


MEDICAID SERVICES MANUAL  
TRANSMITTAL LETTER

May 10, 2011

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE 

SUBJECT: MEDICAID SERVICES MANUAL CHANGES  
CHAPTER 2100 – HOME AND COMMUNITY-BASED WAIVER  
(HCBW) FOR PERSONS WITH MENTAL RETARDATION AND  
RELATED CONDITIONS

**BACKGROUND AND EXPLANATION**

Medicaid Services Manual Chapter 2100 Home and Community-Based Waiver MR has been revised for the following reasons:

- Updated Criminal Background check section to include 5 year requirement as found in all MSM chapters.
- Removed age requirement can be waived with approval by MHDS under several service sections in this chapter.
- Changed requirements for effective date of waiver services for recipients who have a service contract.
- Added age requirement of 18 years of age to Provider Responsibilities throughout the chapter.

These policy changes are effective May 11, 2011.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 05/11 CHAPTER 2100 – HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR PERSONS WITH MENTAL RETARDATION AND RELATED CONDITIONS	MTL 49/10 CHAPTER 2100 – HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR PERSONS WITH MENTAL RETARDATION AND RELATED CONDITIONS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2102	Definitions	Added the following definitions: <ul style="list-style-type: none"> <li>• Annual</li> </ul>

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		<ul style="list-style-type: none"> <li>• Applicant</li> <li>• Statement of Choice</li> </ul> <p>Clarified the following definitions:</p> <ul style="list-style-type: none"> <li>• Direct Services</li> <li>• Direct Supports</li> <li>• Instrumental Activities of Daily Living (IADLs)</li> <li>• Participant-Directed Budget</li> <li>• Periodic Reevaluations</li> <li>• Slot</li> </ul>
2103.1	<b>Waiver Eligibility Criteria</b>	Clarified home and community-based services.
	<b>Coverage and Limitations</b>	Clarified Collaborative case coordination.
2103.2	<b>Waiver Services – Provider Responsibility</b>	Clarified all providers’ responsibilities.
		Added updated language with 5 year requirement for Criminal Background checks.
2103.4	<b>Day Habilitation – Provider Responsibilities/Qualifications</b>	Removed unnecessary language and added and individual provider must be at least 18 years of age.
2103.5	<b>Residential Habilitation Direct Services and Support – Coverage and Limitations</b>	Updated language for Direct Services and Support.
	<b>Provider Responsibilities</b>	Updated Provider Responsibilities including that a Quality Assurance review for certification must be done at least every 3 years.
2103.7	<b>Supported Employment – Provider Responsibilities/Qualifications</b>	Removed unnecessary language and updated existing policy.
2103.9	<b>Community</b>	Removed unnecessary language and updated

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
	<b>Integration Services – Provider Responsibilities/Qualifications</b>	existing policy.
2103.12	<b>Non-Medical Transportation – Provider Responsibilities/Qualifications</b>	Removed unnecessary language and updated existing policy.
2103.16	<b>Intake Procedures – Coverage and Limitations</b>	Added language to state that MHDS may release information about a recipient to providers that the recipient has selected and that it may be necessary to begin waiver services on the 1 <sup>st</sup> of the month to coincide with Service Contracts.
2103.17	<b>Billing Procedures</b>	Removed Provider Responsibility section pertaining to First Health Services.
2104.4	<b>Termination of Waiver Services</b>	Clarified Language.
2104.5	<b>Reduction or Denial of Waiver Services</b>	Added Denial to policy.



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2100 INTRODUCTION

The Home and Community-Based Waiver (HCBW) Program recognizes that many individuals at risk of being placed in intermediate care facilities for persons with mental retardation can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Nevada's Waiver for Persons with Mental Retardation and Related Conditions originated in 1982. 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 Division of Mental Health and Developmental Services (MHDS) and by the Division of Health Care Financing and Policy (DHCFP) and presented to the Nevada State Legislature for approval. Nevada is committed to the goal of providing persons with mental retardation or related conditions with the opportunity to remain in a community setting in lieu of institutionalization. MHDS and DHCFP understand that people who have mental retardation or a related condition are able to lead satisfying and productive lives when they are provided the services and supports needed to do so. Both MHDS and DHCFP are committed to the goals of self-sufficiency and independence.

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2101 AUTHORITY

Section 1915(c) of the Social Security Act 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. DHCFP's Home and Community-Based Waiver (HCBW) for Persons with Mental Retardation and Related Conditions is 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.

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) (Provisions Respecting Inapplicability and Waiver of Certain Requirements)
- Social Security Act: 1902 (A) (State Plans for Medical Assistance)
- Social Security Act: 1902 (w) (State Plans for Medical Assistance)
- Code of Federal Regulations (CFR) (Title 42) 435.1009, (Institutionalized Individuals)
- CFR (Title 42) Part 431, Subpart E (Fair Hearings for Applicants and Recipients)
- CFR (Title 42) Part 441, Subpart G (Home and Community-Based Services (HCBS): Waiver Requirements)
- CFR (Title 42) Part 441, Subpart I (Community Supported Living Arrangements Services)
- CFR (Title 42) Part 483.430(a) (Qualified Mental Retardation Professional (QMRP))
- State Medicaid Manual 4440 (HCBS – Basis, Scope and Purpose)
- Omnibus Budget Reconciliation Act (OBRA) of 1987
- Balanced Budget Act of 1997

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- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Nevada’s HCBW Agreement for Persons with Mental Retardation and Related Conditions
- Nevada Revised Statutes (NRS) Chapter 232.357 (Limitations on Sharing Confidential Information by Divisions)
- NRS Chapter 422 (Health Care Financing and Policy)
- NRS Chapter 424 (Foster Homes for Children)
- NRS Chapter 432.A.024 (Child care facility, defined)
- NRS Chapter 433 (General Provisions)
- NRS Chapter 435 (Persons with Mental Retardation and Related Conditions)
- NRS Chapter 449.004 (“Facility for the care of adults during the day” defined)
- Nevada Administrative Code (NAC) Chapter 435 (Persons with Mental Retardation and Related Conditions)
- NAC Chapter 639 (Pharmacists and Pharmacy)



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2102 DEFINITIONS

These are brief definitions, full detail is located in the section addressing the definition.

**ABLE**

An able parent and/or legal guardian of a minor child, is a Legally Responsible Individual (LRI) who has the option to be present in the home during the time necessary maintenance, health/medical care, education, supervision, support services, and/or the provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) are needed.

**ACTIVITIES OF DAILY LIVING (ADLs)**

ADLs are self-care activities routinely performed on a daily basis, including but not limited to bathing, dressing, toileting, transferring, continence and eating.

**ANNUAL**

For purposes of reassessing waiver recipients, annual means not to exceed 365 days.

**APPLICANT**

An individual who is applying for waiver services.

**ASSESSMENT**

A written assessment of each waiver applicant/recipient, using approved assessment tools and other clinical assessment information, which includes the individual's abilities to perform activities of daily living, the individual's medical and social needs, the individual's support system and all other services received currently by the individual. This assessment identifies the support needs addressed in the individual support plan.

**BUDGET AUTHORITY**

The participant direction opportunity through which a waiver participant exercises choice and control over a specified amount of waiver funds (participant-directed budget).

**CAPABLE**

A capable parent and/or legal guardian of a minor child, is a LRI who is physically and cognitively capable of carrying out necessary maintenance, health/medical care, education, supervision, support services, and/or the provision of needed ADLs and IADLs.

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### CRIMINAL CLEARANCE

A criminal background check must be completed as a condition of employment. All providers and employees of both Divisions must have a State and Federal Bureau of Investigation (FBI) criminal history clearance obtained from the Central Repository for Nevada Records of Criminal History through the submission of fingerprints and receiving the results.

### DAILY RECORD

The daily record is documentation completed by a provider, indicating the type of service provided and the time spent. The documentation will include the recipient's initials with a full signature of the recipient on each daily record. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the Individual Support Plan (ISP). The direct service staff will initial after the daily services are delivered, with a full signature of the direct service staff 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 of services provided and the time spent providing those services.

If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file, or have the ability to make available upon request.

### DAY HABILITATION

Day Habilitation services provide meaningful day and individualized activities that support the recipient's definition of a meaningful day. Day habilitation services enable the recipient to increase or maintain their capacity for independent functioning and decision making.

### DIRECT SERVICES

Direct services assist in the acquisition, retention and improvement of skills necessary for the person to successfully reside in the community. **Direct services are individualized hours that are not shared. Direct services providers participate in the Individual Support Plan (ISP) meetings.**

### DIRECT SUPPORTS

Direct supports are the hours allocated in the participant's ISP for protective oversight. Protective oversight is supervision hours provided to ensure the health, safety and **welfare** of an individual who cannot be left alone **for an extended period of time**. Direct support is funded to individuals residing in a non-family host home **that may not have a second person** or 24-hour homes **which require that the hours be shared with two or more individuals unless the person requires the one to**

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one direct hours as a result of medical or clinical necessity, as determined by the Regional Center Psychologist and Regional Center Nurse.

#### EMPLOYER AUTHORITY

The participant direction opportunity by which the waiver participant exercises choice and control over individuals who furnish waiver services authorized in the service plan.

#### FINANCIAL MANAGEMENT SERVICES (FMS)

FMS is a critical support and important safeguard for participants self-directing their waiver services. The FMS acts as the fiscal agent and manages payroll and employment tasks, and pays invoices for goods and services listed in the individual budget. The FMS also ensures service providers meet the qualifications and training requirements, submit background checks, purchase worker's compensation insurance and submit required quality management and utilization reports. FMS are an administrative activity.

#### INDIVIDUAL BUDGET

An amount of waiver funds that is under the control and direction of the waiver participant when a waiver makes available the Budget Authority participant direction opportunity. Also referred as the "Participant-Directed Budget".

#### INDIVIDUAL SUPPORT PLAN (ISP)

ISP is a document and working tool that identifies: the recipient's interests; personal goals; health and welfare needs; and agreed upon support services that are to be provided through the waiver by contracted providers. The ISP also identifies natural supports and state plan services. The ISP is developed by the Regional Service Coordinators (Case Managers), in partnership with the recipient and their support team, who utilize approved assessment tools to identify the recipient's interests, personal goals, health status and current skills in order to determine the level and type of service and supports required to adequately address health and welfare needs, promote skill acquisition and independence and facilitate achievement of personal goals.

#### INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

IADLs are activities related to independent living including, **but not limited to:** preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication and money management.

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#### INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR) LEVEL OF CARE (LOC)

ICF/MR means an establishment operated and maintained to provide 24-hour personal and medical supervision for a person who does not have illness, disease, injury or other condition that would require the degree of care and treatment which a hospital or facility for skilled nursing is designed to provide. Persons in this facility must have a diagnosis of mental retardation or a condition related to mental retardation. This LOC identifies if an individual's total needs are such that they could be routinely met on an inpatient basis in an ICF/MR.

#### LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

Individuals, who are legally responsible to provide medical support, including; spouses of recipients, parents of minor recipients including adoptive parents, stepparents, foster parents and legal guardians.

#### MENTAL HEALTH AND DEVELOPMENTAL SERVICES (MHDS)

MHDS is a State agency that is part of the Nevada Department of Health and Human Services (DHHS). MHDS is the operating agency for the Home and Community-Based Waiver (HCBW) for Persons with Mental Retardation and Related Conditions.

#### MENTAL RETARDATION

“Mental retardation” means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period prior to age 18. A diagnosis of mental retardation is made based on commonly used standardized tests of intelligence and standardized adaptive behavior instruments.

#### PARTICIPANT-DIRECTED BUDGET

An amount of waiver funds that is under the control and direction of the waiver participant when a waiver makes available the Budget Authority participant direction opportunity. Sometimes called the “individual budget”, **as identified in the Individual Support Plan.**

#### PARTICIPANT-DIRECTED SERVICE

A waiver service that the state specifies may be directed by the participant using the Employer Authority, the Budget Authority or both.

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#### PARTICIPANT DIRECTION

The opportunity for a waiver participant to exercise choice and control in identifying, accessing and managing waiver services and other supports in accordance with their needs and personal preferences.

#### PERIODIC REEVALUATIONS

Revaluations **must be completed for** each recipient **within 365 days** to determine if the recipient continues to need the level of care provided and would, but for the provisions of waiver services, otherwise be institutionalized in an ICF/MR according to 42 Code of Federal Regulations (CFR) 441.302(c)(2)(iii).

#### RECIPIENT

An individual who is enrolled in the Waiver for Persons with Mental Retardation and Related Conditions.

#### RELATED CONDITION

Persons with conditions related to mental retardation are persons who have a severe, chronic disability that is attributable to cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required by a person with mental retardation. It is manifested before the person reaches age 22. It is likely to continue indefinitely. It results in substantial functional limitations in three or more of the following areas of major life activity:

- a. Self Care;
- b. Understanding and use of language;
- c. Learning;
- d. Mobility;
- e. Self-direction; and/or
- f. Capacity for independent living.

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## SCOPE

The types of activities that are undertaken on behalf of a waiver recipient. The definition of the service is termed the “scope” of the service.

## SKILLED SERVICES

Services that are inherently complex and require the specialized training of a nurse or therapist to safely and effectively provide.

## SLOT

The number of available openings which may be offered to eligible recipients during each fiscal year. The number of slots available is determined by the level of legislative funding approved per fiscal year and through an agreement with CMS.

## STATEMENT OF CHOICE

The Statement of Choice is a form used to inform applicants of their right to choose between waiver services or placement in an ICF/MR, as well as their fair hearing rights. The form must be signed by the applicant or the applicant’s authorized representative if the applicant is not capable to sign the document.

## SUPPORT BROKER

The Support Broker assists the participant in the development and management of their services including; budget management, monitoring of expenditures, personnel management and ISP development. These supports are provided in a manner that is flexible, responsive to and directed by the individual participant. A support broker is employed by the support broker agency contracted by MHDS. This is an administrative activity.

## TARGETED CASE MANAGEMENT (TCM)

TCM is a Medicaid State Plan service that provides case management duties for the recipients on this waiver. TCM services are provided by MHDS. The service assists recipients in gaining access to needed HCBW services, Medicaid state plan services, as well as needed medical, social, educational and all other services, regardless of the funding source. Components of targeted case management include: assessment; care planning; referral/linkage and monitoring/follow-up. Refer to Medicaid Services Manual (MSM) Chapter 2500 for details on TCM.

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#### WAIT LIST

When all waiver slots are full, a wait list is utilized for applicants who have been presumed to be eligible for waiver services.

#### WAIVER YEAR

The waiver year begins October 1 and ends September 30 of each year.

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2103 POLICY

2103.1 WAIVER ELIGIBILITY CRITERIA

Nevada's Waiver for Persons with Mental Retardation and Related Conditions waives certain statutory requirements and offers Home and Community-Based Services (HCBS) to eligible recipients to assist them to remain in the community. The target population for this waiver includes all individuals who are diagnosed with mental retardation or a related condition and who have been found eligible and have an open case with a Mental Health and Developmental Services (MHDS) Regional Center. Individuals are eligible if they meet Medicaid eligibility criteria and are either in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) facility or are at risk for ICF/MR placement without the provision of **HCBS** and supports.

2103.1A COVERAGE AND LIMITATIONS

1. Waiver participants must meet and maintain Medicaid's eligibility requirements for all months waiver services are being provided.
2. The Home and Community-Based Waiver (HCBW) for Persons with Mental Retardation and Related Conditions is limited, by legislative mandate and available matching state funding to a specific number of recipients who can be served through the waiver year. When all waiver slots are full, a wait list is utilized to prioritize applicants who have been presumed to be eligible for the waiver.
3. Wait List Prioritization
  - a. First priority is residents of an intermediate care facility for persons with mental retardation or related conditions.
  - b. Second priority is applicants who are at risk of institutionalization due to loss of their current support system or crisis situation.
  - c. Third priority is applicants determined appropriate for waiver services.
4. Division of Health Care Financing and Policy (DHCFF) must assure the Centers for Medicare and Medicaid Services (CMS) that Medicaid's total expenditures for waiver and Medicaid State Plan services will not, in any waiver year, exceed 100 percent of the amount that would be incurred by Medicaid for these individuals in an institutional setting in the absence of the waiver. DHCFF must also document that there are safeguards in place to protect the health and welfare of recipients.
5. Waiver services may not be provided while a recipient is an inpatient of an institution.



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6. The Waiver for Persons with Mental Retardation and Related Conditions Eligibility Criteria:

Applicants or recipients must meet and maintain all criteria to be eligible, and to remain on the Waiver for Persons with Mental Retardation and Related conditions.

a. Eligibility for DHCFP's Waiver for Persons with Mental Retardation and Related Conditions is determined by the combined efforts of the Division of MHDS, the DHCFP and the Division of Welfare and Supportive Services (DWSS). Two separate determinations must be made for eligibility for the Waiver:

1. Service eligibility for the waiver is determined by MHDS regional office staff and authorized by DHCFP's Central Office (CO) staff.

a. A MHDS Regional Center Intake Process, based on supporting documentation, establishes the existence of mental retardation or a related condition.

b. Each applicant/recipient must meet and maintain a level of care category for admission into an intermediate care facility for persons with mental retardation and related conditions. The recipient would require imminent placement in an ICF/MR facility (within 30 to 60 days) if HCBW services or other supports were not available.

c. Each applicant/recipient must demonstrate a continued need for a waiver service(s) to prevent placement in an intermediate care facility for the mentally retarded. Utilization of State Plan Services solely does not support the qualifications to be covered by the waiver.

d. The applicant/recipient must have an adequate support system to provide a safe environment during the hours when HCBS are not being provided. HCBS are not a substitute for natural and informal supports provided by family, friends or other available community resources.

2. Eligibility determination for full Medicaid benefits is made by DWSS.

a. Recipients of the Waiver for Persons with Mental Retardation and Related Conditions must be Medicaid eligible for full Medicaid benefits for all months in which waiver services are provided.

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- b. Services from the waiver for Persons with Mental Retardation and Related Conditions cannot be provided until and unless the applicant is found eligible in both determination areas.
  - c. When Medicaid recipients in the Waiver for Persons with Mental Retardation and Related Condition have to pay for part of the cost of the waiver services the amount they are required to pay is called patient liability.
- 7. If an applicant/recipient 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/recipient must choose one HCBW program and receive services provided by that program.
- 8. Recipients of the Waiver for Persons with Mental Retardation and Related Conditions 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. Collaborative case 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.
- 9. An able and/or capable parent or Legally Responsible Individual (LRI) 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 provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (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. Waiver services 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 their home. Allowance may be given in individual circumstances when there is no other LRI residing in the home and an able and/or capable parent's employment requirements result in prolonged or unexpected absences from the home (not to include voluntary overtime), or when such employment requirements require the able and/or capable parent or LRI to work uninterrupted at home in order to meet the requirement of his or her employer, or when employment requirements include unconventional work weeks or work hours.
- 10. LRIs may not be reimbursed for HCBW services. The LRI must provide verification from a physician, place of employment, or school that they are not capable, due to illness or injury, or unavailable, due to hours of employment and school attendance, to provide services. Additional verification may be required on a case by case basis. Without this

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verification, HCBW services will not be authorized.

2103.1B PROVIDER RESPONSIBILITIES

1. Providers are responsible for confirming the recipient's Medicaid eligibility each month.
2. DHCFP is responsible to collect any patient liability.

2103.1C RECIPIENT RESPONSIBILITIES

Applicants or recipients must meet and maintain all criteria to be eligible and to remain on the Waiver for Persons with Mental Retardation and Related Conditions.

2103.1D MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The children made eligible for Medicaid through their enrollment in the Waiver for Persons with Mental Retardation and Related Conditions receive all the medically necessary Medicaid coverable service available under EPSDT. A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary services that are required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2103.2 WAIVER SERVICES

MHDS, the operating agency for the waiver, determines which services will be offered under the Waiver for Persons with Mental Retardation and Related Conditions. Providers and recipients must agree to comply with the requirements for service provision in accordance with MHDS and DHCFP policies.

2103.2A COVERAGE AND LIMITATIONS

Under this waiver, the following services are covered for individuals who have been indentified utilizing the Level of Care (LOC) assessment to be at risk for ICF/MR placement without the provision of enhanced supports as identified in the Individual Support Plan (ISP).

1. Day Habilitation.
2. Prevocational Services.
3. Supported Employment.

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4. Behavioral Consultation, Training and Intervention.
5. Residential Habilitation, Direct Services and Support.
6. Residential Habilitation, Direct Support Management.
7. Community Integration Services.
8. Counseling (Individual and Group).
9. Non-Medical Transportation.
10. Nursing Services.
11. Nutrition Counseling Services.

The Participant Direction of Waiver Services is designed to support individuals who prefer to direct their own services. This service delivery method is an option available to individuals who are currently served in the MHDS Rural Regional Center geographic areas of Carson City, Douglas, Lyon, Storey, Mineral, Esmeralda, White Pine, Lander, Eureka, Humboldt, Pershing and Churchill Counties. Individuals who choose participant-direction will be assisted by a Financial Management Services (FMS) staff member and Support Broker to access self-directed services.

#### 2103.2B PROVIDER RESPONSIBILITY

1. All Providers:
  - a. Must enroll as a Provider Type 38 and maintain an active provider number.
  - b. May not bill for services provided by a LRI.
  - c. Waiver services furnished by relatives, who meet all certification, training and reporting requirements, may be reimbursed a maximum of 40 hours of direct services per week, per individual or household. Each Regional Center will **have** payment review procedures to ensure that the service for which payment **is being made has a** service authorization and has been rendered in accordance with the Individual Support Plan and the condition that the state has placed on the provision of such services.
  - d. May only provide services that have been identified in the ISP.
  - e. Must verify the Medicaid eligibility status of each HCBW recipient each month.

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f. Individual contractors who provide services in their home must have a certificate from MHDS in order to be compensated for providing services to recipients of the Waiver for Persons with Mental Retardation and Related Conditions.

g. **Criminal Background Checks:**

Under Nevada Revised Statutes (NRS) 449.176 through NRS 449.188, people who have been convicted of certain crimes may not work at certain long term care facilities or agencies. The complete statute is available at <http://leg.state.nv.us/NRS/NRS-449.html> and the requirements applying to Provider Agencies are discussed at length on the Bureau of Health Care Quality and Compliance (HCQC) website: [http://health.nv.gov/HCQC\\_CriminalHistory.htm](http://health.nv.gov/HCQC_CriminalHistory.htm).

All agency personnel including owners, officers, administrators, managers, employees and consultants must undergo State and FBI background check upon licensure and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred.

Documentation of the request and applicable results must be maintained in each employee personnel record and made available to DHCFP upon request. Employees must have the criminal background check through the Nevada Department of Public Safety (DPS) initiated by the hiring/employing agency prior to the employee providing any Medicaid reimbursable services to a recipient. 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. Documentation must be maintained in the employee’s personnel file and submitted to DHCFP upon request.

1. The DHCFP or their designee will not enroll any person or entity convicted of a felony or misdemeanor for any offense which the State agency determines is inconsistent with the best interests of recipients. Such determinations are solely the responsibility of DHCFP.

2. The DHCFP applies the requirements of NRS 449.176 through NRS 449.188 and will deny a provider contract to any applicant, or may suspend or revoke all associated provider contracts of any provider, to participate in the Medicaid program if the requirements of the referenced NRS sections are not met. In addition, see MSM Chapter 100.

a. If the provider receives information related to NRS 449.176 through

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NRS 449.188 resulting from the criminal background check or from any other source and continues to employ a person who has been convicted of an offense as listed above, DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

- b. If the hiring/employing agency does not take timely and appropriate action on the results of the background check as defined in 449.176 through NRS 449.188 and on the HCQC website, DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.
- c. 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 and DHCFP in writing. Information regarding challenging a disqualification is found on the HCQC website at:  
[http://health.nv.gov/HCQC\\_CriminalHistory.htm](http://health.nv.gov/HCQC_CriminalHistory.htm).
- h. Must have CPR and First Aid training within 90 days of hire.
- i. Must complete required training within six (6) months of beginning employment.
- j. Each provider must maintain daily records, fully documenting the scope, frequency and duration of the services provided. The documentation will include the recipients' initials daily with a full signature of the recipient on each daily record. When the recipient is unable to provide a signature due to cognitive and/or physical limitations this will be clearly documented in the ISP. The direct service staff will initial after each service is delivered with a full signature of the direct service staff at the bottom of each daily record. Periodically, DHCFP staff may request this documentation to compare it to billings submitted. The records must be maintained by the provider for at least six (6) years after the date the claim is paid.
- k. Each provider must cooperate with MHDS and/or State or Federal reviews or inspections.
- l. Report any recipient incidents or problems to MHDS on a timely basis.
- m. All service providers other than MHDS must obtain and maintain a service Provider contract with MHDS prior to providing services to a waiver recipient.

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n. Prior authorization for waiver services is made through the written ISP and the service contracts (agreements) which reflect the ISP.

o. Serious Occurrences

Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the MHDS **service** coordinator by telephone/fax within 24 hours of discovery. A completed Serious Occurrence report must be made within five (5) 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:

1. Suspected physical or verbal abuse;
2. Unplanned hospitalization;
3. Neglect of the recipient;
4. Exploitation;
5. Sexual harassment or sexual abuse;
6. Injuries requiring medical intervention;
7. An unsafe working environment;
8. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;
9. Death of the recipient during the provision of Waiver Services (PCS); or
10. Loss of contact with the recipient for three consecutive scheduled days.

p. Notification of Suspected Abuse or Neglect

State law requires that persons employed in certain capacities must make a report to a child protective service agency or law enforcement agency immediately, but in no event later than twenty-four (24) hours after there is reason to suspect a minor child has been abused or neglected. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

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For recipients under the age of eighteen (18), the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For adults' age sixty (60) and over, the Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

1. Child Abuse - Refer to NRS 432B regarding child abuse or neglect.
2. Elder Abuse - Refer to NRS 200.5091 to 200.50995 regarding elder abuse, exploitation, or neglect.
3. Other Age Groups - For all other individuals or vulnerable persons (NRS 200.5091 to 200.50995) defined as "a person 18 years of age or older who:
  - a. suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or
  - b. has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs contact local law enforcement agencies.

**q.** Complaint Procedure

The Provider must respond to all complaints in a reasonable and prompt manner. The Provider must maintain records that identify the complaint, the date received and the response and outcome of the incident.

The Provider must investigate and respond in writing to all written complaints within 10 calendar days of receipt.

The Provider will provide the recipient written notification of the complaint and its outcome. As appropriate, written notification must also be provided to the waiver **service** coordinator at the Regional Center.

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

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



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2. MHDS:

An Interlocal Contract between MHDS and DHCFP is maintained to outline responsibilities of both agencies in the operation and administration of the HCBW for Persons with Mental Retardation and Related Conditions.

3. Provider Agencies:

- a. Agencies employing providers of service to the waiver program must maintain employee files which include background checks, reference checks, Cardio Pulmonary Resuscitation (CPR)/First Aid within 90 days of the beginning of employment and records documenting new employee orientation and annual training to include the number of hours of training provided. All providers are required to provide annual training to employees on recipient rights, confidentiality, abuse, neglect and exploitation, including definitions, signs, symptoms, and prevention as well as reporting requirements. Providers will also complete established training requirements of the specific Developmental Regional Centers.

4. Exemptions from Training

- a. The 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.
- b. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's case record. Where the recipient or other private third party functions as the employer, such individuals may exercise the exemption authority identified above.

2103.2C RECIPIENT RESPONSIBILITIES

The recipient or the recipient's authorized representative will:

1. Notify the provider(s) and service coordinator of a change in Medicaid eligibility.
2. Notify the provider(s) and service coordinator of current insurance information, including the name of other insurance coverage, such as Medicare.
3. Notify the provider(s) and service coordinator of changes in medical status, service needs, address, and location, or of changes of status of LRI(s)/authorized representative.

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4. Treat all staff and providers appropriately.
5. Initial the provider daily record log verifying services were rendered unless otherwise unable to perform this task due to intellectual and/or physical limitations.
6. Notify the provider when scheduled visits cannot be kept or services are no longer required.
7. Notify the provider of missed visits by provider staff.
8. Notify the provider and MHDS Service Coordinator of unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver.
9. If applicable, furnish the provider with a copy of their Advance Directives.
10. Not request a provider to work more than the hours authorized in the Support Plan.
11. Not request a provider to provide service for a non-recipient, family, or household members.
12. Not request a provider to perform services not included in the Support Plan.
13. Contact the service coordinator to request a change of provider.
14. Sign all required forms unless otherwise unable to perform this task due to intellectual and/or physical limitations.

2103.3 SERVICE COORDINATION

2103.3A COVERAGE AND LIMITATIONS

Service Coordination is provided under the Medicaid State Plan Targeted Case Management service (refer to MSM Chapter 2500). This is an integral part of the management of the Waiver for Persons with Mental Retardation and Related Conditions.

2103.4 DAY HABILITATION

Day habilitation services consist of a daily program of functional and meaningful activities that assist with the acquisition, retention or improvement in self-help, socialization and adaptive skills that takes place in a variety of day habilitation settings. Activities and environments are designated to foster the acquisition of skills, appropriate behavior, greater independence and personal choice.

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2103.4A COVERAGE AND LIMITATIONS

A person who receives day habilitation services may also receive supported employment and prevocational services. A person's support plan may include two or more types of non-residential habilitation services. Different services may not be billed during the same time period of the day.

Documentation must be maintained in the recipient's file that indicates this service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Individuals with Disabilities Education Improvement Act (IDEA).

2103.4B DAY HABILITATION PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Provider Agencies:

- a. All provider agencies/organizations providing day habilitation services must meet the requirements for Certificate of Qualification in accordance with NRS 435.230 to 435.320 all inclusive or meet equivalent standards of MHDS rules, regulations and standards and demonstrate a community need.
- b. An employee of an agency that provides habilitation services and has met the requirements for certification under NRS and Nevada Administrative Code (NAC) 435 and/or MHDS policy must provide documentation to DHCFP to maintain approved provider status. MHDS verifies provider qualifications annually.
- c. An employee of an agency must have a High School Diploma or equivalent; however this requirement may be waived with approval from MHDS.
- d. An employee of an agency must have criminal clearance in accordance with MHDS and DHCFP policy.
- e. Must meet all the requirements to be enrolled and maintain status as an enrolled Medicaid provider pursuant to MSM Chapters 100 and 2100, as applicable.

2. Individual Providers:

- a. **Must meet the requirements for certification according to MHDS policy and provide required documentation to DHCFP to maintain approved provider status. MHDS will verify qualification annually.**
- b. **Must be at least 18 years of age.**
- c. Must have a High School Diploma or equivalent; however, this requirement may

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be waived with approval from MHDS.

- d. Must have criminal background check in accordance with MHDS and DHCFP policy.
- e. Must have the ability to implement the recipient's ISP.
- f. Must have the ability to communicate with and understand the recipient.

#### 2103.4C RECIPIENT RESPONSIBILITIES

Refer to section 2103.1C and 2103.2C.

#### 2103.5 RESIDENTIAL HABILITATION – DIRECT SERVICES AND SUPPORT

Residential Habilitation – Direct Services and Supports are designed to ensure the health and welfare of the recipients, and to assist in acquiring, retaining, and improving adaptive skills necessary to reside successfully in their community. These services are individually planned and coordinated, and described in the ISP. The ISP assures non-duplication of Direct Services and Support with other State Plan Services.

#### 2103.5A COVERAGE AND LIMITATIONS

1. Direct Services and Support staff are responsible for the implementation of ISP goals related to residential and community living.

These supports include:

- a. **the participation in the development of the ISP.**
- b. adaptive skill development.
- c. facilitation of ADLs.
- d. facilitation of community inclusion.
- e. facilitation of IADLs to include teaching community living skills; interpersonal and relationship skills; choice making skills; social and leisure skills; budgeting and money management skills.

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- f. providing assistance with self-administration of medication and medication administration (including the use of certified medication aides) that assist the recipient in the most integrated setting appropriate for his or her needs.
2. Direct Services and Support may be provided up to 24 hours a day based on the assessed needs of the recipient to ensure his or her health and welfare. **When an individual resides in a 24-hour setting, direct support hours must be shared by two or more individuals in the 24 hour setting unless the individual requires one-to-one direct support hours as a result of medical or clinical necessity, as determined by the Regional Center Psychologist and Regional Center Nurse.**
3. Direct Services and Support staff are also responsible for:
  - a. protective oversight and supervision to assure health and welfare.
4. Under this service category, the responsibility for the living environment rests with the service agency and encompasses a variety of Supportive Living Arrangements (SLAs).
  - a. SLAs are typically provided within a continuum of care that may include 24-hour services/supports with awake and/or sleep staff that is shared with four or fewer individuals and services based on individual LOC needs to assist in the acquisition, retention and improvement of skills necessary to support the person to successfully reside in their community.
  - b. SLAs with intermittent services are available to a recipient who may choose to live with a family member, in their own home or apartment and/or may share with roommates and access direct services, which may be provided in the home or community, with the goal of enhancing the recipients ability to be as self-sufficient as possible and utilize available community resources.
  - c. Host Homes are typically accessed for up to two younger recipients or more dependent recipients who desire or need a family living situation. Host Home providers are individuals who choose to have their home licensed and/or certified to care for individuals with mental retardation and related conditions. Recipients receiving services from Host Home providers can expect to be included in the Host Homes' family life and activities. Direct services/supports may be utilized to assist in the acquisition, retention or improvement of skills necessary to support the person to successfully reside in their community.
5. Individual SLA homes do not require state licensure; however, individual providers and provider agencies must be approved and certified by MHDS in order to render services to persons with mental retardation and related conditions.

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2103.5B RESIDENTIAL HABILITATION – DIRECT SERVICES AND SUPPORT PROVIDER RESPONSIBILITIES

1. Individual Providers – Provider Managed:
  - a. **Must** be at least 18 years of age.
  - b. Must be certified (including provisional certification) pursuant to NAC 435 and provide required information to DHCFP to maintain approved provider status.
  - c. Must have a High School Diploma or equivalent (may be waived with MHDS approval).
  - d. Must **have** First Aid and CPR training within 90 days of hire.
  - e. Must have criminal clearance in accordance with MHDS and DHCFP policy.
  - f. Must have the ability to implement the recipient’s ISP **and Habilitation Plan**.
  - g. Must have the ability to communicate with and understand the recipient.
  - h. Provider qualifications will be reviewed by MHDS on initial application, within the first year as part of certification review and at least every two years thereafter as part of re-certification review.
  
2. Individual Providers – Participant-Directed:
  - a. Must be at least 18 years of age.
  - b. Must have the ability to communicate with and understand the participant.
  - c. Must provide three reference checks in accordance with MHDS policy.
  - d. Must **have** First Aid and CPR training within 90 days of hire.
  - e. Must have criminal clearance in accordance with MHDS and DHCFP policy.
  - f. Must meet the requirements specified in NAC 435 and provide information to DHCFP to maintain approved provider status.
  - g. Must have the ability to implement the goals and services as identified in the participant’s ISP.

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- h. Must have the ability to communicate with and understand the recipient.
  - i. FMS staff will review provider qualifications at initial application and annually thereafter.
3. Agency Providers – Provider Managed:
- a. Individuals providing direct services and support services must be at least 18 years of age.
  - b. Employees of an agency that provides direct services and support must be certified (including provisional certification) according to NAC 435 and provide the required information to MHDS to maintain approved provider status.
  - c. Must **have** First Aid and CPR training within 90 days of hire.
  - d. Must have criminal clearance in accordance with MHDS and DHC FP policy.
  - e. Must have a High School Diploma or equivalent. This requirement may be waived with MHDS approval.
  - f. Must meet all the requirements to be enrolled and maintain status as an enrolled Medicaid provider pursuant to MSM Chapters 100 and 2100, as applicable.
  - g. MHDS will verify provider qualification on initial application and provisional certification, within the first year as part of the Quality Assurance (QA) review for certification and at least every **three** years thereafter as part of the re-certification QA review.

2103.6 PREVOCAIONAL SERVICES

Prevocational Services are services that prepare recipients for paid or unpaid employment. Services must be reflected in the recipient’s ISP and are directed to habilitation rather than explicit employment.

2103.6A COVERAGE AND LIMITATIONS

- 1. The prevocational services provided under this waiver are not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the IDEA (20 U.S.C. 1401(16 and 17)). Documentation will be maintained in the file of each individual receiving prevocational services that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

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2. Services include teaching skills such as self-care, social skills, attendance, mobility training, task completion, self-direction, problem solving and safety.
3. Services are not job or task oriented, but instead, aimed at a generalized result. Services are reflected in the participants ISP and are directed to habilitation rather than explicit employment objectives.
4. Recipients receiving prevocational services may also receive supported employment services. The recipient's service plan may include two or more types of non-residential habilitation services; however, different services may not be billed during the same time period of the day.
5. When compensated, individuals must be adequately compensated and the compensation must be in accordance with applicable state and federal labor laws (NRS 433).

2103.6B PREVOCATIONAL SERVICES PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Provider Agencies:
  - a. All provider agencies/organizations providing day habilitation services must meet the requirements for Certificate of Qualification in accordance with NRS 435.230 to 435.320, all inclusive or meet MHDS rules, regulation and standards and demonstrate a community need.
  - b. An employee of an agency that provides prevocational services and has met the requirements for certification under NRS and NAC 435 and/or MHDS policy must provide documentation to DHC FP to maintain approved provider status. MHDS will verify provider qualifications annually.
  - c. An employee of an agency must have a High School Diploma or equivalent, however, this requirement may be waived with approval from MHDS.
  - d. Annual certification is required for certified centers meeting requirements under NRS and NAC 435.
  - e. Employees of an agency that provides prevocational services must have criminal clearance in accordance with MHDS and DHC FP policy.
  - f. All providers must meet all requirements to enroll and maintain Medicaid provider status according to MSM Chapters 100 and 2100, as applicable.



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- g. Must meet all conditions of participation according to MSM Chapter 100, Section 102.1.

2103.6C RECIPIENT RESPONSIBILITIES

Refer to Sections 2103.1C and 2103.2C.

2103.7 SUPPORTED EMPLOYMENT

Supported employment service is a combination of intensive ongoing supports and services that prepare recipients for paid employment.

2103.7A COVERAGE AND LIMITATIONS

1. Supported employment is a combination of intensive ongoing supports that enable participants from whom competitive employment at or above minimum wage is unlikely or who may be able to work in a competitive work environment but who, because of their disabilities, need supports to perform in a work setting. Supported employment is conducted in a variety of settings, including enclaves at community businesses and work sites in which persons without disabilities are employed. Supported employment activities are designed to increase or maintain the recipient's skill and independence. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business settings.
2. The supported employment services furnished under this waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving supported employment services that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.
3. Federal Financial Participation will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
  - a. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
  - b. Payments that are passed through to users of supported employment programs; or

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- c. Payments for vocational training that is not directly related to an individual's supported employment program.
- 4. A recipient who receives supported employment services may also receive prevocational or day habilitation services. A recipient's service plan may include two or more types of non-residential habilitation services; however, different services may not be billed during the same time period of the day.

2103.7B SUPPORTED EMPLOYMENT PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Provider Agencies:

- a. All provider agencies/organizations providing supported employment services must meet the requirements for Certificate of Qualification in accordance with NRS 435.230 to 435.320, for certified centers meeting the requirements set forth in NRS and all inclusive or meet MHDS rules, regulations and standards and demonstrate a community need.

1. Annual certification is required NAC 435.

- a. Employees of an agency that provides supported employment services must meet the requirements for certification in accordance with NRS 435 and MHDS policy, and provide required documentation to DHCFP to maintain approved provider status.
- b. **Must be at least 18 years of age.**
- c. Must have a High School Diploma or equivalent; however, this may be waived with approval of MHDS.
- d. Must have criminal clearance in accordance with MHDS and DHCFP policy.
- e. Must meet all requirements to enroll and maintain enrolled Medicaid provider pursuant to DHCFP MSM, Chapter 100 and 2100.

2. Individual Providers – Provider Managed:

- a. Individuals who provide supported employment services must meet the requirements for certification in accordance with NRS 435 and MHDS policy and provide required information to DHCFP to maintain approved provider status.

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- b. Must have a High School Diploma or equivalent; however, this may be waived with approval of MHDS.
  - c. Must have criminal clearance in accordance with DHCFP policy.
  - d. Must have the ability to implement the recipient's ISP.
  - e. Must have the ability to communicate with and understand the recipient MHDS will verify provider qualification on initial application and annually thereafter.
3. Individual Providers – Participant-Directed:
- a. Must be at least 18 years of age.
  - b. Must have the ability to communicate with and understand the participant.
  - c. Must provide three reference checks in accordance with MHDS policy.
  - d. Must **have** First Aid and CPR training within 90 days of hire.
  - e. Must have criminal clearance in accordance with MHDS and DHCFP policy.
  - f. Must meet the requirements specified in NAC 435 and provide information to DHCFP to maintain approved provider status.
  - g. Must have the ability to implement the goals and services as identified in the participant's ISP.
  - h. Must have the ability to communicate with and understand the recipient.
  - i. FMS staff will review provider qualifications at initial application and annually thereafter.

2103.7C RECIPIENT RESPONSIBILITIES

Refer to Sections 2103.1C and 2103.2C.

2103.8 BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION

Behavioral consultation, training and intervention services are intended for unpaid caregivers, paid direct services and/or day habilitation staff or others who provide direct care and supports to the individual. Behavior consultation, training and intervention services consist of functional

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support assessment, positive behavioral support plan development, training and support coordination for an individual and their team related to behavior that compromise an individual's quality of life. Factors that compromise an individual's quality of life include interfering with forming and maintaining relationships, community integration, ADLs, or activities that pose a health and safety risk to the individual or others. This does not include discrete trial training.

Consultation activities are provided by professionals in psychology and closely allied fields with expertise in functional assessment and the provision of positive behavioral supports.

#### 2103.8A COVERAGE AND LIMITATIONS

Behavioral consultation, training and intervention may be provided in the recipient's home, school, workplace, and in the community. The services include:

1. assessment of the environmental factors that are precipitating a problem behavior.
2. development of behavior support plan in coordination with the ISP team.
3. consultation or training on how to implement positive behavior support strategies and/or behavior support plan.
4. consultation or training on data collection strategies to monitor progress.
5. monitoring of recipient and the provider(s) in the implementation and modification of the support plan, as necessary.

#### 2103.8B BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Provider Agencies:
  - a. Employees of behavioral provider agencies must have provisional or regular certification per NRS 435 and have a Bachelor's degree in psychology, special education or closely allied field plus at least one year professional clinical experience using behavior intervention and functional assessment procedures and developing, implementing, monitoring of behavior support plans in applied setting; or
  - b. Master's degree in psychology, special education or closely related field with expertise in functional assessment and the provision of positive behavioral supports.

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- c. Experience working with people with mental retardation or related conditions is preferred.
- d. Must have criminal clearance in accordance with MHDS and DHCFP policy.
- e. Must meet all requirements to enroll and maintain status as Medicaid provider pursuant to DHCFP MSM, Chapters 100 and 2100, as applicable.
- f. MHDS will verify qualifications upon enrollment and annually thereafter.

2. Individual Providers:

- a. Bachelors degree in psychology, special education or closely allied field plus at least one year professional clinical experience using behavior intervention and functional assessment procedures and developing, implementing, monitoring of behavior support plans in applied settings; or
- b. Master's degree in psychology, special education or closely allied field with expertise in functional assessment and the provision of positive behavioral supports.
- c. Experience working with people with mental retardation or related conditions is preferred.
- d. Must have criminal clearance in accordance with DHCFP and MHDS policy.
- e. MHDS will verify qualifications prior to approval of initial provider agreement and annually thereafter.

2103.8C RECIPIENT RESPONSIBILITIES

Refer to Section 2103.1C and 2103.2C.

2103.9 COMMUNITY INTEGRATION SERVICES

Community integration services are based on a comprehensive assessment of the recipient's needs and desires related to community participation and their existing circle of support.

2103.9A COVERAGE AND LIMITATIONS

Community integration services focus on assisting the recipient to join and participate in clubs, organizations, teams or groups that are not specifically affiliated with the disability community.

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Outcomes of this service include friendships/natural supports, increased community connections, and sharing hobbies and/or recreational activities with other community members. Community integration services do not duplicate what is required under IDEA, nor are respite services included.

Community Integration services include:

1. thorough assessment of recipient skills, interests, and preferences;
2. identification of integrated community resources, groups, clubs, teams or organizations where the recipient's interests, skills and preferences would be valued and shared;
3. development of a community inclusion plan in the ISP; and
4. evaluation of the success of the community inclusion plan.

2103.9B COMMUNITY INTEGRATION SERVICES PROVIDER RESPONSIBILITIES/  
QUALIFICATIONS

1. Individual Providers – Participant Directed:
  - a. Must be at least 18 years of age.
  - b. Must have a high school diploma or equivalent.
  - c. Must have at least six months of specialized training and experience in working with individuals with disabilities in a community setting.
  - d. Must have the ability to communicate with and understand the participant.
  - e. Must provide three reference checks in accordance with MHDS policy.
  - f. Must **have** First Aid and CPR training within 90 days of hire.
  - g. Must have criminal clearance in accordance with MHDS and DHCFP policy.
  - h. Must meet the requirements specified in NAC 435 and provide information to DHCFP to maintain approved provider status.
  - i. Must have the ability to implement the goals and services as identified in the participant's ISP.

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- j. Must have the ability to communicate with and understand the recipient.
  - k. FMS staff will review provider qualifications at initial application and annually thereafter.
2. Agency Providers:
- a. Employee of an agency that provides community integration services must meet the requirements for certification (including provisional certification) or Certificate of Qualifications in accordance with NRS 435 and MHDS policy.
  - b. Must have proof of specialized training and experience with methods of enhancing community connections (that is, workshops, assessments, development and implementation of plans for social integration) or certification in community integration service by MHDS.
  - c. Must have knowledge of community resources and groups.
  - d. Must follow all MHDS policies and procedures and provide required information to DHCFP to maintain approved provider status.
  - e. **Must be at least 18 years of age.**
  - f. Must have High School Diploma or equivalent.
  - g. Must **have** First Aid and CPR training **within** 90 days of hire.
  - h. Must have criminal clearance in accordance with MHDS and DHCFP policy.
  - i. Must meet all requirements to be enrolled and maintain status as an enrolled Medicaid provider pursuant to DHCFP MSM Chapters 100 and 2100, as applicable.
  - j. MHDS will verify provider qualifications annually.
3. Individual – Provider Managed:
- a. Proof of specialized training and experience with methods of enhancing social capital (that is, workshops, assessments, development and/or implementation of plans for social integration).
  - b. Must have knowledge and awareness of community resources and groups.

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- c. Must comply with all MHDS policies and procedures.
- d. **Must be at least 18 years of age.**
- e. Must have High School Diploma or equivalent.
- f. Must **have** First Aid and CPR training **within** 90 days of hire.
- g. Must have criminal clearance in accordance with MHDS and DHCFP policy.
- h. Must have the ability to implement the recipient's ISP.
- i. Must have the ability to communicate with and understand the recipient.

MHDS will certify provider qualification annually.

2103.10 COUNSELING SERVICES

2103.10A COVERAGE AND LIMITATIONS

Counseling services provide assessment, support and guidance for waiver participants and/or unpaid caregiver or family members in problem identification and resolution in areas of personal adaptation including interpersonal relationships, self-esteem, community participation, independence, families, friends, work, and psycho-social challenges.

These services are provided based on the participant's need to assure his or her health and welfare in the community. Counseling services may include:

1. individual counseling;
2. group or family counseling;
3. psychological consultation to include the development of therapeutic intervention strategies; and/or
4. skill development and psycho-social education in social interaction, sexuality issues, anger management, problem solving, or other areas to reduce stress and enhance success in the community.



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2103.10B COUNSELING SERVICES PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Individual Provider – Level 1:

- a. All persons providing services under this category must have graduated from an accredited college or university with a Master’s degree in a two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely allied academic field. A closely allied field is licensed by the state by appropriate categories. A graduate level intern supervised by a licensed clinician or mental health counselor may provide these services.
- b. Professional experience in a setting serving persons with mental retardation is preferred.
- c. Criminal clearance in accordance with MHDS and DHCFP policy.
- d. Meets all conditions of participation in the MSM Chapter 100, Section 102.1.
- e. MHDS will verify provider qualifications upon enrollment and prior to expiration of the license; the provider will send a copy of the current license to MHDS/FMS as appropriate.

2. Individual Provider – Level 2:

- a. A graduate level intern who is enrolled in a Master’s level program at an accredited college or university that provides at least a two-year curriculum in counseling, marriage and family therapy, psychology, social work or a closely allied academic field or a doctor level program in a clinical field.
- b. Supervision by licensed clinician or mental health counselor (professional experience in a setting serving persons with mental retardation is preferred).
- c. Criminal clearance in accordance with MHDS and DHCFP policy.
- d. MHDS will verify provider qualifications upon enrollment and at least annually. Provider must show proof of completion of a master’s level program or enrollment as a graduate intern, and identification of supervisor/verification of license.

2103.10C RECIPIENT RESPONSIBILITIES

Refer to section 2103.1C and 2103.2C.

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2103.11 RESIDENTIAL HABILITATION – DIRECT SUPPORT MANAGEMENT

Direct Support Management is designed to ensure that direct services and support provided by agencies are planned, scheduled, implemented in accordance with the recipient’s preferences. Direct Support Management staff will monitor the service provided by the direct services and support staff on a regular basis and as needed depending on the frequency and duration of the approved services.

2103.11A COVERAGE AND LIMITATIONS

1. Direct Support Management staff will assist the recipient in managing their supports within the home and community settings. This service includes:
  - a. assisting the person to develop his or her goals;
  - b. scheduling and attending ISP meetings;
  - c. developing action/service plans as determined in the recipient’s ISP and train residential habilitation direct services and support staff in their implementation and data collection;
  - d. assisting the person to apply for and obtain community resources and benefits such as Medicaid, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Housing and Urban Development (HUD), Food Stamps, housing, etc.;
  - e. assisting the recipient in locating residences;
  - f. assisting the person in arranging for and effectively managing generic community resources and informal supports;
  - g. assisting the person to identify and sustain a personal support network of family, friends, and associates;
  - h. providing problem solving and support with crisis management;
  - i. supporting the recipient with budgeting, bill paying, and with scheduling and keeping appointments;
  - j. observing, coaching, training and providing feedback to direct service staff to ensure they have the necessary and adequate training to carry out the supports and services identified in the ISP;

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- k. following up with health and welfare concerns and remediation of deficiencies;
  - l. completing required paperwork on behalf of the recipient (as needed);
  - m. making home visits to observe the recipient's living environment to assure health and welfare; and
  - n. providing information to the Service Coordinator (Targeted Case Manager) to allow evaluation and assurance that support services provided are those defined in the ISP and are effective in assisting the recipient to reach his or her goals.
  - o. direct Support Managers must work collaboratively with the recipient's Service Coordinator (or TCM).
2. Direct Support Management services provided in this waiver is different from the State Plan TCM, each having a distinct role and purpose in supporting individuals, and no duplication of payments will be made.

2103.11B RESIDENTIAL HABILITATION – DIRECT SUPPORT MANAGEMENT PROVIDER RESPONSIBILITIES/QUALIFICATIONS

- 1. Agency Providers:
  - a. Employees of an agency that provides direct support management services must be at least 18 years of age;
  - b. Must be certified (including provisional certification according to NAC 435) and provide required information to DHCFP to maintain approved provider status;
  - c. Must have a High School Diploma or equivalent and two years experience providing direct service in a human services field and under the direct supervision/oversight of a Qualified Mental Retardation Professional (QMRP) or its equivalent;
  - d. Completion of Bachelor's degree from an accredited college or university in psychology, special education, counseling, social work, or closely allied field;
  - e. Must have criminal clearance in accordance with MHDS and DHCFP policy;
  - f. Meet all requirements to enroll and maintain status as an enrolled provider pursuant to DHCFP MSM Chapters 100 and 2100, as applicable; or

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- g. MHDS will verify Direct Service and Support staff qualification upon application for enrollment for provisional certification and within the first year of enrollment as part of initial Quality Assurance certification review. Verification will occur at least every two years thereafter as part of re-certification review.

2103.11C RECIPIENT RESPONSIBILITIES/QUALIFICATIONS

Refer to Sections 2103.1C and 2103.2C.

2103.12 NON-MEDICAL TRANSPORTATION

2103.12A COVERAGE AND LIMITATIONS

1. Non-medical transportation service is offered in this waiver to enable waiver recipients to gain access to waiver and other community services, activities and resources that were identified in the recipients ISP. Non-Medical Transportation Service enables individuals to participate in work, volunteer at sites or homes of family or friends; civic organizations or social clubs; public meetings or other civic activities and spiritual activities or events. Whenever possible, family, neighbors, friends, or community agencies can provide this service without charge is utilized. This service is offered in addition to the medical transportation services offered under the Medicaid State Plan.
2. Non-medical transportation services under this waiver must be described or identified in the recipient's ISP and pre-authorized before the service is utilized. Whenever possible, family, neighbors, friends or community agencies which can provide this service without charge must be utilized.

2103.12B NON-MEDICAL TRANSPORTATION PROVIDER RESPONSIBILITIES/  
QUALIFICATIONS

1. Individual Providers – Participant Direction:
  - a. Must have a valid Nevada Driver's License and provide proof of liability insurance.
  - b. Must show evidence of vehicle safety inspection prior to hire and are subject to periodic vehicle safety inspections.
  - c. Must be at least 18 years of age.
  - d. Must have a high school diploma or equivalent.

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- e. Must have at least six months of specialized training and experience in working with individuals with disabilities in a community setting.
  - f. Must have the ability to communicate with and understand the participant.
  - g. Must provide three reference checks in accordance with MHDS policy.
  - h. Must **have** First Aid and CPR training within 90 days of hire.
  - i. Must have criminal clearance in accordance with MHDS and DHC FP policy.
  - j. Must meet the requirements specified in NAC 435 and provide information to DHC FP to maintain approved provider status.
  - k. Must have the ability to implement the goals and services as identified in the participant's ISP.
  - l. FMS staff will review provider qualifications at initial application and annually thereafter.
2. Agency Provider – Provider Managed:
- a. An employee of an agency must have a valid Nevada Driver's License.  
  
An agency must have uninterrupted liability insurance per Nevada State Risk Management specification and MHDS policy; automobile insurance, per State of Nevada requirements including all automobiles owned and leased by the agency; and assurance of routine vehicle safety and maintenance inspection on file.
  - b. An employee of an agency that provides direct support services must be certified (including provisional certification) in accordance with NAC 435 as a Supported Living Provider.
  - c. Must have criminal clearance in accordance with MHDS and DHC FP policy.
  - d. Must meet all requirements to be enrolled and maintain status of an enrolled Medicaid provider pursuant to MSM Chapters 100 and 2100, as applicable.
  - e. Must meet all conditions of participation in MSM Chapter 100, Section 102.1.
  - f. MHDS will verify provider qualification prior to approval of initial provider agreement and annually thereafter.

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2103.12C RECIPIENT'S RESPONSIBILITIES

Refer to Sections 2103.1C and 2103.2C.

2103.13 NURSING SERVICES

Nursing Services provide routine medical and health care services that are integral to meeting the recipient's daily needs, such as routine medication administration, tending to the needs of recipients who are ill or require medical attention on an ongoing basis. Nursing services are long term, occur at least monthly, and are necessary to maintain or improve the individual's general health and welfare in the community.

Nursing Services may include medication administration, assessment (including annual nursing assessment), the development of a treatment/support plan, training and technical assistance, monitoring the individual and provider in the implementation of the plan, and documentation of outcomes. Services may be delivered in the recipient's home, day program, or in other community settings. Services may also include referrals to Home Health Care or other medical providers for specific action or treatment under the Medicaid State Plan.

2103.13A COVERAGE AND LIMITATIONS

1. Routine nursing services are services within the Scope of the Nevada Nurse Practice Act.
2. Services must be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of a RN who is licensed to practice as a nurse in the State of Nevada.
3. Nursing Services may include:
  - a. Medication administration.
  - b. Assessments (including nursing assessment).
  - c. Development of treatment plan or support plan.
  - d. Training and technical assistance for paid support staff to carry out treatment plan or support plan.
  - e. Monitoring of the recipient and the provider in the implementation of the plan and documentation of outcomes.
  - f. Referrals to Home Health care or other medical providers for certain treatment

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procedures covered under the Medicaid State Plan.

4. Nursing services may be provided in the recipient's home, day program, or in other community settings as described in the Service Plan.
5. Medical and health care services such as physician services that are not routinely required to meet the daily needs of waiver recipients are not covered under this service. Nursing services provided in this waiver will not duplicate the nursing services covered under the Medicaid State Plan.

#### 2103.13B NURSING SERVICES PROVIDER QUALIFICATIONS/RESPONSIBILITIES

1. Individual Provider – Participant-Directed and Provider Managed – Level 1:
  - a. RN in accordance with NRS 632 licensing requirements.
  - b. Must have criminal clearance in accordance with MHDS and DHCFP policy.
2. Individual Provider – Participant-Directed and Provider Managed – Level 2:
  - a. LPN under the supervision of a RN in accordance with NRS 632 licensing requirement.
  - b. Must have criminal clearance in accordance with MHDS and DHCFP policy.
  - c. MHDS will verify provider qualification (Level 1 and 2) upon enrollment and every two years thereafter. FMS will verify provider qualifications for providers under self-directed services upon enrollment and annually thereafter. Provider will send a copy of the current license to MHDS/FMS as appropriate.
3. Agency Providers – Participant-Directed and Provider Managed:
  - a. Employees of a Home Health Agency (HHA), Nursing Registry, or private service providers must be a RN in accordance with NRS 632.
  - b. Must have criminal clearance in accordance with MHDS and DHCFP policy.
  - c. A LPN must be under the supervision of a RN in accordance with NRS 632 licensing requirements.
  - d. Must meet all requirements to be enrolled and maintain Medicaid provider status pursuant to MSM Chapters 100 and 2100, as applicable.

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- e. Must meet all conditions of participation in MSM Chapter 100, Section 102.1.

MHDS will verify provider qualifications upon enrollment and annually thereafter.

2103.13C RECIPIENT'S RESPONSIBILITIES

Please refer to Sections 2103.1C and 2103.2C.

2103.14 NUTRITION COUNSELING SERVICES

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

2103.14A COVERAGE AND LIMITATIONS

1. Training, education and consultation for recipients and their families or support staff involved in the day-to-day support of the recipient.
2. Comprehensive assessment of nutritional needs.
3. Development, implementation and monitoring of nutritional plan incorporated in the ISP, including updating and making changes in the ISP as needed.
4. Assist in menu planning and healthy menu options.
5. Provide nutritional education and consultation.
6. Provide quarterly summaries of progress on the nutritional plan.

2103.14B NUTRITION COUNSELING SERVICES PROVIDER QUALIFICATIONS/RESPONSIBILITIES

1. Individual – Participant-Directed and Provider Managed:
  - a. Registered Dietician as certified by the American Dietetic Association.
  - b. Must have criminal clearance in accordance with MHDS and DHCFP policy.
  - c. MHDS will verify provider qualification upon enrollment and annually thereafter for self-directed services, and prior to approval of initial provider agreement and every three years for provider-managed individuals.



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2. Agency Providers:
  - a. Registered Dietician by the American Dietetic Association.
  - b. Must have criminal clearance in accordance with MHDS and DHCFP policy.
  - c. Must meet all requirements to be enrolled and maintain Medicaid provider status pursuant to MSM Chapters 100 and 2100.

2103.14C RECIPIENT'S RESPONSIBILITIES

Please refer to Sections 2103.1C and 2103.2C.

2103.15 PROVIDER ENROLLMENT TERMINATION PROCESS

- A. All providers should refer to the MSM Chapter 100 for enrollment procedures.
- B. All providers must comply with all DHCFP and MHDS enrollment requirements, provider responsibilities/qualifications, and DHCFP and MHDS provider agreement and limitations set forth in this chapter.
- C. Provider non-compliance with all or any of these stipulations may result in Nevada DHCFP's decision to exercise its right to terminate the provider's contract.

2103.16 INTAKE PROCEDURES

MHDS has developed policies and procedures to ensure fair and adequate access to the HCBW for Persons with Mental Retardation and Relation Conditions.

2103.16A COVERAGE AND LIMITATIONS

1. SLOT PROVISION
  - a. The allocation of waiver slots is maintained at the MHDS Regional Offices. As waiver slots become available, MHDS determines how many slots may be allocated.
  - b. Waiver recipients who wish to voluntarily terminate from the waiver (e.g., move out of state, or request that his or her waiver services be terminated, etc.) then at a later date, wants to be considered for the waiver, that recipient's name will be placed on the waiting list based on a new referral date.

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- c. A waiver recipient who involuntarily terminates from the waiver due to institutional placement, (e.g., has been placed in a nursing facility, an intermediate care facility for the mentally retarded, or hospital), and after discharge from the facility wants to be re-considered for the waiver.

The recipient will be placed back on the waiver if:

1. The facility discharge occurred within the same waiver year;
2. The recipient still meets the waiver eligibility criteria; and
3. The funding for the waiver service is available.

## 2. WAIVER REFERRAL/WAIT LIST

- a. A referral or inquiry for the waiver may be made by a potential applicant or by another party on behalf of the potential applicant once the recipient is determined eligible for Developmental Services. This process is completed through the initial Support Plan meeting and the service request is appropriate for the applicant's need.
- b. Once MHDS has identified that the applicant is currently receiving services through the regional centers and is presumed eligible for waiver services, a request may be made to be placed on the waitlist, if one exists.
- c. If it has been determined no slot is expected to be available within the 90 day determination period, MHDS will notify DHC FP CO Waiver Unit to deny the application due to no slot available. The applicant will remain on the waiting list.
- d. Once MHDS has matching state funds available the MHDS waitlist policy will be followed.

## 3. WAIVER SLOT IS AVAILABLE

Once a slot and matching state funds are determined available, the applicant, who has been assigned a waiver slot, will be processed for the waiver.

The procedure used for processing an applicant will be as follows:

- a. The MHDS service coordinator will make certain that the Medicaid application, through DWSS, has been completed or updated and will assist in this process as needed.

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- b. The MHDS service coordinator will gather the diagnostic data, and complete the waiver assessment and the level of care assessment.
- c. An Authorization for Release of Information form is needed for all waiver recipients. This form provides written consent for MHDS to release information about the recipient to **providers selected by the recipient to provide waiver services.**

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

The MHDS service coordinator will inform the applicant and/or an authorized representative that, pursuant to NRS 232.357, the Divisions within the Nevada Department of Health and Human Services (DHHS) may share confidential information without a signed Authorization for Release of Information.

- d. The applicant/recipient will be given the right to choose waiver services in lieu of placement in an ICF/MR. If the applicant and/or legal representative prefers placement in an ICF/MR, the service coordinator will assist the applicant in arranging for facility placement.
- e. The applicant/recipient will be given the right to request a hearing if not given a choice between HCBS and ICF/MR placement.
- f. When the applicant/recipient is approved by MHDS for waiver services, the following will occur:
  - 1. A team meeting is held and a written individual support plan developed in conjunction with the recipient and the Individual Support Team to determine specific service need to ensure the health and welfare of the recipient.
  - 2. The recipient, the recipient's family, or the legal representative/authorized representative should participate in the development of the individual support plan.
  - 3. The individual support plan is subject to the approval of the CO Waiver Unit of DHCFP.

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4. Recipients will be given the free choice of all qualified available Medicaid providers of each Medicaid covered service included in his/her written individual support plan. Current individual support plan information as it relates to the services provided must be given to all service providers and kept in the participant's record.
  5. Participants in the MHDS Rural Regional Center geographic areas of Carson City, Douglas, Lyon, Storey, Mineral, Esmeralda, White Pine, Lander, Eureka, Humboldt, Pershing and Churchill Counties may choose the participant direction option for waiver services. The ISP documents the choice of participant direction. The individual's team develops the participant directed budget associated with participant directed services.
- g. All forms must be complete with signature and dates where required.
- h. MHDS will forward all completed waiver program information and a 2734 form requesting approval to the DHCFP Central Office Waiver Unit.
1. If the application is not approved by the DHCFP CO Waiver Unit, the following will occur:
    - a. A NOD stating the reason(s) for the denial will be sent to the applicant by the DHCFP CO Waiver Unit via the Hearings and Policy Unit.
    - b. A 2734 form will be sent to MHDS and DWSS by the DHCFP CO Waiver Unit stating that the application has been denied and the reason(s) for the denial.
  2. If the DHCFP CO Waiver Unit approved the application, the following will occur:
    - a. A 2734 form will be sent by the DHCFP CO Waiver Unit to MHDS and DWSS stating the application has been approved.
    - b. Once the application has been approved by the DHCFP CO Waiver Unit and DWSS, waiver services can be initiated.
- i. If the applicant/recipient is denied by MHDS waiver services, then:
- a. The MHDS service coordinator will send written notice to the DHCFP CO Waiver Unit.

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- b. The DHCFP CO Waiver Unit will send a Notice of Decision (NOD) to the applicant via the Hearing and Policy Unit of DHCFP stating the reason(s) why the application was denied by MHDS.
- c. The DHCFP CO Waiver Unit will also send form NMO-2734 to MHDS and DWSS stating that the application was denied and the reason(s) for the denial.

4. EFFECTIVE DATE FOR WAIVER SERVICES

The effective date for waiver services approval is the completion date of all the intake forms, or the waiver eligibility determination date by DWSS, whichever is later. If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

In some cases, it may be necessary to begin waiver services on the 1<sup>st</sup> of the month to coincide with Service Contracts. In that case, the effective date for waiver services approval is the completion date of all the intake forms or the first of the month the waiver eligibility determination is made by DWSS, whichever is later.

Waiver services will not be backdated beyond the 1<sup>st</sup> of the month in which the waiver eligibility determination is made by DWSS.

5. WAIVER COST

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

2103.17 BILLING PROCEDURES

The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible and only when the service is included in the approved individual support plan.

2103.17A COVERAGE AND LIMITATIONS

MHDS (Provider Type 38) must complete the CMS 1500 for payment of waiver services. Incomplete or inaccurate provider claims will be returned to MHDS by DHCFP's fiscal agent. If the wrong form is submitted it will also be returned to MHDS by DHCFP's fiscal agent.

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2103.18 PERMANENT CASE FILE

A. For each approved waiver recipient, the service coordinator must maintain a permanent case file that documents services provided under the Waiver for Persons with Mental Retardation and Related Conditions.

B. These records must be retained for six years from the date of waiver service(s).

2103.19 SERVICE COORDINATOR RECIPIENT CONTACTS

A. Monthly Contact

1. The service coordinator must have monthly contact with each waiver recipient, or a recipient's authorized or legal representative, or the recipient's direct care service provider. This may be a phone contact. At a minimum, there must be a direct contact visit with each recipient every 3 months.

2. During the monthly contact, the service coordinator will assess the individual's status and satisfaction with services and indicate actions to be taken if any changes are needed.

B. Reassessment

1. Recipients must be reassessed at least annually. The first reassessment must be completed within 365 days of the waiver approval date. Subsequent reassessments must be completed within 365 days of the last reassessment. Reassessments should be conducted in the recipient's home or service provision site.

2. The recipient must be reassessed when there is a significant change in his/her condition.

3. The number of hours specified on each recipient ISP for each specific services except Direct Support Management, are considered the maximum number of hours allowed to be provided by the caregiver and paid by the DHCFP, unless the Service Coordinator has approved additional hours due to a temporary condition or circumstance. Caregivers are allowed to provide fewer services than stated on the ISP if the reason for the providing less service is adequately documented on the daily record.

4. When the recipient service needs increase, due to a temporary condition or circumstance, the service coordinator must thoroughly document the increased service needs in their case notes. The ISP does not need to be revised for

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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 30 days.

5. Direct Support Management hours are defined in the ISP. Approval for temporary increase in the Direct Support Management hours for the participant must receive prior authorization from MHDS and be justified based on health, safety and welfare concerns. If an increase is warranted to exceed a thirty (30) day period, there must be a re-assessment based on thorough documentation in the Direct Support Managers case notes reflecting the health, safety and welfare concerns and the ISP must be revised.

- a. Reassessment Procedures

During the reassessment process, the service coordinator should:

1. Re-affirm the recipient meets the waiver criteria outlined in Section 2103.1A.6 of the MSM Chapter 2100.
2. Re-assess the recipient's ability to perform ADLs, his/her medical and mental status and support systems.
3. Re-evaluate the services being provided and progress made toward the goal(s) stated on the individual support plan.
4. Develop a new individual support plan and review the waiver costs.
5. Re-assess the recipient's LOC.

#### 2103.20 DHCFP ANNUAL REVIEW

The State will have in place a formal system by which it assures the health and welfare of the recipients served on the waiver, the recipient's satisfaction with the services and the cost effectiveness of these services.

#### 2103.20A COVERAGE AND LIMITATIONS

DHCFP (administrative authority) and MHDS (operating agency) will collaboratively conduct an annual review of the waiver program.

1. Provide CMS with information on the impact of the waiver. This includes the type, amount, and cost of services provided under the waiver and provided under the state plan,

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and the health and welfare of the recipients served on the waiver.

2. Assure financial accountability for funds expended for HCBS.
3. Evaluate that all provider standards are continuously met, and that ISPs are periodically reviewed to assure that services furnished are consistent with the identified needs of the recipients.
4. Evaluate the recipient's satisfaction with the waiver program.
5. Further assure 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.

2103.20B PROVIDER RESPONSIBILITIES

Providers must cooperate with DHCFP's annual review process.



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2104 HEARINGS

2104.1 SUSPENDED WAIVER SERVICES

- A. A recipient's case may be suspended, instead of closed, if it is likely the recipient will be eligible again for waiver services within the next 60 days (for example: if a recipient is admitted to a hospital, nursing facility, or intermediate care facility for the mentally retarded). After receiving written documentation from the service coordinator (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 DHC FP CO Waiver Unit.
- B. If at the end of 45 days the recipient has not been removed from suspended status, the case must be closed. A NOD identifying the 60<sup>th</sup> day of suspension as the effective date of closure and the reason for termination will be sent to the recipient by the DHC FP CO Waiver Unit on or before the 45<sup>th</sup> day of suspension.
- C. Waiver services will not be paid for the days that a recipient's case is in suspension.

2104.2 RELEASE FROM SUSPENDED WAIVER SERVICES

If a recipient has been released from the hospital, nursing facility or an ICF/MR before 60 days from the admit date the service coordinator, within five working days of release must:

- a. Complete Form NMO-2734 informing the DHC FP CO of the release of suspension.
- b. Complete a new individual support plan if there has been a significant change in the recipient's condition needs. If a change in services is expected to resolve in less than 30 days a new individual support plan is not necessary. Documentation of the temporary change must be made in the service coordinator's notes. The date of the resolution must also be documented in the service coordinator's notes.
- c. Complete a new service authorization if necessary.
- d. Contact the service provider(s) to reestablish services.

2104.3 DENIAL OF WAIVER APPLICATION

Reasons to deny an applicant for waiver services:

- a. The applicant does not meet the criteria of being diagnosed with mental retardation or having a condition related to mental retardation.

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- b. The applicant does not meet the level of care criteria for placement in an ICF/MR.
- c. The applicant has withdrawn their request for waiver services.
- d. The applicant fails to cooperate with the service coordinator or the HCBS providers in establishing and/or implementing the ISP, implementing waiver services, or verifying eligibility for waiver services.
- e. The applicant's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. Home and Community-Based services are not a substitute for natural and informal supports provided by family, friends or other available community resources.
- f. The agency has lost contact with the applicant.
- g. The applicant fails to show a need for HCBW services.
- h. The applicant would not require imminent placement in an ICF/MR if HCBS were not available.
- i. The applicant has moved out of state.
- j. Another agency or program will provide the services.
- k. MHDS has filled the number of slots allocated to the HCBW for Persons with Mental Retardation and Related Conditions. The applicant has been approved for the waiver waiting list and will be contacted when a slot is available.

When the application for waiver services is denied the service coordinator will send a notification (Form NMO-2734) to the DHCFP CO Waiver Unit identifying the reason for denial. The Waiver Unit will send a NOD for Payment Authorization Request (Form NMO-3582) to the applicant or the applicant's legal representative. The service coordinator will submit the form within 5 days of the date of denial of waiver services.

#### 2104.4 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver:

- a. The recipient no longer meets the criteria of mental retardation or having a **related** condition.
- b. The recipient no longer meets the level of care criteria for placement in an ICF/MR.

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- c. The recipient has requested termination of waiver services.
- d. The recipient has failed to cooperate with the service coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.
- e. The recipient's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. Home and Community-Based services are not a substitute for natural and informal supports provided by family, friends or other available community resources.
- f. The recipient fails to show a continued need for HCBW services.
- g. The recipient no longer requires imminent ICF/MR placement if HCBS were not available. (Imminent placement means within 30 to 60 days.)
- h. The recipient has moved out of state.
- i. Another agency or program will provide the services.
- j. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, intermediate facility for persons with mental retardation, or incarcerated).
- k. DWSS and/or MHDS has lost contact with the recipient.
- l. The recipient fails to pay patient liability.
- m. The recipient has not utilized any waiver services over a 12 month period.

When a recipient is scheduled to be terminated from the waiver program, the service coordinator will send a notification (Form NMO-2734) to the DHCFP CO Waiver Unit identifying the reason for termination. The waiver unit will send a NOD for Payment to the recipient or the recipient's legal representative. The form must be mailed by DHCFP to the recipient at least 13 calendar days before the Date of Action (DOA) on the NOD. Refer to MSM Chapter 3100 for exceptions to the advance notice.

2104.5 REDUCTION **OR DENIAL** OF WAIVER SERVICES

Reasons to reduce **or deny** waiver services:

- a. The recipient no longer needs the number of service/support hours/days which were previously provided.

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- b. The recipient no longer needs the service/supports previously provided.
- c. The recipient's parent and/or legal guardian is responsible for the maintenance, health care, education and support of their child.
- d. The recipient's support system is providing the service.
- e. The recipient has failed to cooperate with the service coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.
- f. The recipient has requested the reduction of supports/services.
- g. The recipient's ability to perform tasks has improved.
- h. Another agency or program will provide the service.
- i. Another service will be substituted for the existing service.
- j. Payments for services provided by relatives, who are not the LRI, are limited to 40 hours per week, per individual served, per household.

When there is a reduction of waiver services the service coordinator will send a notification (Form NMO-2734) to the DHCFP CO Waiver Unit identifying what the reduction is and the reason for the reduction. The DHCFP CO Waiver Unit will send a NOD Form NMO-3582 to the recipient or the recipient's legal representative. The form must be mailed by the agency to the recipient at least 13 calendar days before the DOA on the NOD.

#### 2104.6 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

#### 2104.6A COVERAGE AND LIMITATIONS

- 1. If waiver services have been terminated and the recipient/applicant is eligible for readmission to the waiver as defined in Section 2103.16A.1.b and 2103.16A.1.c and is requesting re-approval within 90 days of closure the service coordinator must complete the following:
  - a. A new waiver assessment;
  - b. A new Statement of Choice;
  - c. A new Individual Support Plan; and

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d. A new LOC Determination.

All forms must be complete with signatures and dates. All forms will be submitted to the DHCFP CO Waiver Unit for approval.

2. If a recipient is terminated from the waiver for more than 90 days, and a slot is available, the recipient is eligible for readmission to the waiver as defined in Section 2103.1A.6, and a new waiver packet has been approved by DHCFP CO, MHDS must issue a new service authorization.

2104.6B PROVIDER RESPONSIBILITIES

MHDS will forward all necessary forms to the DHCFP CO Waiver Unit for approval.

There are no responsibilities for service providers.

2104.6C RECIPIENT RESPONSIBILITIES

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

2104.7 HEARINGS PROCEDURES

Please reference MSM Chapter 3100, Hearings, for hearings procedures.

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2105            REFERENCES AND CROSS-REFERENCES

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Chapter 1400	Home Health Agency
Chapter 2500	Case Management
Chapter 3100	Hearings
Chapter 3200	Hospice
Chapter 3300	Program Integrity
Chapter 3500	Personal Care Services Program