BRIAN SANDOVAL
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
1100 E. William Street, Suite 101
Carson City, Nevada 89701
(775) 684-3600

MICHAEL J. WILLDEN
Director

CHARLES DUARTE
Administrator

NOTICE OF PUBLIC WORKSHOP

Personal Care Services (PCS)
Flexibility of Service Language Revision

Date of Publication:	**December 12, 2012**
Date and Time of Meeting:	**January 8, 2013,** **2:00 pm – 4:00 pm**
Name of Organization:	**The State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP)**
Place of Meeting:	**Northern Nevada Center for Independent Living (NNCIL)** **999 Pyramid Way** **Sparks, Nevada 89431**
Place of Video-Conference:	**Northern Nevada Center for Independent Living (NNCIL)** **331 7th Street** **Elko, NV 89801** **Rebuilding All Goals Efficiently (RAGE)** **2901 El Camino Avenue, Suite 102** **Las Vegas, Nevada 89102**

Agenda

1. **Presentation and Public Comment Regarding Personal Care Services (PCS)**

   a. **The purpose of this workshop is to introduce, discuss and gather stakeholder information on proposed PCS flexibility of service delivery language.**

   b. **Public Comment regarding revised PCS flexibility of service language.**

2. **Other Public Comment on any other DHCFP issue**

3. **Adjournment**

Two or more agenda items may be combined for consideration. Items may be removed from the agenda or discussion of items may be delayed at any time.

Notice of this public workshop meeting and draft copies of the changes will be available on or after the date of this notice at the DHCFP Web site (dhcfp.nv.us); Carson City Central office and Las Vegas DHCFP. The agenda posting of this meeting can be viewed at the follow locations: Nevada State Library; Carson City Library; Churchill County Library; Las Vegas Library; Douglas County Library; Elko County Library; Lincoln County Library; Lyon County Library; Mineral County Library; Tonopah Public Library; Pershing County Library; Goldfield Public Library; Eureka Branch Library; Humboldt County Library; Lander County Library; Storey County Library; Washoe County Library; and White Pine County Library and may be reviewed during normal business hours.

If requested in writing, a copy of the proposal will be mailed to you. Requests and/or written comments on the proposed changes may be sent to the Division of Health Care Financing and Policy, 1100 E. William Street, Suite 101, Carson City, NV 89701.

All persons that have requested in writing to receive the Public Workshop Agenda have been duly notified by mail or e-mail.

Note: We are pleased to make reasonable accommodations for members of the public who are physically challenged and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Division of Health Care Financing and Policy, in writing, at 1100 East William Street, Suite 101, Carson City, or call Rita Mackie at (775) 684-3681, as soon as possible, or e-mail at rmackie@dhcfp.nv.gov

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December 11, 2012

Inter-Tribal Council of Nevada
Billy A. Bell, Tribal Chairman
P.O. Box 457
Ft. McDermitt, NV 89421

Indian Health Board of Nevada
Alvin Moyle, President
556 Rio Vista Road
Fallon, NV 89406

Dear Sirs:

In accordance with established consultation guidelines, the Division of Health Care Financing and Policy (DHCFP) is notifying Nevada tribes of the following proposed change in policy regarding Chapter 3500, Personal Care Services (PCS).

Revisions are being made to the current Flexibility of Service Delivery policy. The total weekly authorized hours for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The provider and recipient will determine how to use the weekly authorized hours on an ongoing basis; however, any changes that do not increase the total authorized hours can be made within a single week without an additional authorization.

There is no anticipated fiscal impact to the policy revision.

If you would like a consultation regarding this new policy, please contact Crystal Johnson at (775) 684-3722 who will schedule a meeting. We would appreciate a reply whether or not you would like this consultation, however if we do not hear from you within 30 days from the date of this letter we will consider that an indication that no consultation is requested.

Sincerely,

Elizabeth Aiello,
Acting Administrator

Cc: Connie Anderson, Chief, Continuum of Care
Tammy Moffitt, SSPS III, Continuum of Care

NOTICE OF PROPOSED REGULATORY ACTION

Regulation or Other Reference:	Medicaid Services Manual (MSM) Chapter 3500, Personal Care Services (PCS)
Requesting Agency:	**DIVISION OF HEALTH CARE FINANCING AND POLICY**

☒ ***Intended Action (30 day notice to public)*** *(Governor's office to be notified before notice is distributed to the public)*

☐ Adoption
☒ Amendment
☐ Repeal

Date of Intended Action:

☐ ***Workshop (15 day prior notice)*** *(Governor's office to be notified before notice is distributed to the public)*

Date of Workshop: January 8, 2013

Notify Governor's office at least 10 days prior to final adoption of regulations

Action is consistent with Governor's regulatory priorities (check all that apply):

☐	a. Affects public health
☐	b. Affects public safety and security
☐	c. Necessary for the pursuit of federal funds and certifications
☒	d. Affects the application of powers, functions and duties essential to the operation of the state agency, department, board or commission at issue
☐	e. Affects pending judicial deadlines
☐	f. Necessary to comply with federal law
☐	g. Regulations will have a positive economic impact for the people of the State of Nevada.

Regulatory Language must be provided as soon as possible.

Original draft ☐ ***Revised language*** ☒

☒ is attached
☐ will be sent

(Send copy of proposed language to agency liaison in Governor's office)

1. What is the problem the regulation is designed to address? Or, if the regulation does not address a specific problem, the value to the public of the regulation?

Medicaid Services Manual (MSM) Chapter 3500 is the Medicaid Policy that outlines program operations for Personal Care Services (PCS).

The program's value to the public is its ability to assist, support, and maintain independent living for people with disabilities and chronic conditions. The program provides supports in the home and also provides support in community settings such as employment sites. Because of this service, persons with disabilities and chronic conditions can lead more independent lives in the community, and the risk of being placed in institutional care is decreased. In addition, since community based services cost significantly less than institutional services, the program has additional value in that it provides a low cost alternative to institutional services in Nevada.

The intent of this policy change is to revise MSM Chapter 3500 to allow for total weekly authorized PCS hours for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) to be combined and tailored in order to meet recipient needs, as long as medical necessity is not altered. The recipient and provider will determine how the weekly hours will be used on an ongoing basis and any changes made within a single week may not go over the total authorized hours.

2. What is the anticipated impact of the regulation on the problem or the anticipated benefits provided by it?

This policy change will allow recipients to use their authorized personal care service hours in a manner that is best suited to their individual needs, conditions and circumstances on a weekly basis.
3. What is the anticipated adverse impact, if any, on impacted groups – including, but not limited to, businesses of all sizes, small communities and government entities?
None anticipated.

4. What is the anticipated cost – both directed and indirect – of the regulation, including, but not limited to, the cost of enactment, enforcement and compliance?
None anticipated.
5. Why is the regulation necessary?
The DHCFP has become aware that being too prescriptive in how personal care services are provided on a weekly basis may cause undue hardship for some recipients. Since the intent of the program is to assist individuals to safely remain in their homes and community, allowing more flexibility in how services are provided, within prescribed policy, will assist recipients to get the authorized services in a manner that best suits their needs. A recipient's condition or circumstance can often change on a daily or weekly basis so this policy revision will allow the recipient a viable avenue to change how their services are provided, according to their needs. The provider community welcomes this change as it will allow their businesses to provide services in a more efficient manner than what is currently written in policy.
6. Are there alternate forms of regulation sufficient to address the problem?
No.
7. Is the regulation written clearly and concisely so as to achieve easy understanding and application?
Yes
8. Do other regulations address the same problem?
No

Elizabeth Ciello (acting) Division Administrator	12/11/12 Date
Tammy Moffit Agency Contact Name & Number	12-11-12 Date

h. receive information upon request regarding DHCFP's policies and procedures, including information on charges, reimbursements, service plan determinations, and opportunity for fair hearing;

i. request a change of Provider;

j. request a change from Provider Agency services to a different service delivery model;

k. have access, upon request, to his or her Medicaid recipient files;

l. request a Fair Hearing if there is disagreement with DHCFP's action(s) to deny, terminate, reduce, or suspend services; and

m. receive in writing the name and contact telephone number of the Governor's Health Assistance Bureau for Hospital Patients. (Toll free telephone number: (888) 333-1597).

3503.1D CONFLICT OF INTEREST STANDARDS

The DHCFP assures the independence of contracted providers performing FAs. Physical and occupational therapists who perform FAs must be an independent third party and may not be:

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

2. financially responsible for the individual;

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

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

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

Note: To insure the independence of individuals performing the FA, providers are prohibited from contacting the physical or occupational therapists directly.

3503.1E AUTHORIZATION PROCESS

1. Prior Authorization

For all initial and reassessment requests for PCS, a physical or occupational therapist will complete the FA for all Medicaid recipients. The DHCFP's QIO-like vendor will complete the service plan and authorize services for all Medicaid recipients. The approved prior

authorization document includes the dates of service, hours and time per day, the number of days per week, and the total authorized units per billing cycle.

Providers must bill only for the dates when services were actually provided, in accordance with the appropriate billing manual. For instance, if services were provided on Monday March 16, Wednesday March 18 and Friday March 20, providers should only bill for those specific dates and not for the entire week's date range.

A PA number will be assigned by the QIO-like vendor, and must be included on all claims submitted for reimbursement. See Section 3503.1D.5 reimbursement section later in this Chapter.

All other authorization requests must be submitted to the QIO-like vendor using the following procedure:

a. Initial Requests - Requests for FAs to initiate PCS are submitted to the QIO-like vendor and can be made by the recipient, a LRI, PCR or individuals covered under the confidentiality requirements of HIPAA. Initial requests may not be made by providers.

   The QIO-like vendor validates that the recipient meets PCS criteria, and if so, will provide the recipient with a list of enrolled and trained physical or occupational therapists to select from for completion of the FA. If the recipient has no preference, then the QIO-like vendor will assign a physical/occupational therapist to complete the FA.

   The recipient is responsible for scheduling and keeping the appointment with the physical or occupational therapist for completion of the FA.

   Taking into account the physical or occupational therapists clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS.

   After completion of the FA, it will be forwarded to the QIO-like vendor, who will continue to the process identified in 3503.1E.1.

a. At Risk Recipient Requests

   Upon receipt of a request for an initial FA, the QIO-like vendor will first complete a risk assessment over the phone, to identify those recipients for whom PCS are urgent to avoid institutionalization, or for whom the service need is the result of an acute medical condition or loss of a primary caregiver or LRI. The intent of the

telephonic risk assessment is to determine if a recipient is at risk of losing or being unable to return to a community setting because of the need for PCS.

When a recipient determined "at risk", the QIO-like vendor will provide a temporary service authorization and make an immediate referral to the DHCFP District Office's Care Coordination Unit. If needed, the Care Coordination Unit will assist the recipient in accessing a physical or occupational therapist and an available Provider Agency.

The QIO-like vendor will provide the recipient with a list of enrolled and trained physical or occupational therapists to select from for completion of the FA. If the recipient has no preference, then the QIO-like vendor will assign a physical/occupational therapist to complete the FA.

The recipient is responsible for scheduling and keeping the appointment with the physical or occupational therapist for completion of the FA.

The selected Provider Agency is notified when a recipient is at risk and agrees, by accepting the case, to initiate needed services within twenty-four (24) hours of case acceptance. The approved service plan and authorization document are faxed to the provider upon acceptance. All other policies in Section 3503.1 apply.

c. Reassessment Requests

Authorizations for PCS are issued by the QIO-like vendor for periods not to exceed one year. Reassessment requests for ongoing services must be submitted to the QIO-like vendor at least 30 calendar days prior to the expiration date of the prior authorization. The request must be submitted on the QIO-like vendor request form specific to PCS. The form includes all required recipient and provider information as well as the units requested and the dates of service for the service interval requested.

d. Significant Change Requests

Requests for reassessment due to significant change in the recipient's condition or circumstances must be submitted to the QIO-like vendor as soon as the significant change is known. A request for reassessment due to significant change in the recipient's condition or circumstances must be accompanied by documentation from the recipient's physician or health care provider.

Significant change in condition may be demonstrated by, for example, a recent hospitalization (within past 14 days), a physician's visit (within past seven days)

resulting in an exacerbation of previous disabling condition, or a new diagnosis not expected to resolve within 30 days.

Significant change in circumstances may include such circumstances as absence, illness, or death of the primary caregiver or LRI.

Significant change in condition or circumstances expects imminent hospitalization or other institutional placement if PCS are not reassessed to meet the recipient's change in service needs.

~~1.~~2. Flexibility of Services Delivery

~~Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization or change in the service plan. This flexibility must demonstrate and document the needs of the recipient, as documented in the approved service plan, and must not take place solely for the convenience of the Provider or the PCA. Documentation of flexibility within a single week must be reflected in the recipient's file.~~

The total weekly authorized hours for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The provider and recipient will determine how to use the weekly authorized hours on an ongoing basis; however, any changes that do not increase the total authorized hours can be made within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider or PCA. The following requirements must be met:

a. Initial Authorized PCS

1. Upon receipt of an initial service plan from the QIO-like vendor, the provider must meet with the recipient in person to determine how ADLs and/or IADLs will be provided to meet the individual's weekly needs.

2. Written documentation of the contact with the recipient regarding provision of services must be maintained in the recipient's file.

b. Annual Reassessment or Update

1. Any change in a service plan must be discussed between the provider and the recipient. This may be done either in person or via the telephone in order to determine how ADLs and/or IADLs will be provided.

2. Changes may be requested on a daily and/or weekly basis when necessary to meet a change in circumstance or condition.

3. The PCS provider must follow their established policies and procedures in order to timely meet recipient requests for changes in service delivery.

4. Written documentation of the contact with the recipient regarding service plan revision must be maintained in the recipient's file.

3. Changes to the Service Plan

When the recipient has an unexpected change in condition or circumstance which requires short-term (less than four weeks) modification of the current service plan and authorization, a new FA is not required. Such a modification is considered in, but is not limited to, the following circumstances:

a. Additional PCS are required for a short time as the result of an acute medical episode or during a post-hospitalization period.

b. A reduction in PCS is requested as a result of improvement in the functional abilities of the recipient or the availability of a LRI to assist with providing PCS.

c. The following procedure must be followed for all short-term modifications of the approved service plan:

1. Documentation must be maintained in the recipient's record of the circumstances that required the short term modification(s) of the approved service plan;

2. Documentation of the short-term modifications of the approved service plan must be completed and sent to the QIO-like vendor and the appropriate home and community-based waiver case manager. The

recipient's signature is not required; however, see item ~~3~~three in this section. Documentation must include the recipient's name, Medicaid number, service level, and the dates during which the modified service plan will be in effect;

3. Documentation must be maintained in the recipient's record that the recipient participated in the development of the modified service plan, including date and method of contact with the recipient;

4. The recipient must be sent a written copy of the modified service plan immediately upon completion; and

5. Upon expiration of the modified service plan, the recipient's original approved service plan is automatically reinstated unless a new FA and service plan are completed due to a significant change in the recipient's condition or circumstance.

4. Single-Service Authorization Request

The recipient's Provider Agency may submit a single-service authorization request, when the recipient requires an extra visit for an unanticipated need(s), such as bowel or bladder incontinence. The Provider Agency must document the medical necessity of the services requested and be the designated provider for the current authorization period. A new FA is not required in these single-service situations.

5. Mileage Authorization Request

Mileage for travel to and from a recipient's home or for shopping is not reimbursable to PCS providers, except in hardship situations in remote or rural areas of the state, where failure to reimburse mileage expenses would severely limit available paid caregivers. Mileage must be approved in advance by the DHCFP District Office care coordinator on a case-by-case basis. The care coordinator will notify the QIO-like vendor of the actual approved mileage. The QIO-like vendor will issue all authorization numbers.

6. Reimbursement

Medicaid reimbursement is made directly to the Provider Agency for services billed using service code T1019.The reimbursement rate is based on a contracted rate which takes into consideration and includes the costs associated with doing business. Consequently, separate reimbursement is not available for the following:

a. Time spent completing administrative functions such as supervisory visits, scheduling, chart audits, surveys, review of service delivery records and personnel consultant;

b. The cost of criminal background checks and TB testing;

c. Travel time to and between recipients home;

d. The cost of basic training, in-service requirements and the CPR and First Aid requirement; and/or

e. Routine supplies customarily used during the course of visits, including but not limited to non-sterile gloves.

7. Improper Billing Practices

Any Provider found by the State or its agent(s) to have engaged in improper billing practices, without limitations, may be subject to sanctions including recoupment, denial or termination from participation in Nevada Medicaid.

The findings and conclusions of any investigation or audit by the DHCFP shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.

Improper billing practices may include, but are not limited to:

a. submitting claims for unauthorized visits;

b. submitting claims for services not provided, for example billing a visit when the recipient was not at home but the PCA was at the recipients residence;

c. submitting claims for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and exact time in and out of the recipients home. Providers shall submit or produce requested documentation upon request of the DHCFP staff;

d. submitting claims for unnecessary visits or visits that are in excess of amount, scope and duration necessary to reasonably achieve its purpose;

e. billing for the full authorized number of units when they exceed the actual amount of service units provided; or

f. submitting claims for PCS services provided by an unqualified paid PCA.

Any PCS or other provider who bills the DHCFP for services rendered by a PCA who has not met all the requirements of this chapter at the time services were rendered (including requirements involving TB testing, training, CPR certification, and criminal background checks) is subject to all administrative and corrective sanction and recoupment's listed in the MSM, Chapter 3300. Any such action taken against a provider by the DHCFP has no bearing on any criminal liability of the provider.

8. Overpayments

All Medicaid overpayments are subject to recovery.

3503.2 SERVICES TO CHILDREN – COVERAGE AND LIMITATIONS

An able and capable parent and/or legal guardian of a minor child, has a duty/obligation to provide the child necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes, but is not limited to, the provisions of ADLs and IADLs. Payment will not be made for the routine care, supervision or services normally provided for the child without charge as a matter of course in the usual relationship among members of the nuclear family.

PCS are not a substitute for natural and informal supports provided by family, friends or other available community resources; however, are available to supplement those support systems so the child is able to remain in the home. LRIs may not be reimbursed by Medicaid for PCS services.

PCS for children with disabilities may be appropriate when there is no legally responsible, able, and capable parent, as defined by the DHCFP, to provide all necessary personal care. Documentation verifying that the recipient's parent or LRI is unavailable or incapable as defined in the MSM Addendum must be provided upon request.

In authorizing PCS services to Medicaid eligible children, the FA factors in the age and developmental level of the child as well as the parental ability and capability to provide the child's personal care needs.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are available to children under the age of twenty-one (21). EPSDT may provide a vehicle for receiving medically necessary services beyond limitations imposed PCS. Services must be deemed medically necessary and prescribed by a physician. Authorization of additional services under EPSDT must take into account the responsibilities of the LRI and age-appropriate service provision as discussed above.

Housekeeping tasks are limited directly to the provision of PCS, such as cleaning the bathtub/shower after a bath/shower has been given. Time is allocated under the bathing task and is not an additional service. When a recipient lives with a parent or other LRI, it is the responsibility of the LRI to perform specific housekeeping tasks, other than those which are incidental to the performance of Personal Care tasks. This includes, but is not limited to other housekeeping tasks, meal preparation, essential shopping, and escort services. All other policies in Section 3503.1 A through D inclusive apply.

3503.3 PCS SERVICES FOR HOME AND COMMUNITY-BASED WAIVER (HCBW) RECIPIENTS

Recipients who are Medicaid eligible under a HCBW are eligible for all State Plan services (including PCS) within individual State Plan service policies.

All policies identified in Section 3503.1 A through D inclusive apply. HCBW Case Managers authorize waiver services.

3503.4 PCS FOR RECIPIENTS ENROLLED IN HOSPICE

PCS may be provided for recipients enrolled in hospice when the need for PCS is unrelated to the terminal condition, and the personal care needs exceed the PCS provided under the hospice benefit.

If a recipient enrolls in hospice, the DHCFP or its designee will conduct an evaluation of an individual's comprehensive personal care needs. The evaluation will differentiate between personal care needs unrelated to the terminal condition and those needs directly related to hospice, clearly documenting total personal care needs. PCS provided under hospice will be subtracted from total PCS needs to document any personal care needs not met by hospice services and which may be provided by the PCA. The PCS provided by a PCA to a recipient because of needs unrelated to the terminal condition may not exceed State Plan program limitations.

3503.5 OUT-OF-STATE (OOS) SERVICES

PCS are allowed OOS for Nevada Medicaid recipients absent from Nevada. OOS PCS are subject to the same limitations and reimbursement as in-state PCS. The recipient or the PCR is responsible for locating PCS OOS. The QIO-like vendor should be contacted for information on OOS PCS agencies' enrollment as a Nevada Medicaid Provider.