MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 24, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF OPERATIONS

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3500 – PERSONAL CARE SERVICES PROGRAM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3500 – Personal Care Services Program are being proposed to add language due to the passage of the 21st Century Cures Act. In December 2016, Congress passed H.R. 34 – 21st Century Cures Act, mandating that all States require the use of an Electronic Visit Verification (EVV) system for all Medicaid-funded personal care services (PCS) that are provided under a state plan or a waiver of the plan, including services provided under Section 1915(c).

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering specific personal care services. Those provider types include, but are not limited to: Personal Care Services (PT 30).

Financial Impact on Local Government: Unknown at this time.

These changes are effective September 25, 2019.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL N/A MSM Ch 3500 – Personal Care Services Program	MTL 20/16 MSM Ch 3500 – Personal Care Services Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3501	**AUTHORITY**	Added 21st Century Cures Act mandate and H.R. 6042 – 115th Congress.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3503.1	**PERSONAL CARE SERVICES (PCS)**	Clarified that all services must be documented in an approved EVV system.
3503.1G	**ELECTRONIC VISIT VERIFICATION (EVV)**	New section added to highlight the 21st Century Cures Act requirements. There are two options in the State of Nevada for use of an EVV system: state option and data aggregator. Various data points are required and outlined in this section.
3503.1I	**PROVIDER RESPONSIBILITIES**	Removed "qualified" as a descriptor for Personal Care Attendant (PCA). PCA qualifications are deemed by Medicaid's sister agency – Division of Public and Behavioral Health (DPBH), Bureau of Health Care Quality and Compliance (BHCQC). Added language to align with MSM 2600 regarding maintaining an active certification with BHCQC. Added EVV language to mandate the use of an EVV system for all personal care services. Added the 21st Century Cures Act to the list of local, state, and federal regulations that agencies must comply with. Added language that the servicing provider must review with the recipient or PCR, the EVV requirements and recipient participation to adhere to the 21st Century Cures Act. Added language that the supervisor (or other designated agency representative) must review with the PCA the EVV requirements and expectations, including the documentation of all personal care services in an approved EVV system. Removed language regarding records. All record requirements are listed in the newly created Section 3503.1G.
3503.1J	**RECIPIENT RESPONSIBILITIES AND RIGHTS**	Added language to agree to utilize a Medicaid-approved EVV system and to confirm services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		electronically, per requirements of the 21st Century Cures Act.
3503.5C	**PROVIDER RESPONSIBILITY**	Added language mandating the use of an approved EVV system to document and verify services.

3501 AUTHORITY

Personal Care Services (PCS) are an optional Medicaid benefit under the Social Security Act (SSA).

Regulatory oversight:

~~Social Security Act~~SSA 1905(a) (24)

Title 42, Code of Federal Regulations (CFR), Section 440.167

Nevada State Plan Attachment 3.1-A (26)

21st Century Cures Act, H.R. 34, Section 12006 – 114th Congress

H.R. 6042 – 115th Congress

3503 POLICY

3503.1 PERSONAL CARE SERVICES (PCS)

PCS provide assistance to support and maintain recipients living independently in their homes. Services may be provided in the home, locations outside the home or wherever the need for the service occurs. Assistance may be in the form of direct hands-on assistance or cueing the individual to perform the task themselves, and related to the performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Services are based on the needs of the recipient being served, as determined by a Functional Assessment Service Plan (FASP) approved by the Division of Health Care Financing and Policy (DHCFP). All services must be performed in accordance with the approved service plan, ~~and~~ must be prior authorized and documented in an approved Electronic Visit Verification (EVV) system. The time authorized for services is intended to meet the recipient needs within program limits and guidelines, facilitate effective and efficient service delivery, and to augment unpaid and paid supports currently in place. Services are not intended to replace or substitute services and/or supports currently in place, or to exchange unpaid supports for paid services.

Legally Responsible Individuals (LRIs) may not be reimbursed for providing PCS.

3503.1A ELIGIBILITY CRITERIA

1. The recipient must have ongoing Medicaid or Nevada Check Up (NCU) eligibility for services;

2. The recipient is not in a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an institution for the mentally ill or a licensed residential facility for groups;

3. The recipient does not have an LRI who is available and capable of providing the necessary care;

4. The recipient or Personal Care Representative (PCR) must be cooperative in establishing the need for the provision of services and comply with the approved service plan;

5. The recipient is capable of making choices about ADLs or has a PCR who assumes this responsibility;

6. PCS must be determined to be medically necessary as defined by the DHCFP or its designee.

3503.1B COVERAGE AND LIMITATIONS

1. Covered Services

3503.1G ELECTRONIC VISIT VERIFICATION (EVV)

The 21st Century Cures Act requires the use of an EVV system to document services that are provided for all personal care services under a Medicaid state plan or waiver program. This mandate requires provider agencies to use an EVV system to record service delivery visit information. Nevada Medicaid utilizes the open-system model, procuring a vendor but also allows agencies to utilize their own EVV system if it meets the 21st Century Cures Act requirements for documentation.

All service information must be recorded in an electronic system that interfaces with either a telephone or an electronic device that generates a timestamp. The provider agency must verify the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV record. All claims must be supported by an EVV entry into an EVV system prior to claim submission.

Provider Agencies must ensure each personal care attendant (PCA) has a unique identifier (National Provider Identification – NPI) associated with their worker profile in the EVV system.

1. STATE OPTION

   A. The EVV system electronically captures:

      1. The type of service performed, based on procedure code;
      2. The individual receiving the service;
      3. The date of the service;
      4. The location where service is provided;
      5. The individual providing the service;
      6. The time the service begins and ends.

   B. The EVV system must utilize one or more of the following:

      1. The agency/~~personal care attendant's~~ (PCA's) smartphone;
      2. The agency/PCA's tablet;
      3. The recipient's landline telephone;

4. The recipient's cellular phone (for Interactive Voice Response (IVR) purposes only);

5. Another GPS-based device as approved by the DHCFP.

2. DATA AGGREGATOR OPTION

A. All Provider Agencies that utilize a different EVV system (as approved by the DHCFP) must comply with all documentation requirements of this chapter and must utilize the data aggregator to report encounter or claim data.

1. Appropriate form must be approved by the DHCFP before use of the system to ensure all data requirements are being collected to meet the 21st Century Cures Act.

2. At a minimum, data uploads must be completed monthly into data aggregator.

3503.1~~HG~~ CONFLICT OF INTEREST STANDARDS

The DHCFP assures the independence of contracted providers completing the FASPs. Physical and occupational therapists who complete the FASPs must be an independent third party and may not be:

1. Related by blood or marriage to the individual or to any paid caregiver of the individual;

2. Financially responsible for the individual;

3. Empowered to make financial or health-related decisions on behalf of the individual;

4. Related by blood or marriage to the Provider who provides PCS to the individual.

The therapist completing the FASP must not have an interest in or employment by a Provider.

Note: To ensure the independence of individuals completing the FASP, providers are prohibited from contacting the physical or occupational therapists directly.

3503.1~~IH~~ PROVIDER RESPONSIBILITIES

PCS providers shall furnish ~~qualified~~ PCAs to assist eligible Medicaid and NCU recipients with ADLs and IADLs, as identified on the individual recipient's approved service plan and in accordance with the conditions specified in this Chapter and the Medicaid Provider Contract.

Additionally, all PCS providers have the following responsibilities:

1. Licensure

In order to enroll as a Nevada Medicaid PCS Provider, a provider must be licensed by the Division of Public and Behavioral Health (DPBH) as an Agency to Provide Personal Care Services in the Home (personal care agency).

Providers must comply with licensing requirements and maintain an active certification and/or license at all times.

2. Provider Enrollment

To become a Nevada Medicaid PCS provider, the provider must enroll with the QIO-like vendor as a Personal Care Services – Provider Agency (Provider Type 30).

3. Electronic Visit Verification (EVV)

Utilize an EVV system that meets the requirements of the 21st Century Cures Act, to electronically document the personal care services provided to Medicaid recipients served by a Medicaid provider.

~~3.~~4. Time Parameters

The Provider will implement PCS in a timely manner. The Provider agrees to furnish qualified staff to provide PCS to eligible Medicaid recipients within five working days of an accepted referral and within 24 hours of an accepted referral if the recipient is identified as "at risk" by the DHCFP or its designee.

PCS providers must meet the conditions of participation as stated in the MSM Chapter 100.

The Provider must comply with all local, state and federal regulations, and applicable statutes, including, but not limited to, Nevada Revised Statutes Chapter 449, Nevada Administrative Code Chapter 449, the Internal Revenue Service (IRS), Federal Insurance Contributions Act (FICA), Occupational Safety and Health Act (OSHA), ~~and~~ the Health Insurance Portability and Accountability Act (HIPAA) and the 21st Century Cures Act.

~~4.~~5. 24-Hour Accessibility

The Provider shall maintain an available telephone line 24 hours per day, seven days per week for recipient contact.

~~5.~~6. Backup Mechanism.

1. The agency is endorsed, certified or licensed by the DHCFP. Compensation or incentives of any kind which encourage a specific recipient to transfer from one provider to another are strictly prohibited.

11. Medicaid and NCU Eligibility

Verification of Medicaid or NCU eligibility on a monthly basis is the responsibility of the Provider Agency.

12. Service Initiation

Prior to initiation of services and periodically as needed, the supervisory staff must review with the recipient or PCR the following:

a. Advanced Directive, including the right to make decisions about health care, and the right to execute a living will or grant power of attorney to another individual.

Refer to MSM Chapter 100 for further information.

b. The agency's program philosophy and policies including:

1. Hiring and training of PCA staff;

2. Agency responsibilities;

3. Providing recipient assistance;

4. Complaint procedure and resolution protocols;

5. Procedure to be followed if a PCA does not appear at a scheduled visit or when an additional visit is required;

6. Information about flexibility of authorized hours in order to meet recipient needs;

7. Non-covered services under PCS;

8. The requirement that each approved service plan must also be reviewed with the PCA;

9. The procedures and forms used to verify PCA provision of services.

10. EVV requirements and recipient participation.

c. The recipient's approved service plan or any changes in the service plan, including the following:

1. Authorized weekly service hours;

2. PCA's schedule;

3. PCA's assigned tasks and pertinent care provided by informal supports;

4. The recipient's back-up plan.

13. PCS Not Permitted

The Provider is responsible to ensure that all PCAs work within their scope of service and conduct themselves in a professional manner at all times.

The following are some of the activities that are not within the scope of PCS and are not permitted. This is not an all-inclusive list.

a. Skilled Care Services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State, are not permitted to be provided by employees of a PCS Agency. PCS services must never be confused with services of a higher level that must be performed by persons with professional training and credentials.

b. Increasing and/or decreasing time authorized on the approved service plan;

c. Accepting or carrying keys to the recipient's home;

d. Purchasing alcoholic beverages for use by the recipient or others in the home unless prescribed by the recipient's physician;

e. Making personal long-distance telephone calls from the recipient's home;

f. Performing tasks not identified on the approved service plan;

g. Providing services that maintain an entire household;

h. Loaning, borrowing or accepting gifts of money or personal items from the recipient;

i. Accepting or retaining money or gratuities for any reason other than that needed for the purchase of groceries or medications for the recipient;

j. Care of pets except in the case where the animal is a certified service animal.

14. Supervision

A supervisor (or other designated agency representative) must review with the PCA the recipient's approved service plan. This must be done each time a new service plan is approved. Documentation of the approved service plan's review must be maintained in the recipient's record.

The supervisor (or other designated agency representative) must clarify with the PCA the following:

a. The needs of the recipient and tasks to be provided;

b. Any recipient specific procedures including those which may require on-site orientation;

c. Essential observation of the recipient's health;

d. Situations in which the PCA should notify the supervisor.

e. EVV requirements and expectations, including the documentation of all personal care services in an approved EVV system.

The supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA. The provider will only be paid for the hours and tasks which are provided according to the approved service plan and are documented on the service delivery records.

15. Complaint Procedure

The Provider must investigate and respond in writing to all complaints in a reasonable and prompt manner. The Provider must maintain records that identify the complaint, the date received, the outcome of the investigation and the response(s) to the complaint.

16. Serious Occurrences

The Provider must report all serious occurrences involving the recipient, the PCA, or affecting the provider's ability to deliver services. The Nevada DHCFP Serious Occurrence Report must be completed within 24 hours of discovery and submitted to the local DHCFP District Office. If the recipient is on a Home and Community Based Waiver (HCBW), the notification shall be made directly to the HCBW case manager's Aging and Disability Services (ADSD) office.

one business day prior to the date services will be terminated. If the recipient is on an HCBW the notification should be made directly to the HCBW case manager's ADSD office.

The Provider must submit written notice, within five working days, advising the DHCFP District Office Care Coordination Unit or the waiver case manager of the effective date of the action of the termination of service, the basis for the action and intervention/resolution(s) attempted prior to terminating services.

The provider is not required to send a written notice if the recipient has chosen to terminate services.

19. Records

a. The provider must maintain medical and financial records, supporting documents and all other records relating to PCS provided. The provider must retain records for a period pursuant to the State record retention policy, which is currently six years from the date of payment for the specified service.

If any litigation, claim or audit is started before the expiration of the retention period provided by the DHCFP, records must be retained until all litigation, claims or audit findings have been finally determined.

1. The Provider must maintain all required records for each PCA employed by the agency, regardless of the length of employment.

2. The Provider must maintain the required record for each recipient who has been provided services, regardless of length of the service period.

~~b. At a minimum, the Provider must document the following on all service records:~~
~~1. Consistent service delivery within program requirements;~~

~~2. Amount of services provided to recipients;~~

~~3. When services were delivered;~~

~~4. Documentation attesting to the services provided, and the time spent providing the service signed or initialed by the PCA and the recipient or PCR.~~

~~c.~~b. The PCA's supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA. The provider will only

be paid for the hours and tasks authorized on the approved service plan, which are clearly documented as being provided on the service delivery records.

20. Health Insurance Portability and Accountability Act (HIPAA), Privacy and Confidentiality

Information on HIPAA, privacy and confidentiality of recipient records and other protected health information is found in MSM Chapter 100.

21. Discontinuation of Provider Agreement

a. In the event that a Provider decides to discontinue providing PCS to any of their service areas, the Provider shall:

1. Provide all current Medicaid recipients with written notice at least 30 calendar days in advance of service discontinuation advising the recipient will need to transfer to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS Providers must be obtained from the QIO-like vendor and included with the notification;

2. Provide the DHCFP with a copy of the written notice of intent to discontinue services, including a list of the affected recipients, at least 30 calendar days in advance of service discontinuation;

3. Continue to provide services through the notice period or until all recipients are receiving services through another Provider, whichever occurs sooner.

b. In the event that the DHCFP discontinues the contractual relationship with a Provider, for any reason, the Provider shall:

1. Within five calendar days of receipt of the DHCFP notification to terminate the contractual relationship, send written notification to all their current Medicaid recipients advising the recipient will need to transfer services to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS providers must be obtained from the QIO-like vendor and be included in this notification.

2. Provide reasonable assistance to recipients in transferring services to another provider.

Providers who fail to satisfactorily meet the requirements discussed above shall be prohibited from participation in a new application for any other PCS provider agreement for a period of not less than one year.

3503.1~~J~~I RECIPIENT RESPONSIBILITIES AND RIGHTS

1. Recipient Responsibilities

The recipient must be able to make choices about ADLs, understand the impact of these choices and assume responsibility for the choices. If this is not possible, the recipient must have a PCR willing to assist the recipient in making choices related to the delivery of PCS.

If the recipient utilizes a PCR, the recipient and the PCR must understand that the provision of services is based upon mutual responsibilities between the PCR and the PCS Provider.

The recipient or PCR is responsible for reviewing and signing all required documentation related to the PCS. The recipient or PCR will:

a. Notify the provider of changes in Medicaid or NCU eligibility;

b. Notify the provider of current insurance information, including the carrier of other insurance coverage, such as Medicare;

c. Notify the provider of changes in medical status, service needs, address and location or in changes of status of LRI(s) or PCR;

d. Treat all staff appropriately;

e. ~~Verify services were provided by, whenever possible, signing or initialing the PCA documentation of the exact date and time the PCA was in attendance and providing services;~~Agree to utilize an approved EVV system for the Medicaid services being received from the Provider Agency.

f. Confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

~~f.~~g. Notify the Provider when scheduled visits cannot be kept or services are no longer required;

~~g.~~h. Notify the Provider of missed visits by provider staff;

~~h.~~i. Notify the Provider of unusual occurrences or complaints;

~~i.~~j. Give the Provider a copy of an Advance Directive, if appropriate;

~~j.~~k. Establish a backup plan in case a PCA is unable to provide services at the scheduled time;

~~k.~~l. Not request a PCA to work more than the hours authorized on the approved service plan;

~~l.~~m. Not request a PCA to work or clean for non-recipients;

~~m.~~n. Not request a PCA to provide services not on the approved service plan.

2. Recipient Rights

Every Medicaid and NCU recipient receiving PCS, or their PCR, has the right to:

a. Receive considerate and respectful care that recognizes the inherent worth and dignity of each individual;

b. Participate in the assessment process and receive an explanation of authorized services;

c. Receive a copy of the approved service plan;

d. Contact the local DHCFP District Office with questions, complaints or for additional information;

e. Receive assurance that privacy and confidentiality about one's health, social, domestic and financial circumstances will be maintained pursuant to applicable statutes and regulations;

f. Know that all communications and records will be treated confidentially;

g. Expect all providers, within the limits set by the approved service plan and within program criteria, to respond in good faith to the recipient's reasonable requests for assistance;

h. Receive information upon request regarding the DHCFP's policies and procedures, including information on charges, reimbursements, FASP determinations and the opportunity for a fair hearing;

i. Request a change of provider;

j. Request a change in service delivery method from the Provider Agency model to the Self-Directed model through an Intermediary Service Organization (ISO);

2. The PCS required are an integral part of the visit. Covered personal care tasks would include undressing/dressing, toileting, transferring/positioning, ambulation and eating. For example, transferring a recipient on and off an examination table is an integral part of a physician visit.

3. An LRI is unavailable or incapable of providing the personal care task en route to or during the appointment.

4. Staff at the site of the visit (surgery center, physician's office, clinic setting, outpatient therapy site or other Medicaid reimbursable setting) is unable to assist with the needed personal care task.

3503.5B AUTHORIZATION PROCESS

1. The provider must contact the QIO-like vendor, the ADSD or Waiver for Persons with Physical Disabilities DHCFP case manager, as appropriate, for prior authorization for escort services.

2. Service should be requested as a single service authorization request. The provider must document the medical necessity of the services.

3. A new FASP is not required in this situation.

3503.5C PROVIDER RESPONSIBILITY

1. The provider must verify that all conditions above are met when asking for an escort services authorization.

2. The provider must include all the above information when submitting the prior authorization request, including the date of service and the amount of time requested. The provider must comply with all other policies in Section 3503.1E.

3. All services must be documented and verified in an approved EVV system.

3503.6 TRANSPORTATION

Transportation of the recipient in a provider's vehicle, the PCA's private vehicle or any other vehicle is not a covered service and is not reimbursable by the DHCFP. Recipients who choose to be transported by the PCA do so at their own risk.

Refer to MSM Chapter 1900, Transportation Services, for requirements of the DHCFP medical transportation program. Nevada Medicaid provides necessary and essential medical transportation to and from medical providers.