units billed fall within the contract hours allowed 96.6%
Amount billed is correct 82.2%
Services provided match the contract hours 85.6%
Frequency matches the contract hours 88.0%
Units provided match units billed and payment received 85.4%
Daily record initialed by recipient 76.0%
Daily record initialed by direct service staff 92.7%
Daily record includes full signature of recipient 91.1%
Daily record includes full signature of direct service staff 86.4%
If applicable, documented on the PCP that recipient is unable to sign 94.8%
Payment to provider is correct based on claim submitted 66.3%
Services paid according to the Medicaid allowable rate 100.0%
Percent of total claims referred to SURS 35.5% (Of 383 claims reviewed, 136 claims were submitted to SURs for further review.
Provider eligible for payment at the time of service 100.0%

Provider Review:

Compliance was reported as an overall rate based on all areas. The review focused on six (6) key areas:

1. Provider Qualifications
2. PCP & Habilitation Plan
3. Recipient Safeguards
4. Records Retention
5. Provider Background Check
6. Completion and Documentation of Training

To avoid duplication of efforts on the provider review results, the reviews conducted by the Aging and Disability Services Division (ADSD) were obtained for all the provider reviews for the 2016-2017 review year.

Multiple projects as well as imminent state and federal deadlines left the DHCFP QA and the ADSD with limited time and resources for this waiver year. As a result, the DHCFP QA unit used all provider reviews conducted by the ADSD staff.

Participant Experience Surveys (PES):

There were ninety-eight (98) recipients selected to be interviewed. The review focused on four (4) key areas:

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

The top five (5) questions with 100% recipient satisfaction for this review period were:
- Choice of Roommates

- Ability to Watch TV When Choose
- Ability to Go to Bed When Choose
- Respect by Staff in Home
- Meal Preparation

The five (5) questions with the highest adverse response resulting in an unmet need were:

Choice in the home (37% unmet)
Choice in staff (46% unmet)
Choice in job activity (24% unmet)
Choice of Living Alone (40% unmet)
Ability to Identify Case Manager (22% unmet)

The review of the data captured it is noted that there is an increase in recipient satisfaction regarding services and the level of care provided. The majority of the recipient population interviewed was very pleased with their Service Coordinators. The recipients reported feeling that their support staff and Service Coordinators were always available and allowed them to voice concerns and resolve any conflicts or issues. In Rural Nevada the recipients expressed that although there are limited number of providers, they were pleased with the available providers.

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:

Case File results:
1. LOC Completed annually of more frequently as needed(85.7%)- Documentation to support LOC determination was incomplete or inaccurate.
Recommendation: When completing the LOC, be sure that all information required on the sheet is filled out and that it matches the recipient's diagnosis.

2. Assessed needs identified on SA are reflected on PCP Support Plan(82.3%)– The Social Assessments and/or the Person Centered Plan (PCP) reviewed did not contain at least one need.
Recommendation: The ADSD supervisors are reviewing case files quarterly and addressing the deficiencies noted. Each Regional Center began conducting trainings to service coordinators (SC) annually regarding proper and consistent documentation of assessed needs and must be reflected on PCP Support Plan.

3. Service Type Specified (74.3%)- In the recipient files, specific JDT services were not noted (i.e. Day hab, Supported Employment, Pre-Vocational, etc.)
Recommendation: The ADSD supervisors are reviewing case files quarterly and addressing the deficiencies noted. Trainings have been implemented to ensure SCs are educated with the types of JDT services and the importance of documenting them. Since the training started, it is evident that compliance in this measure is increasing.

4. Frequency/Duration/Scope of Services Identified(72.3%)– Most of the PCP reviewed did not contain the duration of services. It is noted that the ADSD's recent transition to the new Harmony/WellSky management system contributed to the decline in compliance.
Recommendation: Emphasis on education and training of SCs are being implemented on a yearly basis as well as the ADSD supervisors' quarterly review of case files. When deficiency is noted, supervisors are conducting a one-on-one education with the SC.

5. PCP Signed by Recipient or Designated Representative(56.6%)- This performance measure was implemented and became effective 04/01/2016. Recipients and/or designated representative must sign the PCP indicating that they have actively participated in identifying [their] support and preferred outcomes for next year. Signature of recipient is documented on Support Plan Signature Page implemented by the ADSD.
Recommendation: ADSD has developed a form DS-ISP-1 also referred to as "sign-in sheet" as a validation of recipient signature. The compliance rate in this area is expected to go up in the next year.

6. PCP Signed by service provider(42.3%)- Effective 04/01/2016, providers are required to sign the PCP within sixty (60) days from the date of the Statement of Choice or the date of enrollment, whichever is later. Most of the case files that were noted as deficient did not include the Support Plan Signature Page. Some providers did not include a date and QA was unable to determine the timeliness of the Service Provider signature.
Recommendation: Continue to educate Regional Center staff of the appropriate forms to record Service Provider Signature. Upon receipt of PCP, review the form to ensure providers properly completed and signed the PCP; otherwise notify the providers and obtain signature within 60 days.

7. Recipient informed of rights(77.7%)– This area has an increased compliance of 20% from the previous waiver year. An upward trend in compliance continues to be observed. Cases reviewed did not have the appropriate form with the acknowledgement of recipient's rights.
Recommendation: ADSD supervisors to remind SCs to ensure recipient's rights are completed properly, signed by recipient and filed in the case file.

8. Habilitation Plan in place for services listed on the Support Plan(61.7%)– Several of the files reviewed by QA were missing at least one habilitation plan. Previously, it was outlined that the Harmony/WellSky Case Management system was expected to improve the compliance for this measure by allowing providers to directly access their recipient records and enter steps necessary to achieve recipient's outlined goals. Although the case management system has been implemented, it is not available to providers at this time.
Recommendation: Regional Center staff should ensure that providers submit a habilitation plan for implemented services within the specified time frame. The Regional Center held a training reviewing the

habilitation plan, data collection and the appropriate use of the data in the plan review.

Financial Review Results:

1. Service date(s) billed match the date(s) services were provided (84.6%)- It is noted that the deficiencies found were from JDT services where service dates did not match billed dates.
Recommendation: Review recipient daily logs/timesheets when they are submitted to validate that the dates billed match the dates of services.

2. Amount Correctly billed(82.2%)– Services billed did not match dates of services rendered resulting in incorrect billed amounts. This measure is on an upward trend from the prior year.
Recommendation: Providers are now using Harmony to enter the service authorization. Upon proper completion of the service authorization, the billing is done automatically by Harmony, thus prevent human error. The compliance rate for this section is expected to go up.

3. Services provided (scope) match the PCP Service Authorization Contract Hours(85.6%)– There was a 15% increase in compliance from previous waiver review. Out of the total claims examined, fifty-five (55) claims reviewed showed services provided were outside the scope of services authorized, claims included services that were not authorized and/or were submitted for incorrect procedure codes(billing for T2020 when authorized for T2014).
Recommendation: Continued outreach and education to providers and ADSD regarding the use of the appropriate billing codes. During ADSD QA's certification and review of providers, proper billing training will be included.

4. Service units/days provided match units billed and for which payment was received(85.4%)– With a 16% compliance increase, a significant improvement is shown in contrast to the previous waiver review. Out of the total claims examined, fifty-six (56) claims documented service units provided that did not support the number of units for which payment was received.
Recommendation: When claims are submitted, review the daily logs/timesheets to validate that the number of units billed does not exceed what was authorized. The claims are now processed through the Harmony system lessening error rate.

5. Daily record initialed by recipient(76.0%)– Missing recipient's initials and no documentation indicating recipient is unable to sign or initials daily records.
Recommendation: ADSD to continue reiterating the importance of recipient's initials or sigs and educate providers during ADSD QAs review.

6. Payment to provider correct based on claim submitted(66.3%)– Payments to providers did not match claims submitted. A slight increase in compliance is noted for this performance measure. The continued use of the Harmony system has contributed to the increase in compliance.
Recommendation: Since providers are now submitting their claims electronically through ADSD's Harmony coupled with continuous provider education, it is expected that the compliance rate will continue to improve overtime. ADSD and DHCFP will track and monitor providers to ensure positive outcome.

7. % of total claims referred to SUR - Of 383 cases reviewed 136 (35.5%) were submitted to SURS for further review and recoupment if warrant. At this time, SURs is still in the process of reviewing all cases referred to them. Will update CMS upon receipt of the review outcome.

Monthly Quality Improvement (QI) meetings are collaborative efforts between DHCFP and ADSD to discuss deficiencies and remediation. Deficiencies that are re-occurring are entered and tracked on a priority grid. ADSD and DHCFP are continuously working towards improvement in the quality of care and services that are offered to the recipients participating in the ID Waiver.

Additional recommendations:

All paperwork must be filled in its entirety and reviewed for completeness by ADSD staff across all Regional Centers. Ensure areas for initials, signatures and other information must be completed on the

required documentation.

The Harmony/WellSky face sheet should reflect an accurate waiver start date for every recipient.

It is recommended that all SCs use the Harmony/WellSky Monthly Contact template as this outlines all the components required for review including method and location of contact. The monthly contact must clearly states who SCs had made contact with i.e. recipient, guardian or the providers.

If a recipient is unable to sign/initial due to cognitive and/or physical limitations, this should be clearly documented on the PCP.

It is recommended that Developmental Services develop a process for documenting Regional Center Director approval when more than four (4) individuals reside in an ISLA home.

It is recommended that Regional Centers provide more training to providers on proper documentation, complete necessary forms, required documentation must be on file or readily available upon request, and how to submit clean claims.

Modifications and Updates:

Of those SCs who utilize Harmony/WellSky Case Management system, it clearly documents location of monthly contact as well as recipient satisfaction with waiver services. ADSD's goal is to have all SCs trained on and utilized the database.

ADSD Regional Centers implemented streamlined checklist process of ensuring all required documentation is included within each recipient's case file.

ADSD Regional Centers have incorporated multiple mandatory trainings to educate SCs about the necessary items to be included in the PCP packet as well as addressing concerns outlined during the monthly review meetings. Trainings are offered among all three (3) regional centers and cover topics such as general waiver information, Person Centered-Planning Process, documentation of RSM and completing the Support Plan portion of the PCP etc.

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: Kirsten Coulombe **Date:** 03/29/2019

Contact Information (optional):

Contact Person:

Phone Number:

PRA Disclosure Statement

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