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 waiver's 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 enrollment prioritization criteria to gain entrance to the waiver was updated to reflect statutory language.

Service definitions for the following services were updated and clarified: Homemaker, Respite, and Attendant Care. These definitions were clarified to explain what each service is and what tasks each service may include.

Performance measures were added as required.

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*):
Home and Community Based Waiver for Persons with Physical 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.4150
Waiver Number:NV.4150.R05.00
Draft ID: NV.003.05.00

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

E. Proposed Effective Date: *(mm/dd/yy)*
01/01/13

Approved Effective Date: 01/01/13

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 is requesting a renewal of its existing Home and Community-Based Waiver for Persons with Physical Disabilities, control number 4150.90.R3. This renewal will have control number 4150.90.R4.

The State of Nevada Home and Community-Based Waiver for Persons with Physical Disabilities is operated by the Nevada Division of Health Care Financing and Policy (DHCFP). The DHCFP is the single state Medicaid agency and a division within the Nevada Department of Health and Human Services. The DHCFP is responsible for the administrative authority as well as the operations of this waiver through its Central Office and four District Offices.

The goals of this waiver are to provide the option of home and community-based services as an alternative to institutional nursing facility care and to allow for maximum independence for persons with physical disabilities who would otherwise need institutional nursing facility services.

Eligible participants must satisfy Medicaid requirements, meet a nursing facility level of care, and be at risk of a nursing facility placement.

Eligible participants may be placed on the waiver from a nursing facility, from another waiver, or from the community. An evaluation is performed by a case manager to determine whether an applicant meets the nursing facility level of care requirement for waiver participation. Persons who become waiver eligible may receive the following waiver services: case management, homemaker, respite, attendant care, specialized medical equipment and supplies, assisted living services, chore, environmental accessibility adaptations, home-delivered meals, and personal emergency response systems.

Eligibility determination for the Home and Community-Based Waiver for Persons with Physical Disabilities is completed through the collaborative efforts of the DHCFP 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:
Input from participants, family members, legal guardians, and legally responsible individuals as needed.

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: Anderson

First Name: Constance

Title: Chief, Continuum of Care

Agency: Division of Health Care Financing and Policy

Address: 1100 E. William Street, Suite 222

Address 2:

City: Carson City

State: **Nevada**

Zip: 89701

Phone: (775) 684-3711 **Ext:** ☑ **TTY**

Fax: (775) 684-8724

E-mail: canderson@dhcfp.nv.gov

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

Last Name: Anderson

First Name: Constance

Title: Chief, Continuum of Care

Agency: Division of Health Care Financing and Policy

Address: 1100 E. William Street, Suite 222

Address 2:

City: Carson City

State: **Nevada**

Zip: 89701

Phone: (775) 684-3711 **Ext:** ☑ **TTY**

Fax: (775) 684-8724

E-mail: canderson@dhcfp.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: Connie Anderson

State Medicaid Director or Designee

Submission Date: Mar 14, 2013

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

Last Name:

Michael

First Name:

Willden

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:

(775) 684-4010

E-mail:

m.willden@dhhs.nv.gov

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. This is a renewal of an existing waiver.

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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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:
   Division of Health Care Financing and Policy (DHCFP) Continuum of Care
   (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:

   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:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

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) is contracted with a fiscal agent. One of the responsiblities of the fiscal agent is Medicaid provider enrollment, including waiver service providers. The fiscal agent is responsible for the verification of provider qualifications and enrollment of providers.

   All provider agreements with DHCFP terminate three years from the enrollment date. Providers must reapply through the fiscal agent who verifies provider qualifications and re-enroll providers.

   The fiscal agent prepares a monthly report of all provider enrollments by provider type for 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:
DHCFP assesses the performance of the fiscal agent in enrolling qualified waiver service 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 DHCFP Continuum of Care Unit to ensure that qualified waiver providers are enrolled by the fiscal agent, both at initial enrollment and every three years thereafter.

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	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	☑	☐

Function	Medicaid Agency	Contracted Entity
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 State's quality improvement strategy, provide information in the following fields to detail the State's 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:
PM: Number and percent of qualified providers enrolled. Numerator: Number of providers enrolled. Denominator: Number of providers who apply.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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: Fiscal Agent	☑ **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.
PM: Number and percent of qualified providers enrolled. Numerator: Number of providers enrolled. Denominator: Number of providers who apply.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
The Division of Health Care Financing and Policy has a contractual agreement with the fiscal agent to enroll qualified providers. The contract identifies the responsibilities of the fiscal agent. The fiscal agent is

required to enroll only qualified providers and prepare a monthly report by provider type on enrolled providers and providers who did not meet qualifications. DHCFP staff reviews these reports annually.

DHCFP conducts provider reviews throughout the waiver year of waiver providers not otherwise reviewed during the waiver year by a licensing or other entity. If a waiver provider does not have the proper qualfications, DHCFP may recommend termination as a Medicaid provider. In addition, DHCFP follows up with the fiscal agent to provide guidance or training about the qualifications needed to be enrolled as a waiver provider.

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**	65		☑
	☑	**Disabled (Physical)**	0	64	

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	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			☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

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:

This waiver has no minimum or maximum age limits. Attempts to select the Not Applicable radio button results in error message.

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	771
Year 2	844
Year 3	921
Year 4	1010
Year 5	1105

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	700
Year 2	750
Year 3	785
Year 4	845
Year 5	895

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:

Entry to the Waiver for Persons with Physical Disabilities is based on 1) eligible Nursing Facility residents; 2) eligible applicants who have a severe functional disability as defined by NRS 426.721-426.731; 3) eligible applicants on the wait list for the Waiver for Persons with Physical Disabilities. If there is no wait list, applicants are prioritized using the same criteria.

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, 435.137, 435.138 (Groups deemed to be receiving SSI for Medical purposes)

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 spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.*

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (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 includes 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 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 (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-5-a 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 that you do not need to complete this section and therefore this section is not visible.

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 an entity 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:

All case managers performing initial evaluations of Level of Care for recipients for this waiver program must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse by the State of Nevada Board of Nursing, or have a professional license or certificate in a medical specialty applicable to the assignment, and one year of professional experience providing case management services in a social or health related field or have an equivalent combination of education and experience.

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.

The name of the LOC tool is: NEVADA MEDICAID LEVEL OF CARE (LOC). This tool is used for all programs requiring determination of nursing facility level of care.

The Level of Care Tool consists of five categories which include: ability to self administer medication, treatments and special needs, activities of daily living, need for supervision, and instrumental activities of daily living.

The total numeric score from the assessment tool determines whether an applicant meets nursing facility LOC. There are 13 total functional deficits identified on the Level of Care Assessment Tool. An eligible recipient or pending applicant must meet at least 3 deficits out of the 13 possible.

The five categories are broken down as follows:

Ability to self-administer medication: the inability to safely administer one's own medication counts as one functional deficit. -1

Treatments and special needs: may include suctioning, ventilator dependent, feeding tube, wound care, glucose monitoring, IV lines, oxygen dependent, and pediatric specialty care among others. Treatments or conditions that an individual performs as self-care aren't included as a functional deficit. A recipient/applicant is only required to have one treatment or special need for this category to be counted - 1

Activities of daily living: a total of eight functional deficits are possible in the areas of bathing, dressing, grooming, eating, mobility, transferring, ambulation, and continence - 8

In this category, there are four (4) identifiable levels of assistance. 1) Independent (I) which means the recipient can independently perform this activity or requires no assistance to perform the activity with use of an adaptive device. 2) Supervision (S) which means to the recipient's safety, a caregiver must oversee this activity. 3) Assistance (A) which means the recipient requires help. 4) Dependent (D) which means the recipient is totally dependent upon caregivers to complete this activity for him or her. If any of the areas is determined S, A or D, it counts as a deficit. An area determined as an "I" does not count as a deficit.

Need for supervision: a total of one functional deficit is possible for the areas of wandering, resists care, behavior problem, safety risk, socially inappropriate, verbally abusive, and physically abusive - 1

Instrumental activities of daily living in the areas of meal preparation and homemaking services - 2

Total Possible - 13

Total Needed to Meet Level of Care - 3

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 Level of Care Assessment Tool is used to screen, evaluate, and reevaluate Level of Care for waiver applicants/recipients. There are no other assessments used to evaluate Level of Care.

The tool is used in the Waiver for Physical Disabilities program as: a screening tool if no waiver slots are available and the applicant is placed on the wait list; an initial assessment tool when a waiver slot is available; and as a reevaluation tool. waiver case managers are responsible for conducting LOC evaluations at each level: screening, initial assessment and reevaluation.

Recipients are reevaluated every 12 monhts to verify LOC is met. The 12 month period is measured from within the month of waiver enrollment or the previous LOC evaluation. A LOC reevaluation may also be conducted at any time when there is a significant change in the recipient's condition or circumstances that may affect 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):*

Level of Care assessments are an integral part of case management services. Case managers utilize a tracking system which provides notification when a reevaluation is due. Additionally, whenever there is any need for any action on the case, case managers assess whether any action will be necessary in the near future and address those issues, including LOC evaluations, at the same time.

The DHCFP District Office supervisors review a representative sample of ongoing case files on a monthly basis.

The DHCFP Central Office Quality Assurance (QA) staff conducts a statewide annual waiver review, using a representative sample of waiver participants. A case file review to ensure timely evaluations and reevaluations, among other requirements, is included in this annual review.

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:

Records of evaluations and reevaluations of level of care are maintained by the DHCFP in the District Office for the geographic area in which the recipient resides. These case files are maintained for a minimum of six years after the date the last claim was paid for waiver services for each recipient.

The same process is utilized by any private case management agencies.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of new applicants who meet Level of Care prior to receiving services. Numerator: Number of new applicants who meet Level of Care prior to receiving services. Denominator: Number of new applicants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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 Source (Select one):
Other
If 'Other' is selected, specify:
Intake Packet Reviews - DHCFP Central Office

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):*
	☐ **Weekly**	☐ **100% Review**

☑ **State Medicaid Agency**		
☐ **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: 25%
	☐ **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.

Performance Measure:
Number and percent of recipients whose Level of Care was reevaluated annually.
Numerator: Number of recipients whose Level of Care was reevaluated annually.
Denominator: Number of recipients reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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 proportionate
☐ **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**

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:

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:
Number and percent of recipients whose Level of Care eligibility was accurately determined. Numerator: Number of recipients whose Level of Care eligibility was accurately determined. Denominator: Number of recipients reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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 proportionate

☐ **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:
Number and percent of recipients whose Level of Care eligibility determinations were based on accurate application of policy. Numerator: Number of recipients whose Level of Care eligibility determinations were based on accurate application of policy; Denominator: Number of recipients reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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**
	☐ **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.

Case managers provide a copy of the HCBW Recipient Rights to all individuals at the initial home visit and annual home visits. In addition, case managers review the recipient rights at the 6 month home visit. The form includes the following statements: receive in writing the name and contact number of an official of Nevada Medicaid and the state Advocate's telephone number, and contact your case manager for issues

relating to your care provider or to change your provider agency. The case managers and supervisors name and phone number are written onto this document.

District Office supervisors review intake packets and a sample of ongoing charts monthly using a Case File Review Form which includes waiver assurances and performance indicators indentified in this waiver. Each supervisor sends the statistics on a monthly basis to the District Office Quality Assurance Specialist who compiles the data. The data is sent to Central Office quarterly for review.

Central Office Quality Assurance (QA) staff completes an annual waiver review which strives for a sample of 95/5. Data is compiled and shared with District Office staff. If deficiencies are noted, District Office managers will submit a QIP.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 District Office waiver supervisors review LOC determinations and address concerns or issues with the case manager as issues are identified. The supervisor reviews the assessment to assure the individual meets the required LOC score, has a waiver service need, and meets all eligibility criteria. When the supervisor identifies errors, omissions, or concerns, these are addressed with the case manager for immediate correction.

Deficiencies are remediated through corrective strategies discussed in quality management meetings to confirm coordination of processes in all DHCFP District Offices. The DHCFP Continuum of Care Quality Unit is responsible for monitoring progress based on any Quality Improvement Plan, monitoring established timelines, and reporting progress to the Quality Management Committee.

In addition, the DHCFP Quality Unit at Central Office completes an annual waiver review. During this review, a representative sample of LOC redeterminations are reviewed to ensure the appropriate determination was made. If a decision is incorrect, the QA staff notifies the DHCFP Distric Office Manager, who has the supervisor and case manager take appropriate action. If needed, the DHCFP Central Office staff provides staff training to ensure accurate LOC determinations are made in the future.

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).

Waiver applicants are given a description of services offered under the Waiver for Persons with Physical Disabilities during the intake process. The case manager informs the applicant of their choice between waiver services and institutional care, in addition to their choice of enrolled providers. Prior to entrance to the waiver, all waiver applicants must read, or have the form read to them, and the applicant must sign the Statement of Understanding in which the applicant acknowledges a selection of either waiver services or institutional care.

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.

Division of Health Care Financing and Policy waiver recipient files in the District Office for the geographic area in which the recipient resides. Case files are maintained for a minimum of six years after the date the last claim was paid for waiver services for each recipient.

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 Nevada State Purchasing Division awards contracts for translation and interpretation services to language services entities and these contracts may be used by the DHCFP when necessary to further ensure access to services by limited English proficient persons.

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	**Case Management**		
Statutory Service	**Homemaker**		
Statutory Service	**Respite**		
Extended State Plan Service	**Attendant Care Services**		
Extended State Plan Service	**Specialized Medical Equipment and Supplies**		

Service Type	Service
Other Service	Assisted Living Services
Other Service	Chore Services
Other Service	Environmental Accessibility Adaptations
Other Service	Home Delivered Meals
Other Service	Personal Emergency Response Systems (PERS)

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:

Case Management

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):*

Case Management Services assist participants in gaining access to needed waiver and Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case Management includes initiating and overseeing the process of reassessments of the individual's level of care and the review of plans of care.

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

None

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	Case Management Provider Agency
Agency	Division of Health Care Financing and Policy (DHCFP)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Case Management Provider Agency
Provider Qualifications

License *(specify):*
Employees of the case management provider agencies who provide direct service case management services must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse by the State of Nevada Board of Nursing, or have a professional license or certificate in a medical specialty applicable to the assignment, have at least one year experience as a case manager and must have the ability to complete home visits.

Employees must pass a State and FBI criminal background check.

If applicable, has a business license as required by city, county or state government.

Certificate *(specify):*

Other Standard *(specify):*
Case Management providers must be enrolled as a Waiver Case Management Provider Agency through DHCFP's fiscal agent. The following requirements are verified upon enrollment:
• Must have documentation of taxpayer ID,
• Must have proof of Workers Compensation Insurance,
• Must have proof of Unemployment Insurance Account,
• Must have proof that it is adequately covered against liabilities resulting from claims incurred in the course of operation,
• Must have proof of Business Automobile Liability Coverage,
• Must have proof of liability coverage and compliance with state statute
• Must have a fixed business landline telephone number published in a public telephone directory, and
• Must have a business office that is accessible to the public during established and posted business hours.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Agent for the Division of Health Care Financing and Policy.

Frequency of Verification:
Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Division of Health Care Financing and Policy (DHCFP)
Provider Qualifications
License *(specify):*
Employees of the Division of Health Care Financing and Policy (DHCFP) who provide direct services case management services must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse (RN) by the State of Nevada Board of Nursing, or have a professional license or certificate in a mecial specialty applicable to the assignment, have at least one year experience as a case manager and must have the ability to complete home visits.
Certificate *(specify):*

Other Standard *(specify):*
Employees of the Division of Health Care Financing and Policy (DHCFP)must pass a State and FBI background check.
Verification of Provider Qualifications
Entity Responsible for Verification:
The Division of Health Care Financing and Policy (DHCFP)personnel staff will verify licensure and results of background checks as part of the hiring process.
Frequency of Verification:
Licensure is verified annually.

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:
Homemaker
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):*
Homemaker Services consist of general cleaning such as mopping floors, vacuuming, dusting, cleaning the stove, changing and making beds, washing dishes, defrosting and cleaning the refrigerator, cleaning bathrooms and kitchens, and washing windows as high as the homemaker can reach while standing on the floor. Additional services include shopping for food and needed supplies, planning and preparing meals, laundry activities, and doing routine clean-up for up to two (2) household pets. (Walking pets is not included unless it is a service animal). Additional homemaker activities may be approved on a case by case basis.

The homemaker may assist the recipient and/or legally responsible individual in learning a homemaker routine or skill, so the recipient and/or legally responsible individual may carry on normal living when the homemaker is not present.

The homemaker may accompany the recipient on tasks such as shopping or the laundromat. Transportation for those activities is not reimbursable as a Medicaid expense.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Homemaker services are provided by individuals or agencies who meet provider qualifications and are enrolled as a Medicaid provider through the DHCFP's fiscal agent. Services are provided when the individual regularly responsible for these activities is periodically absent or unable to manage the home.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Individual Provider
Agency	Homemaker Provider Agency or Personal Care Services Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Individual

Provider Type:
Individual Provider

Provider Qualifications

License *(specify):*
None

Certificate *(specify):*
None

Other Standard *(specify):*
Must be enrolled as a Provider Agency through DHCFP's fiscal agent,
Must have documentation of taxpayer ID Number.
Must be trained by the recipient.

All individuals with direct contact with recipients must have proof of criminal background check to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal agent for the Division of Health Care Financing and Policy.

Frequency of Verification:
Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency

Provider Type:
Homemaker Provider Agency or Personal Care Services Agency

Provider Qualifications

License *(specify):*
If applicable, has a business license as required by city, county or state government.
Provider agencies must be licensed through the Bureau of Health Care Quality and Compliance (BHCQC).

Certificate *(specify):*
None

Other Standard *(specify):*
• Must be enrolled as a provider agency through the DHCFP's fiscal agent,
• Must be licensed by the Bureau of Health Care Quality and Compliance (HCQC, Licensure by HCQC requires compliance with Nevada Revised Statute (NRS) 449.176 through NRS 449.188 which is compliance with criminal history background checks
• Must have documentation of taxpayer ID number,
• Must have proof of workers compensation insurance,
• Must have a Nevada Department of Public Safety account for criminal background checks
• Must have proof that it is adequately covered against liabilities resulting from claims incurred in the course of operation,
• Must have a fixed landland telephone and a business office accesible to the public during business hours

• Must have proof of liability coverage and compliance with state statute required by subsection 3 must be verified at the time the agency submits its initial application to the Health Division for a license and upon request by the Health Division.

Agency owners, officers,administrators and management doing business in the State of Nevada must undergo State and FBI criminal background checks to meet the requirements of obtaining licensure through the HCQC and must provide documentation of such prior to approval of a provider application and upon request.

All agency personnel including owners, officers, administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigations (FBI) background check upon licensure and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.

Agency providers must arrange for employees to receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent for the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

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:

Respite

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):*
Respite Services are provided to participants unable to care for themselves. Respite is furnished on a short-term basis due to the absence or need for relief of the primary caregiver for the participant. Services are provided in the participant's home or place of residence.

The respite caregiver may perform general assistance with ADLs and IADLs and/or provide supervision to functionally impaired recipients to provide temporary relief for a primary caregiver.

Federal Financial Participation (FFP) will not be claimed for the cost of room and board, except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite care is limited to 120 hours per recipient, per year.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Respite Provider
Agency	Respite Provider Agency or Personal Care Services Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Individual Respite Provider
Provider Qualifications
License *(specify):*
None
Certificate *(specify):*
None
Other Standard *(specify):*
Must be enrolled as a Provider Agency through DHCFP's fiscal agent,
Must have documentation of taxpayer ID Number.
Must be trained by the recipient.

All individuals with direct contact with recipients must have proof of criminal background clearance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent for the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Respite Provider Agency or Personal Care Services Agency

Provider Qualifications

License *(specify):*

Must be licensed by the Bureau of Health Care Quality and Compliance (HCQC).

Certificate *(specify):*

None

Other Standard *(specify):*

Must be enrolled as a provider agency through the DHCFP's fiscal agent,
• Must be licensed by the Bureau of Health Care Quality and Compliance (BHCQC),Licensure by HCQC requires compliance with Nevada Revised Statutes (NRS) 449.176 through NRS 449.188 which is compliance with criminal history background checks
• Must have documentation of taxpayer ID number,
• Must have proof of workers compensation insurance,
• Must have a Nevada Department of Public Safety account for criminal background checks
• Must have proof that it is adequately covered against liabilities resulting from claims incurred in the course of operation,
• Must have a fixed landland telephone and a business office accesible to the public during business hours
• Must have proof of liability coverage and compliance with state statute required by subsection 3 must be verified at the time the agency submits its initial application to the Health Division for a license and upon request by the Health Division.

Respite providers must have the ability to read and write, and follow written and oral instructions. A respite provider must meet the requirements of NRS 629.091. If services provided are considered "skilled services" the provider must demostrate the ability to perform the tasks as prescribed.

Agency owners, officers,administrators and management doing business in the State of Nevada must undergo State and FBI criminal background checks to meet the requirements of obtaining licensure through the HCQC and must provide documentation of such prior to approval of a provider application and upon request.

All agency personnel including owners, officers, administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigations (FBI) background check upon licensure and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.

Agency providers must arrange for employees to receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment.

All providers must have CPR certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal agent for the Division of Health Care Financing and Policy.

Frequency of Verification:

Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

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:

Extended State Plan Service

Service Title:

Attendant Care 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):*

Personal Care Services such as eating, bathing, grooming, dressing, mobility, toileting and transferring and are an extension to State Plan Services. The services may include hands-on care of both a supportive and health-related nature specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function.

Attendant Care Service may include assistance with eating, bathing, dressing, personal hygiene, ADLs, shopping, laundry, meal preparation and accompanying the recipient to appointments as necessary to enable the individual to remain in the community. This service may include skilled or nursing care to the extent permitted by State law, and may provide for task completion time in excess of maximum times allowed under the State

Plan, with documentation of medical necessity provided.

A recipient may direct his/her own service using the Intermediary Service Organization (ISO) model or choose a Personal Care Services (PCS) provider agency for service delivery.

The ISO delivery model allows a recipient to recruit and select a caregiver who will be referred to the ISO. The ISO will arrange for training of the selected caregiver and and maintain program documentation. A recipient may terminate the caregiver at anytime. When utilizing the ISO option, the ISO will recruit potential caregivers, screen potential caregivers, schedule caregivers, and provide backup when the caregiver has not shown up. The ISO also acts as the fiscal agent and does payroll for these selected caregivers.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Attendant care services cannot, on an ongoing basis, exceed what the State would pay for the recipient in a nursing facility.

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	Personal Care Services (PCS) Provider Agency
Agency	Intermediary Service Organization (ISO)

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Attendant Care Services

Provider Category:
Agency
Provider Type:
Personal Care Services (PCS) Provider Agency
Provider Qualifications
License *(specify):*
Must maintain licensure through the Bureau of Health Care Quality and Compliance (HCQC).
Certificate *(specify):*
None
Other Standard *(specify):*
Must be enrolled as a provider agency through the DHCFP's fiscal agent,
• Must be licensed by the Bureau of Health Care Quality and Compliance (HCQC),Licensure by HCQC requires compliance with Nevada Revised Statute (NRS) 449.176 through NRS 449.188 which is compliance with criminal history background checks
• Must have documentation of taxpayer ID number,
• Must have proof of workers compensation insurance,
• Must have a Nevada Department of Public Safety account for criminal background checks
• Must have proof that it is adequately covered against liabilities resulting from claims incurred in the course of operation,
• Must have a fixed landline telephone and a business office accesible to the public during business hours

• Must have proof of liability coverage and compliance with state statute required by subsection 3 must be verified at the time the agency submits its initial application to the Health Division for a license and upon request by the Health Division.

Agency owners, officers,administrators and management doing business in the State of Nevada must undergo State and FBI criminal background checks to meet the requirements of obtaining licensure through the HCQC and must provide documentation of such prior to approval of a provider application and upon request.

All agency personnel including owners, officers, administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigations (FBI) background check upon licensure and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.

Agency providers must arrange for employees to receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal agent for the Division of Health Care Financing and Policy.

Frequency of Verification:
Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Attendant Care Services

Provider Category:
Agency

Provider Type:
Intermediary Service Organization (ISO)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Must maintain certification through Aging and Disability Services Division (ADSD).

Other Standard *(specify):*
• Must provide proof of certification to operate as an ISO issued by ADSD.
• Must have a fixed land-line telephone number published in a public telephone directory. The sole availability of a cell telephone or facsimile line is prohibited.
• Must be accessible to the public during established and published business hours.
• Must have a tax identification name and number.
• Must have proof of workers' compensation insurance for all personnel employed by the ISO.
• Must have a Nevada Department of Public Safety account for criminal background checks.
• Must have proof of insurance with bodily injury and property damage, with minimum combined single limit (CSL) of $750,000.00 for any owned, hired, and non-owned vehicles used in the performance of the Medicaid provider's contract. The policy shall be endorsed to include the following additional insured language:
• Must have proof of commercial crime insurance with minimum limit required of $25,000 per loss for employee dishonesty.
• It is the ISO's responsibility to assure that employees maintain valid driver's licenses and uninterrupted liability coverage as required by NRS while performing services on behalf of the ISO.

All agency personnel including owners, officers, administrators, managers, employees and

consultants must undergo State and Federal Bureau of Investigations (FBI) background check upon licensure and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.

Agency providers must arrange for employees to receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal agent for the Division of Health Care Financing and Policy.

Frequency of Verification:
Upon enrollment with DHCFP's Fiscal Agent, and every three years at re-enrollment.

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:
Extended State Plan Service

Service Title:
Specialized Medical Equipment and Supplies

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):*
Specialized medical equipment and supplies include devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable

and non-durable medical equipment not available under the Medicaid State Plan.

NOTE: Products must have received approval from the federal Food and Drug Administration (FDA) and be consistent with the approved use. Products or usage considered experimental or investigational are not covered services. Consideration may be made on a case-by-case basis for items approved by FDA as a Humanitarian Device Exemption (HDE) under the Safe Medical Device Act of 1990 and as defined by FDA. That is, a device that is intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 4,000 individuals in the United States per year.

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

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation and where indicated, will be purchased from and installed by authorized dealers.

Service must be prior authorized by DHCFP. Documentation from the recipient's physician or health care provider may be required.

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	Durable Medical Equipment, Prosthetic Devises, Orthotic Devices, and Disposable Medical Supplies (DMEPOS) Provider Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment, Prosthetic Devises, Orthotic Devices, and Disposable Medical Supplies (DMEPOS) Provider Agency

Provider Qualifications

License *(specify):*

All providers must be licensed through the Nevada State Board of Pharmacy (BOP) as a Medical Device, Equipment, and Gases (MDEG) supplier, with the exception of a pharmacy that has a Nevada State Board of Pharmacy license and provides Durable Medical Equipment, Prosthetic Devices, Orthotic Devices, and Disposable Medical Supplies (DMEPOS). Once licensed, providers must maintain compliance with all Nevada BOP licensing requirements.

All employees or individuals with direct contact with waiver recipients must have proof of criminal history background clearance.

Certificate *(specify):*

None

Other Standard *(specify):*

Documentation showing Tax Payer Identification Number.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Agent for the Division of Health Care Financing and Policy.

Frequency of Verification:

Initially and and every three years at re-enrollment.

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:

Assisted Living 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):*

Assisted living services are all-inclusive services furnished by an assisted living services provider. Assisted living services are intended to provide all support services needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/ transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, provided in a home-like environment in a licensed (where applicable) community care facility. Services provided by a third party must be coordinated with the assisted living facility. This service may include skilled or nursing care to the extent permitted by state law. Nursing and skilled therapy services are

incidental, rather than integral to the provision of assisted living services. Payment is not made for 24 hour skilled care. If a recipient chooses assisted living services, no other waiver services may be provided, except case management services.

The service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way promoting maximum dignity and independence, and to provide supervision, safety and security.

Recipients are responsible for room and board and personal items of comfort.

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	Assisted Living Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living Services

Provider Category:
Agency
Provider Type:
Assisted Living Provider
Provider Qualifications

License *(specify):*
HCQC license (if applicable)
Certificate *(specify):*
None
Other Standard *(specify):*
Assisted living providers must:
be enrolled as a waiver provider agency;
provide documentation showing taxpayer identification number; and
proof of workers' compensation insurance or a signed NMO Medicaid Provider Agreement form.

All employees must have a current Cardiopulmonary Resuscitation (CPR) certificate and at least a high school diploma or GED.

All agency personnel including owners, officers, administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigations (FBI) background check upon licensure and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.

If the attendant is providing attendant care services that include skilled services, he or she must meet

the requirement of NRS 629.091.

Providers must arrange training in personal hygiene needs and techniques for assisting with activities of daily living such as bathing, dressing, grooming, skin care, transfer, ambulation, exercise, feeding, use of adaptive aids and equipment, identification of emergency situations and how to act accordingly.

All agency personnel including owners, officers, administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigations (FBI) background check upon licensure and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Agent of the Division of Health Care Financing and Policy.

Frequency of Verification:
Initially and every three years at re-enrollment.

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:
Chore 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):*
Chore services are services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores, such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress, minor home repairs, and removing trash and debris from the yard. These services are provided only when neither the recipient nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.

In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of, or responsible for, their provision and without these services the recipient would be at risk of institutionalization. This is not a skilled professional 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	Chore Services Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:
Agency
Provider Type:
Chore Services Provider Agency
Provider Qualifications
License *(specify):*
None
Certificate *(specify):*
None
Other Standard *(specify):*
Chore services providers must:
be enrolled as a waiver provider agency;
provide documentation showing taxpayer identification number; and
provide proof of workers' compensation insurance or a signed Medicaid Provider Agreement form.

All employees performing direct services to recipients will have an FBI criminal history clearance.
Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Agent of the Division of Health Care Financing and Policy.
Frequency of Verification:
Initially and every three years at re-enrollment.

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:
Environmental Accessibility Adaptations

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):*
Environmental Accessibility Adaptations are physical adaptations to the residence of the recipient or the recipient's family, identified in the recipient's plan of care, that are necessary to ensure the health, welfare and safety of the recipient or that enable the recipient to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the recipient.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the recipient. Adaptations that add to the total square footage of the home are

excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service must be prior authorized by DHCFP. Documentation from the recipient's physician or health care provider may be required.

Must receive landlord's written approval prior to authorizing services.

There is an annual waiver limit of $3230.00 per recipient.

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	Environmental Accessibility Adaptations Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Environmental Accessibility Adaptations Provider
Provider Qualifications
License *(specify):*
Copy of business license from the Nevada Secretary of State (for in state providers) or a copy of the Secretary of State business license in the provider's home state (for out of state providers).
Certificate *(specify):*
None
Other Standard *(specify):*
Environmental Accessibility Adaptations Providers must have:

Documentation showing tax payer identification; and
Contractor's license (if applicable).

All sub-contractors must be licensed or certified if applicable. Modifications, improvements or repairs must be made in accordance with local and state housing and building codes.

All employees or individual with direct contact with waiver recipients must have proof of criminal history clearance.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Agent of the Division of Health Care Financing and Policy.
Frequency of Verification:
Initially and every three years at re-enrollment.

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:

Home Delivered Meals

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):*

Home delivered meals are the provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to a person's home.

Recipients who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician.

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

Home Delivered Meals are limited to two meals per day.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Agency for Home Delivered Meals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Agency for Home Delivered Meals
Provider Qualifications

License *(specify):*
Must have a state, county, or city business license.
Certificate *(specify):*
None
Other Standard *(specify):*
Must be enrolled as a waiver provider for home delivered meals.

Documentation showing taxpayer identification number.

Provider must be a governmental or community provider meeting the requirements of a meal provider under NRS 446 (Food Service Establishment Permit).
All kitchen staff must hold a valid health certificate if required by local health ordinances.
Must be enrolled as a waiver services provider.

Documentation showing taxpayer identification number.

Providers must have a valid permit issued by the Health Authority as defined in NRS 446 (Food Service Establishment Permit).

All providers must comply with applicable federal, state and local code and regulations relating to the public health, safety, and welfare, and to food preparation as required in all stages of food service operation.

Copies of all current inspection reports by health department staff, registered sanitarian, or fire officials should be kept on file by the provider and posted at the meal preparation site.

All employees having direct contact with recipients must have proof of criminal history clearance.

All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services and the U. S. Department of Agriculture and provide a minimum of one-third of the current daily Recommended Dietary Allowances as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Agent of the Division of Health Care Financing and Policy.
Frequency of Verification:

Initially and every three years at re-enrollment.

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:

Personal Emergency Response Systems (PERS)

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):*

PERS is an electronic device which enables certain recipients to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to the recipient's phone and programmed to signal a response center once the "help" button is activated.

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

PERS services are limited to those recipients who live alone, who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive supervision.

This service pays for the device rental and funds monitoring fees on a monthly basis.

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	PERS Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Agency
Provider Type:
PERS Provider Agency
Provider Qualifications
License *(specify):*
Must have a state, county, or city business license.
Certificate *(specify):*
None
Other Standard *(specify):*
Must be enrolled as a waiver services provider.

Documentation showing taxpayer identification number.

Employees who have direct contact with recipients must have proof of criminal history clearance.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Agent of the Division of Health Care Financing and Policy.
Frequency of Verification:
At enrollment with DHCFP's fiscal agent and every three years at re-enrollment.

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.*

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

Direct Service Case Management is limited to eligible participants enrolled in a HCBW services program, when case management is identified as a service on the Plan of Care. The recipient has a choice to have direct service case management services provided by qualified state staff or qualified provider agency staff.

State Staff includes employees of the Division of Health Care Financing and Policy (DHCFP) who are qualified Medicaid case managers for the Waiver for Persons with Physical Disabilities.

Employees of the case management provider agency who provide direct service case management services must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse by the State of Nevada Board of Nursing, or have a professional license or certificate in a medical specialty applicable to the assignment, have at least one year experience as a case manager and must have a valid driver's license. Employees must pass a State and FBI criminal background check.

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):

DHCFP EMPLOYEES:

DHCFP, in compliance with the Department of Health and Human Services (DHHS), requires a criminal background check of any person appointed to a position in the classified or unclassified service whose duties include regular or potential contact with clients of the Division or access to client records. State agencies use NRS 239B.010 "request by agency of State or political subdivision for information on certain persons from Federal Bureau of Investigation" as the citation to request background checks. A criminal background check is required as a condition of employment for any person accepting employment with the agency, to include appointment as a new hire, reinstatement, reemployment, reappointment or transfer.

Employees are fingerprinted within five (5) working days of their date of hire or appointment.

It is the responsibility of the employee's supervisor to ensure the fingerprint cards are completed and submitted to the division personnel officer. The division personnel officer verifies the fingerprint cards have been received and submits the fingerprint cards to the State of Nevada Department of Public Safety (Records and Identification Services). The results of the state and national FBI criminal history search are transmitted back to the Personnel Officer, who notifies the DHCFP Administrator or Deputy Administrator of any negative results. The DHCFP Administrator or Deputy Administrator takes any action necessary.

WAIVER PROVIDERS:

DHCFP requires all waiver providers to have State and Federal criminal history background checks completed. Based on the results of the background check, the DHCFP 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 DHCFP determines is inconsistent with the best interest of recipients.

These convictions include (not all inclusive):

1. murder, voluntary manslaughter or mayhem;
2. assault with intent to kill or to commit sexual assault or mayhem;
3. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
4. abuse or neglect of a child or contributory delinquency;
5. 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 Nevada Revised Statutes (NRS);
6. a violation of any provision of NRS 200.700 though 200.760;
7. criminal neglect of a patient as defined in NRS 200.495;
8. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
9. any felony involving the use of a firearm or other deadly weapon;
10. abuse, neglect, exploitation or isolation of older persons;
11. kidnapping, false imprisonment or involuntary servitude;
12. any offense involving assault or battery, domestic or otherwise;
13. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;
14. conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; or
15. any other offense that may be inconsistent with the best interests of all recipients.

An agency that provides personal care or nursing services in the home is required to conduct a FBI background check of all employees per NRS 449, within 10 days of hiring an employee or entering into a contract with an independent contractor. The provider agency must: (a) Obtain a written statement from the employee or independent contractor stating whether he has been convicted of any crime listed in NRS 449.188; (b) Obtain an oral and written confirmation of the information contained in the written statement obtained pursuant to paragraph (a); (c) Obtain from the employee or independent contractor two sets of fingerprints and a written authorization to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and (d) Submit to the Central Repository for Nevada Records of Criminal History the fingerprints obtained pursuant to paragraph (c).

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.*

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.*

○ **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:

Any willing provider that meets the established criteria for a specific provider type may enroll with DHCFP through its fiscal agent. Enrollment is continuously open for all potential waiver providers.

The fiscal agent website(www.medicaid.nv.gov)lists required documentation for applications to enroll in Medicaid as a waiver provider by specific service type. Supporting information is also available at the Medicaid Services Manual on the DHCFP website which is www.dhcfp.nv.gov.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of provider applicants that meet licensure/certification qualifications prior to delivering services. Numerator: Number of provider applicants that meet licensure/certification qualifications prior to delivering services; Denominator: Total number of provider applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment 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: Fiscal Agent	☑ **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:
Number and percent of currently enrolled providers, by type, that continue to meet licensure/certification qualifications. Numerator: Number of currently enrolled providers, by type, that continue to meet licensure/certification qualifications; Denominator: Total number of currently enrolled providers.

Data Source (Select one):
Provider performance monitoring

If 'Other' is selected, specify:

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 Source (Select one):
Other
If 'Other' is selected, specify:
Provider Re-enrollment 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**

Fiscal Agent		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 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.

Performance Measure:
Number and percent of non-licensed/non-certified provider applicants that meet qualifications prior to delivering services. Numerator: Number of non-licensed/non-certified provider applicants that meet qualifications prior to delivering services; Denominator: Total number of non-licensed/non-certified provider applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Enrollment 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: Fiscal Agent	☑ **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**

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

Performance Measure:
Number and percent of currently enrolled non-licensed/non-certified providers that continue to meet qualifications. Numerator: Number of currently enrolled non-licensed/non-certified providers that continue to meet qualifications; Denominator: Total number of currently enrolled non-licensed/non-certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Re-enrollment 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: Fiscal Agent	☑ **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 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:
Number and percent of agencies whose employees receive required training prior to delivering services. Numerator: Number of agencies whose employees receive training prior to delivering services; Denominator: Number of agencies reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider On Site 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:

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 State's 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.
The Fiscal Agent will not enroll any provider who does not meet Medicaid or waiver provider qualifications.

If problems are discovered during reviews of providers by any agency, DHCFP staff will take apropriate action which may include requiring a Corrective Action Plan (CAP) for remediation, provider suspension, or provider termination. The action taken depends on the nature of the problem and the action of the provider to correct and prevent recurrence of the problem.

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 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care (POC)

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)**
- [x] **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:

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:*

a) At the participant's initial contact with the Division, the participant is informed of services available through the waiver. If the person has an interest in applying for services, a brochure is sent to the participant describing these services. The information is again provided to the participant at the time of the initial plan development and reviewed during monthly contacts thereafter by the waiver case manager.

Qualified case managers are responsible for development of the Plan of Care (POC). The participant is provided the opportunity to actively engage in the development of the POC, including identifying individuals who will be involved in the process. The participant is furnished supports that are necessary to enable him or her to actively engage in the planning process. Information about the range of services and supports offered through the waiver are provided to the participant in advance of development of the POC.

b) The participant has the authority to determine who is included in the POC development process.

The participant, parents/guardians, other family members, friends, health care professionals, and anyone else who has a personal interest in the recipient are encouraged to participate in the planning process. The approved POC form must be used for all participants.

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) At the participant's initial contact with the Division, the participant is informed of services available through the waiver. If the person has an interest in applying for services, a brochure is sent to the participant describing these services. The information is again provided to the participant at the time of the initial plan development and reviewed during monthly contacts thereafter by the waiver case manager.

Qualified case managers are responsible for development of the Plan of Care (POC). The participant is provided the opportunity to actively engage in the development of the POC, including identifying individuals who will be involved in the process. The participant is furnished supports that are necessary to enable him or her to actively engage in the planning process. Information about the range of services and supports offered through the waiver are provided to the participant in advance of development of the POC.

b) The participant has the authority to determine who is included in the POC development process.

The participant, parents/guardians, other family members, friends, health care professionals, and anyone else who has a personal interest in the recipient are encouraged to participate in the planning process. The approved POC form must be used for all participants.

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) The POC is developed as an administrative function of the waiver. Qualified case managers are responsible for the development of the plan of care. The POC is developed by the case manager using a person centered process.

The participant has the authority to determine who is involved in the development of the POC.

This process involves the participant, parents/guardians, other family members, friends, health care professionals, and anyone else who has a personal interest in the recipient. The plan is completed no more than 30 days from waiver enrollment. The POC is reviewed every six (6) months and revised annually, or when a significant change occurs.

b) The case manager completes a LOC assessment and a Social Health Assessment (SHA). The assessment process includes addressing the participant’s activities of daily living (ADLs), which are self care activities, such as bathing, dressing, grooming, transferring, toileting, ambulation, and eating. Instrumental activities of daily living (IADLs), which capture more complex life activities, are also assessed, including meal preparation, light housework, laundry, and essential shopping. In addition, this process includes gathering information regarding the participant’s disability, medical history and social needs. The assessment process considers risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs. Development of the POC considers location, availability of transportation and necessary and desired activities. Personal goals are identified by the participant and documented on the POC initially and each time the POC is updated.

c) At the individual’s initial contact with the Division, the participant is informed of services available through the waivers. If the person has any interest in applying for services, a brochure is provided. The information is again provided to the participant at the time of the initial POC development and reviewed during monthly contacts thereafter by the waiver case manager.

d) The participant always receives a copy of the POC each time it is revised. The POC documents all services available through the waiver. The participant plays an active role in developing the POC that identifies desired

outcomes, needs and preferences. The POC development process ensures that the service plan addresses participant goals, needs (including health care needs) and preferences through the inclusion of the participant, involved family members, designated representatives and health care professionals.

e) The POC identifies the level of assistance required, the type, amount, scope and frequency of services, and the method by which the assistance is to be provided. Service providers are given a copy of the participant's POC and the assigned case manager reviews the document with the participant. The case manager is responsible for authorizing all waiver services. Authorizations are updated as needs change.

f) Monthly contacts with the participants are required and initiated by the case manager to discuss the authorized services and evaluate the participant's level of satisfaction. Contacts may be by telephone, but there must be a home visit to each participant at least every 6 months or more often if the participant has indicated a significant change in health care status or if there are reasons for concern about health, safety, and welfare. During regularly scheduled home visits, case managers are responsible for reviewing the POC for feedback from the participant to help ensure services are delivered as authorized in the plan of care. The DHCFP Central Office QA Unit is responsible for conducting annual program reviews, including reviews of the Plan of Care, using a representative sample.

g) The POC is reviewed every six (6) months at the bi-annual home visit and updated annually, or when a significant change occurs. The case manager is responsible for facilitating the revision of the plan of care.

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.

Potential risks to participants are identified during the initial assessment process and by addressing the amount of assistance needed to safely accomplish Activities of Daily Living (ADLs) and Individual Activities of Daily Living (IADLs). The Social Health Assessment includes a risk assessment which identifies potential risks in the following areas: medical/health, safety at home and in the community, financial, and behavioral. The Social Health Assessment is reviewed every six (6) months and revised as needed.

In addition to the Social Health Assessment, individualized goals, risks, back-up plans, and follow-up on health and safety needs is addressed during the monthly contacts.

The POC is developed by the case manager along with the recipient and identifies the services needed, the level of assistance required, individualized goals, identified risks, risk mitigation, and the identified back-up plan.

The case manager asks the participant, the parent/guardian, to identify back up plans, if they chose an ISO, to provide services if the care provider fails to appear. However, if services are provided by an agency, it is the agency's responsiblity to provide a back up caregiver. As a last resort, the participant is advised to activate their PERS or to call 911.

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.

Potential risks to participants are identified during the initial assessment process and by addressing the amount of assistance needed to safely accomplish Activities of Daily Living (ADLs) and Individual Activities of Daily Living (IADLs). The Social Health Assessment includes a risk assessment which identifies potential risks in the following areas: medical/health, safety at home and in the community, financial, and behavioral. The Social Health Assessment is reviewed every six (6) months and revised as needed.

In addition to the Social Health Assessment, individualized goals, risks, back-up plans, and follow-up on health and

safety needs is addressed during the monthly contacts.

The POC is developed by the case manager along with the recipient and identifies the services needed, the level of assistance required, individualized goals, identified risks, risk mitigation, and the identified back-up plan.

The case manager asks the participant, the parent/guardian, to identify back up plans, if they chose an ISO, to provide services if the care provider fails to appear. However, if services are provided by an agency, it is the agency's responsiblity to provide a back up caregiver. As a last resort, the participant is advised to activate their PERS or to call 911.

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):

The single state Medicaid agency is reponsible for the operation and administration of this waiver. DHCFP District Office case managers develop the Plan of Care. The POC is included in an intake packet which is sent to DHCFP Central Office for review and approval.

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) DHCFP District Office case managers are responsible for implementation of the Plan of Care and health and welfare for each individual. Plans of Care include the type of services to be furnished and the amount, frequency, and duration of each service.

b) Case managers conduct telephone contacts monthly and face-to-face visits at least every six (6) months. During the contact, case managers inquire and document implementation of the service plan and participant health and welfare.

Together with the participant, the case manager decides and documents whether any follow-up is needed and if so what type. The case manager also documents the follow-up action(s) taken and the effectiveness of these actions. For DHCFP case managers, a statistically significant sample of cases is selected each month by DHCFP District Office supervisors for review. Supervisors initiate immediate action when issues arise as a result of this local review process. DHCFP Central Office determines the size of the statistically significant sample to be used in the District Offices by utilizing readily available statistical sample size calculations, revising the sample as necessary to incorporate limitations on available resources.

c) Plans of Care are reviewed every six (6) months and revised annually or when a significant change in circumstance or condition occurs.

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:*

Case managers provide recipients with a list of qualified providers at the initial visit and at any time the recipient requests to change providers.

All recipients sign the Statement of Understanding which includes the following statements:
a. I choose to participate in the Medicaid Home and Community Based Waiver. I understand that my participation is condition based on my eligibility for Medicaid and waiver criteria.
b. I certify that I have been given a list of qualified providers.
c. I certify that I have received information about my Plan of Care and I will actively participate in the development of my Plan of Care.
d. I decline to participate in the above Waiver.

The State is currently revising the Social Health Assessment to include a comprehensive risk assessment and the Plan of Care to include identified risks, risk mitigation, and identified back up plan. In the meantime, case managers are narrating risks in their case narrative and documenting risks on the Plan of Care.

For agency provided services, back up caregivers are the responsibility of the agency. For individuals utilizing the self directed model, he or she must identify a backup plan.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
PM: Number and percent of recipients POCs that address the assessed needs identified in the social health assessment. N: Number of recipients POCs that address the assessed needs identified in the social health assessment; D: Number of recipient POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Performance Measure:
PM: Number and percent of recipients POCs that address health and safety risk factors identified in the social health assessment. N: Number of recipients POCs that address health and safety risk factors identified in the social health assessment; D: Number of recipient POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Performance Measure:
PM: Number and percent of recipients POCs that address personal goals identified in the social/health assessment. N: Number of recipients POCs that address personal goals identified in the social/health assessment; D: Number of recipient POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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**
	☐ **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.

Performance Measure:
PM: Number and percent of recipients POCs that contain the recipients signature indicating participation in POC development. N: Number of recipients POCs that contain the recipients signature indicating participation in POC development; D: Number of recipients POCs reviewed.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

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:
PM: Number and percent of new applicants whose POC is completed within no more than 30 calendar days of waiver enrollment. N: Number of new applicants whose POC is completed within no more than 30 calendar days of waiver enrollment; D: Number of recipients POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's 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:
PM: Number and percent of recipients POCs that are revised annually. N: Number of recipients POCs that are revised annually. D: Number of recipients POCs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Performance Measure:
PM: Number and percent of recipients POCs that are updated when the participants needs changed. N: Number of recipients POCs that are updated when the participants needs changed. D: Number of recipients POCs reviewed where there was a documented change in need.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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**
	☐ **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:

PM: Number and percent of recipients services that are delivered in accordance with the approved POC. N: Number of recipients whose services are delivered in accordance with the approved POC. D: Number of recipients records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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**
	☐ **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:
PM: Number and percent of recipients who indicate during monthly contacts that they are receiving the services they need. N: Number of recipients who indicate they are receiving the services they need. D: Number of recipients reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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**

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:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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:
PM: Number and percent of recipients whose SOU is signed indicating choice of waiver services and institutional care, choice of providers and choice of services.
N: Number of recipients whose SOU is signed indicating choice of waiver services and institutional care, choice of providers and choice of services. D: Number of recipient records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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 Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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 District Office supervisors review intake packets and ongoing charts monthly. Each supervisor sends the statistics on a monthly basis to the District Office Quality Assurance Specialist who compiles the data. The data is sent to Central Office quarterly for review.

Central Office QA staff completes an annual waiver review using a 95% confidence level and 5% confidence interval with the total population of waiver recipients. Data is compiled and shared with District Office staff. If deficiencies are noted, District Office staff submit a Quality Improvement Plan (QIP). Central Office QA staff review the QIP and provide feedback to the District Office staff and works with them through quality management meetings and ongoing monitoring of case files. The quality management committee develops overall improvement plans.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Case managers provide a recipient rights form to the recipient which includes the following:
You have the right to:
• Participate in the development of the Plan of Care and receive an explanation of services proposed.
• Receive a copy of the Plan of Care and a list of alternative resources.
• Receive the names and phone numbers of your assigned Case Manager and their Supervisor.
• Know that all communications and records will be treated confidentially.
• Receive information upon request on Nevada's Medicaid Policies and Procedures, including information on charges, reimbursements and Plan of Care development.
• Participate in the plan when requesting to discontinue services
• Have access, upon request, to Medicaid payment history.
• Receive in writing the name and contact number of an official of Nevada Medicaid and the state Advocate's telephone number.
• Contact your Case Manager for issues relating to your care provider or to change your provider agency.

The case manager and supervisor's names and phone numbers are included on this form.

Supervisors review intake packets and ongoing cases annually. If an error is noted on a POC, this is

remediated immediately by the case manager. Supervisors verify that corrections were made.

DHCFP QA staff completes a waiver review annually. This is completed using a 95% confidence level and 5% confidence interval sample size from the total population of waiver recipients. During the QA review, a sample of POCs are reviewed in accordance with the waiver assurances and sub assurances. If errors are found on a current POC, the QA staff notifies the District Office Manager who will have the case manager make corrections immediately. The supervisor verifies that the corrections were made. This is documented on the QIP which is submitted to DHCFP Central Office.

District Office supervisors provide individual training to the staff that made errors on POCs.

If providers are found to be providing services not in accordance with the plan of care, the case manager is the first individual to provide corrective action to the provider, and then the supervisor. If these actions do not work, DHCFP Central Office staff will provide education and support, and if necessary,sends a corrective action letter, and may suspend the provider from taking new recipients if needed. These corrective actions are on a case by case and severity basis.

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: 8a

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.

Medicaid Services Manual Chapters 2300, Waiver for Persons with Physical Disabilities, 3100, Hearings, identifies the following circumstances under which Notice of Decision (NOD) must be made to a waiver participant or participant of an adverse action:
• Denial of waiver participation
• Suspension of waiver services (such as when hospitalized or place in a skilled nursing facility)
• Termination of waiver services
• Reduction of waiver services

The following language is included on the NOD: “If you do not agree with this decision, you may request a Fair Hearing through Medicaid. To do so, you must submit a written request to the Medicaid office address shown below within ninety (90) days from the date of this notice. The day after the Notice Date is the first day of the 90-day period. If you are currently receiving this Medicaid service(s) and you want this service(s) continued during the hearing process, your hearing request must be RECEIVED no later than the 10th day after the effective date of the proposed action (Date of Action). If you want a Fair Hearing, please sign, date and return this letter. You may represent yourself or be represented at a Fair Hearing by anyone to whom you have given written authorization, such as legal counsel, a relative, a friend or other spokesperson. You must sign this written authorization and it must be furnished to the Medicaid office prior to the conference/hearing. If the recipient is incompetent or incapacitated, a signature is not required and the authorized representative may be someone acting responsibly for the recipient. If you cannot afford legal counsel, the Legal Services Program in your county may be able to help you”.

The Notice of Decision includes the following statements: “If you do not agree with this decision, you may request a Fair Hearing through Medicaid. To do so, you must submit a written request to the Medicaid office address shown below within ninety (90) days from the date of this notice. The day after the Notice Date is the first day of the 90-day period. If you are currently receiving this Medicaid service(s) and you want this service(s) continued during the hearing process, your hearing request must be RECEIVED no later than the 10th day after the effective date of the proposed action (Date of Action). If you want a Fair Hearing, please mark the appropriate boxes, sign, date, and return this letter to the Medicaid office address shown below. To obtain a free copy of the Medicaid regulations relevant to your case, mark the appropriate box below.”

DHCFP has a separate hearings unit located at Central Office. All hearing requests are directed to that unit and are assigned out to a hearings representative. All hearing requests and outcomes are kept within a hearings database.

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:

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).

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).

Alleged abuse, neglect and exploitation is addressed in the Nevada Revised Statutes (NRS) 200.5091, NRS 200.5092, and NRS 200.5093. NRS 200.5091 addresses the policy of the state surrounding identification of abuse, neglect, exploitation and isolation of older and vulnerable persons through reporting. It includes an extensive list of persons required to report these incidents. NRS 200.5092 defines abuse, exploitation, isolation and neglect, while NRS 200.5093 defines certain occupations or employees as mandatory reporters of abuse, exploitation, isolation and neglect. DHCFP expect all providers to be in compliance with all applicable statutes. Reports of abuse, exploitation, isolation and neglect must be reported to the appropriate state oversight agency and the specified law enforcement agency.

Additionally, DHCFP requires all waiver service provides to report all serious occurrences, including occurences of suspected abuse, neglect, exploitation and isolation, as well as falls and injuries requiring medical attention, deaths, unplanned hospital visits, loss of contact, and theft or exploitation. A monthly serious occurrence report is sent to DHCFP Central Office for tracking, trending, and monitoring of timely remediation.

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.

Case managers educate clients regarding reporting requirements and available agency contacts.

Case managers give each recipient an information page at the initial home visit which provides information to them if they suspect they are a victim of abuse, neglect, exploitation, or isolation. The informational page includes phone numbers of various agencies and other additional resources. The information is reviewed every six months at the face-to-face contacts.

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.

Providers are required to submit a Serious Occurrence Report (SOR) within 24 hours of discovery. Case managers have three business days to follow up on cases.

The case manager reviews the Serious Occurrence Report (SOR) to determine what follow up action is required. Supervisory staff reviews the adequacy and effectiveness of the case manager's response to all reports as a normal part of their supervisory reviews.

DHCFP does not investigate allegations of abuse, neglect, or exploitation. Depending on the age or circumstances of the recipient, investigations are conducted by the Division of Child and Family Services, Elder Protective Services, the Bureau of Health Care Quality and Compliance, and law enforcement. DHCFP does not have any authority over the timeframes for these investigations.

For adults aged 60 and over, the Aging and Disability Services Division Elder Protective Services accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

For children under age 18, the Division of Child and Family Services accepts reports of suspected abuse or neglect.

For all other individuals or vulnerable persons defined as "a person 18 years of age or older who: (1) suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or (2) has one or more physical or mental limitations that restrict the ability of the person to perform the normal activities of daily living" local law enforcement agencies accept reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

Participant safeguards include initiation of investigation by local law enforcement, Elder Protective Services, or Child Protective Services. If the person who is reported to have abused, neglected, exploited or isolated an older person, child, or a vulnerable person is the holder of a license or certificate, the information contained in the final

report must be submitted to the Board that issued the license.

The Bureau of Health Care Quality and Compliance (HCQC) is responsible for investigating complaints for state licensed facilities. DHCFP staff is trained regarding the role of the HCQC and how to make appropriate referrals for investigation when events occur that may be considered licensing infractions.

Trending reports of serious occurrences are reviewed quarterly during the quality management meetings which may identify areas needing change or system improvements.

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.

DHCFP is responsible for overseeing the reporting of and response to critical incidents or events as well as timely follow up and remediation if indicated. The number and type of events received by providers are entered into a database and summary reports are produced by type and by provider for review of trends and issues on a monthly basis.

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:

DHCFP is responsible for detecting the use of restraints or seclusion. This is accomplished through the monthly contacts by the case manager and the face-to-face contacts every six months.

If any occurrence of restraints or seclusion is discovered by DHCFP staff, a report will be made to law enforcement immediately. DHCFP will also report to HCQC if the provider is licensed.

Additionally, the annual program reviews of a representative sample help to detect and remediate any systemic issues regarding restraints and seclusion.

○ **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).

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:

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:

DHCFP is responsible for detecting the use of restrictive interventions. This is accomplished through the monthly contacts by the case manager and the face-to-face contacts every six months.

If any occurrence of restrictive interventions is discovered by DHCFP staff, a report is made to law enforcement immediately. DHCFP follows up with HCQC if the provider is licensed.

Additionally, the annual program reviews of a representative sample help to detect and remediate any systemic issues regarding restrictive interventions.

○ **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.

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:

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 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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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).

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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

○ **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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
PM: Number and percent of recipients serious occurrences that were reported according to waiver and/or state policy. Numerator: Number of serious occurrences reported. Denominator: Number of serious occurrences that should have been reported as discovered after the fact.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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 Source (Select one):
Other

If 'Other' is selected, specify:
Serious Occurrence 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:

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

Performance Measure:
PM: Number and percent of recipients serious occurrence reports that include appropriate follow-up by the case manager. Numerator: Number of serious occurrences that received follow-up. Demoninator: Number of serious occurrences requiring follow up.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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 Source (Select one):
Other
If 'Other' is selected, specify:
Serious Occurrence 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):*
	☐ **Weekly**	☑ **100% Review**

☑ **State Medicaid Agency**		
☐ **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:
PM: Number and percent of recipients serious occurrence reports that are reported within 24 hours of discovery. Numerator: Number of serious occurrence reports received within 24 hours. Denominator: Number of serious occurrence reports received.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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 Source (Select one):
Other
If 'Other' is selected, specify:
Serious Occurrence 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**	☐ **Annually**	☐ **Stratified**

Specify:		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:
PM: Number and percent of recipients who received information about how to report A/N/E initially and every six months. Numerator: Total number of recipient who receive information on how to report A/N/E. Denominator: Total number of recipients.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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**
	☐ **Continuously and Ongoing**
	☐ **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.

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.

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.

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.
Per NRS 200.5093, every employee adheres to reporting instances of abuse, neglect, exploitation, and neglect to the proper authorities. In Nevada, Aging and Disabilities Services Division Elder Protective Services is available for individuals age 60 and older. The Division of Child and Family Services (DCFS) for children up to age 18, and for those individuals between 19 years of age and 59, the police must be contacted.

Case managers seek to prevent instances of abuse, neglect, exploitation, isolation and ensure the health, welfare and safety via monthly contacts with the recipients.

Supervisors review a representative sample of ongoing case files which identifies monthly contact, concerns, needs, follow-up action, and waiver services satisfaction. These reviews are captured on the Case File Review Form and submitted to the QM committee as they are completed. QM committee reports this data at quarterly meetings.

Case managers report concerns of abuse, neglect, exploitation, or isolation to the appropriate state agency. Case managers and providers are also responsible for completing DHCFP's Serious Occurrence Report (SOR) forms. As case managers receive SORs from providers, they take appropriate follow-up action regarding the occurrence. The form identifies the type of occurrence and documentation of the case manager's follow-up action. These reports are sent to the District Office Quality Assurrance Specialist monthly. This report is sent to Central Office for tracking and trending. Issues are discussed at the QM meetings.

Central Office QA staff review a sample of ongoing case files during the annual waiver review. These reviews identify monthly contact, concerns, needs, follow-up action, and waiver satisfaction. If a Serious Occurrence was reported, the follow up action is reviewed as well as the monthly contact documentation. This is the verification of follow up to the Serious Occurrence and verification of addressing needs and concerns.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Case managers provide a copy of the HCBW Recipient Rights to all individuals at the initial home visit and annual home visits. In addition, case managers review the recipient rights at the 6 month home visit. The Recipient Rights includes the following statements: the right to not to be physically, sexually, or otherwise abused, not to be neglected, not to be exploited, and not to be isolated. In addition, this form provides contact information for who to contact, including case manager and appropriate state agency, if they suspect they are being abused, neglected, or exploited.

When abuse, neglect, and exploitation are identified, action is taken to protect the health and welfare of the recipient by verifying appropriate follow up is completed. Appropriate follow-up could mean a referral to the Bureau of Health Care Quality and Compliance (HCQC) which is the state licensing agency. Appropriate follow-up could be a report to Division and Child and Family Services or Aging and Disability Services Division. Lastly, if the individual is between 19 and 59, appropriate follow-up is state or local law enforement. These entities are tasked with investigation of reported incidents.

Case managers follow up with recipients on a monthly basis or more frequently as necessary.

Data on types of occurrences is collected and analyzed for trends, and strategies are developed and implemented to prevent future occurrences.

Education is completed to verify that providers are aware of the serious occurrence policy and that they have the current form. Reviewers also verify that serious occurrences are being completed, followed up on, and kept of file. Reviewers always review time frames for reporting serious occurrences. If a provider is not in compliance, education is completed and a Corrective Action Plan is completed. If the provider requests additional training, DHCFP District Office staff will provide training.

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 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 2)

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;
- 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 2)

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, through a benchmark in our Money Follows the Person Grant, is working to build efficiencies and systemwide improvement through developing a Quality Improvement program that encompasses multiple community-based long-term support services. Once this development is complete, the DHCFP will submit an amendment to this section.

Quality Management Committee

The Waiver Quality Management (QM) Committee for the HCBS Waiver for Persons with Disabilities typically meets quarterly. The Committee 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. The QM Committee is comprised of DHCFP management staff, waiver management staff, DHCFP District Office management staff, case management supervisors and/or staff, and the WIN Waiver Quality Assurance supervisor and staff.

The purpose of the Committee is to:
• Identify waiver goals;
• Remediate issues and problems through policy development and clarification;
• Review program data for trending;
• Identify staff training needs and program changes;
• Discuss and identify program improvements; and
• Set priorities for system improvement.

The Committee reviews and analyzes data from reports gathered on a monthly or annual basis. Problem areas are discussed and prioritized based on the seriousness of the problem for solutions. System improvements are prioritized and Central Office works together with the District Office Managers to implement these improvements.

The Committee is responsible for:
• Updating of waiver processes to specifically address CMS assurance components;
• Standardizing education, training and quality systems;
• Monitoring the results of supervisory level monitoring and designing statewide reports;
• Improving program performance and ensuring efficiency; and
• Implementation of waiver assurance monitoring for the health and welfare of recipients.

Documentation of inter-agency meeting minutes, decisions, and agreements are maintained.
Quality improvement activities are prioritized based on regulatory requirements, the likelihood of adverse outcomes or problem prone processes, and the potential to make a significant change to improve the program.

After systems improvements have been identified and action is needed, the DCHFP Central Office staff designs and develops the processes for implementing system improvements. In some cases, a work group may be established to identify possible solutions to needed improvements.

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.

The Continuum of Care Unit has primary responsibility for monitoring and assessing the effectiveness of system design changes. The Chief of Continuum of Care directly supervises the Central Office QA staff, as well as the District Office Managers.

Central Office waiver staff are responsible for monitoring and analyzing the effectiveness of system design changes and for reporting the results to division administration.

Results of monitoring reports are periodically discussed with division administration for the purposes of sharing successes and challenges. Results are also shared with sister agencies for the purpose of the information sharing across waiver programs in order to promote best practices and system design improvements.

Results of quality improvement activities are shared with stakeholders and providers by using both the fiscal agent and DHCFP websites. Information is posted and available on a monthly basis.

DHCFP utilizes a variety of resources to prioritize HCBW quality improvement activities. Results from annual waiver reviews and analysis of performance measure data guides DCHFP in assessing problem areas and prioritizing program improvements. Timelines, resource allocation and project planning are used to accompany each system improvement so that progress towards implementation can be tracked and measured for impact.

Clients, advocates and other stakeholders are encouraged to provide feedback regarding the care and services received. This feedback is evaluated to determine if system design changes will result in improvement in waiver service provision.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Currently, DHCFP is working with other DHHS Divisions to develop a systemwide Home and Community Based Service (HCBS) Long Term Support Services (LTSS) quality improvement system.

Quality management is a system that changes and improves over time. DHCFP Central Office Staff is responsible for monitoring the effectiveness of the improvement strategies throughout the waiver year.

The process of data analysis, setting goals, monitoring outcomes and identifying problem areas leads to continual adjustment of quality activities. The Quarterly Quality Management Meetings are used to evaluate these quality activities on an ongoing basis.

There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate.

DCHFP Central Office staff uses feedback from the quarterly Quality Management meetings, as well as information from the current processes to evaluate the effectiveness, efficiency and appropriateness of the quality activities and updates these activities on an as needed basis. Evidentiary reports, annual review findings, and Quality Improvement Plans (QIP) are utilized to evaluate and set priorities.

The Quality Improvement Strategy is reviewed and update annually, based on information gathered from all of the activities completed throughout the year, and the annual waiver review. If there were no serious concerns, the Strategy may not change. If additional items need to be monitored, DHCFP will modify the Strategy to include this additional monitoring.

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).

a) Waiver provider agencies are not required to secure an independent review of financial statements.

b) A financial review is completed during the annual waiver review. The objective of this review is to confirm the accuracy of provider payments made by examining claims paid and comparing those claims with participant files, Plans of Care, provider qualifications, waiver requirements and DHCFP policy.

The financial review utilizes the statewide random sample selected for the program review. The random sample is selected from the total population of active participants. A list of claims paid is produced from the Medicaid Management Information System (MMIS) for each sample case for all waiver services for one chosen month. A sample month is randomly selected for each recipient in the sample. All waiver claims for that sample month for that participant are examined, in conjuction with the POC and daily record documentation.

The results of the financial review are included in the final waiver review report. The final report is presented to the QM committee, District Office managers, the Chief, Continuum of Care, DHCFP administration and to CMS. The QM Committee 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. If necessary, the results of the financial review are provided to DHCFP Surveillance and Utilization Review Unit.

Additionally, Waiver Quality Assurance staff analyzes findings from the financial review to determine whether the MMIS payment edits are functioning as expected or whether modifications to the MMIS system would prevent future occurrences of erroneous payments. Based on the results of these audits and other analyses, changes to the MMIS system are considered by DHCFP.

c) The Division of Health Care Financing Continuum of Care staff is responsible for conducting the financial review.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(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:
PM: 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):
Financial records (including expenditures)
If 'Other' is selected, specify:

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:	

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:
PM: Number and percent of recipients whose eligibility is verified prior to services being authorized. Numerator: Number of recipients whose eligibility is verified. Denominator: Number of recipients reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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:
		☐ **Other**

	☐ **Continuously and Ongoing**	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:
PM: The Medicaid Management Information System (MMIS) ensures that paid claims do not exceed the authorized limits on services for recipients. Numerator: Number of claims that did not exceed the authorized limit on services. Denominator: Number of claims reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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:	

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 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.

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 State's 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.
Supervisors review a representative sample of ongoing cases annually. If an error is noted with eligibility or with the identification of time spent doing activities associated with direct service case management, this is remediated on a case by case basis immediately by the case manager. Supervisors indicate the needed corrections and verify that corrections were made. This is documented on the Case File Review Tool.

DHCFP QA staff completes a waiver review annually. This is completed using a 95% confidence level and 5% confidence interval with the total population of waiver recipients. During the QA review, a sample of claims are reviewd in accordance with waiver methodology. If errors by a case manager are found, the QA staff notifies the District Office Manager who will have the case manger make corrections immediately. The supervisor will verify that the corrections were made. This will be documented on the Corrective Action Plan which will be submitted to DHCFP Central Office. If errors are made by a provider, the provider will receive a letter notifying them of the error and request a Correction Action Plan.

If claims are discovered to be incorrect, a referral is made to the Surveillance and Utilization Recovery Unit (SURS) within DHCFP. This Unit investigates overpayments and underpayments. This unit will recoup funds providers are not entitled to, or have a provider re-bill for funds they were not paid. In addition, DCHFP staff will provide training to providers on billing procedures. If provider training efforts fail, DHCFP may suspend the provider from accepting new Medicaid recipients and request a corrective action plan.

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 on the same day for multiple provider types such as Personal Care Service Providers and Waiver Providers. When these types of errors are noted, a form called the Production Discrepancy Report (PDR) is completed which identifies the nature of the problem. The PDR is submitted to DHCFP's fiscal agent for a Statement of Understanding which outlines the amount of time and cost to fix the system. Once that is approved by DHCFP IT staff, the work begins. Some MMIS system fixes happen within a month and some may take up to a year. This is due to multiple layers of problems and system testing.

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 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).

All Rates:

The Division of Health Care Financing and Policy (DHCFP) determines all rates. All rates are listed by provider type and rates for this waiver are located on the DHCFP internet website. The specific rates address is: dhcfp.nv.gov/ratesunit.htm.

State Plan Services Rate Methodology:

The rate methodology for State Plan Medicaid Services is outlined in Nevada's State Plan.

All State Plan Amendments regarding Rate Methodology creation or changes are subject to Public Hearing. The public comments are solicited through the Public Hearing process. Some rate determination methodologies are also presented at Public Workshops.

Waiver Rates:

Waiver rates were set in 2002 the Nevada Provider Rates Task Force, which was contracted by a DHCFP to conduct an analysis of provider rates and make recommendations on rate setting. Rates for waiver providers were recommended by the Provider Rates Task Force and adopted by DHCFP. The task force provided the following recommendations for rates setting in the future: 1) Require providers to submit cost information annually to the State so the State can develop a baseline of information on the industry, 2) The State shall rebase rates no less frequently than every 5 years, and 3) For years that rates are not rebased, rates shall be increased by an indepedent inflation index. It must be noted that waiver rates have not increased in the last five years; therefore, rates, for the purposes of the waiver, are increased by an idependent inflation index.

For the purpose of this renewal, the current rates are used in year 1 of the waiver. The base rate is increased by the CPI of 3.4% in years 2 through 5. 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 months percent change, U.S. City by expenditure category. The latest analysis is from November 2010 through November 2011.

The number of recipients is based on the percent of unduplicated recipients that have historically utilized services and the service units are based on projections by ADSD service unit reports for waiver years 2010 and 2011.

Case Management – Public Providers:

The rates for public providers are expected to be higher than those described for private providers. This is due in part to the generally higher administrative costs of public providers and also due to the productivity based on the clientele served. Geographically, Nevada is composed primarily of rural and frontier areas. Experience has been that private providers will not render many services in these areas. The State invariably is the sole provider of case management services for many of these rural and frontier communities. Travel then becomes a large factor in the productivity of public providers serving these areas.

The case management rate for DHCFP employees is based on the Allocap Case Management cost pool in time tracking for each quarter. Case managers indicate the amount of time they spend doing direct services case management by pay period. That information is gathered quarterly and averaged. The rate is a blended rate among all case managers and is increased for years 2, 3, 4, and 5 by 3.4 percent.

Case Management – Private Providers:

Any willing and qualified provider may enroll as a Medicaid provider and provide Direct Service case management. The rate for case management for private providers is based on a market basket model and consistent with the rates established for the same provider type in other Home and Community Based Waivers with the most current percentage increase from the Consumer Price Index for Medical Services. The major component of the market rate is a wage assumption for the case manager. The wage scale for a licensed clinical social worker in State service was used for this component. Average benefits are also applied as a percentage of the hourly wage. This percentage is based on analysis of the average benefits of a licensed clinical social worker in State service. Productivity assumptions are then applied to take into account wage costs, which would not be billable – e.g. no show appointment, phone calls, paperwork. Then a factor for a portion of a supervisor's wage is added into the formula. Then a percentage of 10% for indirect costs and overhead is applied. The final rate is then expressed in 1 hour increments.

This model is designed to approximate the costs of a private provider to render this service. It is not a cost based rate and is increased for years 2, 3, 4, and 5 by 3.4 percent.

The State believes these rates are sufficient to ensure access to services for recipients while still being consistent with efficiency, economy, and quality of services. The State will review the appropriateness of this rate based on future experience with this waiver. To date, no private providers have participated in service delivery.

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 direct bill DHCFP's fiscal agent by submitting an electronic bill through Nevada's Medicaid Management Information System (MMIS). This is true of both public and private providers. Billings do not flow through any intermediary other than the DHCFP's fiscal agent.

1. Determined eligible for the program.
2. All waiver services are prior authorized.
3. The provider is responsible for verifying eligibility monthly.
4. The provider may submit claims weekly or monthly.
5. Claims submitted directly into the MMIS system.
6. MMIS has a series of edits which verifies name, Medicaid number, prior authorization, and the number of units of service authorized. If the claim fails just one of these areas, the claim will deny.
7. Provider must resubmit claims with the correct information.
8. There is an edit in the system which verifies providers do not receive reimbursement over what is authorized.
9. Provider claims are stored in a data warehouse and can be accessed through reports.

Case management is the exception. It is not prior authorized and it is provided on an as needed basis. DHCFP has a Time Tracking System in place which allows case managers to track administrative activities as Waiver

Administration and direct services activities as Medical Case Management. Each case manager has a billing work book and these workbooks must match time tracking. Supervisors review a representative sample of case file reviews monthly in which this area is included.

Administrative activities and direct service activities are split up as follows:

Administrative:
1. Intake referral;
2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance for the Aged, Blind and Disabled (MAABD) application and obtaining documents required for eligibility determination;
3. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility:
4. Issuance of a Notice of Decision (NOD) when a waiver application is denied;
5. Coordination of care and services to collaborate in discharge planning to transition applicants from facilities;
6. Documentation for case files prior to applicant's eligibility;
7. Case closure activities upon termination of service eligibility;
8. Outreach activities to educate recipients or potential recipients on how to enter into care through a Medicaid Program;
9. Communication of the POC to all affected providers;
10. If attendant care services are medically necessary, the case manager is then responsible for implementation of services and continued authorization of services;
11. Completion of prior authorization form prior to submission into the Medicaid Management Information System (MMIS).

Direct Services:

1. Identification of resources and assisting recipients in locating and gaining access to waiver services, as well as needed medical, social, educational and other services regardless of the funding source;
2. Coordination of multiple services and/or providers;
3. Monitoring the overall provision of waiver services, in an effort to protect the safety and health of the recipient and to determine that the POC goals are being met;
4. Monitoring and documenting the quality of care through monthly contact;
5. Ensuring that the recipient retains freedom of choice in the provision of services;
6. Notifying all affected providers of changes in the recipient's medical status, service needs, address, and location, or of changes of the status of legally responsible individuals or authorized representative;
7. Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient;
8. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;
9. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency; and
10. Case Managers must provide recipients with appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case management is an "as needed" service. Case managers must, at a minimum, have monthly contact with recipients and/or the recipients authorized representative of at least 15 minutes per recipient, per month. The amount of case management services must be adequately documented and substantiated by the case manager's notes.

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.)*

☐ **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 reports 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 the services billed are included in the benefit plan.

b) The individual POC lists the services by scope, frequency, and duration. Case manager fax a copy of the appropriate POC to waiver providers and may go over the POC with waiver providers if requested. Providers are required to provide the services listed in the approved POC. The daily record verifies that services were provided in accordance with the approved POC.

c) Verification that services for which payment was made were actually provided occurs as part of the annual program review and the annual financial review, which are based on a representative sample as described previously. Waiver claims are pulled directly from the MMIS system and compared to the appropriate POC and daily records for verifictation of service delivery.

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.**
- [x] **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:

- [ ] **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:

DHCFP District Office staff provides case management as a waiver service. Case management is broken up into Administrative and Direct Service. (Reference I-2.b for a breakdown of Administrative and Direct Services). The type of case management provided is tracked in an electronic time sheet. Only Direct Service case management is billed as a waiver service.

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:

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.

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. *Select one:*

◉ **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.**

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:

☑ **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:

"During the 76th Legislative Session SB 485 was passed which amended the counties responsibility to pay the State's Share of expenditures for indigents who are institutionalized with income at 156% to 300% of the Federal Benefit Rate (FBR). The bill amended this population lowering the FBR to an amount prescribed annually by the Director and included the waiver population within the same income limits. The FBR was lowered to 142%.

The counties reimburse these expenditures through property taxes collected. This is not a CPE mechanism as the counties are not providing the services to these recipients. This is a reimbursement of expenditures in which the counties are responsible to pay through property taxes collected. The expenditures include waiver and state plan services provided by private community providers.

DHCFP obtains those funds from the counties by invoicing each county, monthly, based on projected costs for the recipients the county is responsible for. A reconciliation is completed each quarter.

DHCFP updated the contracts of all 17 Nevada counties which will take effect on July 1, 2013 to state "payments made by the County shall be derived from general county tax revenues or other general revenues of the County".

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:

a) Nevada counties are responsible for a portion of waiver costs. b) The sources of revenue are local or county tax revenues. c) Funds are transferred to the state by the counties.

☐ **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:

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:

Assisted Living Services are provided as a waiver service, in a residential setting, under this waiver. DHCFP policy clearly states reimbursement cannot include room and board or the cost of the building maintenance, upkeep, or improvement. A daily rate has been established which covers the cost of services included in the Assisted Living Services definition. The MMIS payment system ensures the payments do not exceed the allowable daily rate.

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: Nursing Facility

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	10387.11	24776.00	35163.11	56975.00	19927.00	76902.00	41738.89
2	10669.57	25618.00	36287.57	58855.00	20585.00	79440.00	43152.43
3	11044.72	26489.00	37533.72	60797.00	21264.00	82061.00	44527.28
4	11537.19	27390.00	38927.19	62803.00	21966.00	84769.00	45841.81
5	13979.54	28321.00	42300.54	64875.00	22691.00	87566.00	45265.46

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:
		Nursing Facility
Year 1	771	

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:
		Nursing Facility
		771
Year 2	844	844
Year 3	921	921
Year 4	1010	1010
Year 5	1105	1105

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.

Average length of stay is based on the total days of waiver coverage divided by the unduplicated number of recipients served based on the CMS 372 (3c) data for the period of January 1, 2010 through December 31, 2010. The average length of stay in waiver year 2010 was 333 days. The same number of days is used to project average length of stay for all 5 years of the renewal period.

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 for these estimates is as follows:

Users per waiver service:

For each waiver service, the number using the service is estimated using the ratio of users to unduplicated counts of recipients for SFY 2011. The same ratio is applied to the forecasted number of participants for each year.

Units per user:
For each waiver service, the number of units was estimated based on the average units by service for SFY 2011. The same ratio is applied to the forecasted number of participants for each year.

Average cost per unit:
For year one, the current payment rate is used. In years two through five, that average cost is increased by the medical care services CPI of 3.4% 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 months percent change, U.S. City by expenditure category. The latest analysis is from November 2010 through November 2011. The Consumer Price Index indicates a 3.4% growth in medical care.

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:

State plan service estimates for this waiver renewal were based on data for SFY 11 and 12. The cost of prescription medication furnished to dual eligibles is not included in factor D'.

The average cost of Medicaid costs for all other services provided to individuals in the waiver program from SFY 2011. That average cost is increased by the medical care services CPI of 3.4% 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 months percent change, U.S. City by expenditure category. The latest analysis is from November 2010 through November 2011. The Consumer Price Index indicates a 3.4% growth in medical care.

Each year of the waiver is increased by 3.4% beginning in year two.

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:

The nursing facility costs are estimated based on the statewide average nursing facility cost per patient for SFY 2011. That average cost is increased by the medical care services CPI of 3.3% for each year of the waiver. (Medical costs and nursing facility costs differ from 3.4% for medical and 3.3% for nursing facility). 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 months percent change, U.S. City by expenditure category. The latest analysis is from November 2010 through November 2011. The Consumer Price Index indicates a 3.3% growth in nursing facility rates.

Each year of the waiver is increased by 3.3% beginning in year two.

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:

State plan service estimates for this waiver renewal were based on data for SFY 11 and 12. The cost of prescription medication furnished to dual eligibles is not included in factor G'.

The Medicaid costs per person for all services other than Nursing Facility cost for persons in a nursing facility was estimated based on the statewide average costs for these services for SFY 2011. That average cost is increased by the medical care services CPI of 3.4% 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 months percent change, U.S. City by expenditure category. The latest analysis is from November 2010 through November 2011. The Consumer Price Index indicates a 3.4% growth in medical care.

Each year of the waiver is increased by 3.4% beginning in year two.

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	
Case Management	
Homemaker	
Respite	
Attendant Care Services	
Specialized Medical Equipment and Supplies	
Assisted Living Services	
Chore Services	
Environmental Accessibility Adaptations	
Home Delivered Meals	
Personal Emergency Response Systems (PERS)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 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 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**1586130.00**
Case Management Public	15 minutes	696	83.00	25.75	**1487526.00**	
Case Management Private	15 minutes	75	83.00	15.84	**98604.00**	
Homemaker Total:						**240669.00**
Homemaker	15 minutes	170	390.00	3.63	**240669.00**	
Respite Total:						**92390.76**
Respite	15 minutes	84	303.00	3.63	**92390.76**	
Attendant Care Services Total:						**3824528.00**
Agency	15 minutes	150	4832.00	4.63	**3355824.00**	
Non-Agency	15 minutes	25	4832.00	3.88	**468704.00**	
Specialized Medical Equipment and Supplies Total:						**33900.00**
Specialized Medical Equipment and Supplies	Annual	60	1.00	565.00	**33900.00**	
Assisted Living Services Total:						**1279278.00**
Assisted Living Services	Day	39	312.40	105.00	**1279278.00**	
Chore Services Total:						**7861.07**
Chore Services	15 minutes	50	41.05	3.83	**7861.08**	
Environmental Accessibility Adaptations Total:						**145350.00**
Environmental Accessibility Adaptations	Annual	45	1.00	3230.00	**145350.00**	
Home Delivered Meals Total:						