MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 26, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, RECIPIENT HIPAA PRIVACY & CIVIL RIGHTS OFFICER

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2200 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR THE FRAIL ELDERLY

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2200 – are being proposed to bring this chapter in line with the current waiver renewal which was approved on July 1, 2020.

Changes to this chapter include: updating the term "Home and Community-Based Waiver" (HCBW) to "Home and Community-Based Services" (HCBS) throughout the chapter to adhere to CMS guidance; changing the form referred as "NMO-2734" to "Waiver Eligibility Status Form" throughout the chapter; expanding the term "goals" to "personalized goals" throughout the chapter (as applicable); updated the term 'working day' to 'business day' throughout the chapter; updated the term "authorized representative" to designated representative," deleted the term "QIO-like vendor" throughout the chapter and identified the vendor as "fiscal agent" where applicable; added the term Legally Responsible Individual (LRI) throughout the chapter; and corrected the term from 'Waiver Unit' to 'LTSS Unit' throughout the chapter; deleting the term "program" from "waiver program" and replaced with waiver for clarity; added the titles to the Statues and Regulations throughout the chapter.

The policy was revised under Intake, Referral Prescreening process, Placement on the Waitlist and Waiver slot Allocation as the process has been updated and streamlined. Policy was revised in Suspended Waiver Services and reorganized.

The Assisted Living Waiver expired 6/30/14 and was combined with the Frail Elderly (FE) Waiver effective 7/1/2014. Some of the policy from the Assisted Living Waiver Chapter was added to the FE Waiver. Some sections within the FE Waiver were moved to organize the content, and to improve and clarify policies throughout the chapter.

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: None.

Financial Impact on Local Government: Unknown at this time.

These changes are effective January 27, 2021.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL OL CHAPTER 2200 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR THE FRAIL ELDERLY	MTL 31/10, 38/11, 18/19, 22/12, 23/11 CHAPTER 2200 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR THE FRAIL ELDERLY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2200	**Introduction**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. The second paragraph was deleted and replaced with a reworded version that better reflects an overview of the waiver. Several sentences were moved from sections 2201 and modified for clarity.
2201	**Authority**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Added the acronym for the Social Security Act – SSA. Updated the CFR to the appropriate citation style. Added "Section 3715 of the Care's Act, removed CFR 418; 431; 440; 441; 489; State Medicaid Manual Section 4440; Nevada's Home and Community Based Waiver for the Frail Elderly Control Number; and H.R. 6042 115th Congress.
2203.1	**Waiver Eligibility Criteria**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. This section was moved from 2203.2 to 2203.1. The language in this section was reworded for clarity. Added details of existing waiver eligibility requirements: must meet DWSS eligibility; additional requirements for Residential Group Homes for Seniors and Assisted Living Facility; added NAC 449 citation.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		The DHCFP approval and intake requirements have been removed as well as Administrative Case Management Activities.
2203.1A	**Coverage and Limitations**	This section was moved from 2203.2A to 2203.1A. Added clarifications regarding providing and reimbursement of services provided outside eligibility period; clarification in case the recipient is eligible for more than one waiver; criteria for participants in a hospice program; CARES Act guidelines. Deleted a sentence related to Wait List Priority, no policy was changed with the deletion. Clarification regarding changes of placement on the waitlist based on changes in condition/circumstances.
2203.1B	**Provider Responsibilities**	A portion of this section was moved from 2203.1B to 2203.11B.
2203.1C	**Recipients Responsibilities**	A portion of this section was moved from 2203.1C to 2203.11C.
2203.2	**Waiver Services**	This section was moved from 2203.3 to 2203.2.
2203.2A	**Coverage and Limitations**	This section was moved from 2203.3A to 2203.2A. Added language to clarify “remain in the community”.
2203.2B	**Provider Responsibilities**	This section was moved from 2203.3B to 2203.2B. Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Sections have been reworded for clarity. Added Waivers for Adults in a facility based assisted living Provider Type (PT 59); clarified all providers must meet federal, state and local statutes, rules and regulations; added the right to terminate provider contracts for failure to comply with any or all stipulations; providers are responsible for claims submitted; clarified providers capacity and guidelines to provide services; The section regarding Criminal Background checks was updated and portion removed as it is outlined in MSM 100 and is duplicative.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Created new section #3 titled "Recipient Records"; removed paragraphs one to four; added PERS; deleted "Services for waiver recipients residing in a residential; expanded on the requirements of record keeping for the provider's documentation on claims, employees and recipients' files. Added 21st Century Cures Act. Updated NRS # from 449.037 to NRS # 449.0302, original NRS # has been changed, and added the title to the regulations listed within this section. Added information regarding the web based SOR Form available at the fiscal agent's website. Added 3 new reportable events under Incidents and Serious Occurrences. Deleted the "ADSD: in addition to" section an additional responsibilities remaining criteria regarding Criminal Background checks (this is duplicative, it is outlined in MSM 100). The Qualification and Training section added "abuse, neglect, and exploitation, including signs, symptoms, and prevention;" to subsection #5. Created sub-section under # 5: b. "Additional training requirements for Residential Group Homes for Seniors and Assisted Living Facilities" to list the training and qualifications applicable to residential facilities under this section.
2203.2C	**Recipients Responsibilities**	This section was moved from 2203.3 to 2203.2C. Terminology and acronyms were updated per the description provided in the Background and Explanation section above. The content was reorganized, and the language was updated/reworded for clarity. Added criteria of required environment for providers and staff. Added requirement to work with Case Manager and provider to create a back-up plan in case caregiver is unavailable to work. Added regarding annual face-to-face visit.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added guidelines if case management is the only service provided, monthly contact is required. Added recipient is not eligible for EPSDT. Early and Periodic Screening, Diagnostic and Treatment section 2203.2D was removed.
2203.3	**Case Management**	This section was renumbered from 2203.4 to 2203.3 and subsequent sections numbered accordingly. Renamed from "Direct Service Case Management" to "Case Management". The language was updated/reworded for clarity.
2203.3A	**Coverage and Limitations**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. The content was reorganized, and the language was updated/reworded for clarity. Added language to #5 requiring inquiries and narration of recipient's choice to continue waiver services. The last sentence was moved down to create #11 and language was expanded for clarity. Added to detail due diligence regarding ongoing contacts with recipients as outlined in the POC.
2203.3B	**Providers Responsibilities**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.3C	**Recipients Responsibilities**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.4	**Homemaker Services**	This section was renumbered from 2203.5 to 2203.4, and all subsequent sections renumbered accordingly. The first sentence of #2 was moved up from Coverage and Limitations, language was added for clarity.
2203.4A	**Coverage and Limitations**	The following language was added "at the recipient's home, or place of residence (community setting)" and removed "by agencies enrolled as a Medicaid provider."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.4B	**Provider Requirements**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.4C	**Recipients Responsibilities**	Expanded the acronym IVR, Interactive Voice Response.
2203.5	**Chore Services**	This section was renumbered from 2203.6 to 2203.5 and all subsequent sections renumbered accordingly. The beginning of #2 was moved up from 2203.5A Coverage and Limitations, language was added for clarity.
2203.5A	**Coverage and Limitations**	Minor deletions made for clarity and in accordance with the description provided in the Background and Explanation section above.
2203.5B	**Provider Responsibilities**	Replaced “Section” with “MSM.
2203.6	**Respite Care**	This section was renumbered from 2203.7 to 2203.6 and all subsequent sections renumbered accordingly. A portion was moved up from 2203.6A Coverage and Limitations, language was added to describe the services provided.
2203.6A	**Coverage and Limitations**	Language was added to clarify the period of services, the services are provided for the duration of the POC, and services must be prior authorized by ADSD.
2203.6B	**Provider Responsibilities**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Replaced “Section” with “MSM. Deleted “perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their private home;”.
2203.7	**Personal Emergency Response System**	This section was renumbered from 2203.8 to 2203.7 and all subsequent sections renumbered accordingly.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		The first item was moved up from 2203.7A Coverage and Limitations' Language was added to describe the services provided.
2203.7A	**Coverage and Limitations**	Added "The service component includes both, the installation of the device and monthly monitoring. Two separate authorizations are required for payment, the initial installation fee for the device and a monthly fee for ongoing monitoring; both are covered under the waiver."
2203.7B	**Provider Responsibilities**	Replaced "Section" with "MSM. Added monthly monitoring of the PERS device. Removed reference to Better Business Bureau as this is not a requirement for enrollment. Language was updated for clarity.
2203.7C	**Recipients Responsibilities**	This section was renumbered from 2203.9 to 2203.8 and all subsequent sections renumbered accordingly.
2203.8	**Adult Day Care Services**	A portion of #1 and all of #2 and #3 where moved up from 2203.8A Coverage and Limitations, language was added to describe the services provided.
2203.8A	**Coverage and Limitations**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Added language to clarify timeframe of service. Added "Meals must be served in a manner suitable for the recipient and prepared with regard for individual preferences. Special diets and nourishments must be provided as ordered by the client's physician." Deleted "Reference MSM Chapter 1900 for transportation policies."
2203.8B	**Adult Companion Services**	This section was renumbered from 2203.10 to 2203.9 and all subsequent sections renumbered accordingly. Item 1 was moved up from 2203.9A Coverage and Limitations. Language was added to describe the services provided.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.9A	**Coverage and Limitations**	Language was updated for clarity. Added "Reference MSM Chapter 1900 Transportation Services for transportation policies."
2203.9B	**Provider Responsibilities**	Replaced "Section" with "MSM. Language was added for clarity.
2203.10	**Augmented Personal Care**	This section was renumbered from 2203.11 to 2203.10 and all subsequent sections renumbered accordingly. Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.10A	**Coverage and Limitations**	Deletion of the first item listed due to duplication. Added language and details regarding the recipient's placement on the waiver based on the recipient needs. Service Level definitions clarified and added definition for new SL4 approved at the 2017 legislative session for recipients with critical behaviors. Added clarification on reassessment due to changes and the need for providers to keep daily log documentation. Expanded on the definition of personalized care as established by CMS's new HCBS waivers rule. Added language from the Assisted Living chapter regarding core principles for residential facilities providing personalized care.
2203.10B	**Provider Responsibilities**	Replaced "Section" with "MSM. Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Added language regarding the recipient's choice and satisfaction with services provided. Clarifying verbiage was added in accordance with CMS's new HCBS Waiver rules. Section regarding Recipient Records was added.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.10C	**Recipient Responsibilities**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.11	**Administrative Case Management Activities**	This was moved from original section 2203.1 to 2203.11. Subsequent sections (2203.1A Coverage and Limitations, 2203.1B Provider Responsibilities and 2203.1C Recipient Responsibilities) moved and renumbered accordingly. "Intake Procedures" was deleted.
2203.11A	**Coverage and Limitation**	Service activities updated for language clarity through section. Deleting repetitive wording. Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Added screening for LOC determination of level of services offered and development of the POC details.
2203.11B	**Provider Responsibilities**	Added "In addition to the provider responsibilities listed in MSM 2203.3B Case Manager: Language was streamlined for clarity.
2203.11C	**Recipient Responsibilities**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.12	**Intake Procedures**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2203.12A	**Coverage and Limitations**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Replaced 'intake worker' with "ADSD Intake Specialist" to identify the person that will contact the applicant. Updated the requirement for the initial contact for a new referral from 7 days to 15 working days per FE Waiver. Added information regarding time frame requirement to complete face-to- face assessment of 45days (previously 28 days and not included in FE chapter).

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Updated sub-section title from "No Waiver Slots Available" to "Placement on the Wait List"; the section was reworded for clarity. Added language to clarify applicant's placement on the waitlist while financial eligibility is determined and for a slot to become available. Updated sub-section title to "Waiver Slot Allocation". Added language to clarify that once a waiver slot becomes available a second face-to-face visit is required to complete the initial assessment. Added language regarding the procedure for the initial assessment process and requirements to complete the Comprehensive Social Health Assessment (CSHA), forms given to the applicant during assessment. Added time frame to indicate the CSHA is valid for 90 days for applicants on the waitlist. Updated the information the ADSD includes in the initial assessment packet and clarification of the approval/denial process between DHCFP and ADSD.
2203.13	**Annual Waiver Review**	This section was moved, now in section 2203.13.
2203.13A	**Coverage and Limitations**	This section was moved, now in section 2203.13A.
2203.13B	**Provider Responsibilities**	This section was moved, now in section 2203.13B. Updated verbiage to in accordance with Background and Explanation section above.
2203.15	**Provider Enrollment**	This section was moved, now in section 2203.12. Added PT numbers and location information of the enrollment checklist. Section title "2203.12A Coverage and Limitations" was deleted.
2203.16	**Billing Procedures**	This section was renumbered and is now 2203.16. Added link of the fiscal agent's website for Provider Billing Guide Manual information.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Deleted Coverage and Limitations and Provider Responsibilities sections, the information is duplicative of the Provider Billing Guide Manual.
2203.17	**Advance Directive**	This section was renumbered from 2203.15 to 2203.17. This section was moved, now in section 2203.16.
2204	**Hearings Requested Due to Adverse Actions**	The title of the section was updated from "Hearings" to "Hearings Requested Due to Adverse Actions". Added explanation of the hearings process due to adverse action taken on the waiver eligibility.
2204.1	**Suspended Waiver Services**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. The language was updated / reworded for clarity throughout section. Added new suspension reason due to an extended absence
2204.2	**Release from suspended waiver services**	The language was updated / reworded for clarity throughout section.
2204.3	**Denial of waiver application**	Language was updated/reworded for clarity throughout the section. Added note under letter 'm' to explain the Case Manager's responsibility to provide information on how to become a provider and assist as needed before terminating the recipient from waiver services.
2204.4	**Termination of waiver services**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Deleted the first reason as the DHCFP or the ADSD do not terminate waiver services for that reason. Added note under letter 'o' to explain the Case Manager's responsibility to provide information on how

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		to become a provider and assist as needed before terminating the recipient from waiver services. Deleted the "ADSD" on the paragraph at the end of the section, as the Case Manager can be private or from the ADSD. Reworded the last paragraph of this section for clarification that one DWSS receives notification of the recipient's death, the DWSS need to notify ADSD and DHCFP.
2204.5	**Reduction of waiver services**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.
2204.6	**Reauthorization within 90 days of waiver termination**	Introduction was moved from 2204.6A with updates to terminology, and acronyms were updated per the description provided in the Background and Explanation section above.
2204.6A	**Coverage and Limitations**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above. Clarified process for slot allocation for what to do with the slot when someone enters a nursing facility (NF) or hospital. The slot is held 90 days from the date on the notice termination.
2204.6B	**Provider Responsibilities**	This was reworded for clarity.
2204.6C	**Recipients Responsibilities**	This was reworded for clarity.
2205	**Appeals and Hearings**	Added language to clarify the need to inform the applicants and recipients of the opportunity to request a Fair Hearing.

2200 INTRODUCTION

The Home and Community-Based Services ~~Waiver~~ (HCB~~W~~S) Waiver for the Frail Elderly (FE Waiver) ~~Program~~ recognizes that many individuals at risk of being placed in hospitals or ~~n~~Nursing ~~f~~Facilities (NF) can be cared for in their homes and communities, preserving their independence and ties to family and friends at an average cost no higher than that of an institutional care.

~~The Division of Health Care Financing and Policy's (DHCFP) Waiver for the Frail Elderly originated in 1987. The provision of waiver services is based on the identified needs of the waiver recipient. Every biennium the service needs and the funded slot needs of the waiver program are reviewed by the Aging and Disability Services Division (ADSD) and by the DHCFP (also known as Nevada Medicaid) and presented to the Nevada State Legislature for approval. Nevada is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization. Nevada understands that people who are elderly are able to lead satisfying and productive lives when they are provided the needed services and supports to do so. The Division is committed to the goals of self-sufficiency and independence.~~

The FE Waiver is an optional service approved by the Centers for Medicare and Medicaid Services (CMS), which authorizes the Division of Health Care Financing and Policy (DHCFP) the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This waiver allows the provision of services based on the identified needs, and ~~This waiver~~ is designed to provide eligible Medicaid waiver recipients access to both state plan services as well as certain extended Medicaid covered services ~~unique to this waiver. The goal is to allow recipients to live in their own homes, or community settings, when appropriate.~~

Nevada acknowledges that people who are elderly are able to lead satisfying and productive lives when they are provided the needed services and supports to do so. The DHCFP is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization when appropriate.

2201 AUTHORITY

Section 1915(c) of the Social Security Act (SSA) permits states the option to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. ~~The DHCFP Home and Community-Based Waiver (HCBW) for the Frail Elderly is an optional service program approved by the Centers for Medicare and Medicaid Services (CMS). This waiver is designed to provide eligible Medicaid waiver recipients access to both state plan services as well as certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes, or community settings, when appropriate.~~

~~The DHCFP has the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This flexibility is predicated on administrative and legislative support, as well as federal approval.~~

Statutes and Regulations:

- ~~Social Security Act: 1915(c) (HCBW)~~
- ~~Social Security Act: 1916(e) (Cost Sharing – Patient Liability)~~
- ~~Social Security Act: 1902(w) (State Plan for Medical Assistance)~~
- ~~Omnibus Budget Reconciliation Act of 1987~~
- ~~Balanced Budget Act of 1997~~
- Social Security Act: 1915(c) (HCBW)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- ~~42 CFR Part 441, Subparts G and H (Home and Community-Based Services (HCBS): Waiver Requirements; HCBS Waivers for Individuals Age 65 or Older: Waiver Requirements)~~
- ~~42 CFR Part 418 (Hospice Care)~~
- ~~42 CFR Part 431, Subparts B and E (General Administrative Requirements; Fair Hearing for Applicants and Recipients)~~

- ~~42 CFR Part 440 (Services: General Provisions)~~

- ~~42 CFR Part 489, Subpart I (Advanced Directives)~~
- ~~State Medicaid Manual, Section 4440 (HCBW, Basis, Scope and Purpose)~~

- ~~Nevada's Home and Community Based Waiver for the Frail Elderly Control Number~~

- Nevada Revised Statutes (NRS) Chapters 200 (Crimes Against the Person), 426 (Persons with Disabilities), 427A (Services to Aging Persons and Persons with Disabilities), 422 (Health Care Financing and Policy), 449 (Medical and Other Related Facilities), 616 (Industrial Insurance), 629 (Healing and Arts Generally)

- Nevada Administrative Code (NAC) Chapters 427A (Services to Aging Persons), 441A (Communicable Diseases), 449 (Medical and Other Related Facilities)

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

- Section 3715 of the Care's Act
- ~~H.R. 6042 – 115th Congress~~

2202 RESERVED

2203 POLICY

2203.1 WAIVER ELIGIBILITY CRITERIA

The DHCFP's Home and Community-Based ~~Waiver~~Services (HCB~~W~~S) for the Frail Elderly waives certain statutory requirements and offers waiver services to eligible recipients to assist them to remain in their own homes or community.

Eligibility for Medicaid's HCB~~W~~S ~~for the Frail Elderly~~ Waiver is determined by the ~~DHCFP~~, Aging and Disability Services Division (ADSD) and the Division of Welfare and Supportive Services (DWSS). These ~~three~~ State agencies collaboratively determine eligibility for the ~~Frail Elderly~~ Waiver as follows:

1. Waiver benefit plan eligibility is determined by ADSD ~~and authorized by the DHCFP Central Office Waiver Unit~~ by confirming the following criteria:

   a. Applicants must be 65 years of age or older;

   b. Each applicant/recipient must meet and maintain a ~~l~~Level of ~~c~~Care (LOC) for admission into a ~~nursing facility~~NF and would require imminent placement in a ~~nursing facility~~NF (within 30 days or less) if HCB~~W~~S services or other supports were not available;

   c. Each applicant/recipient must demonstrate a continued need for the services offered under the ~~HCBW for the Frail Elderly~~FE Waiver to prevent placement in a ~~nursing facility~~NF or hospital. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver;

   d. The applicant/recipient must require the provision of one waiver service at least monthly;

   e. The applicant/recipient must have an adequate support system. This support system must be in place to ensure the physical, environmental and basic care needs of the applicant/recipient are met in order to provide a safe environment during the hours when home and community-based services are not being provided; and

   ~~a.~~f. Applicants may be placed from a ~~nursing facility~~NF, an acute care facility, another HCB~~W~~S program, or the community.

2. Applicant must meet institutional income and resource guidelines for Medicaid as determined by Division of Welfare and Supportive Services (DWSS).

3. Additional requirements for Residential ~~facility for g~~Groups ~~Homes~~ for Seniors and Assisted Living Facility:

~~In addition to the requirements listed above:~~

a. Applicant/recipient must meet the criteria for placement in a Category 1 or 2 Residential Facility ~~for Groups~~ as defined by NAC 449.1591 and 449.1595.

b. ~~or~~ Residential Group Homes for Seniors and Assisted Living Facility must have the appropriate endorsement for the admission from Health Care Quality and Compliance (HCQC).

~~ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES~~

~~Administrative case management activities are performed by Aging and Disability Services Division (ADSD) case managers and refer to data collection for eligibility verification, Level of Care (LOC) evaluation, Plan of Care (POC) development, and other case management activities that are not identified on the POC.~~

2203.1A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care (provided in a hospital or ~~nursing facility~~NF) within 30 days or less.

2. Recipients on this waiver must meet and maintain Medicaid's eligibility requirements for the waiver. Recipients must be waiver eligible for each month in which waiver services are provided.

3. Services shall not be provided and will not be reimbursed until the applicant/recipient is found eligible for waiver services and must be prior authorized.

4. If an applicant is determined eligible for more than one HCBS Waiver, the individual cannot receive services under two or more such programs at the same time. The applicant must choose one HCBS Waiver and receive services provided by that program.

5. Recipients of the HCBS Waiver who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close coordination between the hospice agency and the waiver case manager

is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.

6. Waiver services may not be provided while a recipient is an inpatient of an institution. Section 3715 of the CARES Act may be utilized where HCBS can be provided in an acute care hospital setting as long as those services are:

   a. identified in an individual's person-centered service plan (or comparable Plan of Care (POC);

   b. provided to meet needs of the individual that are not met through the provision of hospital services;

   c. not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

   d. designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

7. The ~~HCBW for the Frail Elderly~~Waiver is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When ~~all~~no waiver slots are ~~full~~available, the ADSD utilizes a wait list to prioritize applicants who have been presumed to be eligible for the waiver.

   Wait List Priority:~~When funding becomes available, the applicant will be processed for the program based on LOC score, risk factors, and date of referral. Applicants will be considered for a higher advancement on the Wait List based on whether they meet additional criteria. The following criteria may be utilized:~~

   a. Applicants currently in an acute care or ~~nursing facility~~NF and desiring discharge;

   b. Applicants who require maximum assistance and/or are dependent in all three areas of eating, bathing, and toileting~~with the highest LOC score indicating greatest functional deficits~~;

   ~~a.~~c. Applicants requiring services due to a crisis or emergency such as a significant change in support system;

   d. Applicants transitioning from another waiver;

e. Applicants with a terminal illness; or

f. Applicants ~~requiring at least minimal essential personal care assistance (bathing, toileting and eating) as defined by NRS 426.723.~~who do not meet the criteria for priority levels 1-5

Applicants may be considered for an adjusted placement on the wait list based on significant change of condition/circumstances.

~~Waiver services may not be provided while a recipient is an inpatient of an institution.~~

~~Administrative case management activities include:~~

~~1. Intake referral;~~

~~2.~~1. ~~Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance to the Aged, Blind and Disabled (MAABD) application and obtaining documents required for eligibility determination;~~

~~3.~~1. ~~Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility:~~

~~a. The POC identifies the waiver services as well as other ongoing community support services that the recipient needs in order to live successfully in the community. The POC must reflect the recipient's service needs and include both waiver and non-waiver services in place at the time of POC completion, along with informal supports that are necessary to address those needs.~~

~~b.~~a. ~~The recipient's level of care, functional status and needs addressed by the POC must be reassessed annually or more often as needed. The recipient must also be reassessed when there is a significant change in his/her condition which influences eligibility. The reassessment is to be conducted during a face-to-face visit.~~

~~c.~~a. ~~If services documented on a POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible.~~

~~4.1. Issuance of Notices of Actions (NOA) to the Division of Health Care Financing and Policy (DHCFP) Central Office Waiver Unit staff to issue a Notice of Decision (NOD) when a waiver application is denied;~~

~~5.1. Coordination of care and services to collaborate in discharge planning to transition applicants from facilities;~~

~~6.1. Documentation for case files prior to applicant's eligibility;~~

~~7.1. Case closure activities upon termination of service eligibility;~~

~~8.1. Outreach activities to educate recipients or potential recipients on how to enter into care through a Medicaid Program;~~

~~9.1. Communication of the POC to all affected providers;~~

~~10.~~1. ~~Ensure completion of prior authorization form, if required, for all waiver services documented on the POC for submission into the Medicaid Management Information System (MMIS).~~

2203.~~2~~1B PROVIDER RESPONSIBILITIES

~~2203.1B PROVIDER RESPONSIBILITIES~~

Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering waiver services.

~~1. Administrative case management providers (social workers, nurses, certified case managers, etc.) must be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers or as a Registered Nurse by the Nevada State Board of Nursing.~~

~~2.1. Must have a valid driver's license and the ability to conduct home visits.~~

~~3.1. Must adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements.~~

~~4.1. Must have a Federal Bureau of Investigation (FBI) criminal history background check.~~

2203.1C RECIPIENT RESPONSIBILITIES

~~2203.1C RECIPIENT RESPONSIBILITIES~~

Applicants/recipients must meet and maintain all eligibility criteria to become eligible and to remain on the HCBW for the Frail Elderly.

~~1. Applicant/recipients and/or their authorized representative must cooperate with the ADSD by assisting with the assessment and reassessment process, accurately representing skill level needs, wants, resources and goals.~~

~~2.1. Applicants/recipients together with the case manager must develop and/or review the POC.~~

~~2203.3~~2203.2 WAIVER SERVICES

The DHCFP determines which services will be offered under the HCB~~W~~S ~~for the Frail Elderly~~Waiver. Providers and recipients must agree to comply with all ~~program~~waiver requirements for service provision

2203.~~3~~2A COVERAGE AND LIMITATIONS

Under this waiver, the following services are covered if identified in the POC as necessary to remain in the community and to avoid institutionalization.

1. ~~Direct Service~~ Case Management.
2. Homemaker Services.
3. Chore Services.
4. Respite Care Services.
5. Personal Emergency Response System (PERS).
6. Adult Day Care Services.
7. Adult Companion Services.
8. Augmented Personal Care (provided in a residential facility for groups).

~~WAIVER ELIGIBILITY CRITERIA~~

~~The DHCFP's Home and Community-Based Waiver (HCBW) for the Frail Elderly waives certain statutory requirements and offers waiver services to eligible recipients to assist them to remain in their own homes or community.~~

2203.~~3~~2B PROVIDER RESPONSIBILITIES

1. All Service Providers:

a. Must obtain and maintain a ~~HCBW for the Frail Elderly~~ provider number (Provider Type 48, ~~or~~ 57 or 59 as appropriate) through the DHCFP's Fiscal Agent~~QIO-like vendor~~.

b. All providers must meet all federal, state, and local statutes, rules and regulations relating to the services being provided.

c. In addition to this Chapter, the provider must also comply with rules and regulations for providers as set forth in the MSM Chapter 100~~.~~ Medicaid Program. Failure to comply with any or all these stipulations may result in the DHCFP's decision to exercise its right to terminate the provider's contract.

d. Must understand the authorized service specification on the POC, record keeping responsibilities and billing procedures for provided waiver services.

e. Be responsible for any claims submitted or payment received on the recipient's behalf; such claims should be made under penalties of perjury. Any false claims, statement or documents, or concealment of material facts may be prosecuted under applicable federal or state laws.

f. Must understand that payment for services will be based on the level of service or specific tasks identified on the POC and will not be made to legally responsible individuals for furnishing waiver services.

g. All providers may only provide services that have been identified in the POC and that, if required, have a ~~p~~Prior ~~a~~Authorization (PA).

~~a.~~h. Providers must verify the Medicaid eligibility status of each FE Waiver ~~HCBW for Frail Elderly~~ recipient each month.

i. Providers must be able to: perform the duties of the job; demonstrate maturity of attitude toward work assignments; communicate effectively; work under intermittent supervision; deal with minor emergencies arising in connection with the assignment and act accordingly, reporting these to the proper supervisor;

demonstrate ability to understand, respect and maintain confidentiality in regards to the details of case circumstances.

2. Criminal Background Checks

The DHCFP policy requires ~~A~~all waiver providers and it's ~~agency~~ personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and FBI background checks upon licensure and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred (ADSD personnel must follow State of Nevada policy regarding required background checks) and the safety of recipients is not compromised. For complete instructions, refer to the Division of Public and Behavioral Health DPBH) website at dpbh.nv.gov.~~:~~

~~The DHCFP policy requires all waiver providers have State and Federal criminal history background checks completed.~~ The DHCFP's fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100 – Medicaid Program~~, Section 102.2~~.

~~2203.2A COVERAGE AND LIMITATIONS~~

~~7. Services are offered to eligible recipients who, without the waiver services, would require institutional care (provided in a hospital or nursing facility) within 30 days or less. Recipients on this waiver must meet and maintain Medicaid's eligibility requirements for the waiver.~~

~~8.~~7. ~~The HCBW for the Frail Elderly is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are full, the ADSD utilizes a wait list to prioritize applicants who have been presumed to be eligible for the waiver.~~

~~9.~~7. ~~When funding becomes available, the applicant will be processed for the program based on LOC score, risk factors, and date of referral. Applicants will be considered for a higher advancement on the Wait List based on whether they meet additional criteria. The following criteria may be utilized:~~

~~b.~~a. ~~Applicants currently in an acute care or nursing facility and desiring discharge;~~

~~c.~~a. ~~Applicants with the highest LOC score indicating greatest functional deficits;~~

~~d.a. Applicants requiring services due to a crisis or emergency such as a significant change in support system;~~

~~e.a. Applicants transitioning from another waiver;~~

~~f.a. Applicants with a terminal illness; or~~

~~g.a. Applicants requiring at least minimal essential personal care assistance (bathing, toileting and eating) as defined by NRS 426.723.~~

~~10.7. Waiver services may not be provided while a recipient is an inpatient of an institution.~~

~~11. HCBW for the Frail Elderly Eligibility Criteria:~~

~~a. Eligibility for Medicaid's HCBW for the Frail Elderly is determined by the DHCFP, ADSD and the Division of Welfare and Supportive Services (DWSS). These three State agencies collaboratively determine eligibility for the Frail Elderly Waiver as follows:~~

~~1. Waiver benefit plan eligibility is determined by ADSD and authorized by the DHCFP Central Office Waiver Unit by confirming the following criteria:~~

~~b.a. Applicants must be 65 years of age or older;~~

~~c.a. Each applicant/recipient must meet and maintain a level of care for admission into a nursing facility and would require imminent placement in a nursing facility (within 30 days or less) if HCBW services or other supports were not available;~~

~~d.a. Each applicant/recipient must demonstrate a continued need for the services offered under the HCBW for the Frail Elderly to prevent placement in a nursing facility or hospital. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver;~~

~~e.a. The applicant/recipient must require the provision of one waiver service at least monthly;~~

~~f.a. The applicant/recipient must have an adequate support system. This support system must be in place to ensure the physical, environmental and basic care needs of the applicant/recipient are met in order to provide a safe environment during the hours when home and community-based services are not being provided; and~~

~~g.a. Applicants may be placed from a nursing facility, an acute care facility, another HCBW program, or the community.~~

~~h.a. Residential facility for groups:~~

~~In addition to the requirements listed above:~~

~~a. Applicant/recipient must meet the criteria for placement in a Category 1 or 2 Residential Facility for Groups or have the appropriate endorsement for the admission from Health Care Quality and Compliance (HCQC).~~

3. Recipient Records

a. The number of hours specified on each recipient's POC, for each specific service listed ~~(~~except Case Management~~),~~ and PERS, will be considered the maximum number of hours allowed to be provided by the caregiver and paid by the DHCFP's ~~QIO-like vendor~~fiscal agent, unless the case manager has approved additional hours due to a temporary condition or circumstance.

b. Cooperate with ADSD and/or State or Federal reviews or inspections of the records.

c. Provider agencies who are providing waiver services in the home must comply with the 21st Century Cures Act. Refer to Section 2203.14 of this chapter for detailed instructions.

4. Serious Occurrence Report (SOR):

Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the ADSD ~~case manager by telephone/fax~~ within 24-hours of discovery. Providers must complete the web-based Nevada DHCFP SOR Form, available at the fiscal agent's website at www.medicaid.nv.gov, under Providers Forms. A completed SOR form report must be made within five business working days and maintained in the agency's recipient record.

Serious occurrences involving either the provider/employee or recipient may include, but are not limited to the following:

a. Suspected physical or verbal abuse;

b. Unplanned hospitalization;

c. Abuse, ~~N~~neglect, exploitation, ~~or~~ isolation, abandonment, or unexpected death of the recipient;

d. Theft;

e. Sexual harassment or sexual abuse;

f. Injuries requiring medical intervention;

g. An unsafe working environment;

h. Any event which is reported to ~~Elder~~Adult Protective Services (ages 18 years old and above) or law enforcement agencies;

i. Death of the recipient during the provision of waiver services; or

j. Loss of contact with the recipient for three consecutive scheduled days.

k. Medication errors resulting in injury, hospitalization, medical treatment or death.

l. Elopement of a recipient residing in a Residential Group Homes for Seniors or Assisted Living Facility.

The State of Nevada has established mandatory reporting requirements of suspected incidents of Elder Abuse, Neglect, Isolation Abandonment, and Exploitation. The ADSD and local law enforcement are the receivers of such reports. Suspected elder abuse must be reported as soon as possible, but no later than 24 hours after the person knows or has reasonable cause to believe that an elder person has been abused, neglected, isolated, abandoned or exploited. ~~of identification/suspicion.~~ Refer to NRS 200.5091 to 200.50995 "Abuse, neglect, exploitation, isolation, abandonment, or isolation of older and vulnerable persons."~~regarding elder abuse or neglect.~~

5. Adhere to HIPAA requirements.

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records, and other protected health information.

6. Obtain and maintain a business license as required by city, county, or state government, if applicable.

~~6.~~7. Providers for ~~r~~Residential ~~facility for g~~Groups~~s~~ Homes for Seniors and Assisted Living Facility must obtain and maintain required HCQC licensure.

8. Qualification and Training:

a. All service providers must arrange training for employees who have direct contact with recipients of the ~~HCBW programs~~FE Waiver and must have service specific training prior to performing a waiver service. Training at a minimum must include, but not limited to:

1. policies, procedures, and expectations of the agency relevant to the provider, including recipient's and provider's rights and responsibilities;

2. procedures for billing and payment;

3. record keeping and reporting including daily records and SORs;

4. information about the specific needs and goals of the recipients to be served; and

5. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding care goals; respecting recipient rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; abuse, neglect, and exploitation, including signs, symptoms, and prevention; respecting personal property; ethics in dealing with the recipient, family and other providers; handling conflict and complaints; and other topics as relevant.

b. Additional training requirements for Residential ~~facility for g~~Groups~~s~~ Homes for Seniors and Assisted Living Facilities:

In addition to the requirements listed above under section 2203.2B.8a:

1. Caregivers of a residential facility for groups must be at least 18 years of age; be responsible and mature and have the personal qualities which will enable him or her to understand the problems of the aged and disabled; demonstrate the ability to read, write, speak and understand the English language; must possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility and annually receive no less than eight hours of training related to providing for the needs of the residents of a residential facility for groups as outlined in the NAC 449.3975 "Attendants, Qualifications; annual training"; must be knowledgeable in the use of any prosthetic devices or dental, vision or hearing aids that the residents use and must understand the provisions of NAC 449.156 to NAC 449.27706, "Residential Facilities for Groups" inclusive, and Sections 2 and 3 of the regulation, and sign a statement that he/she has read those provisions as outlined in NAC 449.196 "Qualifications and training of caregivers.

2. If a caregiver assists a resident of a ~~r~~Residential ~~facility for g~~Groups~~s~~ Home for Seniors and Assisted Living Facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of Subsection 6 of NRS 449.03~~7~~2 "Medical and other Related Facilities,"~~,~~ which must include, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than four hours of practical training, and obtain a certificate acknowledging the completion of such training; receive annually at least eight hours of training in the management of medication and provide the ~~r~~Residential Group Homes for Seniors~~facility for groups~~ and Assisted Living Facility with satisfactory evidence of the content of the training and his or her attendance at the training; complete the training program developed by the administrator of the ~~r~~Residential Group Homes for Seniors~~facility for groups~~ and Assisted Living Facility pursuant to paragraph (e) of Subsection 1 of NAC 449.2742 "Administration of Medication: Responsibilities of administrator, caregivers and employees of facility"; and annually pass an examination related to the management of medication approved by the HCQC as outlined in NAC 449.196 "Qualifications and trainings of caregivers"..

3. Within 30 calendar days after a caregiver is employed at the Residential Group Homes for Seniors and Assisted Living facility, a caregiver ~~he/she~~

must be trained in First Aid and Cardiopulmonary Resuscitation (CPR) as described in NAC 449.231 "First Aid and Cardiopulmonary resuscitation" and be able to recognize and appropriately respond to medical and safety emergencies.

4. Caregivers staff providing direct care and support to residents must have training specific to the waiver population being cared for at the ~~f~~Residential ~~facility for g~~Groups~~s~~ Homes for Seniors and Assisted Living Facility, including the skills needed to care for recipients with increasing functional, cognitive and behavioral needs. Training will include, but not limited to, techniques such as transfers, mobility, positioning, use of special equipment, identification of signs of distress, First Aid and CPR.

   Must have a separate file for each employee. Records of all employee's training required health certificates, first aid and CPR certifications and documents which are evidence that the employee has been tested for tuberculosis must be in the file. Please refer to NAC 449.200 for additional requirements.

c. Exemptions from Training for Provider Agencies:

1. The provider agency may exempt a prospective service provider from those parts of the required training where the agency judges the person to possess adequate knowledge or experience, or where the provider's duties will not require the particular skills.

2. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the employee's file.

3. ADSD/DHCFP may review exemptions for appropriateness.

~~b. Waiver applications must be approved by the DHCFP Central Office Waiver Unit to ensure the level of care criteria is met.~~

~~c. DWSS validates the applicant is eligible for Medicaid waiver services using institutional income and resource guidelines.~~

~~a. Recipients of the HCBW for the Frail Elderly must be Medicaid eligible for full Medicaid benefits for each month in which waiver services are provided.~~

~~b. Services for the HCBW for the Frail Elderly shall not be provided and will not be reimbursed until the applicant is found eligible for benefit plan services, full Medicaid eligibility, and prior authorization as required.~~

~~c. Medicaid recipients in the HCBW for the Frail Elderly may have to pay for part of the cost of the waiver services. The amount they are required to pay is called patient liability.~~

~~d. If an applicant is determined eligible for more than one HCBW program, the individual cannot receive services under two or more such programs at the same time. The applicant must choose one HCBW program and receive services provided by that program.~~

~~e. Recipients of the HCBW for the Frail Elderly who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.~~

~~2203.2B PROVIDER RESPONSIBILITIES~~

~~1. Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering waiver services.~~

~~2.1. ELECTRONIC VISIT VERIFICATION (EVV):~~

~~The 21st Century Cures Act requires the use of an 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 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.~~

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

~~a. STATE OPTION:~~

~~1. The EVV system electronically captures:~~

~~a. The type of service performed, based on procedure code;~~

~~b. a. The individual receiving the service;~~

~~c. a. The date of the service;~~

~~d. a. The location where service is provided;~~

~~e. a. The individual providing the service;~~

~~f. a. The time the service begins and ends.~~

~~2.1. The EVV system must utilize one or more of the following:~~

~~a. The agency/personal care attendant's smartphone;~~

~~b.a. The agency/personal care attendant's tablet;~~

~~c.a. The recipient's landline telephone;~~

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

~~e.a. Other GPS-based device as approved by the DHCFP.~~

~~f.a. DATA AGGREGATOR OPTION:~~

~~1. All Personal Care 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.~~

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

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

2203.2C RECIPIENT RESPONSIBILITIES

The recipient or, if applicable, the recipient's designated~~authorized~~ representative/Legally Responsible Individual (LRI) will:

1. ~~n~~Notify the provider(s) and the ~~ADSD c~~Case ~~m~~Manager of any change in Medicaid eligibility;

2. ~~n~~Notify the provider(s) and the ~~ADSD c~~Case ~~m~~Manager of current insurance information, including the name of the insurance coverage, such as Medicare;

3. ~~n~~Notify the provider(s) and the ~~ADSD~~ ~~c~~Case ~~m~~Manager of changes in medical status, support systems, service needs, address or location changes, and/or any change in status of designated~~authorized or legal~~ representative/LRI;

4. ~~t~~Treat all providers and their staff members appropriately. Provide a safe, non-threatening and healthy environment for caregiver(s) and the Case Manager(s)~~;~~

5. ~~initial and s~~Sign the provider's daily/weekly record(s) to verify ~~that~~ services were provided (except for Case Management and PERS). If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the SOU and/or the case narrative~~POC~~;

6. ~~n~~Notify the provider or the ~~ADSD c~~Case ~~m~~Manager when scheduled visits cannot be kept or services are no longer required;

7. ~~n~~Notify the provider agency or the Case Manager ~~ADSD~~ of any missed appointments by the provider agency staff;

8. ~~n~~Notify the provider agency or the ~~ADSD c~~Case ~~m~~Manager of any unusual occurrences, complaints regarding delivery of services, specific staff or to request a change in caregiver or provider agency;

9. ~~f~~Furnish the provider agency with a copy of his or her Advance Directive;

10. Work with the Case Manager and/or provider agency to establish a back-up plan in case the caregiver is unable to work at the scheduled time;

11. Understand that a ~~not request any~~ provider may not perform services or ~~to~~ work more ~~than the~~ hours than authorized in the POC;

12. Understand that~~not request~~ a provider ~~to~~may not work or clean for a ~~non-~~recipient's, family ~~or~~ household members or other person(s) living in the home with the recipient;

13. Understand that at least one annual face-to-face visit is required;

14. Understand that if case management is the only HCBS Waiver service, a monthly contact with the Case Manager is required;

15. ~~n~~Not request a provider to perform services not included in the POC;

16. ~~c~~Contact the ~~c~~Case ~~m~~Manager to request a change of provider agency;

17. ~~c~~Complete, sign and submit all required forms on a timely basis; and

18. ~~b~~Be physically available for authorized waiver services, face-to-face~~quarterly home~~ visits, and assessments.

19. Recipients of this waiver are not eligible for EPSDT.

~~Applicants/recipients must meet and maintain~~ all eligibility criteria to become eligible and to ~~remain on the HCBW for the Frail Elderly.~~

~~2203.2D MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)~~

~~Recipients of this waiver are not eligible for EPSDT.~~

~~2203.3 WAIVER SERVICES~~

~~The DHCFP determines which services will be offered under the HCBW for the Frail Elderly. Providers and recipients must agree to comply with all program requirements for service provision~~.

~~2203.3A COVERAGE AND LIMITATIONS~~

~~Under this waiver, the following services are covered if identified in the POC as necessary to avoid institutionalization.~~

~~1. Direct Service Case Management.~~

~~2.1. Homemaker Services.~~

~~3.1. Chore Services.~~

~~4.1. Respite Care Services.~~

~~5.1. Personal Emergency Response System (PERS).~~

~~6.1. Adult Day Care Services.~~

~~7.1. Adult Companion Services.~~

~~8.1. Augmented Personal Care (provided in a residential facility for groups).~~

~~2203.3B PROVIDER RESPONSIBILITIES~~

~~1. All Service Providers:~~

~~a.6. Must obtain and maintain a HCBW for the Frail Elderly provider number (Provider Type 48 or 57 as appropriate) through the DHCFP's QIO-like vendor.~~

~~b.6. In addition to this Chapter, the provider must also comply with rules and regulations for providers as set forth in the MSM Chapter 100.~~

~~c.6. Must understand the authorized service specification on the POC, record keeping responsibilities and billing procedures for provided waiver services.~~

~~d.6. Must understand that payment for services will be based on the level of service or specific tasks identified on the POC and will not be made to legally responsible individuals for furnishing waiver services.~~

~~e.6. All providers may only provide services that have been identified in the POC and that, if required, have a prior authorization.~~

~~f.6. Providers must verify the Medicaid eligibility status of each HCBW for Frail Elderly recipient each month.~~

~~g.6. Criminal Background Checks~~

~~All agency personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and FBI background checks upon licensure and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred (ADSD personnel must follow State of Nevada policy regarding required background checks) and the safety of recipients is not compromised.~~

~~1.4. The DHCFP policy requires all waiver providers have State and Federal criminal history background checks completed. The DHCFP fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100, Section 102.2.~~

~~2. Criminal background checks must be conducted through the Nevada Department of Public Safety (DPS). Agencies do not have to have a DPS account. Individuals may request their own personal criminal history directly from DPS and the FBI and must have the results sent directly to the employer. Information and instructions may be found on the DPS website at: http://nvrepository.state.nv.us/criminal/forms/PersonalNevadaCriminalHistory.pdf.~~

~~3. The employer is responsible for reviewing the results of the employee criminal background checks and maintaining the results within the employee's personnel records. Continued employment is at the sole discretion of the servicing agency. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing~~

~~employment and have this documented in the employee's personnel file. These convictions include (not all inclusive):~~

~~a. murder, voluntary manslaughter or mayhem;~~

~~b. assault with intent to kill or to commit sexual assault or mayhem;~~

~~c. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexual related crime;~~

~~d. abuse or neglect of a child or contributory delinquency;~~

~~e. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in Chapter 454 of the NRS;~~

~~f. a violation of any provision of NRS 200.700 through 200.760;~~

~~g. criminal neglect of a patient as defined in NRS 200.495;~~

~~h. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;~~

~~i. any felony involving the use of a firearm or other deadly weapon;~~

~~j. abuse, neglect, exploitation or isolation of older persons;~~

~~k. kidnapping, false imprisonment or involuntary servitude;~~

~~l. any offense involving assault or battery, domestic or otherwise;~~

~~m. 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;~~

~~n. conduct or practice that is detrimental to the health or safety of the occupants or employees of the facility or agency; or~~

~~o. any other offense that may be inconsistent with the best interests of all recipients.~~

~~Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an "undecided" result is received. If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: http://dps.nv.gov under Records and Technology.~~

~~Providers must be able to: perform the duties of the job; demonstrate maturity of attitude toward work assignments; communicate effectively; work under intermittent supervision; deal with minor emergencies arising in connection with the assignment and act accordingly, reporting these to the proper supervisor; demonstrate ability to understand, respect and maintain confidentiality in regards to the details of case circumstances.~~

~~h. Each provider must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC. The documentation will include the recipient's initials daily with a full signature of the recipient on each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the POC. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. Providers may use electronic signatures on the daily record documentation but using an electronic signature does not remove the provider's responsibility for providing accurate and verifiable documentation indicating the scope and frequency of services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file or make available upon request.~~

~~Periodically, Medicaid Central Office/ADSD staff may request this documentation to compare it to submitted claims. These records must be maintained by the provider for at least six years after the date the claim is paid.~~

~~i. Must have a separate file for each employee. Records of all the employee's training, required health certificates, first aid and cardiopulmonary resuscitation certifications and documents which are evidence that the employee has been tested for tuberculosis must be in the file. Please refer to NAC 449.200 for additional requirements.~~

~~j.6. The number of hours specified on each recipient's POC, for each specific service listed (except Case Management), will be considered the maximum number of hours allowed to be provided by the caregiver and paid by the DHCFP's QIO-like vendor, unless the case manager has approved additional hours due to a temporary condition or circumstance.~~

~~k. Services for waiver recipients residing in a residential facility for groups should be provided as specified on the POC and at the appropriate authorized service level.~~

~~l. If fewer services are provided than what is authorized on the POC, the reason must be adequately documented in the daily record and communicated to the case manager.~~

~~m.6. Cooperate with ADSD and/or State or Federal reviews or inspections.~~

~~n.6. Serious Occurrence Report (SOR):~~

~~Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the ADSD case manager by telephone/fax within 24 hours of discovery. A completed SOR form report must be made within five working days and maintained in the agency's recipient record.~~

~~Serious occurrences involving either the provider/employee or recipient may include, but are not limited to the following:~~

~~a. Suspected physical or verbal abuse;~~

~~b.a. Unplanned hospitalization;~~

~~c.a. Neglect, exploitation or isolation of the recipient;~~

~~d.a. Theft;~~

~~e.a. Sexual harassment or sexual abuse;~~

~~f.a. Injuries requiring medical intervention;~~

~~g.a. An unsafe working environment;~~

~~h.a. Any event which is reported to Elder Protective Services or law enforcement agencies;~~

~~i.a. Death of the recipient during the provision of waiver services; or~~
~~j.a. Loss of contact with the recipient for three consecutive scheduled days.~~

~~k.a. Medication errors resulting in injury, hospitalization, medical treatment or death.~~

~~The State of Nevada has established mandatory reporting requirements of suspected incidents of Elder Abuse, Neglect, Isolation and Exploitation. ADSD and local law enforcement are the receivers of such reports. Suspected elder abuse must be reported as soon as possible, but no later than 24 hours of identification/suspicion. Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.~~

~~o.6. Adhere to HIPAA requirements.~~

~~Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other protected health information.~~

~~p.6. Obtain and maintain a business license as required by city, county or state government, if applicable.~~

~~q.6. Providers for residential facility for groups must obtain and maintain required HCQC licensure.~~

~~Aging and Disability Services Division (ADSD):~~

~~In addition to the provider responsibilities listed in Section 2203.3B, ADSD must:~~

~~a. maintain compliance with the Interlocal Agreement with the DHCFP to operate the HCBW for the Frail Elderly.~~

~~b. comply with all waiver requirements as specified in the HCBW for the Frail Elderly.~~

~~3.6.Qualification and Training:~~

~~a. All service providers must arrange training for employees who have direct contact with recipients of the HCBW programs and must have service specific training~~

~~prior to performing a waiver service. Training at a minimum must include, but not limited to:~~

~~1. policies, procedures and expectations of the agency relevant to the provider, including recipient's and provider's rights and responsibilities;~~

~~2.1. procedures for billing and payment;~~
~~3.1. record keeping and reporting including daily records and SORs;~~

~~4.1. information about the specific needs and goals of the recipients to be served; and~~

~~5.1. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding care goals; respecting recipient rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; respecting personal property; ethics in dealing with the recipient, family and other providers; handling conflict and complaints; and other topics as relevant.~~

~~b.a. Residential facility for groups:~~

~~In addition to the requirements listed above:~~

~~1. Caregivers of a residential facility for groups must be at least 18 years of age; be responsible and mature and have the personal qualities which will enable him or her to understand the problems of the aged and disabled; demonstrate the ability to read, write, speak and understand the English language; must possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility and annually receive no less than eight hours of training related to providing for the needs of the residents of a residential facility for groups; must be knowledgeable in the use of any prosthetic devices or dental, vision or hearing aids that the residents use and must understand the provisions of NAC 449.156 to NAC 449.27706, inclusive, and Sections 2 and 3 of the regulation, and sign a statement that he/she has read those provisions.~~

~~2.1. If a caregiver assists a resident of a residential facility for groups in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: before assisting a resident in the administration of a medication, receive the~~

~~training required pursuant to paragraph (e) of Subsection 6 of NRS 449.037, which must include, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than four hours of practical training, and obtain a certificate acknowledging the completion of such training; receive annually at least eight hours of training in the management of medication and provide the residential facility for groups with satisfactory evidence of the content of the training and his or her attendance at the training; complete the training program developed by the administrator of the residential facility for groups pursuant to paragraph (e) of Subsection 1 of NAC 449.2742; and annually pass an examination related to the management of medication approved by the HCQC.~~

~~3.1. Within 30 days after a caregiver is employed at the facility, he/she must be trained in First Aid and Cardiopulmonary Resuscitation (CPR) as described in NAC 449.231 and be able to recognize and appropriately respond to medical and safety emergencies.~~

~~4.1. Caregivers must have training specific to the waiver population being cared for at the residential facility for groups, including the skills needed to care for recipients with increasing functional, cognitive and behavioral needs.~~

~~5. Service providers/employees must complete either a QuantiFERON®-TB Gold blood test (QFT-G) or a two-step (TB) Tuberculin skin test prior to initiation of services for a Medicaid recipient. Thereafter, each service provider/employee must receive a QFT-G blood test or one step TB skin test annually, prior to the expiration of the initial test. If the service provider/employee has a documented history of a positive QFT-G or TB skin test (+10 mm induration or larger), the service provider/employee must have clearance by a chest X-ray prior to initiation of services for a Medicaid recipient.~~

~~If the service provider/employee has been medically cleared after a documented history of a positive QFT-G or TB skin test which was 10 mm or larger and then by chest X-ray, the service provider/employee must have documentation annually which demonstrates no signs or symptoms of active tuberculosis. The annual screening for signs and symptoms must address each of the following areas of concern and must be administered by a qualified health care provider as defined in NAC 441A.110.~~

~~a. Has had a cough for more than three weeks;~~

~~b. Has a cough which is productive;~~

~~c. Has blood in his sputum;~~

~~d. Has a fever which is not associated with a cold, flu or other apparent illness;~~

~~e. Is experiencing unexplained weight loss; or~~

~~f. Has been in close contact with a person who has active tuberculosis.~~

~~Annual screening for signs and symptoms of active disease must be completed prior to the one-year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the service provider/employee file.~~

~~Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee, stating the date of the test, the date the test was read, and the results, and maintained in the service provider/employee's file. Any lapse in the required timelines above results in non-compliance with this Section.~~

~~In addition, providers must also comply with the tuberculosis requirements outlined in NAC 441A.375 and NAC 441A.380.~~

~~c. Exemptions from Training for Provider Agencies:~~

~~1. The provider agency may exempt a prospective service provider from those parts of the required training where the agency judges the person to possess adequate knowledge or experience, or where the provider's duties will not require the particular skills.~~

~~2.1. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the employee's file.~~

~~3.1. ADSD/DHCFP may review exemptions for appropriateness.~~

~~2203.3C RECIPIENT RESPONSIBILITIES~~

~~The recipient or, if applicable, the recipient's authorized representative will:~~

~~1. notify the provider(s) and the ADSD case manager of any change in Medicaid eligibility;~~

~~2.1. notify the provider(s) and the ADSD case manager of current insurance information, including the name of the insurance coverage, such as Medicare;~~

~~3.1. notify the provider(s) and the ADSD case manager of changes in medical status, support systems, service needs, address or location changes, and/or any change in status of authorized or legal representative;~~

~~4.1. treat all providers and their staff members appropriately;~~

~~5.1. initial and sign the daily record(s) to verify that services were provided. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the POC;~~

~~6.1. notify the provider or the ADSD case manager when scheduled visits cannot be kept or services are no longer required;~~

~~7.1. notify the provider agency or ADSD of any missed appointments by the provider agency staff;~~

~~8.1. notify the provider agency or the ADSD case manager of any unusual occurrences, complaints regarding delivery of services, specific staff or to request a change in caregiver or provider agency;~~

~~9.1. furnish the provider agency with a copy of his or her Advance Directive;~~

~~10.1. not request any provider to work more than the hours authorized in the POC;~~

~~11.1. not request a provider to work or clean for a non-recipient, family or household members;~~

~~12.1. not request a provider to perform services not included in the POC;~~

~~13.1. contact the case manager to request a change of provider agency;~~

~~14.1. complete, sign and submit all required forms on a timely basis; and~~

~~15.1. be physically available for authorized waiver services, quarterly home visits, and assessments.~~

2203.~~4~~3 ~~DIRECT SERVICE~~ CASE MANAGEMENT

~~Direct service c~~Case management service is provided to eligible recipients in the HCB~~W~~WS Waivers ~~program~~ when case management is identified as a service on the POC. The recipient has a choice of ~~direct service~~ case management provided by ADSD or a private case management agency (must be enrolled as a Medicaid provider agency).~~provider agencies.~~

2203.~~4A~~3A COVERAGE AND LIMITATIONS

These services include (not all inclusive):

1. Identification of resources and assisting recipients in locating and gaining access to waiver services and other State Plan services, as well as needed medical, social, educational and other services regardless of the funding source;

2. Coordination of multiple services and/or providers when applicable;

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 personalized goals are being met;

4. Monitoring and documenting the quality of care through ~~monthly~~ contact with recipients:

   a. The case manager must have ~~a monthly~~ongoing contact with each waiver recipient and/or the recipient's designated~~authorized~~ representative/LRI; this may be a telephone contact. At a minimum, there must be ~~a~~ one face-to-face visit with each recipient annually~~once every three months~~. All other ongoing ~~More~~ contacts may be by telephone, fax, e-mail, or face-to-face~~be made if the recipient has indicated a significant change in his or her health care status or is concerned about his or her health and/or safety~~.

   b. When recipient service needs increase, due to a temporary condition or circumstance, the case manager must thoroughly document the increased service needs in their case ~~notes~~narrative. The POC does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed ~~thirty (~~30~~)~~ calendar days. If the recipient is utilizing a private case management agency,

this information must be communicated to the ADSD for ~~prior authorization~~PA adjustment.

c. During the ~~monthly~~ ongoing contact or face-to-face visit, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety, ~~issues~~risk factors, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers. If the recipient is utilizing a private case management agency, this information must be communicated to the ADSD for ~~prior authorization~~PA adjustment.

d. During scheduled visits to a ~~r~~Residential Group Homes for Seniors and Assisted Living Facility~~facility for groups~~, the case manager is responsible for reviewing the POC and daily logs as applicable for feedback from the recipient to help ensure services are delivered as authorized in the POC. In addition, the case manager is responsible for reviewing the medication log to ensure appropriate administration and documentation is completed timely.

5. Ensure~~Making certain that~~ the recipient retains freedom of choice in the provision of services. During the contacts with the recipient, the case manager must inquire and narrate the recipient's choice to continue receiving waiver service;

6. Notifying all affected providers of changes in the recipient's medical status, service~~s~~ needs, address, ~~and location,~~ or of changes of the status of designated~~legally responsible individuals or authorized~~ representative/LRI;

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. The 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 will be considered an "as needed" service. ~~Case managers must continue to 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 billed to the DHCFP must be adequately documented and substantiated by the case manager's notes.~~

~~10.~~

11. When ~~C~~case manager~~s~~ment is the only waiver service identified in the POC, the Case Managers ~~must~~shall continue to have monthly contact with recipients and/or the recipient's designated~~authorized~~ representative/LRI of at least 15 minutes (equal to one unit), ~~per recipient,~~ per month. The duration, scope, and frequency ~~amount~~ of case management services billed to the DHCFP must be adequately documented and substantiated by the ~~c~~Case ~~m~~Manager's narratives~~notes~~.

12. Case Managers must show due diligence to hold ongoing contacts as outlined in the POC (frequency and method). Ongoing contacts are required, every attempt to contact the recipient should be documented. At least three telephone calls must be completed on separate days, if no response is received after the 3rd attempt, a letter must be sent to recipient requesting a return contact. If the recipient fails to respond by the date indicated in the letter, the recipient may be terminated.

~~11.~~13. Monitoring to assure providers of ~~r~~Residential ~~facility for g~~Group~~s~~ Homes for Seniors and Assisted Living Facility meet required program standards.

~~12.~~14. Arranging for the relocation of the recipient, if necessary, when an alternative placement is requested or needed.

2203.~~4B~~3B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.~~3B~~2B, Case Managers must:

1. ~~be~~ Be currently licensed as Social Worker by the State of Nevada Board of Examiners for Social Workers or licensure as a Registered Nurse by the Nevada State Board of Nursing.

2. ~~have~~ Have a valid driver's license and means of transportation to enable face-to face ~~home~~ visits.

In addition, ~~to the requirements listed above,~~ private ~~c~~Case ~~m~~Managers must:

a. ~~h~~Have one~~-~~year experience of working with seniors in a home~~-~~based environment.

b. ~~also p~~Provide evidence of taxpayer ID number, Workman's Compensation Insurance, Unemployment Insurance Account, Commercial General Liability, Business Automobile Liability Coverage and Commercial Crime Insurance.

c. ~~b~~Be employed by a private case management provider agency.

2203.~~4C~~3C RECIPIENT RESPONSIBILITIES

1. Each recipient and/or designated~~his or her authorized~~ representative/LRI must cooperate with the implementation of services and the implementation of the POC.
2. Each recipient is to comply with the rules and regulations of the DHCFP, ADSD, DWSS and the FE Waiver~~HCBW for the Frail Elderly~~.

2203.~~5~~4 HOMEMAKER SERVICES

Homemaker services consist of light housekeeping, meal preparation, shopping, and laundry. These services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage their private residence and is necessary to avoid placement in an institution.

2203.~~5A~~4A COVERAGE AND LIMITATIONS

1. Homemaker services are provided at the recipient's home, or place of residence (community setting)~~by agencies enrolled as a Medicaid provider~~.

2. ~~Homemaker services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage their private residence and is necessary to avoid placement in an institution.~~ Services must be directed to the individual recipient and related to their health and welfare.

3. The DHCFP/ADSD is not responsible for replacing goods which are or become damaged in the provision of service.

4. Homemaker services include:

a. ~~m~~Meal preparation: menu planning, storing, preparing, serving of food, cutting up food, buttering bread and plating food;

b. ~~l~~Laundry services: washing, drying, and folding the recipient's personal laundry and linens (sheets, towels, etc.) excludes ironing. Recipient is responsible for all laundromat and/or cleaning fees;

c. ~~l~~Light housekeeping: changing the recipient's bed linens, dusting, vacuuming the recipient's living area, cleaning kitchen and bathroom areas;

d. ~~e~~Essential shopping to obtain: prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and maintenance of the recipient; or

e. ~~a~~Assisting the recipient and family members or caregivers in learning homemaker routine and skills so the recipient may carry on normal living when the homemaker is not present.

5. Activities the homemaker shall not perform and for which Medicaid will not pay include the following:

a. transporting the recipient in a private car;

b. cooking and cleaning for the recipient's guests, other household members or for the purposes of entertaining;

c. repairing electrical equipment;

d. ironing and mending;

e. giving permanents, dyeing or cutting hair;

f. accompanying the recipient to appointments, social events or in-home socialization;

g. washing walls and windows;

h. moving heavy furniture, climbing on chairs or ladders;

i. purchasing alcoholic beverages that were not prescribed by the recipient's physician;

j. doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow-covered areas, and vehicle maintenance; or

k. care of pets except in cases where the animal is a certified service animal.

2203.~~5B~~4B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.~~3B~~2B, Homemaker Providers must:

1. ~~a~~Arrange and 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; and

2. ~~i~~Inform recipients that the ADSD, the DHCFP or its fiscal agent ~~QIO-like vendor~~ is not responsible for replacement of goods damaged in the provision of service.

Providers are responsible to ensure that Electronic Visit Verification (EVV) requirements and expectations are met, including the documentation of all services in approved EVV System.

Service must be prior authorized and documented in an approved EVV System.

2203.~~5C~~4C RECIPIENTS RESPONSIBILITIES

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

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

2203.~~6~~5 CHORE SERVICES

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. Services needed to maintain a clean, sanitary, and safe home environment. The service must be identified on the POC, is approved by the ADSD CM, authorization must be in place and must be clearly documented on the Comprehensive Social Health Assessment (CSHA) the need for Chore service. 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.

2203.~~6A~~5A COVERAGE AND LIMITATIONS

1. This service includes heavy household chores in the private residence such as:

   a. cleaning windows and walls;

   b. shampooing carpets;

   c. tacking down loose rugs and tiles;

   d. moving heavy items of furniture ~~in order~~ to provide safe access;

   e. packing and unpacking for the purpose of relocation;

   f. minor home repairs; or

   g. removing trash and debris from the yard.

2. ~~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.

3. 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. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any waiver ~~program~~ covered services.

2203.~~6B~~5B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.~~3B~~2B, individuals performing chore services must:

1. be able to read, write and follow written or oral instructions;

2. have experience and/or training in performing heavy household activities and minor home repair; and

3. maintain the home in a clean, sanitary and safe environment if performing heavy household chores and minor home repair services.

Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV System.

Service must be prior authorized and documented in an approved EVV System.

2203.~~6C~~5C RECIPIENTS RESPONSIBILITIES

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. 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.

2203.~~7~~6 RESPITE CARE

Services provided to recipients unable to care for themselves. Respite care is provided on a short-term basis because of the absence or need for relief of those persons normally providing the care~~primary caregiver~~. Respite providers perform general assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) as well as provide supervision to functionally impaired recipients in their private home or place of residence (community setting).

2203.~~7A~~6A COVERAGE AND LIMITATIONS

~~1. Respite care is provided on a short-term basis because of the absence or need for relief of the primary caregiver.~~

~~2.~~1. Respite services may be for 24-hours periods~~care may occur in the recipient's private home~~.

~~3.~~2. Respite care is limited to 336 hours for the duration of the POC~~per waiver year~~.

3. Services must be prior authorized by ADSD.

2203.~~7B~~6B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.~~3B~~2B, Respite Providers must:

~~1. perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their private home;~~

~~2.~~1. ~~h~~Have the ability to read and write and to follow written or oral instructions;

~~3.~~2. ~~h~~Have had experience ~~and/or training~~ in providing for the personal care needs of people with functional impairments;

~~4.~~3. ~~d~~Demonstrate the ability to perform the care tasks as prescribed;

~~5.~~4. ~~b~~Be tolerant of the varied lifestyles of the people served; and

~~6.~~5. Provide ~~arrange~~ training in personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transferring, ambulating, feeding, dressing and use of adaptive aids and equipment, homemaking and household care.

Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV System.

Service must be prior authorized and documented in an approved EVV System.

2203.~~7C~~6C RECIPIENTS RESPONSIBILITIES

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.
2. 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.

2203.~~8~~7 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

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

2203.~~8A~~7A COVERAGE AND LIMITATIONS

~~1. PERS is an electronic device, which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to the recipient's phone and programmed to signal a response center once a "help" button is activated.~~

~~2.~~1. PERS services are limited to those recipients who live alone in a private residence, or who are alone for significant parts of the day in that residence, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The recipient must be physically and cognitively capable of using the device in an appropriate and proper manner.

2. The service component includes both, the installation of the device and monthly monitoring. Two separate authorizations are required for payment, the initial installation fee for the device and a monthly fee for ongoing monitoring; both are covered under the waiver.

3. The necessity for this type of emergency safety measure to prevent institutionalization will be identified in the assessment and included in the POC.

2203.~~8B~~7B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.~~3B~~2B, PERS Providers must:

1. ~~b~~Be responsible for ensuring that the response center is staffed by trained professionals at all times;

2. ~~b~~Be responsible for any replacement or repair needs that may occur and monthly monitoring of the device to ensure is working properly;

3. ~~u~~Utilize devices that meet Federal Communication Commission standards, Underwriter's Laboratory, Inc. (UL) standards or equivalent standards~~, and be in good standing with the local Better Business Bureau~~; ~~and~~

4. ~~i~~Inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

2203.~~8C~~7C RECIPIENT RESPONSIBILITIES

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider and ~~the ADSD c~~Case ~~m~~Manager if the equipment is no longer working.

2. The recipient must return the equipment to the provider when the recipient no longer needs or utilizes the equipment, when the recipient terminates from the waiver program or when the recipient moves from the area.

3. The recipient must not dispose or damage ~~throw away~~ the PERS equipment. This is leased equipment and belongs to the PERS provider.

2203.~~98~~ ADULT DAY CARE SERVICES

Adult D~~d~~ay C~~c~~are ~~facilities provide~~ services are provided in a non-institutional community-based setting , including outpatient settings.~~on a regularly scheduled basis.~~ It encompasses social service needs to ensure the optimal functioning of the recipient.

It is provided on a regularly scheduled basis, in accordance with the goals in the recipient's POC.~~for four or more hours per day, one or more days per week, and is provided in accordance with the goals in the recipient's POC. It is provided in an outpatient setting.~~

2203.~~9A8~~A COVERAGE AND LIMITATIONS

1. ~~Adult day care facilities provide services in a non-institutional community-based setting on a regularly scheduled basis.~~ The emphasis is on social interaction in a safe environment. ~~It is provided for four or more hours per day, one or more days per week, and is provided in accordance with the goals in the recipient's POC.~~ The POC must indicate the number of days per week the recipient will attend.

~~2.1. It is provided in an outpatient setting.~~

~~3.1. It encompasses social service needs to ensure the optimal functioning of the recipient.~~

~~4.~~2. Meals provided are furnished as part of the FE Waiver ~~program~~ but must not constitute a "full nutritional regime" (i.e., three meals per day). Meals must be served in a manner suitable for the recipient and prepared with regard for individual preferences. Special diets and nourishments must be provided as ordered by the client's physician.

~~5.~~3. Service utilization and billing method (per diem/unit rate) will be prior authorized as indicated ~~o~~in the recipient's POC. The per diem rate is authorized when the recipient is in

attendance for six or more hours per day, and the unit rate is authorized for attendance of a minimum of four hours and up to ~~less than~~ six hours per day. Providers must bill in accordance with the approved PA, even if the recipient occasionally attends less than six hours. If the recipient's overall pattern changes and consistently attends less than six hours a day, a change to the ~~new~~ POC and PA will be required to update the service utilization and billing method.

~~6.~~4. Providers must not bill for days a recipient is not in attendance, even if it is a regularly scheduled day. Providers must keep attendance records for each recipient. Claims must reflect dates and times of service as indicated on the attendance records.

~~7. Reference MSM Chapter 1900 for transportation policies.~~

2203.~~9B~~8B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.~~3B~~2B, Adult Day Care Providers must:

~~1.~~ Meet and maintain the service specifications as an adult day care provider as outlined in NAC 449 "Medical Facilities and other Related Entities~~for Care of Adults During the Day~~."

~~2. Comply with the provisions regarding tuberculosis as outlined in NAC 441A.375 and 441A.380.~~

2203.~~10~~9 ADULT COMPANION SERVICES

Adult Companion Services ~~P~~provides non-medical care, supervision and socialization to a functionally impaired recipient in his or her home or place of residence, which are~~may provide~~ furnished on a short term basis or to meet the need for ~~temporary~~ relief for the primary caregiver.

2203.~~10A~~9A COVERAGE AND LIMITATIONS

~~1. Provides non-medical care, supervision and socialization to a functionally impaired recipient in his or her home or place of residence, which may provide temporary relief for the primary caregiver.~~

~~2.~~1. Adult companions may assist or supervise the recipient with ~~such~~ tasks as meal preparation and clean up, light housekeeping, shopping and facilitate transportation/escort as needed. These services are provided as an adjunct to the Adult Day Care ~~Companion~~ Services and must be incidental to the care and supervision of the recipient.

~~3.~~2. The provision of Adult Companion Services does not entail hands-on medical care.

~~4.~~3. This service is provided in accordance with the personalized~~a~~ goal in the POC and is not purely diversional in nature.

~~5.~~4. Transportation is not a covered service. Reference MSM Chapter 1900 Transportation Services for transportation policies.

2203.~~10B~~9B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.~~3B~~2B, Adult Companion Providers must:

1. ~~b~~Be able to read, write and follow written or oral instructions; and

2. ~~h~~Have experience or training in how to interact with recipients with disabling and various health conditions.

Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

Service must be prior authorized and documented in an approved EVV System.

2203.~~10C~~9C RECIPIENTS RESPONSIBILITIES

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. 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.

2203.~~11~~10 AUGMENTED PERSONAL CARE

Augmented ~~p~~Personal ~~c~~Care (APC) provided in a licensed ~~r~~Residential Group Homes for Seniors or Assisted Living ~~f~~Facility ~~for groups~~ is a 24-hour in home service that provides assistance for functionally impaired elderly recipients with basic self-care and ADLs ~~activities of daily living~~ that include as part of the service:

~~A.~~1. Homemaker Services;

~~B.~~2. Personal Care Services;

~~C.~~3. Chore Services;

~~D.~~4. Companion Services;

~~E.~~5. Therapeutic social and recreational programming;

~~F.~~6. Medication oversight (to the extent permitted under State Law); and

~~G.~~7. Services which will ensure that residents of the facility are safe, secure, and adequately supervised.

This care is over and above the mandatory service provision required by regulation for R~~r~~esidential ~~facility for g~~Groups~~s~~ Homes for Seniors and Assisted Living Facility.

2203.~~11A~~10A COVERAGE AND LIMITATIONS

~~1. Augmented personal care in a licensed residential facility for groups provides assistance for the functionally impaired elderly with basic self-care and ADLs such as personal care services, homemaker, chore, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming and services that ensure that the residents of the facility are safe, secure and adequately supervised.~~

~~2.~~1. This service includes 24-hour on-site response staff ~~in home supervision~~ to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence; and provides supervision, safety, and security.

~~3.~~2. Once a FE Waiver recipient/applicant expresses an interest in a residential group setting, they are provided with a list of qualified providers. A case manager is available to provide additional information and guidance related to the individual's specific needs. Consideration may include size of the home, geographic location, proximity to friends and family, available support, activities, food, staff, other residents, likes and dislikes, medical or mental health concerns, whether pets are allowed, and a variety of other individualized preferences.

~~4.~~3. There are ~~three~~ four service levels of A~~ugmented~~ P~~ersonal~~ C~~are~~. The service level provided is based on the recipient's functional needs to ensure the recipient's ~~his/her~~ health, safety

and welfare ~~in the community~~. The ADSD Case Manager determines the service level as an administrative function of the FE Waiver.

a. Level One Daily (minimum assistance):

This level p~~P~~rovides supervision and cueing to ~~monitor the quality and completion~~ complete ~~of~~ basic self-care and ADLs. ~~Some basic self-care services may require minimum hands on assistance. This service level provides laundry services to meet the recipient's needs. If needed this service provides i~~In home supervision is available when direct care tasks are not being completed.

b. Level Two Daily (moderate assistance):

This level p~~P~~rovides ~~minimal~~ physical assistance with moderate hands on care ~~completion~~ of basic self-care and ADLs. Some basic self-care may require a moderate level of assistance. ~~This service level provides laundry services to meet the recipient's needs. If needed t~~This service provides in home supervision with regularly scheduled checks ~~if~~ as needed.

c. Level Three Daily (maximum assistance):

This level p~~P~~rovides ~~moderate~~ physical assistance ~~with~~ to ~~completion~~ complete~~of~~ basic self-care and ADLs. with maximum hands on care. Direct 24-hour supervision and/or safety system (alarm) to ensure safety when supervision is not direct. It includes daily home making for clean up after basic self-care tasks, weekly homemaking for general cleaning, and up to twice daily assistance with meal preparation~~Some basic self-care may require a maximal level of assistance. This service level provides laundry service to meet the recipient's needs. If needed this service provides direct visual supervision or safety systems to ensure recipient safety when supervision is not direct.~~

d. Level Four (Critical Behaviors):

In addition to meeting a level one, two or three for ADLs/IADLs care, level 4 requires substantial and/or extensive assistance with critical behaviors: Behavioral Problems, Resists Care, Socially Inappropriate, Wandering, Physically Abusive to self and/or others, Verbally Abusive, and behaviors that represent a safety risk. Requiring the full attention of staff member when behaviors are present and/or presents a need for additional staffing to redirect and address behaviors. Additional documentation and agency approval required.

Documentation on the daily log for at least 60 days is required to justify amount and types of care for service level determination and verification of proper billing.

All four service levels provide help with laundry; housekeeping; meal preparation and eating; bed mobility and transfers; bathing, dressing, and cl and recreational programs. The service level determines the amount, duration and frequency of the services provided.

All service levels are reassessed annually, or as significant changes occur, and may increase or decrease to reflect the recipient's current level of need.

Documentation on the daily log is required to justify amount and types of care for service level determination and verification of proper billing.

~~5.~~4. Section 1903(a)(1) of the SSA provides funding for Federal Financial Participation (FFP) to States for expenditures for services under an approved State plan. FFP is not available to subsidize the cost of room and board furnished in a ~~r~~Residential ~~facility for g~~Groups Homes for Seniors and Assisted Living Facility. The cost for room and board is a private agreement between the recipient and the Residential Group Homes for Seniors or Assisted Living Facility.

~~6.~~5. Nursing and skilled services (except periodic nursing evaluations) are incidental, rather than integral to the provision of group care services. Payment will not be made for 24-hour skilled care or supervision.

~~7.~~6. Other individuals or agencies may also furnish care directly, or under arrangement with the ~~r~~Residential ~~facility for g~~Groups Homes for Seniors or Assisted Living Facility. However, the care provided by these other entities supplements what is being provided but does not supplant it.

7. Personalized care furnished to individuals who choose to reside in a Residential Group Homes for Seniors or Assisted Living Facility based on their individualized POC, which is developed with the recipient, people chosen by the recipient, caregivers and the Case Manager. Care must be furnished in a way that fosters the independence of each recipient.

8. The Residential Group Homes for Seniors or Assisted Living Facility provides personalized care to the residents, and the general approach to operating the facility incorporates these core principles:

a. Designed to create a residential environment that actively supports and promotes each resident's quality of life and right to privacy.

b. Committed to offering high-quality supportive services that are developed by the facility in collaboration with the recipient's individual needs.

c. Provides a variety of creative and innovative services that emphasize the specific needs of each recipient and the personal choice of lifestyle.

d. Operate and interact with recipients to support recipient's need for autonomy and the right to make decisions.

e. Designed to foster a social climate that allows the recipient to develop and maintain personal relationships with fellow residents and with persons in the general community.

f. Minimize the need for its recipients to move out of the facility as their respective physical and mental conditions change over time.

g. Foster a culture that provides a high-quality environment for the recipients, their families, the staff, any volunteers, and the community at large.

2203.~~11B~~10B AUGMENTED PERSONAL CARE PROVIDER RESPONSIBILITIES

In addition to the responsibilities listed in Section 2203.~~3B~~ 2B providers must:

1. Be licensed and maintain standards as outlined by ~~the Health Division~~, HCQC under NRS/NAC 449 "Medical and other related entities"~~Residential Facility for Groups~~.

2. The provider for a ~~r~~Residential ~~facility for g~~Groups Homes or Assisted Living Facility must:

   a. Notify the ADSD Case Manager within three ~~working~~ business days when the recipient states the desire ~~that he or she wishes~~ to leave the facility.

   b. Participate with the ADSD Case Manager in discharge planning.

   c. Notify the ADSD Case Manager within one working day if the recipient's living arrangements have changed, eligibility status has changed or if there has been a change in ~~his or her~~ health status that could affect recipient's ~~his or her~~ health, safety or welfare.

   d. Notify the ADSD of any incidents ~~occurrences~~ pertaining to a waiver recipient that could affect ~~his or her~~the health, safety, or welfare.

e. Notify the ADSD of any recipient complaints regarding delivery of service or specific staff of the setting. If the recipient is not satisfied with their living arrangements or services, the Case Manager will work with the recipient and the provider to resolve any areas of dissatisfaction. If the recipient makes the decision to relocate to another setting, the Case Manager will provide information and facilitate visits to other contracted settings~~residential facility of groups~~.

f. Provide the ADSD with at least a 30-calendar days' notice before discharging a recipient unless the recipient's condition deteriorates and warrants immediate discharge. When the Case Manager is notified, they assist in relocation and working with staff on transfers/discharges.

~~g. Be responsible for any claims submitted or payment received on the recipient's behalf; such claims should be made under penalties of perjury. Any false claims, statement or documents, or concealment of material facts may be prosecuted under applicable federal or state laws.~~

~~h.~~g. Privacy, dignity, and respect are maintained during the provisions of services. Living units are not entered without permission. ~~Provide care to a newly placed recipient for a minimum or 30 days unless the recipient's condition deteriorates and warrants immediate discharge.~~

~~i.~~h. Conduct business in such a way ~~that~~ the recipient is free from coercion and restraint and retains freedom of choice. Residential Group Homes and Assisted Living Facility must provide services based on the recipient's choice, direction, and preferences.

~~j.~~i. Provide transportation to and from the setting ~~residential facility for groups~~ to the hospital, a ~~nursing facility~~NF, routine medical appointment and social outings organized by the facility. Recipients may choose to enjoy their privacy, participate in physical activities, relax, or associate with other residents. Recipients may go out with family members or friends at any time and may pursue personal interest outside of the residence.

~~k.~~j. Accept only those residents who meet the requirements of the licensure and certification.

~~l.~~k. Provide services to FE ~~w~~Waiver eligible recipients in accordance with the recipient's ~~plan of care~~POC, the rate, ~~program~~ waiver limitations, and procedures of the DHCFP.

~~m.~~l. Not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the FE Waiver ~~HCBW for the Frail Elderly~~ except by written consent of the recipient, ~~his or her authorized~~designated/ ~~or~~ legal representative ~~or family~~.

~~n.~~m. Have sufficient ~~number of~~ caregivers present at the facility to conduct activities and provide care and protective supervision for the residents at all times. The ~~facility~~ provider must comply with HCQC staffing requirements for the specific facility type (for example, an Alzheimer facility).

~~o.~~n. There must be 24-hour on site staff to meet scheduled or unpredictable needs and provide supervision, safety and security, and transportation if one or more residents are present.

~~p.~~o. Not use Medicaid waiver funds to pay for the recipient's room and board. ~~The recipient's income is to be used to cover room and board costs.~~

p. Each recipient must have privacy in their sleeping or living unit:

a) Units or rooms have locking doors. A bedroom or bathroom door in a residential group setting which is equipped with a lock must open with a single motion from the inside. Staff must knock before entering; recipients have the right to choose who enters the bedroom.

b) Recipients sharing units have a choice of roommate.

c) Encourage recipients to utilize personal furniture, furnishing, photo and decorative items to personalize their living space.

3. Recipient Records

a. Each provider must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC.

The documentation will include the recipient's acknowledgment of service. If the recipient is unable to provide the acknowledgment due to cognitive and/or physical limitations, this will be clearly documented on the POC, indicating the designated representative or LRI. Recipients without an LRI can select an individual to act on

their behalf by completing the Designated Representative Attestation Form. The Case Manager will be required to document the designated representative who can sign documents and be provided information about the recipient's care.

b. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file or make available upon request. For electronic signatures, systems and software products must include protection against modifications, with administrative safeguards that correspond to policies and procedures of the ADSD. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information being attested to.

c. Periodically, DHCFP and/or ADSD staff may request daily service documentation to compare it to submitted claims. These records must be maintained by the provider for at least six years after the date the claim is paid.

d. Services for waiver recipients residing in a Residential Facility for Groups and Assisted Living Facility should be provided as specified on the POC and at the appropriate authorized service level.

e. If fewer services are provided than what is authorized on the POC, the reason must be adequately documented in the daily record and communicated to the case manager.

2203.~~11C~~10C RECIPIENT RESPONSIBILITIES

1. Recipients are to cooperate with the providers of ~~r~~Residential ~~facility for g~~Groups~~s~~ Home for Seniors or Assisted Living Facility in the delivery of services.

2. Recipients are to report any problems with the delivery of services to the ~~r~~Residential Group Homes for Seniors or Assisted Living ~~f~~Facility ~~for group~~ administrator and/or ADSD ~~c~~Case ~~m~~Manager.

2201.11 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

Administrative case management activities are performed by ~~Aging and Disability Services Division (~~ADSD~~)~~ case managers and refer to data collection for eligibility verification, ~~Level of Care (~~LOC~~)~~ evaluation, ~~Plan of Care (~~POC~~)~~ development, and other case management activities that are not identified on the POC.

2203.~~12A~~11A COVERAGE AND LIMITATIONS

Administrative case management activities include:

1. Processing of Intake referrals;

2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance to 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 such as:

   ~~d.~~a. Screening assessment for the LOC to determine if the individual has functional deficits and requires the level of service offered in a NF or a more integrated service that may be community-based.~~The POC identifies the waiver services as well as other ongoing community support services that the recipient needs in order to live successfully in the community. The POC must reflect the recipient's service needs and include both waiver and non-waiver services in place at the time of POC completion, along with informal supports that are necessary to address those needs.~~

   b. Development of the POC identifying the waiver services as well as other ongoing community support services that the recipient needs to live successfully in the community.

   c. The recipient's ~~level of care~~LOC, functional status and needs addressed by the POC must be reassessed annually or more often as needed. The recipient must also be reassessed when there is a significant change in his/her condition which influences eligibility. ~~The reassessment is to be conducted during a face-to-face visit.~~

   ~~If services documented on a POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible.~~

4. Request ~~I~~issuance of Notices of ~~Actions~~Decision (NO~~A~~D) to the ~~Division of Health Care Financing and Policy (~~DHCFP~~)~~ ~~Central Office Waiver~~LTSS ~~Unit staff to issue a Notice of Decision (NOD)~~ when a waiver application is denied;

5. Coordination of care and services ~~to~~and collaborate~~ion~~ in discharge planning to transition applicants ~~from facilities~~;

6. Obtaining the necessary ~~D~~ddocumentation 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~~access into care and services through ~~a~~various Medicaid Program;

9. ~~Communication~~Distribution of the POC to all affected providers;

~~11.~~10. Ensure completion of ~~prior authorization~~PA form, if required, for all waiver services ~~documented~~identified on the POC for submission into the Medicaid Management Information System (MMIS) Inter-Change.

2203.11B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in MSM Section 2203.2B Case Manager:

1. ~~Administrative case management providers (social workers, nurses, certified case managers, etc.) m~~Must be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers or as a Registered Nurse by the Nevada State Board of Nursing.

2. Must have a valid driver's license and the ability to conduct home visits.

3. Must adhere to ~~Health Insurance Portability and Accountability Act (~~HIPAA~~)~~ requirements.

4. Must have a Federal Bureau of Investigation (FBI) criminal history background check.

2203.11C RECIPIENT RESPONSIBILITIES

1. Applicant/recipients and/or their ~~authorized~~designated representative/LRI must cooperate with the ADSD by assisting with the assessment and reassessment process, accurately representing skill level needs, wants, resources and personalized goals.

~~3.~~2. Applicants/recipients and/or their designated representative/LRI together with the case manager must develop and/or review the POC.

2203.12 INTAKE PROCEDURES

ADSD has developed policies and procedures to ensure fair and adequate access to the ~~Home and Community-Based~~FE Waiver ~~for the Frail Elderly~~.

~~2203.12 PROVIDER ENROLLMENT/TERMINATION~~

~~All providers must comply with all the DHCFP provider enrollment requirements, provider responsibilities/qualifications, and the DHCFP provider agreement limitations. Provider non-compliance with any or all of these stipulations may result in the DHCFP's decision to exercise its right to terminate the provider's contract.~~

~~2203.12A COVERAGE AND LIMITATIONS~~

~~All providers are to refer to the MSM Chapter 100 for enrollment procedures.~~

~~2203.12B PROVIDER RESPONSIBILITIES~~

~~In addition to the provider responsibilities listed in Section 2203.3B:~~

~~1. All providers must meet all federal, state and local statutes, rules and regulations relating to the services being provided.~~

~~2. ADSD must have an Interlocal Agreement with the DHCFP in order to provide services.~~

~~3. All Other Service Providers must apply for and maintain a contract with the DHCFP through its Fiscal Agent.~~

~~2203.13 INTAKE PROCEDURES~~

~~ADSD has developed policies and procedures to ensure fair and adequate access to the Home and Community-Based Waiver for the Frail Elderly.~~

2203.~~13A~~12A COVERAGE AND LIMITATIONS

1. Referral

a. A referral or inquiry for the FE waiver may be initiated by phone, mail, fax, in person, email or by an applicant or another party on behalf of the ~~potential~~ applicant.

b. The ADSD intake specialist will make phone/verbal contact with the applicant/ designated representative/LRI within ~~seven~~ fifteen working days ~~of~~ from the referral date.

~~b.~~c. If ~~a potential~~the applicant appears to be eligible, a face-to-face visit ~~is~~ must be scheduled and completed within 45 calendar days from the referral date to assess eligibility including the NF LOC determination~~a level of care screening~~.

If the ADSD intake specialist ~~intake worker~~ determines during the face-to-face visit~~referral process that~~ the ~~potential~~ applicant does not appear to meet the ~~waiver~~ FE waiver criteria ~~of~~ financial eligibility, ~~level of care~~LOC, or waiver service need, the applicant will be referred to other agencies for any needed services or assistance.

~~c.~~d. ~~Even i~~If the ~~potential~~ applicant does not meet~~appear eligible or if no slot is available for the HCBW for~~ the F~~rail~~ E~~lderly~~ Waiver criteria, the applicant ~~he or she~~ must be verbally informed of the right to continue the Medicaid application process through DWSS. If DWSS determines the applicant to be ineligible for Medicaid, the applicant may have the right to a fair hearing through the DWSS.

2. Placement on the: Wait List~~/No Waiver Slots Are Available~~.

a. Once the ADSD has identified ~~that~~ the ~~potential~~ applicant ~~appears eligible~~ meets the LOC and has a waiver service need, the applicant is placed on the wait list by priority and referral date.~~and there are no waiver slots available:~~

~~a. The applicant will be placed on the waiver wait list and be considered for a higher advancement based on whether they meet additional criteria. Refer to Section 2203.2A.3.~~

b. Applicants may be considered for an adjusted placement on the wait list based on a significant change of condition/circumstances.

~~b.~~c. If it has been determined no slot is expected to be available within the 90 calendar days determination period, a notification letter is sent to the applicant indicating "No slot is available"~~ADSD will notify the DHCFP Central Office Waiver Unit to~~

~~deny the application due to no slot available and send out a NOD stating the reason for the denial. The applicant will remain on the wait list~~.

~~c.~~3. A Waiver Slot Allocation~~is Available~~:

Once a slot for the waiver is available, the applicant will be processed for the waiver.

~~a.~~ The procedure used for processing an applicant is as follows:

~~a. The ADSD case manager will make certain that the Medicaid application, through DWSS, has been completed or updated and will assist in this process as needed.~~

~~b.~~a. The ADSD ~~c~~Case ~~m~~Manager will conduct a second ~~schedule a~~ face-to-face interview with the applicant to complete the initial assessment.

b. The initial assessment includes addressing ADLs, IADLs, service need, support system and personalized goals.

c. An Authorization for the Use and Disclosure of Protected Health ~~Release of~~ Information ~~f~~Form is needed for all waiver applicants and provides written consent for the ADSD to release information about the applicant to others.

d. The applicant/designated ~~and/or authorized~~ representative/LRI must understand and agree that personal information may be shared with providers of services and others as specified on the form.

e. The applicant will be given the right to choose waiver services in lieu of placement in a ~~nursing facility~~NF. If the applicant and/or legal representative prefers placement in a nursing facility, the case manager will assist the applicant in arranging for facility placement.

f. The applicant will be given the right to request a Fair ~~h~~Hearing if not given a choice between ~~HCBW~~ HCBS Waiver services and ~~nursing facility~~NF placement.

4. The ADSD will send the HCBS Waiver Eligibility Status Form to DWSS for review and approval of Medicaid application.~~ADSD will forward an initial assessment (IA) packet to the DHCFP Central Office Waiver Unit which will include~~:

5. On a monthly basis, the DHCFP Long Term Services and Supports (LTSS) Unit will review a random sample of intake packets for completeness to ensure waiver requirements are being met. The intake packet for review must include:

   a. The current CSHA with the following items embedded:

      1. The NF LOC screening to verify the applicant meets the NF LOC criteria;

      2. At least one waiver service need identified~~Social Health Assessment~~;

      3. The narrative section of the assessment confirming a face-to-face visit was conducted for the initial assessment~~a written POC is developed in conjunction with the applicant/authorized representative based on the assessment of the applicant's health and welfare needs;~~

   ~~a.~~b. the Statement of Understanding/Choice (SOU) must be complete with signature and dates; and

   ~~b.~~c. The HCBS Acknowledgement Form completed including initials, signature, and date.

   d. All forms must be completed with initials, signatures, and dates by the recipient/designated representative/LRI. Electronic signatures are acceptable pursuant to NRS 179 "Electronic Records and Transactions" on forms that require a signature.

   e. The applicant has been informed of their right to participate in the development of the POC using the person-centered approach with the support systems, friends, family of their choice involved. Applicants will be given free choice of all qualified Medicaid providers of each Medicaid covered service included in ~~his/her~~the written POC. Current POC information as it relates to the services provided must be given to all service providers.

      ~~4. a HCBW Eligibility Status Form (Form NMO-2734) requesting the DHCFP's Central Office Waiver Unit approval with the date of approval indicated.~~

      ~~a. Applicants will be given free choice of all qualified Medicaid providers of each Medicaid covered service included in his/her written POC. Current~~

~~POC information as it relates to the services provided must be given to all service providers.~~

~~b. The POC is subject to the approval by the DHCFP Central Office Waiver Unit staff.~~

~~c. All required forms must be complete with signature and dates where required.~~

~~If the DHCFP Central Office Waiver Unit approves the application, the following will occur:~~

~~a. Form NMO 2734 is sent by the DHCFP Central Office Waiver Unit to ADSD and DWSS stating the application has been approved; and~~

~~b.~~6. Once ~~the DHCFP Central Office Waiver Unit and~~ DWSS have approved the application, waiver service can be initiated;

7. ~~Use~~If ~~–~~If the application is denied, DWSS will send a denial NOD to the applicant.~~not approved by the DHCFP Central Office Waiver Unit, the following will occur:~~

~~c. A NOD stating the reason(s) for the denial will be sent to the applicant by the DHCFP Central Office Waiver Unit via the DHCFP Hearings and Policy Unit; and~~

~~d. Form NMO 2734 will be sent to ADSD and DWSS by the DHCFP Central Office Waiver Unit stating that the application has been denied and the reason(s) for that denial.~~

If the applicant is denied by ADSD for waiver services, the ADSD will submit the HCBS Waiver Eligibility Form to the DHCFP LTSS unit requesting a denial NOD be sent to the applicant. The request must include the reason(s) for the denial. The DHCFP LTSS unit will send the applicant the denial NOD. The DHCFP will return the processed HCBS Waiver Eligibility Form and a copy of the NOD to ADSD for their record.~~following will occur:~~

~~a. The ADSD case manager will send an NOA to the DHCFP Central Office Waiver Unit;~~

~~b. The DHCFP Central Office Waiver Unit will send a NOD to the applicant via the DHCFP Hearings and Policy Unit stating the reason(s) why the application was denied by ADSD; and~~

~~c. The DHCFP Central Office Waiver Unit will send Form NMO 2734 to ADSD and DWSS stating that the application was denied and the reason(s) for the denial.~~

~~4.~~8. Effective Date for Waiver Services

The effective date for waiver services is determined by eligibility criteria verified by ADSD, ~~intake packet approval by the DHCFP,~~ and financial eligibility approval date by DWSS, and the residential facility for groups placement move in date, whichever is later.

If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

~~5.~~9. Waiver Cost

The DHCFP must assure CMS that the average per capita expenditures under the waiver will not exceed 100% of the average per capita expenditures for the institutional ~~level of care~~LOC under the state plan that would have been made in that fiscal year, had the waiver not been granted.

2203.13 ANNUAL WAIVER REVIEW

The DHCFP and ADSD have formal systems in place to conduct annual reviews. The purpose of the review is to assure the health and welfare of the recipients, the recipients' satisfaction with the waiver services and providers, the qualifications of waiver providers to deliver services/supports, and assurance of the cost effectiveness of these services.

2203.1~~6~~3A COVERAGE AND LIMITATIONS

The State conducts an annual review~~,~~; ~~which is~~ collaboratively with the ~~conducted by~~ ADSD, with ~~and~~ the DHCFP being the lead agency.~~, with the DHCFP being the lead agency. The DHCFP:~~ The CMS has designated waiver assurances and sub-assurances which States must include as part of an overall quality improvement strategy. The annual review is conducted using the State specified performance measures identified in the approved FE waiver to evaluate operation.

The DHCFP:

1. ~~p~~Provides CMS annually with information regarding the impact of the waiver on the type, amount, and cost of services provided under the waiver and under the State ~~p~~Plan, and through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of the recipients served on the waiver;

2. ~~a~~Assures financial accountability for funds expended for HCB~~W~~S Waiver services;

3. ~~e~~Evaluates that all provider standards are continuously met, and that the POCs are periodically reviewed to assure that the services furnished are consistent with the identified needs of the recipients;

4. ~~e~~Evaluates the recipients' satisfaction with the waiver using Personal Experience Survey (PES) conducted with a random sampling of the recipients to ensure waiver satisfaction. Interviews will be completed throughout the year~~program~~; and

5. ~~f~~Further assures that all problems identified by this monitoring will be addressed by the provider in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

2203.1~~6~~3B PROVIDER RESPONSIBILITIES

ADSD and waiver providers must cooperate with the DHCFP and ADSD's annual review process.

2203.14 ELECTRONIC VISIT VERIFICATION (EVV):

The 21st Century Cures Act requires the use of an ~~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 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.

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

a. STATE OPTION:

1. The EVV system electronically captures:

a. The type of service performed, based on procedure code;

b. The individual receiving the service;

c. The date of the service;

d. The location where service is provided;

e. The individual providing the service;

f. The time the service begins and ends.

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

a. The agency/personal care attendant's smartphone;

b. The agency/personal care attendant's tablet;

c. The recipient's landline telephone;

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

e. Other GPS-based device as approved by the DHCFP.

b. DATA AGGREGATOR OPTION:

1. All Personal Care 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.

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

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

2203.125 PROVIDER ENROLLMENT/TERMINATION

To become a Waiver provider, as a Provider Type (PT) 48, 57 or 59, All providers must comply with all the DHCFP fiscal agents.provider enrollment requirements, provider responsibilities/qualifications, and the DHCFP provider agreement limitations. Provider non-compliance with any or all of these stipulations may result in the DHCFP's decision to exercise its right to terminate the provider's contract. Enrollment checklist and forms can be found on the fiscal agent's website at www.medicaid.nv.gov.

2203.12A COVERAGE AND LIMITATIONS

All providers are to refer to the MSM Chapter 100 for enrollment procedures.

2203.16 BILLING PROCEDURES

The DHCFPState assures that claims for payment of waiver services are made only when an recipient individual is Medicaid eligible, when the service is included in the approved POC, and prior authorizationPA is in place when required.

Refer to the Fiscal Agent's website at: www.medicaid.nv.gov for the Provider Billing Guide Manual.

2203.14A COVERAGE AND LIMITATIONS

All providers (Provider Types 48 and 57) for the HCBW for the Frail Elderly must submit claim forms to the DHCFP's QIO-like vendor. Claims must meet the requirements in the CMS-1500 Claim Form. Claims must be complete and accurate. Incomplete or inaccurate claims will be returned to the provider by the DHCFP's QIO-like vendor. If the wrong form is submitted it will also be returned to the provider by the DHCFP's QIO-like vendor.

2203.14B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, all Providers must:

1. refer to the QIO-like vendor Provider Billing Procedure Manual for detailed instructions for completing and submitting the CMS-1500 form; and

~~2. maintain documentation to support claims billed for a minimum of six years from the date the claim is paid.~~

2203.~~15~~17 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed provider agencies give their clients information about their decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to MSM 100 for further information.

ADSD will provide information on Advance Directives to each applicant and/or the authorized/legal representative. The signed form is kept in each applicant's file at the local ADSD office. Whether an applicant chooses to write his or her own Advance Directives or complete the Advance Directives form in full is the individual choice of each applicant and/or each applicant authorized/legal representative.

~~2203.16 ANNUAL WAIVER REVIEW~~

~~The DHCFP and ADSD have formal systems in place to conduct annual reviews. The purpose of the review is to assure the health and welfare of the recipients, the recipients' satisfaction with the waiver services and providers, the qualifications of waiver providers to deliver services/supports, and assurance of the cost effectiveness of these services.~~

~~2203.16A COVERAGE AND LIMITATIONS~~

~~The State conducts an annual review, which is collaboratively conducted by ADSD and the DHCFP, with the DHCFP being the lead agency. The DHCFP:~~

~~1. provides CMS annually with information regarding the impact of the waiver on the type, amount, and cost of services provided under the waiver and under the State plan, and through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of the recipients served on the waiver;~~

~~2. assures financial accountability for funds expended for HCBW services;~~

~~3. evaluates that all provider standards are continuously met, and that the POCs are periodically reviewed to assure that the services furnished are consistent with the identified needs of the recipients;~~

~~4. evaluates the recipients' satisfaction with the waiver program; and~~

~~5. further assures that all problems identified by this monitoring will be addressed by the provider in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.~~

~~2203.16B PROVIDER RESPONSIBILITIES~~

~~ADSD and waiver providers must cooperate with the DHCFP's annual review process.~~

2204 HEARINGS REQUESTS DUE TO ADVERSE ACTIONS

An adverse action refers to denials, terminations, reductions, or suspensions of applicant's request for services or a recipient's eligibility determination. The DHCFP must grant an opportunity for a hearing to an applicant/recipient/designated representative in the event an adverse action is taken by the DHCFP.

2204.1 SUSPENDED WAIVER SERVICES

A. A recipient's case ~~may~~ must be suspended, instead of closed if it is likely the recipient will be eligible again for waiver services within the next 60 days.

~~(f~~For example, if a recipient is admitted to a hospital, ~~nursing facility~~NF or Intermediate Care Facility for the Intellectually Disabled (ICF/IID~~ICF/MR~~).

B. After receiving written documentation from the ~~c~~Case ~~m~~Manager (HCBS Waiver Eligibility Form ~~NMO-2734~~) of the suspension of waiver services, a NOD identifying the effective date and the reason for suspension will be sent to the recipient by the DHCFP ~~Central Office Waiver~~TSS Unit.

~~A.~~C. Waiver services will not be paid for the days that a recipient's ~~case~~ eligibility is in suspension.

~~B.~~D. If at the end of the 45 calendar days since admission the recipient has not been removed from suspended status, the case must be closed. The ADSD sends ~~a NOA to~~ the "HCBS Waiver Eligibility Status Form" to the DHCFP LTSS ~~Central Office Waiver~~ Unit on or before the 45th day of suspension, identifying the 60th day of suspension as the effective date of termination and the reason for the waiver termination.

~~C.~~E. The DHCFP ~~Central Office Waiver~~ Unit sends a NOD, ~~via the DHCFP Hearings Unit,~~ to the recipient and/or the ~~recipient's~~ designated ~~authorized~~ representative/LRI advising him or her of the date and reason for the waiver closure/termination.

2204.2 RELEASE FROM SUSPENDED WAIVER SERVICES

~~If~~ When a recipient has been released from the hospital or ~~nursing facility~~NF before 60 calendar days of the admit date~~have elapsed~~, the Case Manager must do the following within five ~~working~~ business days of the recipient's discharge~~, the case manager must~~:

~~A. assess the LOC for continued eligibility and complete a new form if it appears the recipient no longer meets a LOC;~~

~~B.~~A. ~~c~~Complete a reassessment if there has been a significant change in the recipient's condition or status;

~~C.~~B. ~~c~~Complete a new POC if there has been a change in services (medical, social or waiver). If a change in services is expected to resolve in less than 30 days, a new POC is not necessary. Documentation of the temporary change must be made in the ~~c~~Case ~~m~~Manager's ~~notes~~narrative. The date of resolution must also be documented in the ~~c~~Case ~~m~~Manager's ~~notes~~narrative; and

~~D.~~C. ~~c~~Contact the service provider(s) to reestablish services.

2204.3 DENIAL OF WAIVER APPLICATION

Basis of denial for waiver services:

A. The applicant is under the age of 65 years.

B. The applicant does not meet the LOC criteria for ~~nursing facility~~NF placement.

C. The applicant has withdrawn his or her request for waiver services.

D. The applicant fails to cooperate with the ADSD or HCB~~W~~S Waiver service providers in establishing and/or implementing the POC, implementing waiver services or verifying eligibility for waiver services. (The applicant's and/or ~~their authorized~~designated representative/LRI's signature is necessary for all required paperwork.)

E. The applicant's support system is not adequate to provide a safe environment during the time when HCB~~W~~S Waiver services are not being provided.

F. The ADSD has lost contact with the applicant.

G. The applicant fails to show a need for HCB~~W~~S Waiver services.

H. The applicant would not require ~~nursing facility~~NF placement within 30 days or less if HCB~~W~~S services were not available.

I. The applicant has moved out of state.

J. Another agency or program will provide the services.

K. The ADSD has filled the number of positions (slots) allocated ~~to the HCBW for the Frail Elderly~~. The applicant has been approved for the waiver wait list and will be contacted when a slot is available.

L. The applicant is in an institution (e.g. hospital, ~~nursing facility~~NF, correctional facility, ICF/~~MR~~IID) and discharge within 60 calendar days is not anticipated.

M. The applicant has chosen a provider or facility that is not an enrolled or qualified Medicaid provider. Note: The Case Manager should provide a list of Medicaid providers to the applicant. The Case Manager will inform the provider that all entities providing services must be enrolled as a Medicaid provider and facilitate contact information to the DHCFP's Fiscal Agent.

N. There are no enrolled Medicaid providers or facilities in the applicant's area.

When the application for waiver services is denied, the ADSD C~~c~~ase ~~m~~Manager sends a~~n NOA to the~~ "HCBS Waiver Eligibility Status Form" to the DHCFP ~~Central Office Waiver~~LTSS Unit. The DHCFP ~~Central Office Waiver~~LTSS Unit sends a NOD to the applicant, ~~via the DHCFP Hearings Unit~~ letting them know that waiver services have been denied and the reason for the denial.

2204.4 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver or to terminate the recipient from the waiver wait list:

~~A. The recipient has failed to pay his/her patient liability.~~

~~B.~~A. The recipient no longer meets the ~~level of care~~LOC criteria for ~~nursing facility~~NF placement.

~~C.~~B. The recipient no longer meets other eligibility criteria as determined by the DWSS.

~~D.~~C. The recipient and/or designated ~~/authorized~~ representative/LRI ~~has~~ have requested termination of waiver services.

~~E.~~D. The recipient has failed to cooperate with the ADSD or HCB~~W~~S Waiver service providers in establishing and/or implementing the POC, implementing waiver services, or verifying eligibility for waiver services. (The recipient's and/or the designated ~~recipient's authorized~~ representative/LRI's signature is necessary on all required paperwork).

~~F.~~E. The recipient's support system is not adequate to provide a safe environment during the time when HCB~~W~~S Waiver services are not being provided.

~~G.~~F. The recipient fails to show a continued need for HCB~~W~~S Waiver services.

~~H.~~G. The recipient is no longer at risk of imminent placement in an ~~nursing facility~~institution within 30 days or less if waiver services were not available.

~~I.~~H. The recipient has moved out of state.

~~J.~~I. The recipient has signed fraudulent documentation on one or more of the provider time sheets and/or forms.

~~K.~~J. Another agency or program will provide the services.

~~L.~~K. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, ~~nursing facility~~NF, correctional facility, or intermediate facility or ICF/IID~~for persons with mental retardation~~).

~~M.~~L. The ADSD has lost contact with the recipient.

~~N.~~M. The physical environment in a residential facility for groups is not safe for the recipient's individual health condition.

~~O.~~N. The recipient's swallowing ability is not intact and requires skilled service for safe feeding/nutrition. Residential facilities for groups are not licensed to provide skilled services. Recipients with a gastrostomy-tube must be competent and manage their tube feeding or they are prohibited by HCQC licensure to be admitted into a residential facility for groups.

~~P.~~O. The recipient has been placed in a residential facility for groups that does not have a provider agreement with the DHCFP. Note: The ADSD's Case Manager should work with the provider before terminating the recipient waiver services, explain that all entities providing services must be enrolled as a Medicaid provider and facilitate contact information to the DHCFP's Fiscal Agent.

P. The recipient of a residential facility for groups chooses to return to independent community living which may not be a safe environment.

Q. Death of Recipient.

When a recipient is terminated from the waiver ~~program~~, the ~~ADSD c~~Case ~~m~~Manager sends the DHCFP ~~Central Office Waiver~~ LTSS Unit the "HCBS Waiver Eligibility Form" ~~an NOA~~ stating the date of termination and the reason(s) for the termination. The DHCFP ~~Central Office Waiver~~LTSS Unit sends a NOD ~~via the Hearings Unit~~ to the recipient and/or ~~to the recipient's authorized~~designated representative/LRI. The NOD must be mailed ~~by~~ to the DHCFP, Hearings Unit, at least 13 calendar days before the listed date of action on the form. Refer to MSM, Chapter 3100 Hearings, for specific instructions regarding notice and recipient hearings.

When a termination from waiver services is due to the death of a recipient, the DWSS will terminate the case, and it will notify the ADSD, and the DHCFP of the date of death.~~informed agency (ADSD, DHCFP or DWSS) will notify the other two agencies of the date of death~~.

2204.5 REDUCTION OF WAIVER SERVICES

Reasons to reduce services are:

A. The recipient no longer requires the number of service hours/level of service which was previously provided.

B. The recipient no longer requires the service previously provided.

C. The recipient's support system is capable of providing the service.

D. The recipient has failed to cooperate with the ADSD ~~c~~Case ~~m~~Manager or HCB~~W~~S Waiver service provider(s) in establishing and/or implementing the POC, implementing waiver services or verifying eligibility for waiver services (the recipient~~'s~~ and/or designated~~the recipient's authorized~~ representative/LRI's signature is necessary on all required paperwork.)

E. The recipient has requested the reduction of services.

F. The recipient's ability to perform ~~activities of daily living~~ADLs has improved.

G. Another agency or program will provide the service.

H. Another service will be substituted for the existing service.

When there is a reduction of waiver services, the updated prior authorization will be submitted, and a NOD will be generated. A hearing can be requested through the Hearings Unit by the recipient and/or designated~~the recipient's authorized~~ representative/LRI. The ~~form~~ NOD must be

mailed ~~by~~ to the DHCFP Hearings Unit ~~to the recipient~~ at least 13 calendar days before the Date of Action on the form.

Refer to MSM Chapter 3100 Hearings, for specific instructions regarding notice and recipient hearings.

2204.6 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

If a recipient is placed in a NF or hospital and waiver services have been terminated, ~~and~~ the recipient ~~is~~may request~~ing~~ to be re-~~approval~~instated within 90 days of closure~~,~~. ~~the recipient still meets a LOC and there is an available waiver slot.~~

2204.6A COVERAGE AND LIMITATIONS

~~1. If waiver services have been terminated and the recipient is requesting re-approval within 90 days of closure, the recipient still meets a LOC and there is an available waiver slot.~~

1. The waiver slot must be held for 90 days from the NOD date.
2. The recipient may request to be placed back on the waiver if:

   a. They still meet LOC;

   b. There is a slot available;

   c. And is released within 90 days.

3. If the termination took place in a prior waiver year and the recipient still meets a LOC, slot availability and emergent need will be taken into consideration for readmission into the waiver.

~~The ADSD case manager completes and sends to the Medicaid Central Office Waiver Unit the following:~~

~~a. A LOC form;~~

~~b. Social Health Assessment;~~

~~c. A new SOU if there has been a change in the authorized/legal representative;~~

~~d. A new POC if services have changed; and~~

~~e. A Form NMO 2734 requesting the DHCFP Central Office Waiver Unit approval with the date of approval indicated.~~

~~f. All required forms must be complete with signatures and dates as applicable.~~

~~2.~~4. If 90 calendar days has elapsed from the NOD date the~~a recipient is terminated from the waiver for more than 90 days~~, slot~~s~~ is allocated to the next person on the waitlist~~are available and the recipient is eligible for readmission to the waiver as defined in Section 2203.13A.3, a complete waiver packet must be forwarded to the DHCFP Central Office Waiver Unit for authorization~~.

2204.6B PROVIDER RESPONSIBILITIES

ADSD will ensure appropriate action is taken when re-authorizing a recipient~~forward all necessary forms to the DHCFP Central Office Waiver Unit for approval~~.

2204.6C RECIPIENT RESPONSIBILITIES

Recipients must cooperate fully with the reauthorization process to assure approval of ~~his/her~~ request for readmission to the waiver.

2205 APPEALS AND HEARINGS

Refer to MSM Chapter 3100 Hearings for specific instructions regarding notice and hearing procedures. Recipients are informed of their rights to a fair hearing at the initial face-to-face visit and annually thereafter when they are given the Recipients Rights Form.