Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The following are the changes made to this five-year renewal of the Nevada Waiver for Individuals with Intellectual Disabilities and Related Conditions:

All references to “Related Conditions” have been removed and replaced with “Developmental Disabilities,” as defined in Nevada Revised Statutes 435.007. This language change was approved through Nevada Assembly Bill No. 224 during the 2017 Nevada Legislative Session.

The Division of Health Care Finance and Policy (DHCFP) Continuum of Care Unit has been renamed to the “Long Term Services and Supports Unit” (LTSS).

The DHCFP’s Provider Enrollment Unit and the fiscal agent has changed the provider revalidation term to five (5) years.

Performance Measures have been modified, as applicable.

The ADSD’s ELCID and DS-Now database systems have been replaced with the Harmony information system.

The Individual Service Plan (ISP) is now named the Person Centered Plan (PCP).

The service definition and provider qualifications for Career Planning have been modified, as this service was not being utilized due to a lack of providers that qualified under the previous qualifications. These changes now bring Nevada’s Career Planning service in line with other states with a similar service.

The service definition for nursing was expanded to allow for additional types of nursing services not covered by Medicaid State Plan.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

HCBS Waiver for Individuals with Intellectual and Developmental Disabilities

C. Type of Request: renewal

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NV.0125
Waiver Number:NV.0125.R07.00
Draft ID: NV.009.07.00

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

Regular Waiver

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

10/01/18

Approved Effective Date: 10/01/18

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The State of Nevada Home and Community-Based Services Waiver for Individuals with Intellectual and Developmental Disabilities is administered by the Division of Health Care Financing and Policy (DHCFP) and operated by the Aging and Disability Services Division (ADSD); both divisions of the Department of Health and Human Services (DHHS).

The goal of this waiver is to provide the option of home and community-based services as an alternative to Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID) placement, and to allow for maximum independence for individuals with developmental disabilities who would otherwise be placed in an ICF.

The target population includes individuals of all ages who have an intellectual and developmental disabilities . Individuals must satisfy Medicaid requirements, meet an ICF/IID level of care, and be at risk of institutional placement.

Eligible participants may be placed on the waiver from an ICF/IID, or from the community. An evaluation is performed by an ADSD service coordinator in order to determine whether an applicant meets the ICF/IID level of care required for waiver participation. Persons who become waiver eligible may receive the following waiver services:

Day Habilitation
Residential Support Services
Prevocational Services
Supported Employment
Behavioral Consultation, Training and Intervention
Career Planning
Counseling (Individual and Group)
Residential Support Management
Non-Medical Transportation
Nursing Services
Nutrition Counseling

Eligibility determination for the Home and Community-Based Services Waiver for Individuals with Intellectual and Developmental Disabilities is completed through the collaborative efforts of the DHCFP, the ADSD, and the Division of Welfare and Supportive Services (DWSS).

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and

welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met

for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for

each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

In order to secure public input into the development of the waiver, a statewide public workshop was held in March 2018, that was open to the general public, providers, recipients and employees. During the workshop attendees were given an opportunity to voice opinions, concerns and share ideas related to the development of the waiver. A web page was added to the Division of Health Care Financing and Policy providing the following information: the proposed waiver, the current waiver and instructions on providing public comment. Additionally, each Regional Center solicits ongoing recommendations for improvements from employees. No specific focus groups were held at this time as there is not sufficient budget for service changes to be made.

A combined effort with ADSD and DHCFP was made to provide opportunity to the public for input regarding the ID Waiver renewal. Each Developmental Services Regional Center solicits input from employees, recipients and community providers of Home and Community-Based Services (HCBS). The general public was notified on May 16, 2018, of the waiver renewal, where to view the renewal application, and how to submit comments and input. This public noticed was posted at several public locations throughout Nevada as well as the following web link: http://dhcfp.staging.nv.gov/Home/features/Waiver_for_Individuals_with_Intellectual_Disabilities_and_Related_Conditions/. The public comment period ended June 17, 2018.

During the comment period the Long Term Services and Supports (LTSS) Unit received one comment during the 30-day period regarding the ID waiver renewal. It was noted that Pre-employment services should have a time limit. Many of our supports do not have a time limit as the need for services is ongoing for the majority of recipients.

Another comment was received after the 30-day period. Within the statement received several points pertained to the operational policy of the waiver. The suggestions were forwarded to the appropriate staff at the ADSD. The one point that did impact the renewal was a concern with the “related conditions” vs “developmental disabilities” language. The areas of concerns where reviewed and the verbiage updated to better reflect the intent and definition.

Legislative or public hearings were held when enhancements or new initiatives were being considered for funding. Public hearings were conducted when policy changes were made.

Input from Tribal Government was solicited; in response to (J) below. The Tribal Government was presented with information regarding the waiver renewal during a quarterly Tribal Council Meeting held on April 10, 2018. Tribal Members of the Inter-Tribal Council of Nevada where sent a letter dated May 9, 2018 as notification of the waiver expiration date, an overview of the changes expected to be made to the waiver, anticipated fiscal impact and offer of a consultation regarding the waiver renewal. This is in addition to the public comment period that was made available to ensure an ample timeframe to submit comments.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Coulombe

First Name:

Kirsten

Title:

Social Services Chief III

Agency:

Division of Health Care Financing and Policy

Address:

1100 East William Street, Suite 101

Address 2:

City:

Carson City

State: **Nevada**

Zip:

89701

Phone:

(775) 684-3747 **Ext:** ☒ **TTY**

Fax:

(775) 687-8724

E-mail:

kirsten.coulombe@dhcfp.nv.gov

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

Last Name:

Adams

First Name:

Jessica

Title:

Health Program Manager III

Agency:

Aging and Disability Services Division

Address:

3416 Goni Rd., Bldg. D-132

Address 2:

City:

Carson City

State: **Nevada**

Zip:

89706

Phone:

(775) 684-5894 **Ext:** ☐ **TTY**

Fax:

(775) 687-0574

E-mail:

jnadams@adsd.nv.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Kirsten Coulombe

State Medicaid Director or Designee

Submission Date: Dec 6, 2018

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Whitley

First Name: Richard

Title: Director

Agency: Department of Health and Human Services

Address: 4126 Technology Way, Suite 100

Address 2:

City: Carson City

State: **Nevada**

Zip: 89706-2009

Phone: (775) 684-4000 **Ext:** ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Not applicable as this is a renewal.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

"The State assures that the settings transition plan included with this renewal will be subject to any provisions or requirements included in the state’s approved Statewide Transition Plan. The State will implement any required changes upon CMS approval of the Statewide Transition Plan and will make conforming changes to this waiver when it submits the next amendment or renewal.”

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continued from Appendix I-2.a:

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

The survey will allow for provider comments and questions.
- Administration of the survey.
- Analysis and compilation of survey data.

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

Timeline for cost study:
- Begin process October 2018
- Survey to providers by January 2019
- Survey returned to DHCFP by April 2019
- Analysis and compilation of data May-July 2019
- Public Workshop for Waiver amendment August 2019
- Finalized cost Study to CMS by September 30, 2019

The State will also include in the rate study a comparison analysis of rates between Nevada and neighboring states with similar ID waiver services.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

○ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Aging and Disability Services Division (ADSD)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Division of Health Care Financing and Policy (DHCFP) maintains administrative oversight over the Waiver for Individuals with Intellectual and Developmental Disabilities. This is done through an Interlocal Agreement between the DHCFP and the ADSD, which is renewed every five years. Through the Interlocal Agreement, the DHCFP performs the following administrative functions:

Ensures the rules and regulations pertaining to the waiver population are being followed;
Ensures that all individuals who meet requirements for the waiver are provided equal access;
Ensures that appropriate waiver intake activities are followed for the determination of waiver eligibility;
Reviews and approves all waiver intake packets to ensure applications meet level of care and disability criteria;
Conducts training and technical assistance concerning waiver requirements;
Monitors waiver caseloads against approved budgeted limits and monitors expenditures annually;
Conducts annual program and financial reviews of the waiver;
Sends the recipient a Notice of Decision (NOD) for terminations, reductions, suspensions and denials in accordance with policy, which includes, but is not limited to, the recipient's right to a fair hearing;
Notifies the ADSD, in writing, to continue waiver services pending the outcome of a fair hearing, if requested by the recipient;
Processes ADSD claims in accordance with Medicaid policy and limitations; and
Updates and reviews waiver policy, as needed.

The Interlocal Agreement further defines the operation of the waiver and the responsibilities of the ADSD, which include the evaluation of level of care and service plan development. The ADSD is also responsible for ongoing monitoring of the waiver by conducting ongoing case file reviews and provider certification reviews.

A Quality Assurance Review Report will be completed by the DHCFP Quality Assurance (QA) staff utilizing documented information from monthly waiver reviews. This evaluation reviews a sample of the recipients enrolled in the waiver statewide.

The DHCFP is responsible for annual 372 reporting.

The DHCFP and the ADSD work collaboratively on the development of the Home and Community-Based Services (HCBS) Evidentiary Report.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The Division of Health Care Financing and Policy (DHCFP) contracts with a fiscal agent. One of the responsibilities of the fiscal agent is Medicaid provider enrollment, including waiver service providers. The fiscal agent is responsible for the verification of provider qualifications and the enrollment of providers.

All provider agreements with the DHCFP terminate five (5) years from the enrollment date. Providers must revalidate through the fiscal agent, who verifies provider qualifications, and then revalidates providers.

The provider qualifications are based on provider type and provider specialty. On the Medicaid website www.medicaid.nv.gov, each provider type has a checklist for enrollment or revalidation. An applicant or providers (due for revalidation) must be certified or recertified by ADSD before enrollment or revalidation occurs.

The fiscal agent prepares a monthly report of all provider enrollments, by provider type, for the DHCFP review.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- (●) **Not applicable**
- ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

  - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

    Specify the nature of these agencies and complete items A-5 and A-6:

  - [ ] **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

    Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The DHCFP is responsible for assessing the performance of the fiscal agent in the enrollment of qualified providers.

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The DHCFP Provider Enrollment Unit collaborates with the DHCFP Long Term Services and Supports (LTSS) unit in order to ensure that qualified waiver providers are enrolled by the fiscal agent; both at initial enrollment and every five (5) years thereafter. The DHCFP staff review reports created by the fiscal agent annually, which include enrollments, revalidations, denials, and terminations.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that*

applies):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☐
Level of care evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☐
Prior authorization of waiver services	☒	☒	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☐	☒
Execution of Medicaid provider agreements	☒	☐	☒
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐	☐
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions

drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.1.a.1 Number and percent of waiver intake packets submitted by the operating agency that are approved by the DHCFP. N: Number of waiver intake packets submitted by the operating agency that are approved by the DHCFP. D: Total number of intake packets submitted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Intake Packet Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.1.a.2 Number and percent of providers who have executed Medicaid agreements prior to providing services to waiver recipients. N: Total number of providers who have executed Medicaid agreements. D: Total number of providers reviewed.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.a.3 Number and percent of areas of compliance, as verified through the DHCFP waiver review of the operating agency. N: Number of areas of compliance, as verified through the DHCFP waiver review of the operating agency. D: Number of areas reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Waiver Review

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

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/+/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
a.i.a.4 Number and percent of waiver expenditures that do not exceed approved limits. N: Total waiver expenditures. D: Approved limits.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Data

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHCFP monitors hearings and appeals for waiver services. Nevada Medicaid Services Manual (MSM) Chapter 100 is located on the DHCFP website and outlines provider requirements and administrative sanctions. The DHCFP has a Provider Enrollment unit that tracks providers who are on sanction periods.

The DHCFP Central Office Quality Assurance (QA) Unit conducts annual programmatic and financial reviews of this waiver. The DHCFP has the ability to break out the review findings by geographical office or Statewide, to identify trends that may be applicable to a specific regional office or generalized program issues.

The State strives for a sample size producing a probability of 95% and a confidence level of 5%. The State accomplishes this in the following ways:

The DHCFP Central Office Quality Assurance unit uses the following approach for the review process of the ID Waiver.

A random sample is selected producing a probability of a 95 percent confidence level with a +/- 5 confidence interval (95/5) determining the statewide total of recipient files to be reviewed by the operating agency supervisors and the DHCFP Central Office QA staff. A second sample producing a probability of a 95 percent confidence level with a +/- 10 confidence interval (95/10) is generated using the same list to determine the required number of recipient cases [to include recipient files and Personal Experience Surveys (PES)] that the DHCFP Central Office QA staff will evaluate throughout the review year.

This randomized list is used to determine the number of recipient cases required to be completed, ensuring that at least 25 are selected from each regional office. Once the first 25 slots are appointed to each regional office, the DHCFP Central Office QA staff will continue to add slots in order of randomization to determine the number of recipients to pull for each regional office. The total number of slots will be divided evenly over the year to identify the exact number of active files to be pulled monthly from each regional office.

The annual report will include recipients active at any time between October 1 to September 30 of each waiver year. The evidence report will be submitted in accordance with the waiver reporting schedule.

INTAKE PACKET REVIEWS –
Waiver packets for all new applicants (or recipients who had a break in service) are sent to the staff in the Long Term Services and Support Unit of the DHCFP Central Office for completeness. When the packets arrive, the administrative assistant creates an electronic record for each packet. It is maintained at the DHCFP Central Office.

The DHCFP Central Office staff reviews 100% of all packets received for completeness and conducts a content review of at least 25% of all packets. A 25% sample is identified by simply selecting every fourth record on the list of packets received. Additionally, staff has the option of selecting packets for additional content reviews.

A record of review results for all waiver packets is entered into an electronic database that includes an indication of whether the packet was reviewed for completeness and also reviewed for content and applicable errors found, if any.
The purpose of the content review is to evaluate whether important elements are met and documented, such as:

- the waiver request form, NMO-3010, is completed properly;
- the applicant meets the waiver criteria regarding LOC;
- the LOC matches the social assessment;
- the PCP is objective, comprehensive, and meets the recipient's needs;
- goals are identified in the PCP;
- scope, frequency and duration of services are identified in the PCP;
- identification of potential risks; and
- PCP and Statement of Choice are signed.

Results of the reviews are entered electronically and maintained at the Central Office in a Database.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

DHCFP WAIVER REVIEW:

Monthly Quality Improvement (QI) meetings are conducted to review findings and address areas that are below 86% compliance. Any assurances that are below 86% for the review year are assigned to a priority grid. The QI members analyze and identify the probable cause of the deficiency and develop a plan to improve performance.

The QI members are responsible for conducting the QI Projects for the waiver review as problems arise as well as at the time of the final Annual Waiver Review Report.

If any QI project(s) are not completed at the time the evidence report is submitted, accomplishments to date will be reported and a status of the QI project(s) will be provided.

INTAKE PACKET REVIEWS

Waiver packets selected for content review are not approved until all important elements described below are met and documented as completed. Errors, omissions, or questions that would delay approval, if not addressed immediately, are communicated via telephone or e-mail to the appropriate Regional Center Waiver Coordinator for immediate remediation of the problem. For the remainder of the waiver packets, if an item is missing, an e-mail or phone call is communicated to the Regional Center Waiver Coordinator and the packet is not approved until the missing element is provided. Supervisors utilize these communications for training of Service Coordinators as indicated. Additionally, the DHCFP Long Term Services and Support Supervisor has developed systems to identify evolving trends that require statewide training, policy development, or policy clarification. Results of the Intake Packet Reviews are aggregated quarterly and presented to the ADSD during the quarterly quality management meeting. Any areas of concern are addressed and discussed during this meeting.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☒	**Intellectual Disability**	0		☒
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The state further specifies its target group(s) as follows:

The State further specified its target group(s) as follows: Developmental Disability as defined in the Nevada Revised Statutes 435.007. This waiver has no minimum or maximum age limits.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

- ○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

  Specify the formula:

- ○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2603
Year 2	2720
Year 3	2842
Year 4	2958
Year 5	3075

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- (●) **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (◉) **Not applicable. The state does not reserve capacity.**
- (○) **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (◉) **The waiver is not subject to a phase-in or a phase-out schedule.**
- (○) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (◉) **Waiver capacity is allocated/managed on a statewide basis.**
- (○) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

When an individual makes a request to be placed on the waiver and there are no waiver slots available, the Regional Center will add the individual to the waiver waitlist and notify the DHCFP of the waitlist placement through an Eligibility Status Form.

The waitlists are prioritized:
Priority 1 = current resident of an ICF/IID;
Priority 2 = applicants at risk of institutionalization due to a loss of their current support system or in a crisis situation; and
Priority 3 = all other applicants deemed appropriate for waiver services. Available slots are first given to those deemed priority 1 or 2. If there are no priority 1 or 2 applicants on the waitlist, available slots are then given to those deemed priority 3.

All three Regional Centers meet on a monthly basis to discuss the waiver waitlist as a whole to ensure available slots are filled in a timely manner. Each ADSD Regional Center maintains a waitlist for Waiver funding.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- ○ **§1634 State**
- ◉ **SSI Criteria State**
- ○ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ○ **No**
- ◉ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional state supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

  42 CFR 435.135; 42 CFR 435.222; 42 CFR 435.225; 42 CFR 435.227; 42 CFR 435.110; 42 CFR 435.116; 42 CFR 435.118.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver**

group under 42 CFR §435.217. *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

◉ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

○ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage: [ ]

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

◉ **Other**

Specify:

The maintenance needs allowance is equal to the individual's total income as determined under the post-eligibility process, which includes income that is placed in a Miller Trust.

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

  Specify:

- ( ) **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

  The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which included income that is placed in a Miller Trust.
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near

future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Service Coordinators are all employed by the State of Nevada and must meet the qualifications as a condition of employment. The Division of Human Resource Management ensures the qualification is met at the time of appointment to the position. The State Medicaid Agency does not review the qualifications for service coordinators.

In addition, qualifications for employment as a service coordinator is aligned with the 42 CFR 483,430(a). The ADSD HR ensures copies of current licensure and certifications are in each employee file.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

In order to meet the ICF/IID level of care criteria, the individual must meet all of the following:

1. Have substantial functional impairments in three (3) or more of six (6) areas of major life activity (mobility, self-care, understanding and use of language, learning, self-direction, and capacity for independent living). * For children age 6 yrs and younger, to have intensive support needs in areas of behavioral skills, general skills training, personal care, medical intervention, etc., beyond those required for children of the same age.

2. The individual has a diagnosis of an intellectual disability, or developmental disability. The onset of an intellectual disability must have occurred before the age of 18, and the onset of a developmental disability must have occurred on or before age 22.

3. Must require monthly supports by, or under the supervision of, a health care professional or trained support personnel. The monthly support may be from one entity or may be a combination of supports provided from various sources.

4. The individual cannot be maintained in a less restrictive environment without supports or services. Through the assessment process the team has identified the individual as being at risk of needing institutional placement (ICF/IID) without the provision of at least monthly supports.

The service coordinator documents the criteria on the Level of Care (LOC) determination form.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

  Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The ADSD service coordinators are responsible for the completion of the Level of Care Determination (LOC) form. After the initial determination, participants are reevaluated at least every 12 months to reaffirm eligibility, including LOC. The 12 month period is measured from the month of waiver enrollment or previous evaluation/reevaluation. A new LOC is also required whenever there is an interruption in an individual's waiver eligibility or if there has been a significant change in an individual's condition or functional status that would affect the LOC.

Support for completing the LOC determination form is based on record information, including prior psychological assessments and prior assessments of adaptive functioning, annual social assessments and the Person Centered Plan (PCP). Historic documentation and other documentation needed for Regional Center eligibility is obtained by Regional Center intake and psychological services staff. The Service Coordinator is responsible for ensuring all needed documentation is obtained prior to completion of the LOC.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

The level of care assessment is an integral part of case management services. The ADSD service coordinators maintain tickler files, which provide notification when a reevaluation is due. Additionally, if there is a need for any action on the case, service coordinators assess whether an action will be necessary in the near future and addresses those issues, including LOC evaluation, at that time.

Developmental Services supervisory staff conduct annual program reviews, using a representative sample of recipients. Included in this annual review is a service review of the individual record to ensure timely determinations, evaluations and reevaluations. In the Harmony Information System, service coordinators indicate each date of LOC completion, which allows for statewide and Regional Center reports that monitor the timeliness of LOC assessments and reevaluations. These reports are reviewed monthly by each Regional Center during supervisory meetings.

The DHCFP Central Office Quality Assurance (QA) staff conducts a statewide annual waiver review using a sample of ongoing waiver recipients. A case file review is completed to ensure timely evaluations and re-evaluations, among other requirements. Results of these reviews are provided to Developmental Services staff so that any compliance concerns can be remediated.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

An individual record is established for each waiver recipient. The assessments, support plans and level of care evaluations are maintained in the individual record. The records are maintained by the Division of Aging and Disability Services in the regional office for the geographic area in which the participant resides. Written or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum of six (6) years after the date the last claim is paid for waiver services for each recipient.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a

hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.a.1 Number and percentage of new waiver applicants who meet a Level of Care (LOC) prior to service delivery. N: Number of new waiver applicants who meet a LOC prior to service delivery. D: Total number of new applicants, who meet a LOC.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Application Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied***

appropriately and according to the approved description to determine participant level of care.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.c.1 Number and percent of waiver LOC determinations and re-determinations completed based on the accurate application of Division policies and procedures. N: Number of LOC determination and re-determinations completed based on the accurate application of Division policies and procedures. D: Number of determinations and re-determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Waiver Review Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/+/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: DS Regional Centers
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Issues with the timeliness and accuracy of the Level of Care (LOC) prior to service delivery are documented by DS waiver coordinators on the Waiver Application Spreadsheet. Inaccurate waiver packets are returned to the service coordinator, who has 30 days to provide corrections. Supervisors document the dates of correction on the Waiver Application Spreadsheet. Data from the Waiver Application Spreadsheet is aggregated by the QA unit on an annual basis. Leadership meetings are utilized to discuss instances where corrections were not made properly or timely. Adjustments to the quality strategy are made based on these findings.

The annual date of LOC completion is recorded in the statewide note-taking system, Harmony. Each month, service coordinators and supervisors run a report indicating those LOC's that are due within the month. Data from these reports is aggregated quarterly. Harmony also provides a report on LOC's that were not completed timely. Remediation is completed through feedback and additional training during monthly unit meetings.

Supervisory and QA staff review a sample of 25% ongoing case files annually by utilizing the HCBS Waiver Service Review Form. The review form addresses all waiver requirements, including timeliness of LOC's. Data is collected throughout the year and aggregated annually. Results of the HCBS Waiver Service Review Forms are entered into the statewide database system, Harmony, allowing for automated reports for QA purposes by service coordinators, supervisors, QA staff, and the DHCFP. Systems-level remediation is completed though feedback and additional training at unit meetings.

Waiver packets selected for content review by the DHCFP Central Office staff are not approved until all important elements described below are met and documented as completed. Errors, omissions, or questions that would delay approval, if not addressed immediately, are communicated via telephone or e-mail to the appropriate service coordinator and the supervisor for immediate remediation of the problem. Additionally, the DHCFP Long Term Services and Supports Supervisor has developed systems to identify evolving trends that require statewide training, policy development, or policy clarification. Results of the Intake Packet Reviews are aggregated quarterly and presented to the ADSD during quarterly quality management meetings. Any areas of concern are addressed and discussed during this meeting.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Applicants are given a description of services offered under the waiver during the intake process. The assigned service coordinator informs the applicant of their choice between waiver services and placement in an ICF/IID, in addition to their choice of qualified providers.

Prior to enrollment in the waiver and annually thereafter, all waiver participants review and sign a "Statement of Choice" that includes the following:

"I have actively participated in identifying my supports and preferred outcomes for the next year. I have been able to choose the provider of my support services. I am aware that I can ask for a change of state service coordinator or provider agency if I am not satisfied with the help I am getting. If I am eligible for Medicaid, I understand that I may select any available Medicaid provider. I understand I may request changes in service and service provider at any time."

The applicant, or designated and/or legal representative, then signs the Statement of Choice in order to document the choice of waiver service.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

A record is established for each participant. The Statement of Choice is maintained in the participant's record. The record is maintained by the Aging and Disability Services Division at the waiver operating agency office for the geographic region that the participant resides and a copy of the form is provided to the participant.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The Aging and Disability Services Division employs bilingual staff or contracts with translators. Additionally, the Nevada State Purchasing Division awards contracts for translation and interpretation services to language service entities and these contracts may be used by the ADSD when necessary to further ensure access to services by limited English proficient persons. Many brochures and forms are available in both English and Spanish.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Day Habilitation**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Residential Support Services**		
Statutory Service	**Supported Employment**		
Other Service	**Behavioral Consultation, Training and Intervention**		
Other Service	**Career Planning**		
Other Service	**Counseling Services**		
Other Service	**Non-Medical Transportation**		
Other Service	**Nursing Services**		
Other Service	**Nutrition Counseling Services**		
Other Service	**Residential Support Management**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Day Habilitation Services are regularly scheduled activities in a non-residential setting, separate from the recipient's private residence or other residential living arrangement. Services include assistance with the acquisition, retention, or improvement in self-help, socialization and adaptive skills that include performing activities of daily living and community living. Activities and environments are designed to foster the acquisition of skills; building positive social behavior and interpersonal competence, greater independence and personal choice. The services furnished are identified in the recipient's PCP according to the recipient's needs and individual choices.

Day Habilitation services focus on enabling the recipient to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the recipient's person-centered services and support plans, such as physical, occupational, or speech therapy. Day Habilitation may not provide for the payment of services that are vocational in nature; for the primary purpose of producing goods or performing services.

Day Habilitation services may also be used to provide supported retirement activities. As some recipients get older they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their community. This might involve altering schedules to allow for more time throughout the day, or supports to participate in hobbies, clubs and senior-related activities in the community.

Day Habilitation Services are subcontracted under the service provision of Jobs and Day Training (JDT) Service Authorizations.

Information is maintained in the file of each recipient receiving this service; documenting that the service is not available in a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

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

Recipients who receive day habilitation services may receive two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same period of the day.

Day habilitation may not provide for the payment of services that are vocational in nature; for the primary purpose of producing goods or performing services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider-Managed
Individual	Provider-Managed

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1

Comply with all Developmental Services Standards of Service Provision for all Jobs and Day Training Providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency- Aging & Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Individual

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

Comply with Developmental Services Standards of Service Provision for all Jobs and Day Training Providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Prevocational Services should enable recipients to attain the highest level of vocation in the most integrated setting and by matching the recipient's interests, strengths, priorities, abilities and capabilities to the job while following applicable federal wage guidelines. The services are intended to develop and teach general skills. Examples include but are not limited to: . ability to communicate with supervisors, co-workers and customers in the workplace setting; generally accepted workplace conduct and dress; an ability to follow directions; an ability to complete tasks; workplace problem solving skills and strategies; and workplace safety and mobility training.

Prevocational service provides for learning and work experience, including volunteer work, where a recipient can develop general, non-job or task-specific strengths and skills that contribute to employability in paid employment within integrated community settings. Services are expected to occur over a defined period to time and with specific outcomes to be achieved, as identified in the recipient's PCP. The services are designed to create a path to integrated, community-based employment for which a recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Recipients receiving prevocational services must have employment-related goals in their PCP; the general habilitative activities must be designed to support such employment goals. Competitive, integrated employment in the community for which a recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, is considered to be the optimal outcome of prevocational services.

Prevocational Services are subcontracted under the service provision of Jobs and Day Training (JDT) Services Authorizations.

Information is maintained in the file of each recipient receiving this service; documenting that the service is not available in a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

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

Recipients who receive prevocational services may receive two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same period of the day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Provider-Managed
Agency	Provider-managed

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Individual

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

Comply with Developmental Services Standards of Service Provision for all Jobs and Day Training Providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency - Aging and Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Provider-managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

Comply with all Developmental Services Standards of Service Provision for Jobs and Day Training Providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency- Aging & Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Support Services

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Residential Support Services are designed to ensure the health and welfare of the recipient, through protective oversight and supervision activities and supports to assist in the acquisition, improvement, retention, and maintenance of the skills necessary for a recipient to successfully, safely, and responsibly reside in their community. Services are provided throughout the course of normal activities of daily living, as well as in specialized training opportunities outlined in the recipient's Person Centered Plan (PCP). These services are individually planned and coordinated, assuring the non-duplication of services with other Medicaid State Plan Services.

Residential support service staff are trained and responsible for implementing Individual Habilitation Plan goals, objectives, and service supports related to residential and community living. These supports can include personal care and activities of daily living that are not paid for through Medicaid State Plan PCA services, supports for health and welfare needs, effective communication skills, community inclusion and the development of natural support networks, mobility training, survival and safety skills, support and teaching of interpersonal and relationship skills, making choices and problem solving skills, community living skills, social and leisure skills, money management skills, as well as support and skill training in health care needs, to include medication management. Residential support services emphasize positive behavior strategies, including interventions and supervision designed to maximize community inclusion while safeguarding the recipient and general public. Services also support exercising recipient rights and protect against rights violations and infringements without due process.

Residential Support Services may be provided on a continuum of service delivery model ranging from intermittent to twenty-four (24) hour supported living arrangements, as determined by the PCP team. Residential support services are provided in either the service recipient's natural family home or in a non-provider owned home or apartment; owned or leased in the service recipient's name or on behalf of the service recipient, with the exception of approved Shared Living services and provider owned homes that have been approved by the Regional Center. The provider is required to have a lease with each service recipient living in a provider owned home. Residential support services are provided in integrated settings within community residential neighborhoods.

Supported living arrangements are not provided in segregated or disability-specific housing complexes. Residential support services in a twenty-four (24) hour setting are limited to four (4) recipients sharing staff support hours, as agreed upon by the PCP teams. Exceptions may be made on a case-by-case basis and must be approved by the DS Regional Center, the ADSD Quality Assurance unit and DHCFP. Shared Living supported living arrangements are limited to two (2) service recipients residing in one home, unless otherwise authorized by the DS Regional Center.

Supportive living arrangements do not require state licensure; however, the Aging & Disability Services Division must approve service agencies through their certification process in order to provide such services.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which costs of room and board are excluded for residential habilitation is specified in Appendix I-5. Payment is not made directly or indirectly, to members of the individual’s immediate family, except as provided in C-2.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Provider-Managed
Agency	Provider-managed

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Support Services

Provider Category:

Individual

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

Comply with all Developmental Services Standards of Service Provision for Supported Living Service Providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging & Disability Services Division

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Support Services

Provider Category:

Agency

Provider Type:

Provider-managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Meets all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meets all Conditions of Participation in Medicaid Services Manual 102.1.

Comply with Developmental Services Standards of Service Provisions for all Supported Living Service Providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual

Category 2:	Sub-Category 2:
03 Supported Employment	03022 ongoing supported employment, group
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Sub-Category 1:
Individual Supported Employment is for recipients who need intensive, ongoing supports in order to obtain and maintain a job that meets personal and career goals in competitive, customized employment, or self-employment, in an integrated work setting within the general workforce for which the individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Individual supported employment services do not include payment for supervision, training, support or adaptations typically available to other workers without disabilities in similar positions in the business. Individual supported employment services also does not include supports needed for unpaid, volunteer opportunities.
One approach to individual supported employment is customized employment. Customized employment means individualizing the employment relationship between employees and employers in ways that meet the needs of both. It is based on an individualized determination of the strengths, needs and interests of the person with disabilities and is also designed to meet the specific needs of the employer. Customized employment assumes the provision of reasonable accommodations and support necessary to perform the functions of a job that is individually negotiated and developed.
Supported Employment Services are authorized under the service provision of Jobs and Day Training (JDT) Service Authorizations. Co-workers who meet provider standards may provide individual supported employment if the furnished services are not a part of the co-worker's normal duties.
Information is maintained in the file of each recipient receiving this service; documenting that the service is not available in a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses.

Sub-Category 2:
Small Group Employment Supports are services and training activities provided in regular business, industry and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile work crews which employ small groups of recipients in integrated employment in the community with the goals of sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which the recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small group supported employment services does not include payment for supervision, training, support or adaptations typically available to other workers without disabilities in similar positions in the business. Small group employment services also does not include supports needed for unpaid, volunteer opportunities.
Supported Employment Services are authorized under the service provision of Jobs and Day Training (JDT) Service Authorizations. Co-workers who meet provider standards may provide small group supported employment services if the furnished services are not a part of the co-worker's normal duties.
Information is maintained in the file of each recipient receiving this service; documenting that the service is not available in a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses.

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

Recipients who receive supported employment services may receive two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same period of the day.

Medicaid funds cannot be used to assist in the costs of starting or operating a business.

Supported employment individual employment services and small group employment services does not include facility based work settings, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workforce.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Provider-Managed
Agency	Provider-Managed

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapter 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

Comply with all Developmental Services Standards of Service Provision for Jobs and Day Training Providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapter 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

Comply with all Developmental Services Standards of Service Provision for Jobs and Day Training Providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Consultation, Training and Intervention

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Behavioral consultation, training and intervention services provide behaviorally-based assessment and intervention for recipients, as well as support, training, and consultation to family members, caregivers, paid residential support staff, or jobs and day training staff. This service also includes participation in the development and implementation of Person Centered Plan and/or positive behavior support plans, necessary to improve an recipient's independence and inclusion in their community, increase positive alternative behaviors, and/or address challenging behavior.

Services may be provided in the recipient's home, school, workplace, or in the community. Services may include:
- Functional Behavioral Assessment and an assessment of environmental factors that are precipitating a problem behavior;
- Development of a behavioral support/intervention plan in coordination with team members;
- Consultation or training on how to implement positive behavior support strategies and/or behavior support/intervention plans;
- Consultation or training on data collection strategies to monitor progress;
- Monitoring of the recipient and/or the provider during the implementation of the plan and updating the plan as necessary.

Services are not covered by Medicaid State Plan services and are provided by professionals in psychology, behavior analysis and related fields.

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

Behavioral Consultation, Training and Intervention may not exceed $5,200.00 per year. For extenuating circumstances, additional hours require the written approval of the Regional Center Manager.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider-Managed
Individual	Provider-Managed

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Consultation, Training and Intervention

Provider Category:

Agency

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The two levels of Behavioral Consultation, Training and Intervention are as follows:

Level 1 - Master's Level. Employee of a contract provider agency who has provisional or regular certification, per NRS 435, who holds a Master's or Doctoral level licensure and/or certification per NRS 641; or an employee of a contract provider agency who has provisional or regular certification, per NRS 435, and who has a Master's degree in psychology, special education or closely allied field with expertise in functional assessment and the provision of positive behavioral supports and is approved by the ADSD to provide the service; or an employee of a Regional Center meeting requirements as specified in the following State of Nevada Department of Administration class specifications: 10.135-10.141 Mental Health Counselor I-V.

Level 2 - Bachelor's Level. Employee of a contract provider agency who has provisional or regular certification, per NRS 435, who holds a Bachelor's level licensure and/or certification per NRS 641; or an employee of a residential provider agency who has provisional or regular certification, per NRS 435, and who has a Bachelor's degree in psychology, special education or closely allied field, plus at least one year's professional clinical experience using behavior intervention and functional assessment procedures and developing, implementing, and monitoring of behavior support plans in applied settings and is approved by the ADSD to provide the service.

Experience serving individuals with intellectual and developmental disabilities.

Meets all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meets all Conditions of Participation in Medicaid Services Manual 102.1.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency- Aging & Disability Services Division (ADSD)

Frequency of Verification:

Verification occurs upon initial application and annually thereafter. Provider sends a copy of the current license to the Aging & Disability Services Division (ADSD) upon license renewal.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Consultation, Training and Intervention

Provider Category:

Individual

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The two levels of Behavioral Consultation, Training and Intervention providers are as follows:

Level 1 - Master's Level. Professional holding Master's or Doctoral level licensure and/or certification per Nevada Revised Statute (NRS) 641; or Master's degree in psychology, special education or closely allied field with expertise in functional assessment and the provision of positive behavioral supports and approval by the ADSD to provide the service.

Level 2 - Bachelor's Level. Professional holding Bachelor's level licensure or certification per NRS 641; or Bachelor's degree in psychology, special education or closely allied field plus at least one year's professional clinical experience using behavior intervention and functional assessment procedures and developing, implementing, and monitoring of behavior support plans in applied settings and approval by the ADSD to provide the service.

Experience serving individuals with intellectual and developmental disabilities.

Must meet all requirements to enroll and maintain status as an approved Medicaid provider pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meets all Conditions of Participation in Medicaid Services Manual 102.1

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Verification occurs upon initial application and annually thereafter. Provider sends a copy of the current license to the Aging & Disability Services Division (ADSD) upon license renewal.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Career Planning

HCBS Taxonomy:

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

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Career Planning is a person-centered, comprehensive employment planning and support service that provides recipients with assistance in order to obtain, maintain or advance in competitive employment or self-employment. It is time-limited and focuses on engaging a recipient in identifying a career direction and developing a plan for achieving competitive, integrated employment with pay at or above the state's minimum wage.

Career planning includes:
- Activities that are primarily directed at assisting a recipient with identification of an employment goal; and
- A plan to achieve this goal (e.g., job exploration, job shadowing, informational interviewing, assessment of interests, labor market research) that are associated with performing competitive work in community integrated employment.

Providers of this service may coordinate, evaluate and communicate not only with the recipient, but also with their guardians, their support team, employers and others who can assist with discovering a recipient's skills, abilities, interests, preferences, conditions and needs. This support and evaluation should be provided to the maximum extent possible in the presence of the recipient and should be conducted in the community, but completion of activities in the home or without the presence of the recipient should not be precluded.
- If a waiver recipient is employed, career planning may be used to explore other competitive employment career objectives which are more consistent with the person's skills and interests, or to explore advancement opportunities in his or her chosen career.
- Career planning should be reviewed and considered as a component of a recipient's person-centered services and support plan, no less than annually, more frequently as necessary, or as requested by the recipient.
- These services should be designed to support successful employment outcomes consistent with the recipient's goals.
- Career planning may include social security benefits support, training, consultation and planning as well as assessments for the use of assistive technology in the workplace to increase independence.
- The setting for the delivery of services must be aligned with the individualized need and that which is most conducive in developing a career objective and a career plan.

Career planning services are subcontracted under the service provision of Jobs and Day Training (JDT) Service Authorizations.

Career Planning furnished under the waiver may not include services available from a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16-17) of the Individuals with Disabilities Education Act (IDEA).

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

Recipients who receive career planning services may receive two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same period of the day. If a waiver recipient is receiving prevocational services or day habilitation services, career planning may be used to develop experiential learning opportunities and career options consistent with the person's skills and interests. If a recipient is employed and receiving either individual or small group supported employment services, career planning may be used to find other competitive employment that is more consistent with the person's skills and interests or to explore advancement opportunities in his or her chosen career.

Career Planning is limited to 216 hours provided within a six (6) month time period each year. No two six (6) month periods may be provided consecutively. Written authorization by the Regional Center Manager is required for amounts in excess of the limit.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider-Managed
Individual	Provider-Managed

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Career Planning

Provider Category:

Agency

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Other Standard (specify):

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

Comply with all Developmental Services Standards of Service Provision for Jobs and Day Training Providers.

Experience in working with individuals with intellectual and developmental disabilities providing employment services and job development. Must demonstrate knowledge of person-centered career planning, job analysis, supported employment services, situational and community-based assessments, best practices in customized employment, and knowledge of the business needs of an employer.

Valid Nevada driver's license required. Must have access to an operational and insured vehicle and be willing to use it to transport recipients.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Career Planning

Provider Category:

Individual

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Meet all requirements to enroll and maintain status as an approved Medicaid provider to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

Comply with all Developmental Services Standards of Service Provision for Jobs and Day Training Providers.

Experience in working with individuals with intellectual and developmental disabilities providing employment services and job development. Must demonstrate knowledge of person-centered career planning, job analysis, supported employment services, situational and community-based assessments, best practices in customized employment, as well as knowledge of the business needs of an employer.

Valid Nevada driver's license required. Must have access to an operational and insured vehicle and be willing to use it to transport recipients.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Counseling Services

HCBS Taxonomy:

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Counseling services provide assessment/evaluation, individual and group counseling services, consultation, therapeutic interventions strategies, risk assessment, skill development, psycho-educational activities, support and guidance for waiver recipients and/or family members, caregivers, and team members, which are not covered by the Medicaid State Plan and which improve the recipient's personal adaptation and inclusion in the community. This service provides problem identification and resolution in areas of interpersonal relationships, community participation, independence, and attaining personal outcomes, as identified in the recipient's PCP. Services are provided by professionals in psychology, counseling, and related fields and who have expertise in intellectual/developmental disabilities.

Counseling services are specialized and adopted in order to accommodate the unique complexities of enrolled recipients. Services include consultation with team members, including family members, support staff, service coordinators and other professionals comprising the recipient's support team; individual and group counseling services; assessment/evaluation services; therapeutic intervention strategies; risk assessment; skill development; and psycho-educational activities.

Services are provided based on the recipient's need to assure his or her health and welfare in the community and enhance success in community living.

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

Counseling services may not exceed $1,500.00 per year. Written authorization by the operating agency is required for amounts in excess of the limit.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider-Managed
Individual	Provider-Managed

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling Services

Provider Category:

Agency

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Professionals holding a Master's degree or higher and licensure by appropriate categories through the State of Nevada Board of Psychological Examiners, Board of Examiners for Social Workers, Examiners for Marriage and Family Therapists and Clinical Professional Counselors. Professional experience serving persons with intellectual and developmental disabilities.

Certificate *(specify):*

Other Standard *(specify):*

Employees of a Regional Center meeting requirements as specified in the following State of Nevada Department of Administration class specifications: 10.135-10.141 Mental Health Counselor I-V.

Meets all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meets all Conditions of Participation in Medicaid Services Manual 102.1.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Verification occurs upon initial application and annually thereafter. Provider sends a copy of the current license to the Aging & Disability Services Division (ADSD) upon license renewal.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling Services

Provider Category:

Individual

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Level 1: Professionals holding a Master's degree or higher and licensure by appropriate categories through State of Nevada Board of Psychological Examiners, Board of Examiners for Social Workers, Examiners for Marriage and Family Therapists and Clinical Professional Counselors. Professional experience serving persons with intellectual and developmental disabilities.

Certificate *(specify):*

Other Standard *(specify):*

Level 2: A graduate-level intern who is enrolled in a Master's level program at an accredited college or university that provides at least a two-year curriculum in counseling, marriage and family therapy, psychology, social work or a closely allied academic field or a doctoral level program in a clinical field; supervision by a licensed clinician or mental health counselor.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency- Aging & Disability Services Division (ADSD)

Frequency of Verification:

Level 1: Upon enrollment, and prior to expiration, provider will send a copy of the current license to the ADSD, as appropriate.

Level 2: Upon enrollment, and at least annually, proof of completion of a Master's level program or enrollment as a graduate intern; identification of supervisor/verification of license.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

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

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Non-Medical Transportation services are offered in order to enable waiver recipients to gain access to community services, activities and resources, that are identified in the Person Centered Plan (PCP). Non-medical transportation services allow recipients to engage in normal day-to-day, non-medical activities such as going to the grocery store or bank, participating in social events and other civic activities, or attending a worship service.

Whenever possible, family, neighbors, friends or community agencies are utilized to provide this service without charge. This service is in addition to the non-emergency transportation service offered under the Medicaid State Plan, which includes transportation to all Medicaid covered services and appointments and can be arranged at least 48 hours in advance, as well as for emergency medical transportation.

This service will not duplicate or impact the amount, duration and scope of the medical transportation benefit provided under the Medicaid State Plan.

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

Non-medical transportation cannot exceed $100.00 per month. Written authorization by the DS Regional Center is required for amounts in excess of the limit.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Provider-Managed
Agency	Provider-Managed

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Must meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

A valid Nevada Driver's License required. Must have access to an operational and insured vehicle and be willing to use it to transport recipients.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Must meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

A valid Nevada Driver's License required. Must have access to an operational and insured vehicle and be willing to use it to transport recipients.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nursing Services

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

There are three components of this service: Medical Management, Nursing Assessment, and Direct Services (over and above Medicaid State Plan).

Medical Management (Comprehensive Medical Community Support Services):

These services will be provided by a RN or LPN under the supervision of a RN licensed in the state. Services are geared toward the development of health services support plans; professional observation and assessment, individualized program design and implementation, training of direct support staff or family members to carry out treatment; monitoring of staff knowledge and competence to improve health outcomes; assistance with revision of health support plans in response to new or revised treatment orders or lack of positive outcomes of current supports by staff; monitoring/assessment of the recipient's condition in response to current health supports provided; and as needed assistance with referrals to other medical providers. The functions outlined for this service differs from case management in that this service relates directly to the medical needs of the individual.

In addition, nurses may attend PCP team meetings and medical visits as needed to provide advocacy, resource information and recommendations to team and treating physicians to facilitate health supports.

Nursing Assessment:

This service will be completed by a Registered Nurse (RN) to identify the needs, preferences, and abilities of the recipient. This assessment includes an interview with the recipient and/or their designated or legal representative, an observation by the nurse, and considers the symptoms and signs of condition, verbal and nonverbal communications, medical and social history, medication and any other information available.

The nurse will assess vital signs, skin color and conditions, motor and sensory nerve function, reproduction, dentition, height, nutrition, rest, sleep patterns, oral health, physical activities, elimination, and level of consciousness. Additionally, the following social and emotional factors will be assessed which include religion, occupation, attitudes on health care, mood, emotional tones, family ties and responsibility. The assessment is extremely important because it provides recommendations for medical and mental health care and follow-up which are shared with the recipient's team for review and inclusion in the PCP. Nursing assessments may be performed and completed upon approved referral and authorization of the service coordinator. Assessments are completed by a Registered Nurses (RN) and provide the basis for recommendations for medical and mental health care and follow-up; which are shared with the person's team for review and inclusion in the individual's support plan.

The assessment includes: an interview with the recipient and/or their designated or legal representative; identification of diagnoses, including symptoms and signs of condition; assessment of verbal and nonverbal communication skills; a review of medical and social history including current medication and drug history; as well as other information available from either records or interviews with staff and family.

Direct Services:

This service provides routine medical and health care services that are integral to meeting the daily needs of participants. This includes the routine administration of medication by nurses tending to the needs of recipients who are ill and providing care to recipients who have ongoing medical needs. Direct skilled nursing services are intended to be provided by an RN or Licensed Practical Nurse (LPN) in a community setting, including home or work, as described and approved in the recipient's Person Centered Plan (PCP). LPN's must be under the supervision of a RN licensed in the state. Services include skilled medical care that is integral to meeting the daily medical needs of recipient. These services are intended to allow individuals under this waiver to live safely within an integrated community setting.

Services are limited to those that only a licensed professional can provide; not those that unlicensed staff can provide. For example, activities of daily living are not skilled services.

Skilled services include, but are not limited to: medication administration, wound care, nasogastric or gastronomy tube feeding, ostomy care, tracheotomy aspiration care, and catheter care. Direct services will be reimbursed when

the procedure can be only be performed safely by a RN or LPN. Factors to consider when determining the need for direct nursing services include: the complexity of the procedure; the recipient's functional and physical status; the absence of a caregiver who is trained to perform the function; and that the service is reasonable and necessary.

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

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

Nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including providing training and qualifications) from skilled nursing services in the Medicaid State plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider-managed
Individual	Provider-Managed

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing Services

Provider Category:

Agency

Provider Type:

Provider-managed

Provider Qualifications

License *(specify):*

Employee of a Home Health Agency, Nursing Registry, or private service provider who is a Licensed Registered Nurse (RN) per NRS 632.

Employee of a Home Health Agency, Nursing Registry or private service provider who a Licensed Practical Nurse (LPN) and who is under the supervision of a Licensed Registered Nurse per NRS 632.

Certificate *(specify):*

Other Standard *(specify):*

May subcontract services under a provider certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Meets all requirements to enroll and maintain status as an enrolled Medicaid provider pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meets all Conditions of Participation in Medicaid Services Manual 102.1.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging and Disability Services Division (ADSD)

Frequency of Verification:

Verification occurs upon initial application and annually thereafter. Provider sends a copy of the current license to the Aging & Disability Services Division (ADSD) upon license renewal.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing Services

Provider Category:

Individual

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Per NRS 632, must be a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of a Registered Nurse.

Certificate *(specify):*

May subcontract services under a provider certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Meets all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Verification occurs upon initial application and annually thereafter. Provider sends a copy of the current license to the Aging & Disability Services Division (ADSD) upon license renewal.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nutrition Counseling Services

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Nutrition Counseling Services include assessment of a recipient's nutritional needs, development, and/or revision of a recipient's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to the successful implementation of the nutritional plan.

These services include training, education and consultation for recipients, family members, or support staff involved in the day-to-day support of the recipient; comprehensive assessment of nutritional needs; development, implementation and monitoring of the nutritional plan incorporated into the recipient's PCP, including updating and making changes to the plan as needed; aid in menu planning and making healthy options; nutritional education and consultation; and developing quarterly summaries of progress on the nutritional plan.

Nutritional counseling services under the waiver differ in nature, scope, supervision arrangements, or provider type (including providing training and qualifications) from nutritional counseling services in the Medicaid State plan.

These waiver-covered dietitian duties are above and beyond those approved and covered under Medicaid State Plan Services, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

This service is limited to $1,300 per year, per recipient. Written authorization by the Regional Center Manager is required for amounts in excess of the limit. This service does not include the cost of meals or food items.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider-Managed
Individual	Provider-Managed

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutrition Counseling Services

Provider Category:

Agency

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

The agency employee who provides nutrition counseling must be registered as a Dietician by the American Dietetic Association.

Certificate *(specify):*

Other Standard *(specify):*

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participating in Medicaid Services Manual 102.1.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Verification occurs upon initial application and annually thereafter. Provider sends a copy of the current license to the Aging & Disability Services Division (ADSD) upon license renewal.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutrition Counseling Services

Provider Category:

Individual

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Registered as a Dietician by the American Dietetic Association.

Certificate *(specify):*

Other Standard *(specify):*

Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services, Chapters 100 and 2100, as applicable.

Meet all Conditions of Participation in Medicaid Services Manual 102.1.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Verification occurs upon initial application and annually thereafter. Provider sends a copy of the current license to the Aging & Disability Services Division (ADSD) upon license renewal.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Residential Support Management

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Residential Support Management is designed to ensure the health and welfare of recipients receiving residential support services from agencies in order to assure those services and supports are planned, scheduled, implemented and monitored as the recipient prefers, and as needed, depending on the frequency and duration of approved services.

Residential support managers assist the recipient with managing their residential supports. Residential support managers:

1) Assist the recipient with developing his or her goals;
2) Schedule and attend Person Centered Planning Meetings;
3) Develop habilitation plans specific to residential support services, as determined in the recipient's PCP and train residential support staff in implementation and data collection;
4) Assist the recipient with applying for and obtaining community resources and benefits, such as Medicaid, SSI, SSDI, HUD, Food Stamps, Housing, etc.;
5) Assist the recipient with locating residences;
6) Assist the recipient in arranging for and effectively managing generic community resources and informal supports;
7) Assist the recipient with identifying and sustaining a personal support network of family, friends, and associates;
8) Provide problem solving and support with crisis management;
9) Support the recipient with budgeting, bill paying, and scheduling and keeping appointments per the PCP;
10) Observe, coach, train and provide feedback for waiver services provided by residential support staff in the recipient's home to assure they have necessary and adequate training to carry-out the supports and services identified in their PCP;
11) Follow-up with health and welfare concerns and remediation of deficiencies;
12) Complete required paperwork on behalf of the recipient;
13) Make home visits to observe the recipient's living environment to assure health and welfare; and
14) Provide information to the Service Coordinator (Targeted Case Manager) to allow evaluation and assurance that support services provided are those defined in the PCP and are effective in assisting the recipient reach his or her goals.

Residential support managers must work collaboratively with the recipient's Targeted Case Manager. Residential Support Management services are different from Targeted Case Management. The Targeted Case Manager is responsible for the development of the PCP, which is the overall Home and Community Based Services plan, in consultation with the PCP team. The Residential Support Manager is responsible to develop, implement, and monitor the specific residential habilitation plan related to Residential Support Services.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider-Managed

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Support Management

Provider Category:

Agency

Provider Type:

Provider-Managed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Employees of the residential support service agencies who provide residential support management services must have a high school diploma or equivalent and two (2) year's experience providing direct services in a human service field and be under the direct supervision and oversight of a QIDP or equivalent; or completion of a Bachelor's degree from an accredited college or university in psychology, special education, counseling, social work, or closely allied field.

The agency must be certified by Nevada Developmental Services, pursuant to NRS 435 and Developmental Services Policies and Procedures.

Other Standard *(specify):*

Meets all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP Medicaid Services Manual, Chapters 100 and 2100, as applicable.

Meets all Conditions of Participation in Medicaid Services Manual 102.1.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating agency - Aging & Disability Services Division (ADSD)

Frequency of Verification:

Initial application for provider enrollment for provisional certification, and then up to every three (3) years thereafter, as part of the recertification review process.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Developmental Services service coordinators of the Aging & Disability Services Division (ADSD).

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

AGING AND DISABILITY SERVICES DIVISION (ADSD) EMPLOYEES:

All ADSD employees require fingerprint background checks upon hire. The ADSD requires a criminal background check be completed as a condition of employment. All employees of the Aging & Disability Services Division must be fingerprinted within five (5) days of employment. This includes all administrative staff, supervisors and service coordinators.

It is the responsibility of an employee's supervisor to ensure fingerprint cards are completed and submitted to the Division Personnel Officer. The Division Personnel Officer submits the fingerprint cards to the State of Nevada Department of Public Safety Record and Identification Services. The results of the state and national FBI criminal history search are transmitted back to the Personnel Officer, who notifies the ADSD Administrator or Deputy Administrator of any positive results. The ADSD Administrator or Deputy Administrator takes any action necessary as a result of the background check.

PROVIDER AGENCIES:

The DHCFP policy requires all contracted providers and employees of service provider agencies have completed background checks prior to providing services to waiver recipients. The DHCFP's fiscal agent will not enroll any person or entity convicted of a felony or misdemeanor under Federal or State Law for any offense which the State agency determines is inconsistent with the best interest of recipients. Such determinations are solely the responsibility of the Division. The fiscal agent may deny a provider contract to any applicant or may suspend or revoke all associated provider contracts of any provider to participate in the Medicaid program if the applicant or contractor has been convicted of any of the listed offenses.

Based on the results of the background check, the fiscal agent will not enroll any provider agency whose operator has been convicted of a felony under Federal or State law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. The following list, though not exhaustive, provides examples of crimes indicating that a provider is ineligible and inconsistent with the best interest of recipients:

- Murder, voluntary manslaughter or mayhem;
- Assault with intent to kill or to commit sexual assault or mayhem;
- Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
- Abuse or neglect of a child or contributory delinquency;
- A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of the Nevada Revised Statutes (NRS);
- A violation of any provision of NRS 200.700 through 200.760;
- Criminal neglect of a patient, as defined in NRS 200.495;
- Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent coercion or misappropriation of property;
- Any other felony involving the use of a firearm or other deadly weapon;
- Abuse, neglect, exploitation or isolation of older persons;
- Kidnapping, false imprisonment or involuntary servitude;
- Any offense involving assault or battery, domestic or otherwise;
- Conduct inimical to the public health, morals, welfare and safety of the people of the people of the State of Nevada in the maintenance and operation of the premises for which a provider is issued;
- Conduct or practice that is detrimental to the health or safety of the occupants or employees of the facility or agency; or
- Any other offense that may be inconsistent with the best interest of all recipients.

Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. An "undecided" result is not acceptable. If an employee, or independent contractor, believes that the information provided as a result of the FBI criminal background check is incorrect, he or she may immediately inform the employing agency or the Division (respectively) in writing. An employing agency or the Division, which is so informed within five (5) days, may give the employee, or independent contractor, a reasonable amount of time, but not more than 60 days, to provide

corrected information before terminating the employment, or contract, of the person pursuant to this section.

All employees of provider agencies are required to complete a new criminal background check every five (5) years. In addition, all contract providers and their employees who will have direct contact with service recipients are required to have fingerprint background checks completed upon hire and every five years thereafter. The background checks are not transferable between agencies, so all staff must complete new background checks if they begin employment at another contract provider agency.

The State of Nevada Department of Public Safety conducts the background inquiry. Fingerprint cards are submitted to the Federal Bureau of Investigation (FBI) for a federal background check and the Nevada Department of Public Safety for a state background check. Each contract provider agency is also responsible for searching staff names on the Office of Inspector General Exclusion Program list upon staff hire and at least annually thereafter.

The DHCFP Provider Enrollment Unit has implemented an integrity-based eligibility process, which includes screening measures beyond the minimum required Affordable Care Act (ACA) mandates. The purpose of the DHCFP Provider Enrollment Unit Quality Assurance (QA) process is to ensure compliance is maintained in accordance with the ACA mandates and the fiscal agent's contract requirements.

Sample sizing should be equal to 5-15% of all intake work for the previous month, depending on the number of QA referrals received. QA referrals will be submitted through the Provider Enrollment inbox, by: Provider Enrollment Program Specialist, SUR, Administration, etc. A monthly report of all issues identified will be presented to Administration/Chief for review and approval.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- (●) **No. The state does not conduct abuse registry screening.**
- ( ) **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

  Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

  ☐ **Self-directed**

  ☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

All services are determined by the person and their support team through the implementation of person centered planning processes as described in Appendix D regardless of the relationship of the staff member to the person.

Those relatives who are legal guardians are prohibited from payment. "Legal guardian" is defined as a person appointed by the court who has the legal responsibility to manage the affairs of someone the court has determined to be incompetent, incapacitated or susceptible to undue influence.

Specific circumstances in which payment would be made may include an individual who requires ICF/IID care and the service being provided is not a function which a relative would normally provide for the individual without charge as a matter of course in the usual relationship among members of the nuclear family and the service would otherwise need to be provided by a qualified provider of residential or non-residential services funded under the waiver. The relative must meet all certification, training and reporting requirements that apply to other providers of the same category of waiver services. Services that are furnished by relatives must be documented in the same manner as services provided by non-relative staff members. The Service Coordinator is responsible for monitoring and ensuring that the service plan is implemented as intended. This is accomplished through the provision of quality assurance activities, including monthly contact, quarterly face-to-face visits, home visits, work visits, and follow-up with providers. On a monthly basis, Service Coordinators also review a random sample of logs completed by residential support staff, including relatives, to ensure support plans are being implemented as authorized.

Relatives can perform habilitative services, including residential support services, day habilitation, pre-vocational services and supported employment, and non-medical transportation services. Relatives can perform up to 175 hours a month (roughly 40 hours a week) of direct residential support services based on the needs of the individual as determined by the support team and documented in the PCP. These residential support services must be habilitative in nature with the individual acquiring, improving or maintaining independent living skills. Relatives may provide day habilitation, pre-vocational or supported employment services as described in the PCP support plan. Again, these services must be habilitative in nature with the individual acquiring, improving or maintaining independent living and work skills. Relatives may also be paid for non-medical transportation services when the PCP authorizes habilitative activities that take place in the community. Any service provided by a relative is not a replacement for natural supports.

During initial and annual re-assessment, a PCP is developed and re-evaluated with recipients/Authorized Representative (AR), families, relatives/caregivers present. The PCP is centered around the recipient's needs. Once PCP has been developed, all services must be prior authorized by ADSD and entered into their system, Harmony. The DHCFP QA Unit conducts annual programmatic and financial review of the services rendered to recipients, which include those services provided by a relatives. The reviews ensure the recipient is receiving the services authorized in the PCP, payments made are for services rendered and recipient satisfaction of services and other assurances and sub-assurances. Additionally, QA conducts an annual Participant Experiment Survey (PES).

Payment will be limited to 40 hours per week, per recipient served, per household. Payment may be made to immediate family defined as biological, adoptive, or step-parents, grandparents, siblings, aunts, uncles, nieces, nephews, cousins, children and great-grandparents, for habilitation services only.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

If an individual or entity is interested in providing services to waiver recipients, they must contact either the State Medicaid agency Provider Enrollment Unit or the ADSD to obtain the enrollment information. The Developmental Services Regional Centers distribute the provider application packet upon request. Potential providers must complete the application process with ADSD as well as Medicaid provider application prior to providing services. The requirements and procedures to qualify as a provider are available via https://www.medicaid.nv.gov/ , the ADSD is currently working towards updating our public website to include policies and the standards of service provision. Providers may qualify and enroll at any given time.

Currently for the ADSD process, a potential provider must contact any Regional Center to begin the certification process including obtaining the provider application, standards of service provision and ADSD policy on the provider application process. The provider application must be returned with the specific documentation listed in the application. Applications submitted to the Regional Centers are reviewed within 30 days. If information is missing or requires clarification, the applicant is notified and given 30 days to submit any needed information. Once the application is complete, the applicant is notified of either an application denial or a request for an interview with various Regional Center QA and management staff. Approval or denial of the applicant is given within 10 days of the interview. If approved, Regional Center will issue certification and Regional Center staff work with the provider to complete training and any other needed processes to complete the provider enrollment process as soon as possible. New providers are initially accepted the provider is issued a Provisional Certification and Regional Center staff are informed the new provider is now available to accept vendor calls for needed services. A Quality Assurance Review is scheduled 9 to 12 months after beginning service provision. Based on the Quality Assurance Review, Developmental Services certifies new providers for up to a three (3) year period.

The certified providers are required to enroll with the DHCFP fiscal agent. Certified providers must complete the Provider Enrollment Packet. The fiscal agent reviews the documentation provided and is required to make a determination within five (5) business days to enroll a provider into the program. If the provider is missing documentation a request to provide the verifications is sent to the provider. There is no time limit as to when this needs to be provided. Providers are required to re-validate with the fiscal agent every 5 (five) years.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.a.1. Number and percent of providers who meet Division standards for certification. N: Number of providers who meet Division standards for certification. D: Total number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider certification data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.a.2. Number and percent of approved specialized service provider applicants who meet waiver requirements. N: Number of approved specialized service provider applicants who meet waiver requirements. D: Total number of approved specialized service provider applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.a.3. Number and percent of approved provider applicants that meet certification qualifications prior to delivering services. N: Number of approved provider applicants that meet certification qualifications prior to delivering services. D: Total number of approved provider applicants.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Harmony

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.c.1. Number and percent of provider agencies that meet training requirements for certification. N: Number of provider agencies reviewed that meet training requirements for certification. D: Total number of provider agencies reviewed for certification.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Certification Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Data is gathered and reviewed from various sources, including provider qualification tracking documents and provider certification QA results data; which incorporate data from incident management reporting, abuse, neglect, exploitation, isolation and mistreatment tracking, denial of rights and restraint data, and environmental QA review data. This data is reviewed to identify provider-specific trends and patterns of noncompliance with DS standards and policy. These data findings are reviewed with the provider and followed-up with a formal request for a plan of improvement. Time frames for the submittal and implementation of the plan of improvement are determined by the area of noncompliance; not to exceed 90 days. DS QA staff review and accept plans of improvement and track for validation of implementation, consistent practice, and positive outcomes. Providers who are unable to meet basic assurances, fail to sustain plans of improvement strategies, or fail to ensure consistent practice across the service delivery system are subject to sanctions, up to and including, the issuance of a probationary certification, contract reductions, and termination of service contracts.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person Centered Plan (PCP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☒ **Other**
Specify the individuals and their qualifications:

Qualified Intellectual Disability Professional (QIDP), as defined in 42 CFR 483.430 (a).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a) All service coordinators receive initial and ongoing training in the person-directed planning process and provides information and education to the participant, and family or guardian as appropriate, on the person-directed planning process, what options are available, and how to exercise rights. Prior to the team meeting, the service coordinator actively engages and empowers the participant in leading and directing the development of their personal vision and goals for the future. A personal vision describes what is most important to the person from their perspective. It helps define the life the person wishes to have in the next few years, including where the person wishes to live, recreate, and work. Additionally, it helps define who is important in their life and who they consider to be their support network. If the participant is a minor, the family is asked to develop the future vision with the child, as appropriate.

b) Participants direct their person centered team meetings to the greatest extent possible. If the participant is interested, the service coordinator, or provider, helps them develop their agenda and direct their own planning meeting. The participant is afforded respect, encouraged, and given opportunities to express themselves throughout the planning process.

Waiver participants have the opportunity and are encouraged to actively lead and direct the development of their person centered plan, including identifying individuals who will be involved in the planning and support process. The team consists of at minimum, the participant, service coordinator, parent or designated and/or legal guardian if appropriate, and any applicable provider representative(s). The participant may also invite others they are close to or who know them well, such as teachers, friends, therapists, and family members. Service coordinators assist the participant with deciding when and where team meetings are held.

At the planning meeting, the team discusses the difference between the participant's preferred future, or vision and desired outcomes, and their current situation. This process provides direction for the identification of goals and assures that the meeting focuses on the participant and his or her priorities, preferences, and perspective.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) Developmental Services (DS) uses a person-directed planning process. Assessment information assists the team with identifying barriers to reaching the person's vision, desired outcomes, and support needs. Goals related to reaching the vision are developed based on the person's desired life outcomes, as well as any needs for maintaining appropriate health and welfare. This information is provided to the person centered team for plan development at the Person Centered Plan meeting.

In conjunction with the participant and other members of the person centered team, the service coordinator facilitates the development of the Person Centered Plan, Developmental Services' plan of care process known as the PCP. At the planning meeting, the difference between the participant's preferred future, or vision, and the current situation provides direction for the identification of desired outcomes and goals. DS service coordinators use the same format for documenting the PCP statewide. The PCP format assures that all necessary information is discussed and documented by the team to meet the participant's assessed needs, as well as waiver compliance.

Each participant's PCP is developed a minimum of every 12 months and updated whenever requested by participant or when there is a significant change in the participant's needs, condition, or functional status that may affect the level of waiver services.

b) The PCP is developed utilizing applicable assessments that may include a social assessment, health assessment, risk assessment, or self-medication administration assessment tool. The assessment process addresses the participant's activities of daily living (ADLs) skills, or self-care activities, such as bathing, dressing, grooming, transferring, toileting, and eating. Instrumental activities of daily living (IADLs) are assessed and capture more complex life skills, including meal preparation, light housework, laundry, and essential shopping. In addition, this process includes gathering information regarding the participant's disabilities, educational information, current medical status and medical history, preventative health care needs, risks to health and personal safety, social network, backup plans, equipment needs, behavioral status, current support system, unmet service gaps, desired life outcomes and personal goals. Information for the completion of assessments is provided by the participant, support staff, health professionals, and may also include information from others who know the person well. Thereafter, assessments are updated and obtained for the purpose of updating the PCP annually or as the participant's needs change.

c) Participants are informed of the services available under the waiver program by the service coordinator during an initial support plan meeting. Thereafter, at least annually, participants are informed by their service coordinator of the services covered under the waiver program and Medicaid State Plan, as well as other available generic resources and supports.

d) Support plans include timelines for the implementation of specific goals and objectives, as well as the assignment of responsibility to specific team members, or others, for the implementation of those goals and objectives. The PCP also includes current health status and future health care needs. A temporary interim support plan may be developed in order to initiate services prior to the finalization of a full support plan. The interim support plan allows for a 30-day assessment period; after which a more detailed support plan is developed. A finalized support plan must be in place within 60 days of the person centered team meeting.

e) The support plan is inclusive of all the services and supports that are provided to meet the assessed needs of the participant. The service coordinator is responsible for understanding all services provided to the service recipient, gathering assessment information, developing the PCP based on team recommendations, facilitating plans for any necessary referrals, and monitoring all services, as part of support plan implementation.

If a service recipient is receiving other services or State Plan services, the Service Coordinator will obtain a release of information and contact those programs to obtain a copy of their service plan. These service plan(s) will be used by the support team in the coordination and development of the PCP additionally service authorizations are used to ensure services are not duplicated. Scans of the service plan(s) are uploaded as notes into the electronic record, so they are available to anyone performing a service review.

The PCP identifies the level of assistance required, type, amount, scope, frequency, and duration of services, as well as the method by which assistance is to be provided. Service providers are given a copy of the participant's service plan and must agree to provide the services as described in the plan by signing the final support plan within 60 days of the PCP meeting. The service coordinator reviews the documents with the participant. The participant or their legal representative then consents to the plan by signing the final support plan within 60 days of the PCP meeting. The service

coordinator is responsible for authorizing all waiver services. Authorizations are updated as needs change.

f) The service coordinator is responsible for monitoring and ensuring that the support plan is implemented as intended. This is accomplished through the provision of quality assurance activities, including monthly contact, quarterly face-to-face visits with the participant, home visits, work visits, and follow-up with providers to ensure that PCP implementation is meeting the participant's needs, that the participant is satisfied with services, and the service plan is resulting in progress toward his or her goals.

The required monthly contact with the participant, a participant's designated and/or legal representative, or the participant's residential support services or Jobs and Day Training provider, is conducted by the service coordinator to discuss and assess the authorized services, as well as to evaluate the participant's level of satisfaction. Contacts may be made by telephone; however, there must be a face-to-face contact with each participant at least every three (3) 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 and safety.

g) At a minimum, there must be a quarterly review of the PCP to assess the continued needs, goals, and preferences of the service participant. The review may include the following: data on the progress of individual goals, assessment of the participant's medical condition (nursing notes, assessments, medical records, physician visit notes, etc.), and assessment of environmental conditions. If necessary, the PCP is updated and revised based on the needs and requests of the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

A Risk and Support Screening Tool is updated annually as a means of assessing health and safety risks. If there are identified health or community risks, the service coordinator may make referrals to specialists who can assess the situation and consult with the team on how to mitigate the risk. These may include psychologists, counselors, behavioral consultants, nurses, dietitians, and allied therapists. Once the risk has been evaluated, the team develops a safety plan to address those risks and incorporates it into the PCP. Strategies to mitigate risks are designed to respect the needs and preferences of the waiver participant. Some of the strategies may include supports other than waiver services and the use of individual risk agreements that permit the participant to acknowledge and accept the responsibility for addressing certain types of risk. All support plans include detailed information about the service participant’s health care needs, physicians, medications, and the person(s) responsible for assuring that specific and routine health care needs, including preventative health care needs, are met.

All support plans designate a specific team member or person responsible for each goal, objective, or area of support. The PCP team identifies in the support planning process the designated back up staff that will be available and trained to ensure there is no disruption in services if the designated responsible party is unable to fulfill their responsibilities. If services are provided by an agency, it is the agency's responsibility to provide a backup residential support staff. If the residential support staff fails to provide services, the participant or a support person is asked if there is a backup plan available. Additionally, the PCP team identifies natural supports (family, friends) that are available and able to provide backup should the provider staff fail to appear to provide services. If back up is not available, the person/family is advised to call 911 if necessary. Individuals receiving intermittent residential habilitation services are assisted with obtaining Personal Emergency Response Services as assessed to be appropriate. If the Regional Center Service Coordinator is notified by a service recipient that the provider staff failed to arrive as scheduled and health and safety are of concern, the service coordinator will stay on the phone with the recipient and provide reassurance and guidance while making arrangements for emergency backup. Providers of 24-hour living services are required by certification to have sound back up emergency plans and coverage to ensure there is no disruption in service. Additionally, service recipients receive training on responding to emergency situations by Residential Habilitation Service providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Prior to waiver enrollment, and annually thereafter, each participant or designated and/or legal representative reads and signs a "Statement of Choice" form. The Statement of Choice reads, “I have actively participated in identifying my supports and preferred outcomes for the next year. I have been able to choose the provider of my support services. I am aware that I can ask for a change of state service coordinator or provider agency if I am not satisfied with the help I am getting. If I am eligible for Medicaid, I understand that I may select any available Medicaid provider. I understand I may request changes in services and supports at any time.” Service coordinators provide names of qualified waiver service providers and facilitate meetings with participants and potential providers to explore service options. The participant chooses their preferred provider and the service coordinator facilitates the initiation of services.

Participants have contact with their Service Coordinator on at least a monthly basis. During these contacts, Service Coordinators inquire if the individual is satisfied with their services and if they would like to make any changes. Information will be given about qualified providers whenever the participant asks or otherwise indicates they would like a new service or service provider. If instructed to do so by the participant, the Service Coordinator will complete an anonymous vendor call which is sent to all qualified providers for the desired service. The participant and their family/guardian, as applicable, is then supported by the Service Coordinator in interviewing potential providers that expressed interest in the providing the needed service. After a provider is selected, a revised PCP support plan is developed as needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Developmental Services (DS) regional center staff are responsible for the development of all Person Centered Plans (PCPs). The PCP is included in an intake packet, which is sent to the Home and Community-Based Waiver Long Term Services and Support unit of Health Care Financing and Policy (DHCFP) for review and approval. The DHCFP is responsible for entering the appropriate waiver benefit line for each participant into the Medicaid Management Information System (MMIS) prior to the start of waiver services. The benefit line is what authorizes payment for the providers of waiver services.

The service plan is entered directly into ADSD Harmony database. DHCFP QA has access to the Harmony system which allows them to review the service plan. Service Plans are reviewed as part of the DHCFP QA annual review. The evaluation reviews a sample of the recipients enrolled in the waiver statewide.

A random sample is selected producing a probability of a 95 percent confidence level with a +/- 5 confidence interval (95/5) determining the statewide total of recipient files to be reviewed by the operating agency supervisors and the DHCFP Central Office QA staff. A second sample producing a probability of a 95percent confidence level with a +/- 10 confidence interval (95/10) is generated using the same list to determine the required number of recipient cases [to include recipient files and Personal Experience Surveys (PES)] that the DHCFP Central Office QA staff will evaluate throughout the review year.

This randomized list is used to determine the number of recipient cases required to be completed, ensuring that at least 25 are selected from each regional office. Once the first 25 slots are appointed to each regional office, the DHCFP Central Office QA staff will continue to add slots in order of randomization to determine the number of recipients to pull for each regional office. The total number of slots will be divided evenly over the year to identify the exact number of active files to be pulled monthly from each regional office.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☒ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) DS service coordinators are responsible for monitoring and documenting the provision of waiver services, as well as participant health and welfare. This monitoring is completed through a multi-component approach, including: monthly contacts with waiver participants, their designated and/or legal representatives, or the residential support services or jobs and day training provider in order to discuss and authorize services, as well as evaluate the participant's level of satisfaction; and home visits for participants receiving residential supports, scheduled according to the type or level of support, with higher supervision needs having more frequent visits, such as participants receiving intensive, 24-hour residential support.

b) On a monthly basis, a post audit of services is conducted by service coordinators who review a random sample of logs and data completed by residential support managers, residential support staff, jobs and day training staff, or specialized service providers to ensure that support plans are being implemented as authorized by the Person Centered Team, that data is measurable, and progress is noted. Residential support services and jobs and day training providers also submit quarterly reports detailing progress made towards the outcomes and goals stated in the PCP which are reviewed by the service coordinators.

c) Person Centered Plans are reviewed at least quarterly and revised annually, at the recipients request or when a significant change in circumstance or condition occurs.

When an area of concern is identified the service coordinators meet with the recipient and parties involved to discuss changes or modifications.

In order to assure the health, safety and welfare of recipients and assess on a continual basis recipients' satisfaction with services, the following quality assurance tools are used: Quality Assurance (QA) Questionnaire-Participant Experience Survey (PES) is completed during a visit to the client's home or by telephone. ADSD supervisory staff conducts a sample of reviews of the recipient's Level of Care (LOC) and Person Centered Plan (PCP) annually, at a minimum. The ADSD QA unit complies this data for tracking and trends purposes. The information collected is shared with supervisory staff and DHCFP at the quarterly QA meetings for remediation and educational opportunities. When a problem with service plan implementation is identified, the Service Coordinator is responsible for performing needed follow up to correct the problem(s). This remediation is documented in their Targeted Case Management notes. ADSD supervisory and QA staff conduct a sample of chart reviews each year, including a review of notes showing that "needs/concerns are followed up and documented monthly.

Problems related to a breakdown of systems by the contract provider are referred to the QA department at each Regional Center. If needed, a plan of improvement (POI) will be issued to the provider for needed corrections. This POI will be monitored by QA staff until closure.

b. Monitoring Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.a.1 Number and percent of records reviewed where the PCP addresses the assessed needs of the recipient. N: The number of records reviewed that have needs addressed. D: Total number of PCPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Waiver Review Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/+/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: DS Regions
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.a.2 Number and percent of PCPs reviewed that included personal goals consistent with person centered planning. N: Number of PCPs reviewed that included personal goals consistent with person centered planning. D: Total number of PCPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Waiver Review Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/+/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: DS Regions
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
a.i.a.3 Number and percent of PCPs reviewed that address health and safety risk factors. N: Number of PCPs reviewed that address health and safety risk factors. D: Total number of recipient PCPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Waiver Review Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/+/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: DS Regions
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

a.i.c.1 Number and percent of recipient's PCPs that are reviewed annually. N: Number of recipient's PCPs that are reviewed annually. D: Total number of recipient's PCPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Waiver Review Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/+/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: DS Regions
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

Performance Measure:
a.i.c.2 Number and percent of recipient PCPs that are updated when the recipient's needs changed. N: Number of recipient PCPs that are updated when the recipient's needs changed. D: Number of recipient PCPs reviewed with a documented change in need.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Waiver Review Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/+/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group:

		DS Regions
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.d.1 Number of waiver recipients whose services were delivered in accordance with the PCP, including the type, scope, amount, duration and frequency identified in the PCP. N: Number of waiver recipients whose services were delivered in accordance with the PCP, including the type, scope, amount, duration and frequency identified in the PCP. D: Number of all waiver recipients reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Waiver Review Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/+/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: DS Regions
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

HCBS Financial Review Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/+/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.e 1 Number and percent of recipients whose Statement of Choice (SOC) is signed indicating choice of waiver services and choice of service providers. N: Number and percent of recipients whose Statement of Choice (SOC) is signed indicating choice of waiver services and choice of service providers. D: Number of recipient records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Waiver Service Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence

		Interval = 95%/+/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: DS Region
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

A 25% sample of waiver recipients statewide are reviewed by ADSD trained staff using the HCBS Waiver Review Form. This review form addresses all waiver requirements. The sample is assigned to reviewers by agency Quality Assurance (QA) staff, with data collected throughout the year. The review results include whether the PCP is consistent with assessment information and addresses all needs of the recipient, whether health and welfare issues are addressed, risks were assessed, personal goals are included in the PCP, the PCP was developed within approved timelines, and the PCP and service authorization specify the type, scope, frequency, and duration of each service.

The completed HCBS Waiver Review Forms are provided to supervisors of service coordinators for their review and follow-up. Supervisors identify items on the review that require follow-up and discuss the results with the service coordinator. The service coordinator has 30 days to make corrections in the individual's record, document actions taken with the date completed, and returns this information to their supervisor. The supervisor is then responsible for verifying that corrections have been made within the established time frames.

Results of the HCBS Waiver Service Review Form are entered into the statewide database system, Harmony, allowing for automated reports for QA purposes by service coordinators, supervisors, QA staff, and the DHCFP. Reports provide analysis of the percentage of reviews showing a deficiency for each item and trends are followed over time. QA staff review these results quarterly. Systems-level remediation is completed through feedback and additional training by DS staff at service coordination meetings.

Monthly QI meetings are conducted to review findings from the annual waiver review process and address areas that are below 86% compliance. Any areas that are below 86% are evaluated to determine if a QI project is necessary. If it is, the project is assigned to a priority grid. The QI members analyze and identify the probable cause of the deficiency and develop a plan to improve performance. Minutes are taken at all QI meetings to document identification and resolution of all issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Prior to enrollment in the waiver, all waiver applicants review and sign a "Statement of Choice" form which includes a statement regarding their right to a fair hearing.

"I have been informed of the right to a fair hearing if I have not been able to choose Home and Community-Based Services instead of placement in an ICF/IID or Medicaid Home and Community-Based Services are denied, reduced, suspended, or terminated."

Medicaid Services Manual (MSM), Chapter 2100 - Waiver for Individuals with Developmental Disabilities, and Chapter 3100 - Hearings, identifies the following circumstances under which a Notice of Decision (NOD) must be given to a waiver participant or applicant of an adverse action:

- Denial of waiver participation
- Suspension of waiver services, such as when hospitalized or placed in a Skilled Nursing Facility
- Termination of waiver services
- Reduction of waiver services

If one of the above negative actions occurs, a Notice of Decision (NOD) stating the reason(s) for the negative action will be sent to the applicant by the DHCFP Long Term Services and Supports unit per MSM, Chapters 2100 and 3100. ADSD service coordinators are responsible for sending notification of negative actions via Form 3010, indicating the negative action and the reason to DHCFP, for DHCFP to issue the NOD.

A “Fair Hearing Request Form” is included with the NOD and states the following: “If you disagree with Medicaid’s decision regarding requested benefits, you may request a Fair Hearing by completing, signing and returning this form to Nevada Medicaid within ninety (90) days of the effective date (Date of Action), shown on the enclosed Notice of Decision. The day after the effective date is the first day of the 90-day period. If you are currently receiving the Medicaid benefit in question, and you want to continue receiving this benefit during the Fair Hearing process, your Fair Hearing request must be received no later than the 10th day after the effective date (Date of Action) shown on the enclosed Notice of Decision. At the Fair Hearing, you may represent yourself or be represented by a family member, lawyer, or other responsible adult. To be represented by someone else, you must sign a written authorization which must be received by Nevada Medicaid before the hearing preparation meeting (you can grant authorization by completing the appropriate fields below). A signature is not required for a recipient who is incompetent or incapacitated. If you cannot afford legal counsel, one of the Legal Services Programs listed below may be able to help.”

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

Responsibility to inform recipient of their right to a fair hearing:

1) DS service coordinators are responsible for explaining the Statement of Choice to applicants, and obtaining a signature on that document. The Statement of Choice indicates an applicant’s right to a fair hearing.

2) DHCFP is responsible for informing participants of their rights to a Fair Hearing through its responsibility to send Notice of Decisions (NODs) for the following reasons: denial, suspension, reduction, and termination. The NOD outlines the participant’s right to a Fair Hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a)

the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The ADSD has policy in place that provides individuals access to due process. This includes their right to review and understand their rights responsibilities, restrictions, and complaints during the provision of waiver services.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All providers are required to have a grievance or complaint procedure, which is reviewed by Quality Assurance staff during the provider certification process. If a recipient is concerned about their provider services, they can ask for a copy of the grievance procedure. Their service coordinator, or any other person of their choice, can help the service recipient file a grievance through the provider agency's grievance procedure. The recipient may file a grievance regarding provider concerns, services not provided, abuse, neglect, exploitation, isolation and mistreatment. Once a complaint or grievance is received by the ADSD, they will address the concerns within one (1) working business day.

The recipient can request that their service coordinator schedule a special support team meeting as soon as possible to assist in resolving a complaint or unmet need.

If the recipient is not satisfied with the resolution from the support team meeting, the recipient can request a review by the service coordinator's supervisor within thirty (30) days of the support team meeting. If the recipient is still not satisfied with the resolution, they can ask for a review by the Regional Center Human Rights Committee (HRC). HRC then reviews their concerns at the next regularly scheduled meeting and sends findings with recommendations to the Regional Center Director within five (5) working days after the meeting. The Regional Center Director reviews the findings and issues a final decision within ten (10) working days.

The ADSD policy 23-1 Participant Rights and Due Process, requires each DS regional center to have a procedure for receiving and processing grievances. If the recipient wants to file a complaint against regional center staff or decisions, they will be supported by their service coordinator, other regional center staff, or any other person of their choice in filing a complaint, per regional center policy.

The Administrator of the ADSD is the final authority if all previous steps fail. The review takes place within thirty (30) days of the last decision. Recipients also have the right to request assistance from the Nevada Disability Advocacy and Law Center, Inc.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Aging and Disability Services Division (ADSD) has a comprehensive incident management reporting and review process. Providers are required to report all incidents of recipient injury; elopement; rights violations; restraint use; medication errors; hospitalizations; emergency room visits; death; suspected or alleged abuse, neglect, exploitation, isolation, or mistreatment; unlawful behavior, theft; treatment refusals; missed medical appointments; threats of self-harm or harm to others; and all complaints or allegations of mistreatment or rights violations voiced by recipients, designated and/or legal representative, families, staff, and the general public.

Contract providers and regional center staff report all incidents through Harmony, the ADSD's electronic information management system. Contract providers are required to describe the incident, how it occurred and a plan of action for remediation and prevention in the future. All incident reports are electronically submitted through an online system (Harmony) and the assigned regional center service coordinator is the first level of regional center review. Within the Harmony incident record, the regional center service coordinator will note additional information on the action the support team has taken in follow-up, remediation and prevention of future occurrences. Per ADSD policy, the service coordinator must complete a "Serious Occurrence Report" form within the Harmony incident record for all incidents that fall into the "Serious Occurrence" categories of:

a. SUICIDE

b. DEATH

c. SUICIDE ATTEMPT

d. ASSAULT/VIOLENCE/THREAT

e. SUSPECTED ABUSE/NEGLECT/EXPLOITATION/ISOLATION/MISTREATMENT

f. ELOPED/MISSING/AWOL

g. INJURY/ILLNESS - Requiring medical attention or admission to an acute care hospital

h. SERIOUS INJURY OF UNKNOWN ORIGIN - Suspicious based on the nature or circumstance of the injury; not correlated to the functional or medical status of the individual

i. LEGAL/CRIMINAL

j. MEDICATION ERRORS – Requiring medical attention or not corrected within 24 hours

k. OTHER - Any event which adversely affects, or has the potential to affect, the health and safety of a person receiving services, which does not fall into one of the other categories. This includes, but is not limited to, the following examples:

- HIPAA violations
- Evacuations, fires, and hazardous material events
- Major property damage
- Sexual acting-out; not meeting the definition of abuse
- Media events
- Potential State liability issues
- Any other event requiring notification of an outside agency including, but not limited to, paramedics, police, fire department, and Child Protective Services (CPS).

The Harmony incident record, including the incident report, the serious occurrence report (if applicable) and noted follow-up, is then reviewed by the service coordinator's supervisor for possible closure. Additional reviews for all serious occurrence reports are conducted by regional center Quality Assurance (QA) staff, the Regional Center Manager and/or Division Administration. The service coordinator is notified of any additional follow-up that is identified during these reviews. All follow-up must be completed before the Harmony incident record is closed.

Regional center QA staff track and trend all submitted incident reports and serious occurrences through the use of Harmony reports and/or excel spreadsheets. Additionally, the ADSD requires contract providers to track all incidents reported to the regional centers for trending purposes and quality improvement as part of the provider's internal quality

assurance process.

Incident reports are required to be submitted through Harmony to the regional center within 24 hours of serious occurrences and within two (2) business days for other reportable incidents. All Developmental Services (DS) and contract provider employees are mandatory reporters for abuse, neglect, exploitation, isolation, and mistreatment. Incidents of suspected or alleged abuse, neglect, exploitation, isolation, or mistreatment are required to be verbally reported via person-to-person contact to the regional center service coordinator or supervisor within one (1) business hour of discovery, followed by submission of a report to Harmony within 24 hours. The regional center service coordinator is required to verbally report via person-to-person contact any allegation or suspicion of abuse, neglect, exploitation, isolation, or mistreatment to the supervisor, director, or designee, within one (1) business hour of learning of the event. Serious Occurrence Reports must be written in Harmony by the service coordinator within one (1) working day. Regional center service coordinators and contract providers ensure notification to appropriate child welfare or law enforcement agencies, as applicable by law, as soon as possible and no longer than 24 hours of discovery or suspicion thereof (Nevada Revised Statutes (NRS), Chapter 200).

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Recipients, families, caregivers and designated and/or legal representatives receive information about the ADSD policy related to abuse, neglect, exploitation, isolation and mistreatment, and the reporting thereof, from regional center intake staff prior to the initiation of services, and at least annually thereafter, from the assigned service coordinator. Additionally, regional center service coordinators discuss abuse and neglect, regulations and laws for reporting, and address prevention steps with recipients and families on a more frequent basis, as applicable, for recipients identified to be at higher risk. The ADSD requires contract providers of supported living and jobs and day training programs to conduct monthly rights training with recipients, or as recommended by the PCP team, based on the assessed needs of a recipient. Recipients are taught how to report, who to notify, and are encouraged to talk about issues that may be considered abuse, neglect, exploitation, or isolation as well as other rights violations. The training curriculum and materials used by contract providers is developed and/or approved by the regional centers and designed specifically to facilitate ease of understanding, including the use of pictures and simplified language.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The ADSD, under Developmental Services (DS), has a multi-level review system for incidents and serious occurrences. Each regional center receives reports through Harmony from contract providers, or regional center service coordinators, regarding serious occurrences listed in Section G.1.a. within 24 hours of discovery and within two (2) business days for all other incidents. In addition, any incident of death or alleged abuse, neglect, isolation, or mistreatment must be verbally reported by the contract provider to the regional center service coordinator or supervisor within one (1) business hour. The service coordinator or supervisor must then report the death or allegation of abuse, neglect, isolation, or mistreatment to their supervisor or the Regional Center Manager, or designee, within one (1) business hour of learning of the event. All reports to the regional center are reviewed and evaluated by service coordinators and supervisors. Service coordinators or supervisors determine whether the report falls under reportable "Serious Occurrence" guidelines, as established under DS policy, and needs to be forwarded to QA staff, the Regional Center Manager and DS Administrator, or designee. Serious Occurrence Reports are generated by the assigned service coordinator within the Harmony incident record and submitted electronically through Harmony to QA staff and the Regional Center Manager for review within 24 hours of notice. Serious occurrences related to death, allegations of abuse, neglect, exploitation, isolation or mistreatment, or other critical incidents involving State liability issues are also reviewed by the Division Administrator, or designee. QA staff, the Regional Center Manager and/or the DS Administrator, or designee, reviews Serious Occurrence Reports to determine the need for further follow-up or clarification prior to closure. Any incidents involving abuse, neglect, exploitation, isolation, or mistreatment or other critical incidents that may involve State liability issues, are forwarded by the DS Administrator to the assigned DS Deputy Attorney General for further review and possible investigation.

Incident review and response considers the severity of the event and frequency of similar reports for the recipient and/or provider of services. Once the evaluation is completed, one or more of the following may be done:

• The service coordinator completes follow up with the provider and assures that the recipient and others are in a safe environment.

• Allegations of abuse, neglect, exploitation, isolation or mistreatment require an investigation by either law enforcement, the Division, the Regional Center or the contract provider. Until an investigation is completed, any accused staff members are immediately re-assigned from having direct contact with any service recipients pending the outcome of the investigation, DS approval and law enforcement report closure, as applicable.

• The regional center ensures that the appropriate law enforcement agencies are notified of a suspicion or allegation of abuse, neglect, exploitation, isolation, or mistreatment per reporting requirements set forth under the Nevada Revised Statutes (NRS), Chapter 200. If a report is made to law enforcement, per NRS 200, the contract provider or regional center conduct investigations based on the recommendation of law enforcement. Occasionally, DS and law enforcement investigations are completed concurrently; however, the majority of DS investigations are initiated after the completion of a law enforcement investigation in order to avoid disrupting the law enforcement investigative process. Allegations in which the accused is not a provider, or regional center employee, are investigated solely by the appropriate law enforcement agency. The Nevada Bureau of Health Care Quality and Compliance is notified of allegations involving licensed entities, as appropriate.

• Contract provider agencies follow their DS-approved internal policies and procedures for documentation and investigation of an incident. Contract providers utilize employees with investigation techniques and report writing training provided by DS Administration. A written report using the DS-approved investigation report template and guidelines is submitted by the contract provider to the regional center QA department within 10 days of discovery, unless approval for an extension has been granted by the regional center QA Department. The regional center QA team thoroughly reviews all investigation reports to ensure that required information listed in the investigation guidelines is included, findings and conclusions are sound and reflective of the information in the summary of investigative activities, and that plans for remediation, systems improvement, and timelines for completion are included, as applicable to the findings. QA staff follows-up with the contract provider to obtain any missing information. Accused staff are not approved to resume direct contact with service recipients until the investigation report is accepted. Under certain circumstances, the regional center or Division conducts an investigation in lieu of the contract provider based on the assessment of the severity, scope, or potential for perceived or actual conflict of interest. All unexpected, or suspicious in nature, deaths are investigated by the regional center.

• The Regional Center Manager, designee, or DS Division Administrator, may initiate a formal investigation conducted by Division-trained investigators based on the review of the initial report.

• After an investigation is completed, the regional center communicates with the involved contract provider and reviews the findings and recommendations. It is the responsibility of the agency completing the investigation to inform the recipient, guardian, or any applicable family members, of the outcome of the investigation. Regional center QA requires a written plan of action from the provider within ten (10) days, unless otherwise agreed upon by the regional center due to extenuating circumstances, to address remediation and prevention strategies based on the findings of the investigation. The plan of action includes timelines for the implementation of action steps and is reviewed and followed-up on by regional center QA staff, as necessary. Investigations are not closed until the regional center is satisfied and confident that a thorough investigation was conducted, remediation is appropriate, and the plan of action includes adequate prevention strategies. Follow-up by regional center QA staff occurs monthly, with typical validation and closure within 90 days.

• Regional center employees involved in an incident are required to submit a plan of action to DS Administration along with the investigation report findings within ten (10) days of notification of a suspected or alleged incident. Follow-up reporting for plans of action are made at least monthly, or as directed by DS Administration, until closure is approved.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Incident report data is entered directly into the Harmony database by the contract provider and Regional Center staff. Contract providers indicate the applicable service coordinator and supervisor at the time of incident entry. Service coordinators and supervisors are required to review and respond to new incident reports every workday. Entry into Harmony also allows for Regional Center QA staff to track the status of open incidents, investigation reports, and plans of action at least monthly with follow-up, as warranted, until closure.

A component of Regional Center QA Review for Provider Certification assesses the effectiveness of the provider's internal incident reporting system to ensure incidents are reported and investigated in compliance with DS policy and methods for tracking, trending, and responding to identified patterns. Regional center QA staff track and trend serious incidents by category, provider, and the type of follow-up required. Harmony reports are produced by category and provider for review of trends and patterns. The data is reported quarterly to the Regional Center Management Team, with trends and patterns of concern identified for review, recommendations, and follow-up action taken with providers, as warranted. Data analysis findings are also used by the regional center for development and revision of policy and provider service standards and regulations, as well as for staff and provider training. Additionally, regional center QA is strengthening processes for sharing data with the Division of Health Care Financing & Policy (DHCFP) at quarterly State QA team meetings.

The DHCFP has access to the Harmony data base that contains the serious occurrence information. The data produced by the Harmony data base is reviewed quarterly by the DHCFP. DHCFP will be running Serious Occurrence Reports (SOR) on a monthly basis for tracking and trending. The serious occurrence reporting data is reviewed and discussed during the QA quarterly management meeting that DHCFP participates in. The data is presented and discussed to identify trends and areas of concerns. The ADSD and DHCFP collaborate remediation, training, follow-up needed, revisions to policies or actions to ensure the health and welfare of the recipients.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The ADSD utilizes person centered planning and values-based support when addressing the needs of recipients. Person centered planning is driven by an understanding of the recipient's personal goals. For recipients with severe social or behavioral support needs, treatment is built on prevention through positive, supportive interventions and building adaptive skills that facilitate the recipient's ability to communicate needs and feelings in a socially acceptable manner; reducing episodes of undesirable "target" behaviors. Restraint and other intrusive interventions are viewed as a last resort method to be used only in an emergency situation, as defined in NRS 433.5466. "Emergency" is defined as a situation in which immediate intervention is necessary to protect the physical safety of a person or others from an immediate threat of physical injury or to protect against an immediate threat of severe property damage. Restraint is considered by DS to be an emergency and safety intervention; not a therapeutic technique. Restraint procedures are not initiated or maintained as a substitute for treatment, as punishment, or for the convenience of staff, and may only be utilized as stipulated in NRS 433 and Division policy.

Use of a restraint procedure is viewed as an exception or extreme event for any recipient. Except for unforeseen emergencies, restraint may only be incorporated into a crisis plan if the recipient's support team has developed and implemented a positive behavior support plan that is both based on a functional assessment of the target behavior(s) and incorporates setting events, antecedents, response-building, and consequence support strategies. All decisions to incorporate restraint in an approved crisis plan are based on a thorough assessment of the recipient that addresses factors contraindicating restraint use, such as a history of sexual abuse, physical abuse or other violence, medical or psychiatric issues, and cultural issues. All crisis plans that incorporate restrictive interventions must be reviewed and approved by the regional center's Human Rights and/or Behavior Intervention Committees. The crisis plans are also monitored quarterly by the service coordinator. Quarterly monitoring includes a review of behavior support and crisis plan data (e.g. frequency of problem behavior, frequency of positive alternative behavior, frequency of use of crisis plan, frequency of use of PRN medications, etc.). Additionally, the providers of residential support services, as well as the provider of jobs and day training services, are required to provide a report of progress to the service coordinator quarterly. This report includes a summary of progress with the behavior support plans and use of crisis plans. The service coordinator also participates with all data reviews by the Human Rights and/or Behavior Intervention Committees, which monitor the crisis plans, as well.

The ADSD prohibits the use of aversive interventions, seclusion, or chemical restraint. Physical and mechanical restraint may only be utilized by staff trained in an approved physical restraint technique or mechanical restraint application.

The ADSD contracted providers may only utilize crisis intervention techniques approved by the Regional Center. DS standards for service provision require crisis intervention programs to be nationally recognized with evidence of an annual review and revision to curriculum based on current best legal, behavioral, and ethical practices.

All regions have Behavioral Intervention Committees (BIC) that monitor the services provided to individuals who have had restraint in the past, take multiple psychotropic medications to manage behavior, or who are deemed to be at high risk for restraints or restrictions in their lives. The BICs, in addition to providing ongoing monitoring, provide technical assistance such as positive behavior support and program review/approval to help understand and address the root causes of the perceived need for restraint or medication management.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

All physical or mechanical restraint used for emergencies or medical treatment are reported through the Harmony incident management system on the DS-approved Restraint and Denial (RAD) form. The RAD requires information on the type of restraint(s) used, amount of time in restraint, less restrictive interventions utilized prior to the use of a restraint technique, as well as the number and names of staff involved, including their level of restraint training. Crisis Prevention/Intervention Certification in a DS approved program is required for any employee who is likely to utilize restraint procedures. The organization must provide evidence of adherence to stipulations or standards of training as established by the approved program i.e. Safety Care, CPI, MANDT, SOARS, etc. An approved program requires national recognition and evidence of annual review and update of curriculum based on best legal/behavioral/ ethical practices of standards of care. (Note: Only staff with current certification in an approved program may implement any type of restraint use.).

Incidents in which an emergency intervention is utilized are reported via Harmony, including the completion of the RAD form, and reviewed by the regional center service coordinator, supervisor, QA staff, Regional Center Manager and ADSD Administration. Any detection of restraint use not reported per policy, or any indication of an unauthorized use of restrictive interventions, is addressed with the contract provider for corrective action and resolution.

The recipient's person centered team monitors the support and crisis plans on an ongoing basis. When interventions that restrict a recipient's rights are used and not approved through due process, the contract provider must also submit a Report of Denial of Rights (DOR) to the DS Regional Center. The service coordinator, QA staff, Regional Center Manager and DS Administration review the DOR form. In addition to the above oversight process, the regional center provides another level of oversight through Behavioral Intervention and/or Human Rights Committees. These committees generally meet once per month. Person centered plans that include interventions restricting individuals' rights must be reviewed and approved. The committees determine the frequency of ongoing review for specific support plans. Reviews are completed at least annually. Regional center management and QA staff monitor reviews completed by HRC/BIC to ensure policies and procedures are consistent in practice.

All incident reports and DOR reports are entered into the Harmony information system. Regional center QA staff track and trend rights restrictions by category, provider, and the type of follow-up required. This data is reported quarterly to the Regional Center Management Team with trends and patterns of concern identified for review, recommendations, and follow-up action taken with providers, as warranted. Data analysis findings are also used by the regional center for the development and revision of policy and provider service standards and regulations, as well as for staff and provider training. This data is also utilized as a component of the Quality Assurance Review for Provider Certification; requiring a plan of action for any misuse of restrictive interventions or failure to adequately report use, per DS policy.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Per NRS 435.610, individual rights cannot be denied except for the protection of the individual's health and safety and/or the health and safety of others. The types of restrictive interventions that can be utilized for the protection of health and safety include restrictions of: freedom of movement (i.e. locked doors and full access to own environment and community); privacy (i.e. search of personal property and confidentiality of records); freedom of association (i.e. having visitors each day and contact with people of own choosing); make and receive confidential phone calls and mail; keep personal possessions including own clothing; and free access to own spending money. The use of aversive interventions, as defined in NRS 433.456 through 433.554, is prohibited.

Positive behavior support strategies are employed prior to the authorization and use of restrictive interventions. Interventions that restrict the rights of service recipients must be part of a support plan that has been reviewed and approved by the regional center's Human Rights (HRC) and/or Behavioral Intervention Committees (BIC). The support team must delineate the non-restrictive strategies used and actions taken to prevent the need for the restrictive intervention, as well as the teaching plan so that the restriction may be lifted when safe and appropriate, in the documents submitted to the HRC and/or BIC for approval of the restrictive intervention. Plans that contain approved restrictive interventions are reviewed by HRC and/or BIC at least annually depending on the severity of the restriction and determined need for oversight. Provider staff is required to take data on the use of the restrictive intervention. This data is then presented to HRC and/or BIC during their review.

Provider staff that administers approved restrictive interventions procedures must have a minimum of a high school diploma as well as orientation and annual training on Positive Behavior Approaches, Personal Rights/Responsibilities, Dignity and Respect, and Due Process of Restrictive Interventions. For every service recipient for whom restrictive interventions have been approved, provider management staff is required to train all residential support staff on the proper use of the specific approved restrictive interventions in that service recipients support plan.

Various methods are employed to detect the unauthorized use of restrictive interventions. Regional center service coordinators conduct monthly contacts, face-to-face quarterly contacts and annual PCP meetings. Each of these activities offers the opportunity to discuss the services received by the recipient and the methods by which the services are given, including the use of any restrictive interventions. In addition, service coordinators conduct work site and home visits to observe the work and living environments of the individual and to observe the services being delivered. Quality assurance staff also conducts work site and home visits of a sample of waiver recipients to complete environmental QA reviews. During these reviews, the environment is reviewed for restrictions such as freedom of movement, privacy and free access to spending money. Provider staff is interviewed regarding their implementation of support plans and the use of any restrictive interventions. Any unauthorized use of restrictive interventions is immediately reported to both the service coordinator and provider agency management. Use of restrictive interventions is also reviewed during the provider certification process by QA staff. Unauthorized use of restrictive interventions can result in provider certification sanctions up to and including provider termination.

Unauthorized and/or emergency use of restrictive interventions that have not gone through due process must be reported on the Division Denial of Rights (DOR) form within Harmony. This form is reviewed by the regional center service coordinator, quality assurance staff, and Regional Center Manager. It is then reviewed by Aging and Disability Services Division (ADSD) Administration. Compiled DOR data is sent to the Commission on Behavioral Health, established per NRS 433, for review. The Commission may request specific DOR forms to review based on reported data. Regional Center Managers must attend meetings of the Commission on Behavioral Health to respond to questions and report activities to address rights denials.

The ADSD Administration, or the Commission, may request additional information from the Regional Center Manager for clarification, review, or investigation of the denial of rights, if there are questions regarding the appropriateness of the action taken in denying an individual's rights. Regional Center Managers must attend meetings of the Commission on Behavioral Health, established in NRS 433, to respond to questions and report activities to address rights denials.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and

overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The individual's support team monitors support and crisis plans on an ongoing basis. When interventions that restrict individual's rights are used and not approved for due process, the provider must submit a Report of Denial of Rights to the DS Regional Center. The service coordinator, quality assurance staff, and Regional Center Director reviews the Report of Denial of Rights. This form is then submitted directly to the Aging and Disability Services Division Administrator for review by the Commission on Behavioral Health. The Commission reviews these quarterly and reports back to the ADSD.

In addition to the above oversight processes, regional centers provide another level of oversight through Behavioral Intervention Committee and Human Rights Committees. Information regarding the use of restrictive interventions is reported directly to the behavior Intervention Committee by the service coordinator and community provider based on the assigned schedule (monthly, quarterly, biannually, annual). These committees generally meet once per month. Any individual's support plan that includes interventions restricting rights must be reviewed and approved. By DS policy, reviews are conducted at least annually. The oversight committee determines the schedule for on-going oversight reviews based on recommendations that may include: request for plan revision; addition or revision of data collection methods to measure progress; request for psychiatric or other medical follow up; etc. Minutes of the meeting discussion and recommendations along with schedule for next review are submitted to DS targeted case managers and service providers. ADSD as the operating agency has a tracking system in place. Reports are presented in the Quality Management Meeting.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The ADSD continuously monitors for the unauthorized use of seclusion through the review of incident reports. In addition, direct support staff and recipients are questioned about rights restrictions during environmental quality assurance reviews performed by service coordinators and QA staff.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Several entities are responsible for monitoring of medication regimens.

Recipients requiring support with medications are first monitored by the medical professionals prescribing the medication(s) annually or additionally, as needed. Medical visits are completed as directed by the prescribing medical professional and no less than annually. Residential support staff who take recipients to these appointments bring a list of all current medications, including dose and frequency, to each visit to ensure that all medical professionals involved in the recipient's care are aware of all medications taken by the person. In addition, residential support staff will collect and share data on target symptoms, as well as any observed side effects, at these medical appointments. Any medication side effects are also reported to the prescribing medical professional immediately upon observation by staff.

The full PCP support team reviews all medication on at least an annual basis during the development of the annual PCP.PCPs are reviewed, at least quarterly, by the PCP team to assess changes in the recipient's condition and effectiveness of plans. Any changes in medications must be reported to the Service Coordinator and other team members by the residential services provider within two business days. In addition, Service Coordinators are required to assess the person's condition on a monthly basis and review the PCP at least quarterly. When necessary, all Regional Centers have nurses on staff that can review complex medication regimens at the request of the Service Coordinator.

For recipients taking multiple behavior modifying medications, each regional center's Behavior Intervention Committee (BIC) reviews these medications on at least an annual basis. BIC requests information regarding the use of behavior modifying medications and, depending on the complexity of the medication regime (e.g., polypharmacy) and/or recipients' support needs, reviews and monitors the medication regimen on a quarterly, biannual, or annual basis. The BIC determines the review schedule. Review outcomes and recommendations are provided directly to the service coordinator and provider.

Contracted providers of residential services are responsible for daily medication supports and monitoring, as well as for collecting and sharing data on target symptoms and behavior with the treating physician in order to assess the effectiveness of the medications. Medication side effects are also monitored by the contract provider and communicated to the treating physician and pharmacy, as appropriate.

Finally, QA staff are required to complete an environmental review of all 24-hour residential settings on at least an annual basis and this includes a review of medication administration records. Service Coordinators are required to review medication administration records in 24-hour residential settings on a quarterly basis.

All medication errors, medication refusals and observed medication side effects are reported by the residential services provider as an incident report. These reports are reviewed by the assigned Service Coordinator and Supervisor for the identification of patterns and needed remediation.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

A) The Behavioral Intervention Committees review, at least annually, the use of multiple behavior-modifying medications by assessing physician's notes, discussing potential side effects, and reviewing behavioral data related to behavior support plans to measure medication effectiveness. Any concerns from committee members regarding the efficacy of a particular medication or concurrent use of contraindicated medications are noted with follow-up to the prescribing physician with a subsequent re-review completed by the committee.

All residential support staff administering medication per Nevada Administrative Code (NAC) 435.675 must successfully complete a program concerning the administration of medication which is approved by Developmental Services. All curriculums are reviewed by the statewide health committee, which includes nurses and quality assurance staff. Oversight for training compliance is included in the provider certification process. Providers of supported living and their residential support staff are required to report any errors in medication administration. DS tracks and trends this information on both a systemic and individual level. Any organizational trends are presented to the provider and a plan of action is developed and implemented. Individual trends/risks are presented to the support team for remediation.

a) Contract providers are required to use a DS-approved physician visit form for all physician or specialist visits. This form requires the provider to list all medications currently being taken by the recipient. Contract providers are required to establish a recipient with a pharmacy of the recipient's choice for all prescriptions, including over-the-counter medications, in order to enable identification of contraindicated medications. Contract providers are required to have copies of side effects information sheets for all medications taken by the service recipient on-hand and available for staff.

Oversight and monitoring to ensure that recipient's medications are managed appropriately is conducted by service coordinators during monthly contacts, quarterly face-to-face visits, and by reviewing physician or psychiatric consults. In addition, Regional Center QA staff review all 24-hour supported living arrangements at least once per year. This review includes observations and interviews with of residential support staff and individual served, review of documentation, and environmental assessment of the home to determine its compliance with standards for health, safety and welfare. Additional monitoring is provided by the Regional Center QA Team's analysis of environmental QA review findings, incident report data, DOR data, and Human Rights/Behavior Intervention Committee's documented concerns.

b) Any problems and/or concerns are addressed by the support team for correction. Individual incident reports related to medication errors are followed-up by the service coordinator and QA staff in order to ensure that remediation occurs. Identified patterns and trends are addressed with the provider on a systemic level and may require the provider to submit a formal plan of action, depending on the level of severity of risk to the recipient's health and safety. QA staff will then validate corrections have been made and are maintained.

c) The ADSD is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Developmental Services uses an assessment tool to determine a recipient's ability to self-administer medications. This assessment is completed upon the initiation of residential support services and is reviewed by the recipient's person centered team at least annually. Residential support staff of a contracted provider may administer medication to recipients if trained, and currently certified, in a DS-approved medication administration program. All medication administration curriculums are approved by the statewide health committee, which includes nurses and quality assurance staff.

Residential support staff must administer medication according to health care provider instructions. The recipient, or guardian, provides written authorization to receive medications from residential support staff, in accordance with NRS 435.375, 453.213 and NAC 435.675. Additionally, the recipient receives a physical examination by a health care provider annually, or as physical conditions change. The health care provider determines if the recipient is medically cleared to receive medications from residential support staff.

Residential support staff must refer a recipient receiving residential support services to a health care provider if:

- The recipient's medical condition changes or the recipient develops a new or additional medical condition;
- The medication does not accomplish the treatment objective, as identified by the health care provider, when administered as prescribed; and
- Any emergency situation develops.

NAC 435.675, Section 3, identifies when residential support staff cannot administer medication, as well as the types of medications that are not allowed to be administered.

Recipients who are capable of self-administration of medication are monitored and supported based on assessed needs and as recommended by their person centered team. It is a DS requirement, and component of contract provider standards, that all residential support staff receives orientation and annual training in medication support management.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

The Aging and Disability Services Division (ADSD).

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

Wrong person, wrong medication, wrong dose, wrong time, wrong route, missed dose, and unavailable medication.

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

Contracted providers must submit incident reports to the regional center related to medication errors involving the wrong person, wrong medication, wrong dose, wrong time, wrong route, missed dose, unavailable medication, as well as a refused dose. Medication errors resulting in an adverse reaction, or rising to suspected neglect, are considered serious and must be reported to the regional center within 24 hours. All other incidents involving medication errors may be reported within two (2) working days.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Reviews conducted by BIC are focused only on the use of multiple behavior modifying medication. BIC requests data on target behaviors in an effort to assess if the medications are truly having an impact on target behavior frequency or scope. In addition, a Regional Center nurse will review the medications for potential drug interactions. Any findings by BIC are given to the Service Coordinator and residential service provider for discussion with the prescribing medical professional(s). When needed, a Regional Center nurse will contact the prescribing medical professional(s) regarding potential drug interactions.

BIC review is specifically designed to monitor potentially harmful effects of the use of multiple behavior modifying medications. As indicated above, follow up needed after the BIC review can be completed by the Regional Center nurse, the Service Coordinator and/or the residential services provider to ensure the prescribing medical professional(s) is aware of any discovered concerns.

All other medication monitoring described above is performed for all medications prescribed to the individual. Incident reports submitted for all medication errors, medication refusals and observed medication side effects are reviewed by the assigned Service Coordinator and Supervisor for the identification of individual error patterns. QA staff are responsible for monitoring overall incidents submitted by each provider agency for the identification of systemic error patterns.

Individual incident reports related to medication errors are followed-up by the service coordinator and QA staff to ensure that remediation occurs. Identified patterns and trends are addressed with the provider on a systemic level and require a formal plan of action and, depending on the level of severity of risk to the recipient’s health and safety, may be subject to sanctions, including the issuance of a probationary certification and reduction in contracts.

The ADSD staff is responsible for the oversight and monitoring of the recipients' medications. The staff verifies that medications are managed appropriately by reviewing medical orders and completing monthly contacts. DS staff track and trend submitted incident reports, as well as environmental review findings, on both a systemic and individual level. Any organizational trends are presented to the provider and a plan of improvement is developed and implemented. Individual trends/risks are presented to the support team for remediation.

Data is used in the certification review process of contract providers. Data analysis findings are also used by the regional center for the development and revision of policy and provider service standards and regulations, as well as for staff and provider training.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.a.1 Number and percent of recipients who are informed of their rights, including the right to be free from abuse, neglect, exploitation, isolation and mistreatment. N: Number of recipients who are informed of their rights, including the right to be free from abuse, neglect, exploitation, isolation and mistreatment. D: Total number of recipients reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Waiver Review Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/+/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: By DS Region
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.a.2 Number and percent of serious occurrences subject to investigation that are completed within the timeframes established by Division policy and procedures. N: Number of serious occurrences subject to investigation completed within the timeframes established by Division policy and procedures. D: Total number of serious occurrences investigated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.b.1 Number and percent of recipient serious occurrence reports that include appropriate follow up. N: Number of serious occurrence reports that received appropriate follow up. D: Total number of serious occurrence reports requiring follow up.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.c.1 Number and percent of restraints reported that are in compliance with established Division policy and procedure and state requirements. N: Number of restraints reported that are in compliance with established Division policy and procedure and state requirements. D: Total number of restraints reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.c.2 Number and percent of providers in compliance with Division policy and procedures and state requirements for rights restrictions, not including restraint. N: Number of providers in compliance with Division policy and procedures and state requirements, not including restraint. D: Total number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certification QA results.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.d.1 Number and percent of 24 hour supported living arrangements (SLA) that are in compliance with DS policy and state requirements for medication management and administration. N: Number of 24 hour SLAs that are in compliance with DS policy and state requirements for medication management and administration. D: Total number of 24 hour SLAs that provide medication management and administration.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Harmony

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
a.i.d.2 Number and percent of recipients who receive information annually regarding preventative healthcare. N: Number and percent of recipients reviewed who receive information annually regarding preventative healthcare. D: Total number of recipients reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Waiver Review Form

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/+/-5%
☐ **Other** Specify:	☐ **Annually**	☒ **Stratified** Describe Group: DS Region
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Data is gathered and reviewed from various sources, including incident reports, HCBS Waiver Review Forms, Denial of Rights/Restraint and Denial information, abuse, neglect, exploitation, isolation and mistreatment tracking data, Provider Certification QA results data and Environmental Reviews. This data is reviewed to identify trends and patterns of noncompliance with DS standards and policy. Follow-up is done by requesting corrective action. There are three (3) levels of remediation:

• Individual recipient- Data is shared with the person centered team who addresses patterns of concern through support team planning with follow-up by the regional center service coordinator and QA staff to ensure the contract provider staff have implemented corrective actions and support strategies.

• Patterns and trends of noncompliance identified that cross the provider and/or regional center service delivery system- Data is shared with regional center administration, service coordinators, and the provider network to assess cause, as well as to develop quality improvement strategies and systems for monitoring outcomes.

• Patterns and trends of noncompliance specific to a particular contract provider- Data is shared with the provider with the requirement to develop and implement a formal plan of action. Providers who are unable to meet basic assurances, fail to sustain plans of action strategies, or fail to ensure consistent practice across service the delivery system are subject to sanctions, up to and including issuance of probationary certification, contract reductions, and termination of service contracts.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities*

of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State of Nevada is a large rural state with two major urban areas 500 miles apart (Las Vegas, in Clark County, and Reno, in Washoe County). The rural area of Nevada covers over 90,000 square miles. The three Developmental Services (DS) agencies, Desert Regional Center (DRC), Rural Regional Center (RRC), and Sierra Regional Center (SRC), have a quality improvement system to cover services within the state. The regional centers work diligently to establish and maintain consistent basic assurances and quality improvement practices across the state. Statewide initiatives that have been developed in this way include the implementation of the Harmony Information System in July of 2016 after several years of development. Harmony replaced many previous legacy systems allowing for DS to have recipient information, such as electronic notes used to document all contacts completed by service coordinators, Person Centered Plans, diagnoses and risk assessments; provider information, such as certification findings and required business licenses; service authorizations and billing claims; and incident management all in one statewide electronic database. Other statewide initiatives include provider certification and quality assurance processes, HCBS Waiver Review processes, and investigation processes.

DS maintains a robust structure for communicating between regional centers to share approaches to common issues and coordinate strategies for quality improvement and operating the waiver program. The components of this structure comprise the building blocks of the Quality Improvement System (QIS). Communication between these components assures coordination between regional centers, DS Administration, the Division of Health Care Financing and Policy (DHCFP), as well as other partnering agencies, such as the Division of Public & Behavioral Health, other programs within the Aging & Disability Services Division, and contracted community providers; resulting in a comprehensive and integrated QIS. The components of the QIS are described below:

REGIONAL QUALITY IMPROVEMENT SYSTEM COMPONENTS:

LEADERSHIP MEETINGS: Each Regional Center Manager holds regularly scheduled meetings with key management staff, including Quality Assurance Specialist IIIs. The purpose is to share important information across the agency, identify problem areas needing attention, and prioritize quality management goals. The Leadership Team discusses ways to remediate problem areas and is responsible for the implementation of remediation strategies through department staff and stakeholders, such as participants, family members, other state agencies, community partners and contract service providers. An example of this process is the provision of additional training for service coordinators and contracted service providers as a result of data indicating trends and patterns of an inconsistent application of standards. Another example is the strengthening of standards and policy to address health and welfare concerns, as identified through incident management systems.

PROVIDER MEETINGS: Each regional center holds regular meetings with contracted service providers. These meetings are designed to maintain good collaboration with community service providers, share ideas and information, and establish collaborative workgroups for quality improvement when areas are identified as needing attention. New quality improvement policies, processes or procedures are shared with all contracted service providers at these meetings.

STATEWIDE QUALITY IMPROVEMENT SYSTEM COMPONENTS:

STATEWIDE QUALITY ASSURANCE TEAM: At the center of the quality improvement system in Nevada is the Statewide Quality Assurance Team (SQAT). The core team is composed of Quality Assurance Specialist IIIs (QAS III) from each regional center and the Developmental Services Health Program Manager that oversees waiver and statewide quality management systems. Additionally, Quality Assurance Specialist IIs (QAS II) from each regional center and the ADSD Quality Assurance Manager participate as members of SQAT as needed. The purpose of the SQAT is to coordinate quality assurance (QA) and quality improvement (QI) activities across the state. The team monitors performance across the statewide service delivery system, with providers, service coordinators, supervisors, department heads and Regional Center Managers, as well as develops reports as necessary for the DHCFP. The regional QAS IIIs bring issues identified at the regional level to the attention of the statewide group in order to discuss and evaluate whether an issue should be addressed on a statewide level. In addition, SQAT develops and refines the discovery process by looking at data and seeing how data is collected regionally. It ensures that discovery processes for the HCBS waiver are carried out in a consistent, valid and reliable manner across the state. In its analysis of statewide data, SQAT identifies strategies for improvement or remediation to be implemented in each region. In this way, statewide QI projects are coordinated through SQAT which continues to monitor progress made as a result of regional implementation activities and reports back to the

agency Managers and the DHCFP.

Examples of statewide quality initiatives and processes developed and implemented by the Statewide QA Team include the incident management system within Harmony, provider application, enrollment and certification systems, provider QA reviews for certification, the HCBS Waiver Review system, and other various tracking and data analysis systems in Harmony. These processes allow the Statewide QA Team to generate data reports on performance indicators to assess whether regional center and statewide strategies are working to promote desired outcomes for individuals and the regional centers, support health and welfare of service recipients, facilitate compliance with standards and regulations, and promote provider capacity.

MANAGER'S MEETINGS: At the statewide level, Regional Center Managers meet regularly to address issues and assure coordinated follow-up. The Developmental Services Health Program Manager reports on statewide SQAT activities and recommendations at the Regional Manager's Meeting. The Regional Center Managers share information, assess program performance, address requests from Aging & Disability Services Division (ADSD) administration or the DHCFP, and make decisions regarding priorities and use of agency resources for QA and QI projects. The managers coordinate regional workgroups and projects for statewide consistency in work processes and provide consistency in leadership to regional center staff. Managers are also responsible for coordinating requests from DHCFP and reviewing the implementation of the waiver program. An example of data reviewed at this level is the HCBS Waiver Review results and the development of statewide training plans to improve the quality of services and waiver compliance. Managers follow-up to assure implementation of QA and QI initiatives at the regional level through their regional Leadership meetings. The Developmental Services Health Program Manager follows-up on issues related to statewide QI activities by taking decisions back to the Statewide Quality Assurance Team (SQAT) and, from there, to regional center supervisors and staff.

DEVELOPMENTAL SERVICES OPEN LINE: Open Line meetings are scheduled monthly between each regional center and the ADSD Developmental Services Deputy Administrator. Statewide issues identified at SQAT or Manager's Meetings are brought to the Open Line meeting to ensure any quality improvement efforts are consistent statewide and have the support of Developmental Services administration. This group works closely to review and update policies, as well as to ensure compliance with the provision of waiver services for participants, caregivers, and family members. New or revised quality tools are introduced and modified to fit the needs of the three Developmental Services regional centers.

DHCFP/SQAT: The Statewide QA Team is responsible for developing reports and other information on the performance measures for the waiver that are shared with the DHCFP at a quarterly meeting. The Regional Center Managers also attend this meeting. The ADSD staff review the data and trends in the reports, describe remediation strategies and implementation status, and discuss future plans with the DHCFP staff. The DHCFP uses this opportunity to provide program oversight, make inquiries, and may ask for additional information or a corrective action plan based on the information provided and analyzed by both the ADSD and the DHCFP.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Developmental Services is committed to using information generated to measure the effectiveness of strategies and processes implemented to improve quality in services. Developmental Services generates a variety of reports displaying the aggregated outcomes and indicator data by region. Reports are provided to groups who share responsibility for monitoring program effectiveness and the results of the implementation of quality improvement strategies.

DS Administration and Regional Center Managers look at reports provided by the regional centers that measure outcomes related to the priority goals that have been set. The effectiveness of the improvement strategies is evaluated after they have been implemented through an analysis of data provided by the agency. Quality improvement is a dynamic process and additional data may be requested at any time to evaluate, update, or develop new goals.

At the regional level, the Leadership Team of each agency looks at aggregated data provided by the QA department staff in order to evaluate the effectiveness of change strategies. The QAS III makes periodic reports to the team by providing summaries of data trends (i.e., incident reports by type or provider, results of investigations and provider QA Reviews) and follows-up on other quality improvement initiatives that are requested by the team.

The Statewide Quality Assurance Team (SQAT) is the main body for evaluating information across the statewide DS system. It is also the committee that develops new data collection tools and processes. Various data reports have been developed in the Harmony information system that can retrieve data on both a statewide and regional center basis. SQAT continues to request additional Harmony data report development as needed to ensure data is gathered and evaluated in a consistent manner.

SQAT generates data reports for analysis at many levels. Monthly and quarterly reports are analyzed by team members to determine whether quality improvement or remediation strategies are having the desired effect. In addition, SQAT determines whether other data and reports are needed based on information coming to them from committees at various levels of the system. SQAT works closely with IT staff to develop capacity in Harmony for data aggregation, trending, and design changes. It then provides feedback reports to the various entities for further improvement or updates of goals and plans.

The Statewide QA Team meeting minutes document the data reviewed, improvement strategies developed, the entity responsible for implementation in the regions, and status reports tracking effectiveness of the strategies.

The Statewide QA Team develops a quarterly report for the DHCFP and the Regional Center Managers that summarizes performance measures in the waiver. Annually, a composite annual report is produced that is made available to stakeholders, as well as other interested parties.

Finally, the DHCFP maintains administrative authority over the Home and Community Based Services Waiver for Individuals with Intellectual and Developmental Disabilities. The DHCFP is responsible for ensuring that the design and operations of the waiver are consistent with federal Medicaid statutes and regulations. The DHCFP quarterly meetings with the Statewide QA Team are a forum for the regional centers to discuss and share information on improvement strategies that are being implemented based on the analysis of the data shown in the reports. These meetings are also a time when the QA team reviews the aggregated data reports from the preceding reporting period that measure the performance indicators included in the waiver.

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

The QIS is a dynamic system that changes and improves over time. The process of data analysis, goal-setting, strategy design and implementation, monitoring, and continued measurement of outcome indicators, leads logically to continued refinement and adjustment of the system. The responsibility for these ongoing improvements is a collaborative effort between the Regional Center Managers and the Statewide QA Team. The Statewide Quality Assurance Team provides the Regional Center Managers with the measurement of new indicators, assessment and refinement of data sources for reliability and validity, and development and improvement of data collection systems, in order to assist with ongoing improvements.

At least annually, the Regional Center Managers and members of the Statewide QA Team schedule a meeting to discuss the effectiveness of the quality improvement system statewide. Discussion is held regarding what is working, or results that show improvements, what needs improvement, and what can be done to refocus the system, if needed. This is also when desired priority outcomes are agreed upon for both the DHCFP and the regional centers.

Key members of the Statewide QA Team also hold statewide annual quality improvement retreats in order to evaluate effectiveness of the statewide QA/QI systems and to develop plans for the next steps to be taken for making improvements in the overall quality management system.

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

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

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Legislative Counsel Bureau Audit Division intends to contract with a public accounting firm to conduct the State of Nevada's Single Audit for the fiscal years ended June 30, 2014, 2015, 2016 and 2017. The Single Audit is an audit of the State's financial statements and federal awards. The State of Nevada's Basic Financial Statements are prepared by the Office of the State Controller and are included in the State's Comprehensive Annual Financial Report. https://www.leg.state.nv.us/App/CareerOpenings/Postings/LCB/AUDITRFP20142017.pdf

a) The Division of Health Care Financing and Policy (DHCFP) conducts a financial review as part of the annual waiver review.

b) The Aging & Disability Services Division (ADSD) has a number of procedures in order to assure financial compliance. The ADSD's Harmony information system receives Medicaid waiver eligibility information for each recipient each month from the Medicaid Management Information System (MMIS). Billing claims are submitted by the contract provider into the Harmony information system. Harmony only submits claims to the MMIS for services that are eligible for waiver funding for recipients who are eligible for the Medicaid waiver for the month of service. In addition, the MMIS has built-in edits, which will deny any claim of individuals who are not Medicaid-eligible. The ADSD financial staff receive monthly Remittance Advice Reports from the fiscal agent, in which data is compiled and tracked on those individuals whose claims were not paid based on ineligibility.

State staff complete a post-payment review of a random sample of paid claims each month to assure that services that are billed to the waiver correspond to those identified in the Person Centered Plan (PCP), as prior authorized and waiver-eligible. This audit consists of a review of all service logs to ensure billed services are properly documented. Audit findings are reported to the applicable contract provider, who has 30 days to provide any additional documentation, if applicable. Any overpayments must be reimbursed by the provider within 30 days of notice of the final audit findings, unless a specific reimbursement plan has been approved by the regional center. The regional center ensures billing to the DHCFP was accurate and makes adjustments as needed. Final findings of overpayments are also reported to the DHCFP Surveillance and Utilization Review unit.

Financial reviews are completed, at a minimum, on all recipients selected in the random sample for case file reviews. A month is randomly selected for each recipient in the sample and claims for the selected review month for the recipient are examined, together with the information in the recipient's case file. The DHCFP QA Unit or operating agency will request the daily logs, the prior authorization, and the provider rates as well as any other backup documentation necessary for the selected month from the specified provider.

All financial claims will be reviewed to ensure assurances, sub-assurances and performance measures are being met. The DHCFP QA Unit verifies elements in the following assurance categories: a) Waiver Administration and Operation, b) Recipient Access and Eligibility c) Recipient Services, d) Person Centered Planning and Service Delivery, e) Recipient Safeguards, and f) Financial Accountability.

The results of the financial review are included in the final waiver review report. The final report is presented to the ADSD, LTSS, and the DHCFP Administration. The results are evaluated to assess the seriousness and pervasiveness of problems, identify goals to remediate issues and problems through policy development, policy clarification, system and program changes, staff training and other remedies. When necessary, the results of the financial review are referred to the DHCFP Surveillance and Utilization Review Unit.

c) The Division of Health Care Financing and Policy (DHCFP) and the Aging and Disability Services Division (ADSD)

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.a.1 Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record and prior authorization. N: Number of recipients claims that are coded and paid correctly in accordance with the service plan, daily record and prior authorization. D: Number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Provider Financial Audits

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%/+/-5%*
☐ ***Other*** *Specify:*	☐ ***Annually***	☒ ***Stratified*** *Describe Group:* *DS Region*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
HCBS Financial Review Form

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%/+/-10%*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *Semi-Annually*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
a.i.b.1 Number and percent of provider payment rates which are consistent with the rate methodology in the approved waiver. N: Total number of payment rates reviewed which are consistent with the rate methodology in the approved waiver. D: Total number of payment rates reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100%***

		Review
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

Performance Measures a.i.a.1: Results of the financial reviews are reported to the DHCFP Quality Management (QM) Committee, which assesses the seriousness and pervasiveness of problems, identifies goals to remediate issues and problems through policy development, policy clarification, system and program changes, staff training and other remedies, and follows-up on remediation progress.

When an individual problem is discovered from either the ADSD or the DHCFP, research is done and results are provided to each other and a Plan of Correction is determined. This may be as simple as a phone call or an e-mail. If the issue is more detailed, meetings are scheduled. Outcomes are documented and shared with the DHCFP QM Committee.

Performance Measures a.i.b.1: If there are errors found within the MMIS system during the annual review, there is a mechanism in place to correct these issues. The errors that have been noted in the past include incorrect rates, payments edits that are not functioning, or payment edits that need to be included so claims pay appropriately. When these types of errors are noted, a form called Production Discrepancy Report (PDR) is completed which identifies the nature of the problem. The PDR is submitted to the DHCFP's fiscal agent for a Scope of Work which outlines the amount of time and cost to fix the system. Once that is approved by the DHCFP IT staff, the work is prioritized.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ◉ ***No***
- ○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The DHCFP and the ADSD are the responsible entities for rate determination; however, the DHCFP rates units, will be the lead to perform all rates and cost study. Once rate is determined, it is presented to the legislature for approval. All approved rates are then entered MMIS for oversight to ensure providers are paid uniformly and based on their provider type. Rate study will be conducted every four (4) years per Assembly Bill 108.

The DHCFP and the ADSD conduct public workshop, attend advisory council meetings to gather public input. Additionally, each provider type has representatives and present their concerns or issues to the DHHS, state agencies, and attend legislative sessions. The DHCFP website is also an avenue to solicit public input as well as through mail, fax or email.

The DHCFP rate staff uses DSS Reporting and periodically analyze number of claims paid, net payments to billing providers, service count, the number of patients, total expenditures and estimated cost per patient. If the report indicates a drop in the number of claims, patients or billing providers by 25%, the DHCFP will first verify that it is not due to a seasonal phenomenon and if it is a local or statewide impact. If it is not related to a seasonal phenomenon, the DHCFP will query the District Offices and the Fiscal Agent staff to determine if access issues are being reported. If no access issues are being reported, the DHCFP will continue to track the data and make ongoing public inquiries through public forums, workshops, council meetings which also address provider issues/concerns.

The state also monitors billed claims for fluctuations in utilization of waiver services through reports obtained from MMIS and financial reviews conducted by DHCFP Quality Assurance (QA) unit annually. ADSD's QA unit certifies and monitors applicants who want to enroll as PT 38, before an applicant can become Medicaid provider; and, reviews ID waiver providers to ensure compliance with the approved waiver, Medicaid policies and licensure/certification requirements. Recipients are surveyed annually utilizing the Participant Experience Survey (PES) to ensure their health, safety and welfare. Any discrepancies found are reported to the state's licensure agency, or DHCFP Surveillance Utilization Review unit and copies of reported discrepancies are also provided to LTSS unit for tracking and trending.

In 2/2017, ADSD implemented a new Serious Occurrence Report (SOR) database called Harmony for reporting complaints/grievances. The ADSD has one (1) working business day to respond to all complaints. The DHCFP staff also has access to Harmony for tracking and trending all complaints/grievances through ADSD.

Private Provider Rates – The ADSD is the billing agent for private providers for the following services: Day Habilitation; Prevocational Services; Residential Support Services; Supported Employment; Behavioral Consultation, Training and Intervention services; Career Planning; Counseling Services; Non-Medical Transportation; Nursing Services; Nutritional Counseling Services and Residential Support Management. The ADSD pays the private providers the total computable amount and then bills the DHCFP for the federal share of expenditures. Rates paid to the private providers for: Day Habilitation; Prevocational Services; Residential Support Services; Supported Employment; and, Residential Support Management were set in 2002 by the Nevada Provider Rates Task Force. EP&P consultant was contracted by the DHCFP to conduct an analysis of provider rates and make recommendations on rate-setting. The base rate for these services were developed and adopted by the DHCFP using a provider cost survey and market analysis. The rates are comprised of level of staffing (FTEs) per billing unit; the wage level for supervisor and direct care staff using wage information from the Bureau of Labor Statistics; employee related expenses at 27% which includes benefits such as paid vacation, paid sick leave, holiday pay, health insurance, etc.; amount of non-billable time spent by staff (productivity adjustment at 30 minutes per day) as well as staff training time; 15% was added to the hourly direct care and ERE cost for non-direct care activities. This is the base rate for these services. The EP&P study further recommended allowing for cost of living adjustments/inflation in future years. Rate adjustments for inflation increased the base rate by 29.6% since 2002. The Division proposed rate increases at each bi-annual legislative session; however, there had been no approved rate increase for SFY 08 and thereafter due to the state's economic situation until SFY 16. The increase for each year was based on availability of funds. Public testimony is allowed during the Legislative process when rate increases are proposed through the budget process. The Base rate is the same for all private providers.

Other Waiver services such as: Behavioral Consultation, Training and Intervention services; Counseling Services; Nursing services; and, Nutritional Counseling Services are reimbursed at the DHCFP approved rate for like services using the State Plan reimbursement methodology. For example, reimbursement rates for nursing services are set using the rate for Home Health Nursing services fee schedule approved in the Medicaid State Plan Attachment 4.19 - B. These rates can be found on the DHCFP website at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules. Changes to the reimbursement methodology for State Plan services require a public hearing with a 30-day advance notice process and a Tribal notice 60-days in advance. The same rate is paid to all private providers providing these waiver services.

The non-medical transportation maximum rate is $100.00 per month; however, the average monthly payment per recipient is $79.16 per month. The Non-Medical Transportation rate is comparable to other states. As Career Planning was a new service, it was not part of the EP&P study and the DHCFP does not cover these services for any other provider type, so the reimbursement rate was established by evaluating surrounding state's reimbursement rates. The same rate is paid to all private providers for these waiver services.

The ADSD communicates the rates through the development of a PCP. This plan provides the service, individual to staffing ratio, type, scope, duration and frequency of services to be provided. The provider of service enters into a written provider contract with the ADSD. A service authorization for each recipient is developed in Harmony in accordance with their PCP. A review of service provision is required annually. If changes to the plan are needed, which result in changes to what is reimbursed, a special PCP team meeting is held, and correspondence sent to each provider to communicate future service authorization and billing changes due to staff ratio and/or service units.

Waiver service expenditures listed in Appendix J were calculated using the SFY 2017 actual expenditures (reported from the CMS 372 report), divided by the SFY 2017 actual number of recipients, divided by the estimated number of working days to determine the average unit cost. The average unit cost is reflected in Appendix J. Rate increases to the private servicing providers were not approved in the State's 2018 to 2019 budget cycle, so the inflation factor was not applied until year three of this waiver on Schedule J. For purposes of this renewal, the base rate is increased by the CPI of 1.3% for each year of the waiver. The inflation factor is from the U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index – All Urban Consumers (not seasonally adjusted), 12 month percent increase change, U.S. City by expenditure category. The latest analysis is from January 1, 2016 through December 31, 2016.

Public Provider Rates - In addition to the private providers, the ADSD staff provides direct medical services for the following: Behavioral Consultation, training and intervention; Counseling Services and Nursing Services. These services are a cost based rate utilizing Certified Public Expenditure (CPE) funding.

An Interim Rate is established on an interim basis for direct medical services per unit of service at the lesser of the ADSD billed charges or the provider-specific interim rate. The provider-specific interim rate is an annual rate for the specific services for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period. Interim rates are normally based on program experience and cost data during the prior fiscal year. However, in the case of the ADSD, who is the new operating agency for this waiver, current fiscal year budgeted expenditures were also considered in setting the interim rate for the first year of operation.

Annual Cost Report Process:

The ADSD will complete an annual cost report for all medical services delivered during the previous state fiscal year covering July 1 through June 30. The primary purpose of the cost report is to document the ADSD's total Medicaid-allowable cost for delivering the medical services, including direct costs and indirect costs, based on the methodologies/steps described below and to reconcile its interim payments to the total Medicaid-allowable costs. The annual Medicaid Cost Report includes a certification of funds statement to be completed, certifying the ADSD's actual, incurred allocable and allowable costs/expenditures. All filed annual Cost Reports are subject to audit by the DCHFP or its designee. To determine the Medicaid-allowable direct and indirect costs of providing covered services to Medicaid-eligible clients, the following steps are performed:

Direct costs for covered services include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay, and travel. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are accumulated on the annual cost report, resulting in total direct costs.

A CMS approved time study is required when providers of service do not spend 100% of their time providing the Medical services and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and

direct services. The direct medical services time study percentage is applied against the net direct and indirect costs. Total Medicaid allowable costs is reduced by any revenue, e.g. Medicaid copayments, TPL, received for the same services to arrive at the total Medicaid net allocable and allowable costs.

Cost Reconciliation Process:

The ADSD will be responsible for reconciling total allowable computable costs reported on the cost report to the Medicaid interim payments for Medicaid services delivered during the reporting period as document in the MMIS, resulting in cost reconciliation.

Cost Settlement Process:

If the ADSD interim payments exceed the actual, certified costs for services to Medicaid clients, the DHCFP will recoup the federal share of the overpayment. If the actual, certified costs exceed the interim Medicaid payments, the DHCFP will pay the federal share of the difference to the ADSD.

Continued in Main Module

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Providers prepare and submit claims directly to the ADSD's Harmony information system for payment. The ADSD's Harmony system, in turn, submits claims to the DHCFP for reimbursement of the federal share through the MMIS system.

Billings do not flow through any intermediary other than the fiscal agent for the federal share and the ADSD for direct provider claims.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

○ ***No. state or local government agencies do not certify expenditures for waiver services.***

◉ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☒ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

The ADSD certifies actual expenditures of the total computable costs incurred. Certification includes that the expenditures are allocable and allowable for federal participation. The DHCFP pays the federal share of the lower of billed charges or an interim rate. Claims are submitted to the DHCFP through MMIS. The provider specific interim rate is the annual rate for a period of time pending the completion of a cost report, cost reconciliation and cost settlement for that period. The cost settlement is completed by the DHCFP staff. The ADSD has a cost allocation plan to demonstrate how direct and indirect costs are allocated to the different programs and services provided by the Division. The cost allocation plan is in accordance with OMB Circular A-87 and approved by DCA. Pending current revisions due to the merge of divisions and subsequent revisions to the CAP will be submitted to DCA. A time study is required for state staff that does not spend 100% of their time to any one program and/or service.

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

a) The Medicaid Management Information System (MMIS) assures that all claims for payment are made when the recipient was eligible for Medicaid waiver payment on the date of service, 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. The recipient and provider subsystems enroll members in the various benefit plans and maintain and report enrollee eligibility data while also supplying demographic and other data used to adjudicate payment requests. The reference subsystem and the claims processing subsystem identify the covered services for the benefit plan, as well as the associated edits and pricing. The claims processing subsystem then produces fully adjudicated payment requests, which are then selected by the financial subsystem for check-writing and other financial processing. When a participant's eligibility for the waiver is terminated, the benefit plan is updated to indicate the date of termination. As claims are processed for payment, an edit is performed to ensure the date on the claim is within the eligibility dates identified in the benefit plan and that the services billed are included in the benefit plan.

b) The Person Centered Plan (PCP) support plan lists services by scope, frequency, and duration. Service coordinators furnish a copy of the appropriate PCP to waiver service providers and review the PCP with waiver service providers, if requested. Providers are required to sign the PCP support plan within 60 days of the PCP meeting stating they agree to provide the waiver services as described.

c) Verification that services for which payment was made were actually provided occurs as part of the annual program review and annual financial review; based on a representative sample. Waiver claims are pulled directly from the MMIS system and compared to the appropriate PCP and daily records for verification of service delivery. The Medicaid Management Information System (MMIS) assures that claims for payment are made only when the recipient is eligible and only for services included in the PCP. Additionally, state staff complete a post-payment review of a random sample of paid claims each month to ensure that services that are billed to the waiver correspond to those identified in the PCP. Claims submitted by the provider are pulled from Harmony and compared to all service logs to ensure billed services are properly documented.

When a person is determined to be eligible for the waiver, a benefit plan is entered into the MMIS system with the beginning date of eligibility and authorized services. When a participant's eligibility for the waiver is terminated, the benefit plan is updated to indicate the date of termination. As claims are processed for payment, an edit is performed to ensure the date on the claim is within the eligibility dates identified in the benefit plan and that the services billed are included in the benefit plan.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through

which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

All waiver providers prepare and submit claims directly to the ADSD's Harmony information system for payment. The ADSD pays the claim to the provider and then the ADSD's Harmony system, in turn, submits claims to the DHCFP for reimbursement of the federal share through the MMIS system.

State staff complete a post-payment review of a random sample of paid claims each month to assure that services that are billed to the waiver correspond to those identified in the Person Centered Plan (PCP), as prior authorized and waiver-eligible. This audit consists of a review of all service logs to ensure billed services are properly documented. Audit findings are reported to the applicable contract provider, who has 30 days to provide any additional documentation, if applicable. Any overpayments must be reimbursed by the provider within 30 days of notice of the final audit findings, unless a specific reimbursement plan has been approved by the regional center. The regional center ensures billing to the DHCFP was accurate and makes adjustments as needed. Final findings of overpayments are also reported to the DHCFP Surveillance and Utilization Review unit.

The DHCFP conducts an annual financial review of services provided under this waiver. The fiscal portion of the annual review determines the accuracy of provider payments made by examining claims paid and comparing these with the participant's file, Individual Support Plan, provider qualifications, and waiver requirements. A list of claims paid is produced from the Medicaid Management Information System (MMIS) for each sample case for all waiver services.

A management report of the annual financial audit findings is provided to the DHCFP. Pertinent information is shared with the ADSD and then the ADSD provides the DHCFP with a Plan of Correction (POC) for both the program and fiscal audits by identifying goals and timelines to remediate problems through policy development, policy clarification, system and program changes, staff training, and other remedies.

The DHCFP analyzes review findings to determine whether the MMIS payment edits are functioning as expected and whether modification to the MMIS would prevent future occurrences or erroneous payments. If so, system changes are recommended.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The following services may be provided directly by the ADSD staff: Behavioral consultation, intervention, and training, Nursing services and Counseling services.

All additional qualified providers are subcontracted and paid through the ADSD.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ◉ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

The DHCFP recoups payment from the provider requesting payment in full by check, electronic fund transfer or through a journal voucher processed through the State Accounting System. Once the federal share of funds are received the recoupment is reported on the CMS 64.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for*

expenditures made by states for services under the approved waiver. Select one:

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ○ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ◉ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

Reassignment may be made to the Aging and Disability Services Division (ADSD).

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services***

through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The Division of Aging and Disability Services (ADSD) is appropriated SGF through the budget process. Funds are directly expended by the ADSD as CPEs.

☒ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Through IGT, the counties are responsible to reimburse the ADSD for the State's share of expenditures for supportive living arrangement services for children under 18 years old regardless if the child is eligible for Medicaid waiver services. Supportive living arrangements are not provided by the counties so they are not CPE and there is no potential of recycling funds. The county funds are derived from county tax and/or county general revenue.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or*

sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

○ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☒ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Pursuant to Nevada Revised Statutes (NRS) 435.010 the counties are responsible to pay the ADSD through IGT for the State's share of expenditures on behalf of children under the age of 18 who receive waiver services regardless if the recipient is eligible for Medicaid. The county is billed monthly by the ADSD for authorized services and monthly reimbursement is reviewed for the state match portion of the waiver costs for certain recipients. The State's share may be 100% for non-Medicaid recipients or the non-federal share for Medicaid eligible waiver recipients. County funds are derived from general county tax revenues or other general revenues of the County.

These funds are not transferred to the DHCFP nor does DHCFP bill the counties for reimbursement of these expenditures. Counties do not provide waiver medical services for this waiver program; therefore, no federal or IGT funds are sent back to the counties. There is no recycling of funds.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The DHCFP policy states that residential support services reimbursement cannot include room and board, or the cost of building maintenance, upkeep or improvement. The rate is established only on the cost of services included in the service description. The MMIS payment system ensures the payments do not exceed the allowable rate. The operating agency fiscal staff distinguish reimbursable authorized waiver services from room and board and other non-waiver expenditures in their invoice and billing procedures in order to insure improper billing to the DHCFP does not occur.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	49658.23	11554.00	61212.23	208448.00	14272.00	222720.00	161507.77
2	58158.86	11704.00	69862.86	211158.00	14457.00	225615.00	155752.14
3	58301.44	11856.00	70157.44	213903.00	14645.00	228548.00	158390.56
4	58475.28	12010.00	70485.28	216684.00	14835.00	231519.00	161033.72
5	58631.19	12166.00	70797.19	219501.00	15028.00	234529.00	163731.81

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	2603	2603
Year 2	2720	2720
Year 3	2842	2842
Year 4	2958	2958
Year 5	3075	3075

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in*

item J-2-a.

The estimated average length of stay is 341 days. The estimated Average Length of Stay was based on trend analysis of the previous years 372 reports containing data from the WY 2014, 2015 and 2016 years.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Number using waiver services:
Using data provided by the Division of Health Care Financing Policy's MMIS system for FY 2017 as the base year for each distinct waiver service, the caseload count for each service is estimated using the ratio of actual users by service in 2017 to the actual unduplicated count of active waiver participants applied to Waiver Caseload projected for each Waiver renewal year. The Waiver Caseload projections are based on a 36.7% waiver utilization target as a percent of general caseload projections using a Linear Trend calculation.
The 36.7% was estimated based on the total waiver caseload plus the total of individuals already receiving a service on the waiver waitlist divided by general caseload adjusted for anticipated terminations and general caseload growth.

Average units per user:
FFY 2017 Actual counts and dollars provided by the Division of Health Care Financing Policy for each distinct service were used to calculate average number of units per user. These same units per user were used for all 5 years of the waiver renewal (FFY 2019-2023).

Average cost per unit:
The state legislature did not increase rates for the first year of the waiver (SFY 2019), thus historical rates were used. For FFY 2020 to 2023 the inflation factor from the U.S. Department of Labor, Bureau of Labor Statistics, December 2016 Consumer Price Index – All Urban Consumers (not seasonally adjusted), 12 months percent change (1.3%). Residential Support Services were adjusted from $5.12 for FFY 2019 per 15 minute to $6.25 for the remaining years of the waiver renewal (Years 2 - 5) in anticipation that the Nevada State Legislature will approve a rate increase to align state rates with CMS approved waiver rates.

Factor D total:
For each waiver service, the number of users is multiplied by the units per user, times the cost per unit, to arrive at a total estimated cost per user. The extended cost for each service is summed to arrive at a total waiver cost. That total waiver cost is divided by the total estimated unduplicated participants (from Table J-2-a) to arrive at Factor D.1

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' Derivation, other "State Plan Costs" is based on actual expenditures, as reported by the CMS 372 Report, for years 2010 to 2015 of Waiver Base 125 on the CMS Waiver portal, which serves the same target population. For FFY 2016 to 2018, the average of the December 2012 to 2016 Consumer Price Index, or "calendar year All Urban Consumers (not seasonally adjusted), 12 months percent change, of 1.3% was applied to all three years. These average costs and percentages were used to build estimated costs forward to the end of the waiver renewal period, FY 2023.

Based on historical changes tracked on the 372 report from 2001 to 2015, this is believed to be the most reasonable estimate given past history demonstrates that average costs do not follow the Medical Care Service component of CPI consistently. This is why general CPI was used instead.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G Derivation for the waiver renewal was based on actual expenditures, as reported by the CMS 372 Report, for years 2010 to 2015 of Waiver Base 125 on the CMS waiver portal, which serves the same target population and unpublished actual expenditures from the Department of Health Care Financing policy for 2016 and 2017. Because the budget is already set for SFY 2019 no inflation factor was applied since wages and other primary costs remain unchanged. For FFY 2020 to 2023 the inflation factor from the U.S. Department of Labor, Bureau of Labor Statistics, December 2016 Consumer Price Index – All Urban Consumers (not seasonally adjusted), 12 months percent change (1.3%).

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' Derivation, other "State Plan Costs" is based on actual expenditures, as reported by the CMS 372 Report, for years 2010 to 2015 of Waiver Base 125 on the CMS Waiver portal, which serves the same target population. For FFY 2016 to 2018, the average of the December 2012 to 2016 Consumer Price Index, or "calendar year All Urban Consumers (not seasonally adjusted), 12 months percent change, of 1.3% was applied to all three years. These average costs and percentages were used to build estimated costs forward to the end of the waiver renewal period, FFY 2023.

Based on historical changes tracked on the 372 report from 2001 to 2015 this is believed to be the most reasonable estimate given past history indicates that average costs do not follow the Medical Care Service component of CPI consistently. This is why general CPI was used instead.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Day Habilitation	
Prevocational Services	
Residential Support Services	
Supported Employment	
Behavioral Consultation, Training and Intervention	
Career Planning	
Counseling Services	
Non-Medical Transportation	
Nursing Services	
Nutrition Counseling Services	
Residential Support Management	

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Day Habilitation Total:						***15221959.74***
Day Habilitation	*Per Hour*	*1011*	*582.00*	*25.87*	***15221959.74***	
Prevocational Services Total:						***9209150.86***
Prevocational Services	*Per Hour*	*1082*	*329.00*	*25.87*	***9209150.86***	
Residential Support Services Total:						***94185041.92***
Residential Support Services	*Per 15 Min*	*1916*	*9601.00*	*5.12*	***94185041.92***	
Supported Employment Total:						***3302305.50***
Supported Employment	*Per Hour*	*370*	*345.00*	*25.87*	***3302305.50***	
Behavioral Consultation, Training and Intervention Total:						***1257240.60***
Behavioral Consultation, Training and Intervention	*Per 15 minutes*	*987*	*60.00*	*21.23*	***1257240.60***	
Career Planning Total:						***90439.80***
Career Planning	*Per 15 minutes*	*193*	*60.00*	*7.81*	***90439.80***	
Counseling Services Total:						***9409.76***
Counseling Services	*Per 15 minutes*	*23*	*16.00*	*25.57*	***9409.76***	
Non-Medical Transportation Total:						***1566550.00***
Non-Medical Transportation	*Per Trip*	*1649*	*19.00*	*50.00*	***1566550.00***	
Nursing Services Total:						***368421.06***
Nursing Services					***368421.06***	

GRAND TOTAL:	***129260375.64***
Total Estimated Unduplicated Participants:	***2603***
Factor D (Divide total by number of participants):	***49658.23***
Average Length of Stay on the Waiver:	*341*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per 15 Min	739	42.00	11.87		
Nutrition Counseling Services Total:						**14861.20**
Nutrition Counseling Services	Per 15 Min	106	10.00	14.02	**14861.20**	
Residential Support Management Total:						**4034995.20**
Residential Support Management	Per 15 Min	1899	415.00	5.12	**4034995.20**	
				GRAND TOTAL:		**129260375.64**
				Total Estimated Unduplicated Participants:		**2603**
				Factor D (Divide total by number of participants):		**49658.23**
				Average Length of Stay on the Waiver:		341

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**16108456.32**
Day Habilitation	Per Hour	1056	582.00	26.21	**16108456.32**	
Prevocational Services Total:						**9752714.79**
Prevocational Services	Per Hour	1131	329.00	26.21	**9752714.79**	
Residential Support Services Total:						**120192518.75**
Residential Support Services	Per 15 Min	2003	9601.00	6.25	**120192518.75**	
Supported Employment Total:						**3490385.70**
Supported Employment	Per Hour	386	345.00	26.21	**3490385.70**	
Behavioral Consultation, Training and Intervention Total:						**1330608.60**
Behavioral Consultation,					**1330608.60**	
				GRAND TOTAL:		**158192103.64**
				Total Estimated Unduplicated Participants:		**2720**
				Factor D (Divide total by number of participants):		**58158.86**
				Average Length of Stay on the Waiver:		341

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training and Intervention	Per 15 Min	1031	60.00	21.51		
Career Planning Total:						**95394.60**
Career Planning	Per 15 Min	201	60.00	7.91	**95394.60**	
Counseling Services Total:						**9945.60**
Counseling Services	Per 15 minutes	24	16.00	25.90	**9945.60**	
Non-Medical Transportation Total:						**1658129.05**
Non-Medical Transportation	Per Trip	1723	19.00	50.65	**1658129.05**	
Nursing Services Total:						**389736.48**
Nursing Services	Per 15 Min	772	42.00	12.02	**389736.48**	
Nutrition Counseling Services Total:						**15620.00**
Nutrition Counseling Services	Per 15 Min	110	10.00	14.20	**15620.00**	
Residential Support Management Total:						**5148593.75**
Residential Support Management	Per 15 Min	1985	415.00	6.25	**5148593.75**	

GRAND TOTAL:	**158192103.64**
Total Estimated Unduplicated Participants:	**2720**
Factor D (Divide total by number of participants):	**58158.86**
Average Length of Stay on the Waiver:	341

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**17059118.40**
Day Habilitation					**17059118.40**	

GRAND TOTAL:	**165692688.17**
Total Estimated Unduplicated Participants:	**2842**
Factor D (Divide total by number of participants):	**58301.44**
Average Length of Stay on the Waiver:	341

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Hour	1104	582.00	26.55		
Prevocational Services Total:						**10324710.90**
Prevocational Services	Per Hour	1182	329.00	26.55	**10324710.90**	
Residential Support Services Total:						**125533075.00**
Residential Support Services	Per 15 Min	2092	9601.00	6.25	**125533075.00**	
Supported Employment Total:						**3691379.25**
Supported Employment	Per Hour	403	345.00	26.55	**3691379.25**	
Behavioral Consultation, Training and Intervention Total:						**1409377.20**
Behavioral Consultation, Training and Intervention	Per 15 Min	1078	60.00	21.79	**1409377.20**	
Career Planning Total:						**100926.00**
Career Planning	Per 15 Mini	210	60.00	8.01	**100926.00**	
Counseling Services Total:						**10496.00**
Counseling Services	Per 15 Min	25	16.00	26.24	**10496.00**	
Non-Medical Transportation Total:						**1754802.00**
Non-Medical Transportation	Per Trip	1800	19.00	51.31	**1754802.00**	
Nursing Services Total:						**412828.92**
Nursing Services	Per Min	807	42.00	12.18	**412828.92**	
Nutrition Counseling Services Total:						**16537.00**
Nutrition Counseling Services	Per Min	115	10.00	14.38	**16537.00**	
Residential Support Management Total:						**5379437.50**
Residential Support Management	Per 15 Min	2074	415.00	6.25	**5379437.50**	

GRAND TOTAL:	**165692688.17**
Total Estimated Unduplicated Participants:	**2842**
Factor D (Divide total by number of participants):	**58301.44**
Average Length of Stay on the Waiver:	341

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**17988514.20**
Day Habilitation	Per Hour	1149	582.00	26.90	**17988514.20**	
Prevocational Services Total:						**10885623.00**
Prevocational Services	Per Hour	1230	329.00	26.90	**10885623.00**	
Residential Support Services Total:						**130693612.50**
Residential Support Services	Per 15 Min	2178	9601.00	6.25	**130693612.50**	
Supported Employment Total:						**3897810.00**
Supported Employment	Per Hour	420	345.00	26.90	**3897810.00**	
Behavioral Consultation, Training and Intervention Total:						**1485752.40**
Behavioral Consultation, Training and Intervention	Per 15 Min	1122	60.00	22.07	**1485752.40**	
Career Planning Total:						**106565.40**
Career Planning	Per 15 Min	219	60.00	8.11	**106565.40**	
Counseling Services Total:						**11057.28**
Counseling Services	Per 15 Min	26	16.00	26.58	**11057.28**	
Non-Medical Transportation Total:						**1850799.88**
Non-Medical Transportation	Per Trip	1874	19.00	51.98	**1850799.88**	
Nursing Services Total:						**435355.20**
Nursing Services	Per 15 Min	840	42.00	12.34	**435355.20**	

GRAND TOTAL:	**172969886.36**
Total Estimated Unduplicated Participants:	**2958**
Factor D (Divide total by number of participants):	**58475.28**
Average Length of Stay on the Waiver:	341

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutrition Counseling Services Total:						**17484.00**
Nutrition Counseling Services	Per 15 Min	120	10.00	14.57	**17484.00**	
Residential Support Management Total:						**5597312.50**
Residential Support Management	Per 15 Min	2158	415.00	6.25	**5597312.50**	

GRAND TOTAL:	**172969886.36**
Total Estimated Unduplicated Participants:	**2958**
Factor D (Divide total by number of participants):	**58475.28**
Average Length of Stay on the Waiver:	341

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**18936243.00**
Day Habilitation	Per Hour	1194	582.00	27.25	**18936243.00**	
Prevocational Services Total:						**11457589.50**
Prevocational Services	Per Hour	1278	329.00	27.25	**11457589.50**	
Residential Support Services Total:						**135854150.00**
Residential Support Services	Per 15 Min	2264	9601.00	6.25	**135854150.00**	
Supported Employment Total:						**4108346.25**
Supported Employment	Per Hour	437	345.00	27.25	**4108346.25**	
Behavioral Consultation, Training and Intervention Total:						**1564305.60**
Behavioral Consultation,	Per 15 Min	1166	60.00	22.36	**1564305.60**	

GRAND TOTAL:	**180290919.63**
Total Estimated Unduplicated Participants:	**3075**
Factor D (Divide total by number of participants):	**58631.19**
Average Length of Stay on the Waiver:	341

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training and Intervention						
Career Planning Total:						**112449.60**
Career Planning	Per 15 Min	228	60.00	8.22	**112449.60**	
Counseling Services Total:						**11633.76**
Counseling Services	Per 15 Min	27	16.00	26.93	**11633.76**	
Non-Medical Transportation Total:						**1949051.92**
Non-Medical Transportation	Per Trip	1948	19.00	52.66	**1949051.92**	
Nursing Services Total:						**458325.00**
Nursing Services	Per 15 Min	873	42.00	12.50	**458325.00**	
Nutrition Counseling Services Total:						**18450.00**
Nutrition Counseling Services	Per 15 Min	125	10.00	14.76	**18450.00**	
Residential Support Management Total:						**5820375.00**
Residential Support Management	Per 15 Min	2244	415.00	6.25	**5820375.00**	

GRAND TOTAL:	**180290919.63**
Total Estimated Unduplicated Participants:	**3075**
Factor D (Divide total by number of participants):	**58631.19**
Average Length of Stay on the Waiver:	341