

Nevada



Operational Protocol

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

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Nevada Department of Health and Human Services
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A. Project Introduction

1. Organization and Administration

Part 1. Systems Assessment and Gap Analysis

1. A description of the current LTC support systems that provide institutional and home and community-based services, including any major legislative initiatives that have affected the system. What State legislative and/or regulatory changes need to be made to further rebalance the LTC system and promote HCBS?

A decade of work in Nevada has resulted in a long-term care (LTC) program that is currently substantially balanced. As outlined below, Nevada seeks to further strengthen its Medicaid program by improving on key areas that will allow the state to build upon and continue its progress.

Annual data released by Thomson Reuters showing percentages of spending that states make on institutional versus home and community-based care is a good demonstration of how balanced Nevada's LTC system actually is. The latest data available for 40 states show that Nevada is the 12th highest state out of those 40 in the percentage of its LTC budget that is spent on Home and Community-Based Services (HCBS). In 2009, Nevada spent 46.8% of its long term care expenditures on HCBS.¹ Nevada's success at rebalancing is the result of steady work over the last decade. The 2008 AARP report comparing the balance in each state's long term care system highlighted the progress that Nevada had made:

*"Recent Medicaid trends indicate that Nevada has made significant progress in increasing access to HCBS for Medicaid participants. In 1999, more participants received nursing home services than received HCBS, but by 2004, participants receiving HCBS nearly equaled participants in nursing facilities. In fact, between 1999 and 2004, the number of participants receiving HCBS more than doubled."*²

¹ See <http://www.hcbs.org/files/193/9641/FY2009InstitutionCommunityRankings.pdf>

² American Association for Retired Persons, (2008, July), *A Balancing Act: State Long-Term Care*, Washington, D.C. p. 90 Retrieved on 11-22-10 from http://assets.aarp.org/rgcenter/il/2008_10_ltc.pdf

While percentage comparisons between expenditures and the overall number of persons receiving institutional and HCBS are important indicators, rebalancing is a complex, multi-dimensional process. The Nevada State Profile Tool reported on where Nevada stands on the following dimensions of rebalancing:³

- Consolidated State Agency – State services are primarily focused within the cabinet level Department of Health and Human Services (DHHS), with operation and/or funding of long-term supports segregated by the population being served. The Division of Health Care Financing and Policy (DHCFP) is the operational entity for Nevada’s Medicaid program.
- Single Point of Access – Nevada does not have a single point of access to help people access long-term care services, but is in the process of developing Aging and Disability Resources Centers (ADRCs), has a statewide 2-1-1 program, and has multiple referral points for long-term supports.
- Institutional Supply Controls – Certificate of Need (CON) controls in place for nursing facilities and most other health care related programs are limited to projects with costs exceeding \$2 million in counties with populations of less than 100,000.
- Transition from Institutions – Nevada obtained its first 1915(c) waiver in 1982, and has obtained an additional four 1915(c) waivers since then. The state has been operating its own nursing home transition program for nearly ten years, and has benefited from Real Choice System Grants that have strengthened its home and community-based programs.

³ State of Nevada – Division of Health Care Financing and Policy, (2009, March), *State Profile Tool: Long Term Support Services*, Carson City, NV pp. 17-28. Retrieved on 11-21-10 from <https://dhcfnv.gov/pdf%20forms/FactSheets/SPT-NEVADA%20FINAL%203-31-09.pdf>

- Continuum of Residential Options – Nevada provides four primary residential options for the elderly, developmentally disabled and physically disabled: (1) an individual’s own home; (2) shared adult living arrangements or apartments; (3) residential facilities for group care, including assisted living; and (4) institutional or nursing facilities. The lack of affordable housing continues to be a serious problem.
- Participant Direction – The State has focused on participant-centered planning to develop the Plan of Care and self-directed choices in both its State Plan services Personal Care Services (PCS) and its Waiver for Persons with Mental Retardation and Related Conditions.
- Quality Management – Quality has been established through review of care plans and provider reviews. An administrative structure of successive reviews and quality management committees has been established. The quality processes and the agency that completes the review are dependent on the program that is under review. Agencies that provide services under the Medicaid State Plan and multiple waiver programs may be reviewed by DHCFP, Mental Health and Developmental Services (MHDS) and the Aging and Disability Services Division (ADSD). These reviews may be conducted more than one time in a year, depending on the State Plan and Waiver program review cycle. Proposed Quality Management efficiencies are incorporated in the discussion relevant to Benchmark #5.

This broader, multi-dimensional review from the State Profile Tool of Nevada’s rebalancing elements shows what a small, well organized state can do despite a lack of affordable housing and continuing budgetary constraints. Essential to Nevada’s progress has been a well-balanced home and community-based waiver program and a continuing nursing home diversion and

transition program.

The table below shows the specific services available in each of Nevada's five waivers and the 2008 utilization of these services within each waiver program. Three of the five waivers are for the elderly: the Waiver for the Frail Elderly (CHIP), the Waiver for the Elderly in Adult Residential Care (WEARC) and the Assisted Living (AL) waiver. The CHIP waiver emphasizes in-home care while the WEARC waiver emphasizes group residential care and the AL waiver emphasizes assisted living arrangements. The Waiver for Persons with Physical Disabilities (WIN) also emphasizes in-home care. The greater array of services available for both the CHIP and WIN waivers shows the array of services that support these in-home options. Whereas, in the WEARC waiver, the personal care services cover a bundle of personal care services provided in the group home. The Waiver for Persons with Mental Retardation and Related Conditions (MRRC) emphasizes supported living and day habilitation. Taken together, the five waivers support a variety of living arrangements and provide the supports necessary to maintain persons in these arrangements. Since the approval of the Operational Protocol Version 1.4, Nevada has combined the CHIP and WEARC waivers. The state now operates four waivers rather than five.

Table 1. Services and Utilization for Nevada HCBS Waivers, SFY 2008

Waiver Services	AL	CHIP	WIN	WEARC	MRRRC
Case Management	60	1,565	559	460	
Assisted Living	59		22		
Companion Services		169			
Chore/Home Maintenance		31	23		
Social Adult Day Care		143			
Homemaker		166	68		
PERS – units		230	43		
PERS—monitoring		940	392		
Respite		33	51		
Attendant Care			85		
Environmental Adaptations			27		
Home Delivered Meals			398		
Specialized Medical Equipment			25		
Personal Care				456	
Habilitation Day					1,458
Supported Living					1,339
Counseling					274
Habilitation Residential					57
Total Unduplicated Participants	60	1,570	559	465	1,686

Data Source: Nevada Division of Health Care Financing and Policy

The next table provides operating statistics on the five HCBS waivers as of September 2010.

APPENDIX

Table 2. Data for Nevada's HCBS Waivers, September 2010

Waiver	Legislatively Funded Slots	Unduplicated Count Year to Date	Current Caseload	Wait List	Average Time Until Placement (in months) Priority	Average Time Until Placement (in months)
AL	53	31	30	2	Unavailable	0.17
WIN	579	615	564	127	1.38	19.40
MRRC	2157	1732	1639	123	Unavailable	8.30
CHIP	1241	1339	1233	142	Unavailable	1.03
WEARC	416	449	393	70	Unavailable	1.37

Data Source: Division of Health Care Financing and Policy

In addition to waiver services, Nevada also provides other services to persons with intellectual disabilities and related conditions. These include:

- Employment Counseling and Vocational Services
- Family Support
- Residential Support
- Service Coordination

The artful combination of supporting both in-home and residential options, plus the use of PCS under the optional benefits in the Medicaid State Plan and the other services shown above, has produced a substantially balanced long-term care program.

Areas where Rebalancing Could be Strengthened

The major “gaps” or differences between the current level of rebalancing and more desirable levels include:

- Strengthening the Facility Outreach and Community Integration Services (FOCIS)

program, the state's Olmstead-response institutional diversion and transition program;

- Building administrative and budgeting mechanisms to use savings on nursing home expenditures to fund HCBS;
- Enhancing quality improvement systems that cross multiple programs and services;
- Improving housing alternatives; and
- Improving overall care coordination for Medicaid LTC recipients, including those dually eligible for Medicare.

More research will be necessary to determine if statutory, regulatory, or administrative changes are needed to address these rebalancing issues. These gaps appear to concentrate around funding, interagency, and administrative procedural issues. Furthermore, it is doubtful, given the current state budgetary limitations, that additional funding can be made available. The state's prolonged and serious budget situation puts significant constraints on what might otherwise be reasonable goals to achieve.

2. An assessment of what Medicaid programs and services are working together to rebalance the State's resources and a description of any institutional diversion and/or transitions programs or processes that are currently in operation. What additional Medicaid programs and services are needed to increase HCBS and decrease the use of institutional care?

Nevada is proud of its institutional diversion and transition program. As one of Nevada's responses to the U.S. Supreme Court's Olmstead decision in 1999, the DHCFFP Facility Outreach and Community Integration Services (FOCIS) program came into existence. FOCIS began as a pilot program in northern Nevada in 2002, was expanded to southern Nevada in 2003, and became available throughout the state in 2004. FOCIS was initiated in response to the Task Force on Disability Strategic Plan for Persons with Disabilities, and was aided in 2003 by a CMS Money Follows the Person grant to promote community integration. In July 2006, collaboration

with Southern Nevada Center for Independent Living and FOCIS was established through the Funds for Healthy Nevada grant, Transition Housing Assistance Program. The grant expired June 30, 2010.

FOCIS has been very successful. The following table shows the number of transitions and diversions the program has accomplished in the last four years. In 2010, approximately half the persons transitioned were under age 65, and approximately 54% of the people transitioned had been in an institutional setting for 91 days or longer.

Table 3. Number of FOCIS Transitions and Diversions, 2007-2010

FOCIS by Year	Transitions	Diversions
SFY 2007	163	155
SFY 2008	128	254
SFY 2009	170	188
SFY 2010	160	111

Data Source: Division of Health Care Financing and Policy

A significant reason for the success of the program is the coordination with a number of different organizations that is a hallmark of the FOCIS program. For example, FOCIS provides in-service trainings annually for the following entities:

- Long Term Care Facilities
- Rehabilitation Facilities
- Acute Hospitals
- Mental Health and Developmental Services Facilities
- Centers for Independent Living

FOCIS cooperates with, and receives referrals from, many sources, including:

- Medical institutions
- Other agencies
- Recipients, their legal guardians, family members or friends
- Weekly Level of Care Report
- Minimum Data Set (MDS) Quarterly Reports
- Nursing facilities

FOCIS links with multiple programs. Persons who are diverted and transitioned receive services from:

- Aging and Disabilities Resource Centers,
- Administration on Aging programs through the Aging and Disability Services Division.
- State Plan personal care services and other State Plan services,
- Centers for Independent Living, and
- Home and community-based 1915(c) waiver programs.

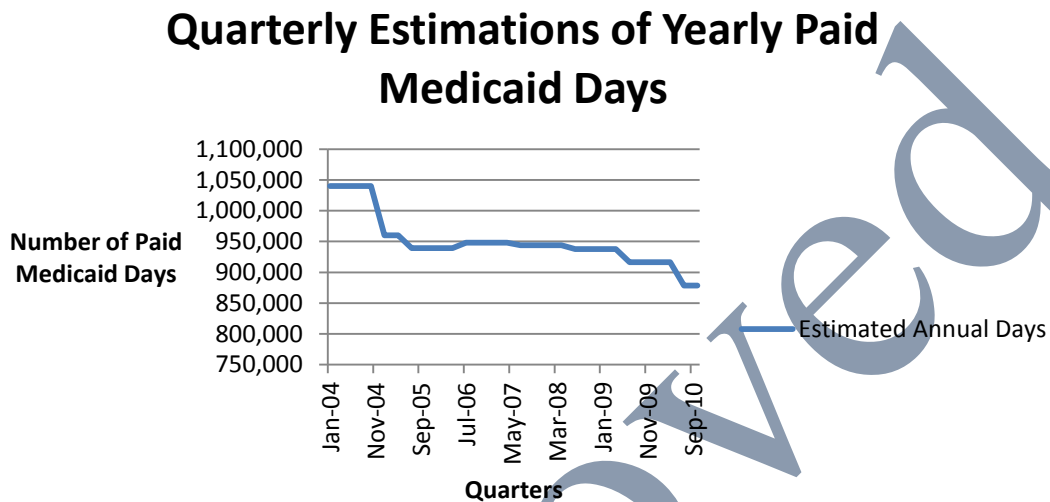
The net effect of this collaboration has been a pronounced reduction in the number of Medicaid paid nursing home days. On the one hand, Nevada has had both a fast growing and steadily aging population. Data from the 2008 State Plan for Elders noted that from 1990 to 2000 the number of seniors in Nevada age 65 or older increased by 72 percent, while the increase nationwide was only 12 percent. The number of seniors age 85 or older in Nevada increased by 128 percent, versus 38 percent nationwide.⁴ On the other hand, the number of Medicaid paid nursing home days has gone down. The DHCFP Rates Unit makes quarterly adjustments to nursing home rates and each quarter estimates the annual number of paid Medicaid days that are applicable to that quarter. The following graph shows that the annual estimate of nursing home days has fallen from 1,041,001 in the January 2004 quarter to 878,302 in the October 2010 quarter. The SFY 2011 2nd quarter budget neutral Medicaid rate including the Provider Tax Pool was \$189.38⁵. A maximum estimate of the amount of cost avoidance savings in FY 2011

⁴ Nevada Division for Aging Services, (2008, September), *State Plan Services for Nevada's Elders, October 1, 2008 to September 30, 2012*, Carson City, NV. Retrieved on 11-22-10 from http://www.nvaging.net/sp/state_plan.htm

⁵ See, retrieved on 11-23-10, <https://dhcftp.nv.gov/Rates/NFR/Oct10/Rates%20Calculation%20Worksheet.pdf>

potentially attributable to FOCIS exceeds \$30.6 million in state, county and federal expenditures.⁶

Figure 1. Quarterly Estimates of Annual Paid Medicaid Days, January 2004-October 2010



New and different services may not be needed in Nevada. What is needed is funding services that enhance the effectiveness of FOCIS, mechanisms for more flexible funding of HCBS waiver services, and affordable housing. Advocates, state staff, and legislators have positively responded to the need for more HCBS services and improved provider rates; however, the continuing budget crisis makes such responses difficult to sustain.

3. A description of the number of potential participants who are now living in institutions including the number of residents in nursing homes who have indicated they would like to transition into the community.

In September 2010, the 48 nursing facilities in Nevada had 5,671 beds of which 4,646 were filled. The 4,646 residents included 2,800 Medicaid residents.⁷ Minimum Data Set (MDS) Section Q answers for the 2010 Third Quarter indicate that 30.6% of the MDS reports were

⁶ Savings estimate was calculated as follows: 443 fewer residents * \$189.38 per day * 365 days = \$30,621,799.

⁷ See, retrieved on 11-23-10, <https://dhcfp.nv.gov/Nursing%20Forms/2010/9-2010.pdf>

checked Yes for Question Q1, indicating a desire to return to the community.⁸ It is not clear how many of the persons who indicate a desire to return to the community would avail themselves of transition opportunities. As noted above, the FOCIS program currently transitions about 160 persons a year, but works with even more individuals as some persons ultimately choose not to, or are not able to, transition.

Nevada has only eight Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). One is operated by the State Mental Health and Developmental Services (MHDS) Desert Regional Center in Las Vegas and the other seven are privately operated. Of the seven private ICFs/MR, six have six beds or less, and one is an 18-bed ICF/MR. These ICFs/MR have a total capacity of 102 beds. Additionally, the State uses five out-of-state ICF/MRs: four in Utah and one in Arizona. Currently, there are three Nevada Medicaid recipients placed in out-of-state ICFs/MR. There is no equivalent to the MDS Section Q used with ICFs/MR, so we do not have indicators of how many ICF/MR residents would express a desire to return to the community. For the purpose of establishing benchmarks, as shown in the benchmark section, state staff members have estimated the number of residents that can be transitioned. The estimate is based on the experience of state staff in transitioning residents from the state's developmental center in northern Nevada, which was closed in September 2008.

4. A description of any current efforts to provide individuals with opportunities to self-direct their services and supports. Would your State be developing additional opportunities for participants to self-direct?

The Self-Direction section of this Operational Protocol and the Self-Direction Submittal Form Appendix D discuss Nevada's self-direction programs at length. Briefly, self-direction is used in two programs:

⁸ See, retrieved on 11-23-10, http://www.cms.gov/MDSPubQIandResRep/04_activeresreport.asp?isSubmitted=res3&var=Q1a&date=32

First, a self-direction option is available for Medicaid State Plan PCS. Individuals are assisted by an intermediary service organization (ISO) to access self-directed services as part of receiving personal care.⁹ Over ten percent, or 64 out of 615 individuals on the waiver for persons with a physical disability, used a self-directed PCS. There were 12 certified ISO's as of March 22, 2010. Persons using State Plan PCS can elect the ISO/self-directed option regardless of their participation on an HCBS waiver.

Second, the Waiver for Persons with Mental Retardation and Related Conditions has a pilot project in the Nevada areas served by the MHDS Rural Regional Center. This pilot project is currently limited to participants residing in these rural regions. As of October 1, 2010, there were six participants enrolled in this pilot.

Nevada will maintain these current opportunities for individuals to self-direct their own services and supports. DHCFP will support the waiver pilot project for self direction, and assist MHDS in expanding this program in future waiver years. Nevada continues to support these self-direction opportunities, but also plans to review any administrative processes or cultural beliefs that currently inadvertently contribute to low utilization of self-direction opportunities. Training of state staff and stakeholders is an integral part of removing inadvertent barriers.

5. Describe the stakeholder involvement in your LTC system. How will you include consumers and families as well as other stakeholders in the implementation of the MFP program?

Stakeholder collaboration is discussed at length in Stakeholder Involvement section 4 of the Operational Protocol. Because of its small size and culture, Nevada has traditionally had broad stakeholder involvement in HCBS programs. For example, representatives from 45 different

⁹ ISOs are defined in Nevada statute at Nevada Revised Statutes (NRS) 426.218. See <http://www.leg.state.nv.us/nrs/NRS-426.html>

organizations were involved in writing the State Profile Tool.¹⁰

The Aging and Disability Services Division (ADSD) conducted a survey of 5,000 Nevada seniors during the period 2006-2008.¹¹ This size of survey was large enough to provide statistically meaningful results for different geographies within Nevada. The survey made 212,000 call attempts and completed interviews with 5,000 persons over the age of 50. ADSD also prepares three State Plans: one for aging programs, one for independent living, and one for programs for persons with disabilities. These plans are done in conjunction with advisory committees and public hearings so that Nevadans can provide input into the Division's planning efforts.

Nevada also has a unique committee structure not found in most states. The state has a Strategic Plan Accountability Committee (SPAC) for both seniors and people with disabilities, established by Executive Order. In the most recent legislative session, the SPAC for people with disabilities became the Nevada Commission on Services for People with Disabilities, with its duties and powers set forth in NRS 427A.1217. The state also benefits from activities of the Nevada Silver Haired Legislative Forum, created to identify and act upon issues of importance to aging persons.

The Division of Mental Health and Developmental Disabilities is advised by the Commission on Mental Health and Developmental Services. Established in law by Nevada Revised Statutes, the ten member commission advises the Division on all major policy decisions.¹²

¹⁰ State of Nevada – Division of Health Care Financing and Policy, (2009, March), *State Profile Tool: Long Term Support Services*, Carson City, NV pp. 2-3. Retrieved on 11-21-10 from <https://dhcfp.nv.gov/pdf%20forms/FactSheets/SPT-NEVADA%20FINAL%203-31-09.pdf>

¹¹ Cannon Survey Center, (2008, August), *Portrait of Nevada's Seniors: A Two-Year Study 2006-2008*, University of Las Vegas, Las Vegas, NV. Retrieved on 11-23-10 from <http://surveys.unlv.edu/pdfs/2008Portrait%20of%20Nevadas%20Seniors.pdf>

¹² For a description of the committee see <http://www.leg.state.nv.us/NRS/NRS-433.html>

In addition to these boards and commissions, day-to-day implementation of care planning provides for stakeholder comment. Case managers are required to make efforts to seek out the comments of family members and the individual for whom the care plan is being developed. Evidence of family and individual involvement in the development of the care plan is one of the quality indicators that care plan reviews consider. Additionally, the ADSD extends support to resident and family councils in nursing facilities, which provides another opportunity for stakeholder input.

This commitment to engaging stakeholders extends to the development of this Operational Protocol. In developing its draft Operational Protocol, Nevada held two stakeholder meetings. Approximately 30 individuals from 24 organizations attended. At each meeting, the purpose of the MFP Demonstration was explained to attendees, and they were asked for advice and input as to which services should be included in the demonstration. In addition to these public meetings, visits were made to four nursing facilities. Residents and discharge planners were interviewed regarding the difficulties in transitioning from a nursing home and the services that might be needed to make the transition successful.

The process of collecting stakeholder feedback will continue once the MFP Demonstration is operational. Neither transition nor diversion are possible without the willing and active participation of the individual. This participation will be obtained through frequent meetings and discussions with the person to ensure that community arrangements are satisfactory, involving the person in the care planning, checking back with the person after the transition has occurred, and conducting holistic care coordination to be sure that the right services are being provided in a timely way. The current procedures of the FOCIS program include these stakeholder involvement opportunities, and these will be continued under the MFP Demonstration.

Part 2. Description of the Demo's Administrative Structure

Describe the Administrative structure that will oversee the demonstration. Include the oversight of the Medicaid Director, which agency will be the lead agency, all departments and services that will partner together, the administrative support agencies that will provide data and finance support and what formal linkages will be made and by what method, (i.e. Memorandum of Agreement, reorganization).

The Operational Protocol is submitted by the single state Medicaid agency, the Department of Health and Human Services (DHHS). The Division of Health Care Financing and Policy (DHCFP) will be responsible for the day to day management of the MFP Demonstration grant. DHCFP is responsible for administering State Plan services accessible to MFP Demonstration participants. DHCFP provides assurances to CMS for all Medicaid-funded programs. Program operation for HCBS waivers may be delegated to other DHHS offices, with DHCFP retaining oversight.

The Aging and Disability Services Division (ADSD) operates two 1915(c) waivers targeting the elderly population, which include: HCBW for the Frail Elderly (CHIP), HCBW for Persons in Adult Residential Care (WEARC) which are now combined, and the Assisted Living Waiver (AL). ADSD's operating responsibilities include data collection for eligibility verification, evaluation of level of care (LOC), plan of care development (POC), and annual reassessments. The Division of Health Care Financing and Policy (DHCFP) exercises administrative authority over the operation of the waivers and issues policies, rules and regulations related to the waivers. ADSD and DHCFP have an executed interlocal agreement which outlines each agency's responsibility. ADSD provides monthly data on caseload, and DHCFP waiver staff track expenditures and service utilization. ADSD holds a quarterly quality management meeting in which DHCFP staff participate. DHCFP completes the annual CMS372 report and conducts annual waiver reviews. ADSD and DHCFP collaborate when waiver

evidentiary reports are due.

The HCBW for Persons with Mental Retardation or Related Conditions (MRRC) is operated by Mental Health and Developmental Services (MHDS). DHCFP exercises administrative authority over the operation of the waiver and issues policies, rules and regulations related to the waiver. MHDS provides monthly caseload data to DHCFP and waiver supervisors at DHCFP track waiver expenditures and service utilization. DHCFP completes the annual CMS372 and conducts annual waiver reviews. MHDS and DHCFP collaborate when the waiver evidentiary report is due. MHDS and DHCFP work under an interlocal agreement that outlines each agency's responsibilities, and are currently working to update this interlocal agreement.

DHCFP will oversee the MFP Demonstration under the overall direction of the DHCFP Administrator (i.e., the state's Medicaid Director). DHCFP's Grants Management Unit section will hire an MFP Project Director. The Project Director will be responsible for coordinating a core work group to complete the design and development of the Operational Protocol. This core work group, under the coordination of the Project Director, will lead the implementation and activities for sustaining the MFP Demonstration. DHHS established a Core Work Group under the MFP planning grant for ongoing communication and development of the MFP Demonstration. The MFP Core Work Group includes DHCFP, ADSD, MHDS, CILs, and representation from both urban and rural Nevada counties. Nevada's MFP Demonstration will encompass three target populations, and therefore, it will be critical for these groups to continue collaborating in every aspect of the MFP Demonstration.

2. Benchmarks

Provide a list of proposed annual benchmarks that establish empirical measures to assess the State's progress in transitioning individuals to the community and rebalancing its long-term care system. In the application, two specific benchmarks were required by all awardees. These two benchmarks are:

Benchmark #1

- **Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.**

The benchmark analysis table shown below is based on the historical experience of Nevada's Facility Outreach and Community Integration Services (FOCIS) program, and from state staff based on experience in transitioning individuals from institutional settings.

Table 4. Benchmark #1, Estimated Number of Individuals to be Transitioned, 2011-2019

Populations to be Transitioned	Older Adults	Developmental Disability ¹	Physical Disability	All Persons
Calendar Year 1 - 2011	0	0	0	0
Calendar Year 2 – 2012	5	0	5	10
Calendar Year 3 – 2013	17	1	17	35
Calendar Year 4 – 2014	34	2	34	70
Calendar Year 5 – 2015	38	2	38	78
Calendar Year 6 - 2016	41	2	41	84
Calendar Year 7 - 2017	52	2	52	106
Calendar Year 8 – 2018	50	2	50	101
Calendar Year 9 - 2019	19	1	19	40
Total	256	12	256	524

¹ *There is no age restriction for persons with developmental disabilities.*

Nevada has been operating a nursing home diversion and transition program since 2002, and this effort was aided by a CMS Money Follows the Person grant in FY 2003.¹³ Nevada, like

¹³ Nevada was awarded four Real Choice Systems Change Grants during the early 2000's: Community-Integrated Personal Assistance Services and Supports in 2001, Real Choices: Improving Community Services and Supports for

other successful states such as Pennsylvania, Washington and Michigan, built upon its earlier work, continued its program, and continues to successfully operate a transition and diversion program. In 2010, the FOCIS program helped divert 111 persons and transitioned 160 persons. In September 2010, the 48 nursing facilities in Nevada had 5,671 beds of which 4,646 were filled. The 4,646 residents included 2,800 Medicaid residents.¹⁴ Roughly speaking, the FOCIS program transitioned 160 of 2,800 persons or six percent of Medicaid nursing facility residents. This is a substantial percentage and is well above the percentages that most state nursing home transition programs achieve.

The 160 persons transitioned in 2010 were roughly split between those under the age of 65 and those over the age of 65. Slightly more than half (54%) of the 160 persons had been in the nursing home over 90 days. It is these operating statistics that provide an empirical basis for the benchmark projections. Beginning in the third year of the MFP Demonstration, Nevada is projecting to help transition an additional two percent of its nursing home residents to the MFP Demonstration on an annual basis.

Benchmark #2

- **Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program.**

The following table shows projected expenditures on Medicaid HCBS expenditures for state fiscal years 2011-2016.

Special Needs Children in Nevada, Family-to-Family Health Care Information and Education Center Project in 2003, Money Follows the Person Rebalancing Initiative also in 2003.

¹⁴ See, retrieved on 11-23-10, <https://dhcfp.nv.gov/Nursing%20Forms/2010/9-2010.pdf>

Table 5. Benchmark #2, Projected HCBS Expenditures, 2011-2016

Year	Projected HCBS Expenditures
2011	\$ 161,939,197
2012	\$ 165,880,999
2013	\$ 169,822,802
2014	\$ 173,764,605
2015	\$ 177,706,407
2016	\$ 181,648,210

The expenditures were projected by looking at historical costs for state fiscal years 2000 through 2010 for the following services:

- Personal Care Services--(Provider Agency and ISO)
- Mental Retardation and Related Conditions Waiver (MRRC)
- Frail Elderly Waiver (CHIP)
- Elderly in Adult Residential Care Waiver (WEARC)
- Persons with Physical Disabilities Waiver (WIN)
- Assisted Living Waiver (AL)
- Home Health Agency Services
- Hospice Services

Nevada anticipates these projected expenditures to be reasonable estimates unless the legislature reduces the appropriation for these services or takes other action to reduce Medicaid HCBS expenditures, in light of the state's ongoing and critical budget crisis.

Additional Measurable Benchmarks

As shown in the systems assessment above, Nevada has operated a continuous nursing home diversion and transition program for close to a decade. The additional benchmarks shown below will seek to test mechanisms to remove financing obstacles to rebalancing, strengthen existing self-directed care efforts, and provide more efficient quality assurance.

Benchmark #3

At the heart of the MFP Demonstration is rebalancing. After the Operational Protocol Version 1.4 was approved, the Nevada 2011 Legislature passed Senate Bill 485 which revised the provisions governing the payment by the State for certain care provided under the State Plan for Medicaid. The Legislature amended NRS.422.272(c), which eliminates the specific income requirement the state's county governments pay for the non-federal nursing home costs. SB 485 changed the net computable income per month from a rate "between 157% and 300% of the Supplemental Income (SSI) levels "to a percentage prescribed annually by the Director."

Because of the current budget crisis, neither the counties nor the state can afford to spend more money on Medicaid services. This concern inhibits counties from entering into an arrangement with the state whereby the counties would help pay for the HCBS services of the person who was transitioned from a nursing home. Counties are concerned that as persons leave nursing facilities the vacated beds will be "backfilled" and counties will end up paying more (i.e., the cost of HCBS services for the transitioned nursing home resident, as well as the cost of the "new" nursing home resident). These concerns exist despite an occupancy rate of 82.6% in November 2010.¹⁵ County staff members indicate that nursing facilities tend to restrict the number of Medicaid recipients they serve because of low Medicaid reimbursement.¹⁶ What

¹⁵ Monthly occupancy figures for Nevada nursing facilities are available at <https://dhcfnv.gov/nursing.htm>

¹⁶ The October 2010 SFY 2011 Budget Neutral Medicaid Rate Including Provider Tax Pool is \$189.38 and its calculation is shown at <https://dhcfnv.gov/Rates/NFR/Oct10/Rates%20Calculation%20Worksheet.pdf>

happens, county staff members say, is that the restriction in supply creates a de facto waiting list for the beds available and persons wait in hospitals until a bed becomes available. Consequently, the occupancy rate is illusory and beds always get backfilled.

The state has parallel concerns in that with the county paying the cost set by the percentage determined by the Director for a person in a nursing home, if the person that leaves the home uses HCBS waiver services, state general fund expenditures will increase. This concern with backfill has been a persistent issue since the beginning of the FOCIS program and the first additional benchmark proposes a methodical way of approaching and resolving it over the course of the five-year MFP Demonstration. The approach suggested is to conduct a fact gathering stage and collaborate with the counties to develop a comprehensive plan that incorporates the changes made by Legislators to SB 485 and NRS 422.272.

Year Three

- Conduct a study of nursing home occupancy;
- Call or visit all nursing facilities and interview nursing home staff;
- Call or visit all counties and collect data from county staff;
- If necessary, conduct interviews with hospital staff;
- Write report discussing bed capacity issues and estimating number of persons to be transitioned;
- Discuss findings with counties

Year Four

- Collaborate with counties to develop a plan to deal with occupancy concerns;

- Reach substantive agreement with counties about ongoing transition efforts; and
- Implement new agreement.

Year Five

- Monitor results of agreement.
- Report results of new agreement;

Year Six

- Collaborate with counties on any changes that need to be made; and
- Implement new understandings and refine them.

As this multi-year benchmark shows, a deliberative approach is proposed. During the second year an environmental scan of the counties, nursing facilities and hospitals would be conducted and reported. County staff indicate they are supportive of the philosophy of the MFP Demonstration and their concerns primarily involve the potential budget impact on the counties. With this fact base developed during the second year, discussions with the counties about these financial concerns can be fruitfully held and an agreement can be reached on how transition activities can be financed and improved.

While the activities by year are not quantitative, they are verifiable and measureable. They are discrete steps in a logical, methodical process that has deliverables and can be observed. When successful, this effort will remove a substantial barrier to the rebalancing of services in Nevada.

Benchmark #4

Nevada recognizes the need to offer Medicaid recipients the opportunity to self-direct and self-determine their care, as appropriate. The terms are often used interchangeably, but the fundamental shift in power allows individuals to control their own services and supports, while

at the same time maintaining an appropriate level of accountability. The State of Nevada has defined self determination as freedom for individuals, who as a result of their disability and vulnerability have often been oppressed, segregated and isolated within society. It is defined by a set of guiding principles that assure freedom, choice and self-direction in their lives.

Nevada offers a self-direction option for PCS, a delivery option designed to allow recipients more autonomy and responsibility in the provision of PCS. The option is utilized by accessing services through an intermediary service organization (ISO). An ISO is an entity acting as an intermediary between Medicaid recipients who elect the self-directed service delivery model, and the personal care assistants. ISO services must be provided in a manner that affords individuals and their representatives choice and control over the services they receive and the qualified providers of those services. Persons using State Plan PCS can elect the ISO/self-directed option regardless of their participation on an HCBS waiver.

Nevada will maintain these current opportunities for individuals to self-direct their own services and supports. Nevada continues to support the self-direction option for State Plan PCS, but would seek to utilize MFP Demonstration activities as a vehicle to increase the utilization of self-directed PCS. Under the MFP Demonstration, Nevada plans to review any administrative processes or cultural beliefs that currently inadvertently contribute to low utilization of self-direction opportunities. Training of state staff and stakeholders to reinforce this self-directed option is an integral part of removing inadvertent barriers. The following table shows of the planned increase in Medicaid PCS recipients receiving self-directed services for state fiscal years 2011-2016, as the result of eliminating administrative processes or cultural beliefs that inadvertently act as barriers to self-direction opportunities:

Table 6. Benchmark #4, Projected Increase in Recipients Choosing Self-Directed PCS, 2011-2016

Year	Participants Receiving Self-Directed PCS
2011	300
2012	307
2013	313
2014	319
2015	326
2016	331

Benchmark #5

Improving the usefulness of the current FOCIS information system is a significant need of the MFP Demonstration. The improvement would not only improve administrative efficiency but also improve quality and continuity of care. Currently the information system has limited utility. Built on a Microsoft ACCESS platform, it is a standalone database of records on persons who participate in the FOCIS program. Databases used by the two regional offices are not linked to a single statewide database.¹⁷ The system does not have information on services, costs, critical incidents, or key dates such as first day of eligibility for the Demonstration.

For example, to study the effect of the 90-day institutional stay requirement, every FOCIS case in 2009 had to be manually checked to determine how many persons had been transitioned before 90 days in the nursing home and how many were transitioned after a stay of 90 days or more. The existing database has lookup functions to enter and retrieve records. It does not have service information in it and cannot provide simple information such as what services were provided to participants when they transitioned and where they went to live.

What is needed is to integrate multiple data streams into a single, statewide database. These data streams include:

¹⁷ Readers of this Operational Protocol may be surprised that the Nevada northern and southern regional offices have different databases. While Nevada is a smaller state in terms of population it is a large state in terms of size. The distance between the Reno office and the Las Vegas office is greater than the distance between Boston and Washington, D.C.

- Cost data about the one-time transition services (e.g., household set up costs received by persons);
- HCBS waiver and other State Plan services and costs received after the transition;
- The residences that persons reside in after transition;
- Case management and care coordination notes;
- Survey data such as the state's satisfaction survey and the Demonstration's Quality of Life survey;
- Critical incident data, milestone data such as dates of admission to hospitals or return to nursing home; and
- Other information required by CMS.

As mentioned above, a more robust data system would support quality of care by enabling staff to better track what services persons receive after they transition and what happens to those persons. For example, the state would like to track the cost of the one-time services used by persons being transitioned. This is a difficult task with the current database. Another example is that District Offices currently use different databases to track FOCIS participants and HCBS waiver participants. There are quality of care and case management advantages to combining or linking these standalone databases.

The new database also needs to be checked against other standalone systems used by the Department so duplication of effort does not occur. For example, ADSD and MHDS use different case management systems that allow for the entry and retrieval of case management notes, while DHCFP does not have an automated system.

Data processing projects can be long and complicated, especially if interfaces to the state's Medicaid Management Information System (MMIS) are required. The strategy considered in the

approach to this benchmark is to improve the efficiency of using downloads from MMIS. For example, Nevada staff customarily query MMIS and receive claims information. This information can be downloaded in the form of Excel databases. One strategy of better linking the FOCIS database system to MMIS would be to expedite the linking of routine queries so downloads are made directly and routinely to a software package that is more easily manipulated.

Year Two

- Work with state Department of Information Technology to gain approval for project;
- Complete scoping work for single statewide system, including CMS data requirements;
- Convene cross-department information systems core group;
- Price cost of work phases;
- Review plan requirements with program staff and obtain approval of phases and costs;
- and
- Commence work.

Year Three

- Complete work, including implementation and testing;
- Train staff on new systems; and
- Revise FOCIS Desk Manual.

Year Four

- Make modifications to system, as necessary; and
- Operate new system.

Year Five

- Operate new system.

While these goals do not lend themselves to quantitative measurement, the steps in implementing the benchmark are verifiable, measurable and discrete, and when accomplished will substantially improve the quality and continuity of care that participants receive.

Benchmark # 6

The Department finds itself in the position of developing multiple quality assurance programs for Medicaid LTC services. Quality assurance requirements have consistently expanded over the last decade and now require more administrative time and cost than they did ten years ago. Nevada's four HCBS waivers are operated by three Divisions within DHHS, and all four are administered by DHCFP. Each Division operates its own quality assurance program. At the heart of rebalancing is increasing the use of home and community-based programs. In order to increase their use, quality assurance procedures have to be effectively and efficiently operated and administered.

Quality of care may be improved by identifying those elements of quality that span the Divisions such as case reviews, versus those that are unique to each Division, such as visits to specific service providers. The HCBS providers may also be monitored separately related to the provision of Medicaid State Plan services. Elements of quality that span HCBS can then be studied to see if a single quality of care approach would improve quality outcomes and be more efficiently administered. This is also a multi-year effort that would first involve data collection and then move to implementation and operational phases.

Below we propose a methodical process for consolidating quality assurance efforts to ensure that the highest quality services are delivered in the most administratively efficient, effective and consistent manner possible.

During Year Two of the MFP Demonstration, DHCFP will:

- Convene cross- departmental quality study group;
- Prepare program descriptions of how quality is measured;
- Identify common requirements and common quality procedures;
- Identify requirements that cannot be standardized;
- Solicit opinions from stakeholders;
- Design one quality program for all HCBS and related services; and
- Obtain agreements from Divisions' and Department leadership.

Early in Year Three of the MFP Demonstration, DHCFP will:

- Prepare implementation policy and materials;
- Train Division staff on consolidated quality program;
- Explain relevant parts of new quality assurance program to providers;
- Inform recipients of quality assurance procedures; and
- Implement new quality assurance program.

Also beginning in Year Three of the MFP Demonstration, DHCFP will implement a consolidated quality assurance process. This new quality assurance processes will have a more person-centered, rather than programmatic, orientation to assess participant's health and welfare across HCBS waivers and State Plan PCS and 1915 (i) programs. The new process will be more efficient and ensure continuous improvements that cross traditional boundaries of HCBS waiver and State Plan services. The following table shows projected number of Medicaid LTC recipients subject to annual quality assurance review that integrated HCBS waiver assurance and State Plan quality measurement into a single, person-centered review for calendar years 2011-2016.

Table X. Benchmark #6, Projected Consolidated QA Reviews, 2011-2018

Year	Participants Reviewed
2011	0
2012	0
2013	0
2014	80
2015	125
2016	125
2017	125
2018	125

Participants' reviews are extended to ensure proper appropriate policies and procedures are in place. The MFP Demonstration provides an opportunity to work on quality assurance and Nevada will use this opportunity to strengthen HCBS by ensuring that effective and efficient quality assurances support its HCBS programs. This more consolidated approach is an important foundation as Nevada moves toward more expanded HCBS options under Community First Choice and connecting existing case management activities with broader care coordination efforts through Patient Centered Medical Homes.

B. Demonstration Implementation Policies and Procedures

1. Participant Recruitment and Enrollment

a. How will the service provider be selected and does the State intend to engage the State's Centers for Independent Living in some role in the transition process.

The target population for the MFP Demonstration will be those individuals with physical disabilities and adults age 65 and older; however, there will be no age-based restrictions. In addition, individuals residing in institutions for people with intellectual disabilities will be part of the target population with no age-based restrictions. DHCFP plans to leverage existing provider networks for Qualified HCBS and Demonstration Services wherever and whenever feasible. MFP participants that are enrolled in one of Nevada's 1915(c) waiver programs will have a choice of providers among those participating in the state's HCBS program. Participants will also have a choice of enrolled providers for Medicaid State Plan services.

Once the need for specific providers has been identified, DHCFP will collaborate with Nevada's licensing agency, the Bureau of Health Care Quality and Compliance (HCQC) in identifying additional providers to participate in the provider network. It is anticipated that the initial focus will be on recruiting providers in rural Nevada. Efforts to recruit additional providers may include such efforts as informational mailings, workshops, announcements on the QIO-like vendor websites, and other methods as the opportunity arises.

The State of Nevada has two active Centers for Independent Living (CILs); each serving residents in the northern and southern areas of the state, respectively. Under the auspices of the MFP Demonstration project, some Demonstration Services (i.e., Community Transition Services, Housing Coordination) not available through the network of enrolled HCBS providers may be

provided by CILs or other nonprofit organizations. Note: PERS would be an example of a Demonstration Service provided through the HCBS provider network. DHCFP plans to work with community organizations to deliver such services. These service providers will be selected through an RFP or subgrant process. Transition Navigation, a Demonstration Service, will be provided by state staff associated with DHCFP's FOCIS program. FOCIS is a key part of Nevada's response to the Olmstead Decision, to ensure every recipient has the right to live in the least restrictive environment. FOCIS is a Medicaid administrative function staffed by social workers, nurses and other licensed health care professionals. The role of the FOCIS program is both to assist individuals at risk of institutional placement to continue to live in community settings by accessing Medicaid services and resources (diversion), and to assist individuals currently residing in an institutional setting in returning to community living by accessing appropriate and medically necessary Medicaid services (transition). FOCIS is a voluntary service intended to provide Medicaid recipients with alternatives to institutional living.

Consistent with current FOCIS program practices, non-Medicaid eligible individuals encountered in the course of outreach or education efforts will continue to be referred to a CIL or other community agencies that assist with transitions.

- b. The participant selection mechanism including the criteria and processes utilized to identify individuals for transitioning. Describe the process that will be implemented to identify eligible individuals for transition from an inpatient facility to a qualified residence. Please include a discussion of:**
- The information/data that will be utilized (i.e., use of MDS Section "Q" or other institutional data);**
 - How access to facilities and residents will be accomplished**
 - The information that will be provided to individuals to explain the transition process and their options, as well as the state process for dissemination of such information.**

The State of Nevada has several case finding methods currently used with the FOCIS program. One case finding mechanism used by DHCFP will be nursing home MDS, Version 3.0

Section Q. This section of the MDS identifies individuals that are interested in returning to the community. Prior to MDS 3.0 Implementation in October 2010, DHCFP was using this mechanism to identify individuals for potential return to the community. Quarterly reports were received by DHCFP identifying participants who possibly could transition. With the implementation of MDS 3.0 in October 2010, DHCFP District Offices are designated as the Local Contact Agency and receive referrals to FOCIS through this process.

In addition to MDS Section Q, weekly reports are received from DHCFP's QIO-like vendor for performing Level of Care (LOC) screenings that are completed prior to any nursing facility admission per 42 CFR 440.230(d). The QIO-like vendor also performs Pre-Admission Screenings and Resident Review (PASRR) screenings to assure that individuals with serious mental illness, an intellectual disability and/or related conditions entering or residing in Medicaid-certified nursing facilities receive appropriate placement and services. In accordance with 42 CFR 483.106, all applicants of Medicaid-certified nursing facilities must be screened through the PASRR Level I and, if appropriate, the PASRR Level II process. DHCFP will continue this coordination process with the PASRR/LOC screenings to identify individuals who may transition from institutional placements under the MFP Demonstration.

Finally, MFP participants may be identified by referrals from qualified institutions and other agencies, or referrals from recipients, their legal guardians, family members or friends. Brochures and referral forms are distributed to facility staff, residents and families, and are also provided to the community and other agencies. The referral network is deliberately designed to be wide and comprehensive.

Since the expansion of FOCIS statewide in 2004, DHCFP has maintained excellent relationships with institutional facilities. Access to facilities and residents has not been an issue

in Nevada. The outreach process begins with providing information regarding FOCIS and available services to providers, recipients and the community. A letter of interest and brochures are mailed to facility staff annually. In-service trainings are provided for the following facilities and community organizations:

- Long Term Care Facilities
- Rehabilitation Facilities
- Acute Hospitals
- Mental Health and Developmental Services Facilities
- Centers for Independent Living (CILs)

During the initial contact, the MFP candidate is informed of their right to decide where they will live. An initial meeting is scheduled to discuss preferences, services and supports available in the community. The candidate has a choice to participate or not to participate in a transition plan. During this initial contact, the MFP/FOCIS Health Care Coordinator discusses the Statement of Understanding, which includes statements about choice. If the candidate chooses to pursue opportunities to return to the community, the candidate agrees to an assessment and participates in developing their written transition plan. The participant signs and receives a copy of the Transition Plan Agreement.

c. The qualified institutional settings that individuals will be transitioning from, including geographical considerations and targeting. If targeting certain facilities, the names of the identified facilities and an explanation of how the facilities being targeted meet the statutory requirements of an eligible institution.

The target facilities will be the 48 nursing facilities located throughout the state. Nevada enrolls providers by provider type, and the target facilities are all provider type 19. In addition, the Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), which are provider types

16 and 68, are both public and private ICFs/MR. There are eight of these facilities in the state.

d. The minimum residency period to conform to the changes made to Section 6071 by the ACA reducing the minimum number of consecutive days to 90 in an institutional setting with the statutory exception noted in the ACA; and who is responsible for assuring that the requirement has been met.

The minimum residency period of 90 consecutive days will be verified by the MFP/FOCIS Health Care Coordinator through enrollee and benefits inquiry in the Medicaid Management Information System (MMIS). This inquiry enables verification of Medicaid coverage (to exclude Medicare short-term rehabilitation services per ACA requirements) through the assigned Medicaid benefit plan. Documentation for all eligible individuals will be tracked in a custom database.

e. The process (who and when) for assuring that the MFP participant has been eligible for Medicaid at least one day prior to transition from the institution to the community.

Prior to being eligible as an MFP participant, the MFP/FOCIS Health Care Coordinator will verify one day of Medicaid eligibility by using the MMIS and state's eligibility system, Nevada Operations of Multi-Automated Data Systems (NOMADS). The NOMADS eligibility research is also obtained through an enrollee and benefits inquiry to determine eligibility.

f. The process for determining that the provision of HCBS to a participant enables that participant to be transitioned from a qualified institution. Formal Level of Care determinations are not required prior to transitioning into the MFP program for the 365 day period. States may elect to develop an assessment of eligibility that takes into consideration the readiness for an individual to transition into the community with identified transition services and appropriate long-term care services.

When the MFP participant chooses to pursue opportunities to leave a qualified facility, a Setting Neutral Assessment is completed with the participant and used to identify specific needs for the transition. In order to ensure HCBS are appropriate for the recipient, the following components are included:

- Family and Friends Support
- Finances
- Community Integration, Social, Faith, Recreation
- Health Care
- Mental Health and/or Addiction Supports
- Personal Assistance
- Assistive Technology
- Housing
- Transportation

The Setting Neutral Assessment considers the individual's preferences, support system and services needed to assist in the best possible community placement and successful transition. The FOCIS/MFP Health Care Coordinators will work closely with applicants to determine an individual's appropriateness for transition. Consideration will be given to the applicant's desires, the desires of the family, legal representative, or guardian, and the recommendations of the applicant's medical professionals involved in the applicant's care. The decision will also consider the applicant's participation in and completion of goals established in the transition plan.

g. The State's policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will be taken to identify and address any existing conditions that led to re-institutionalization in order to assure a sustainable transition.

MFP Participants who have transitioned have the right to fail, be re-institutionalized, and have another opportunity to participate in community living. Whenever appropriate, those conditions that led to re-institutionalization will be addressed in the subsequent transition

planning process. If the participant is subsequently transitioned back to the community after being readmitted to a qualified institution, the participant may receive another 365 days of Demonstration Services if permitted by CMS.

- h. The State's procedures and processes to ensure those participants, and their families will have the requisite information to make informed choices about supports and services. The description shall address:**
- i. How training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the State's protections from abuse, neglect, and exploitation, including how participants (or other informal caregivers) can notify appropriate authorities or entities when the participants may have experienced abuse, neglect or exploitation.**
 - ii. Identify the entity or entities that are responsible for providing training and/or information and how frequently training and education are furnished.**

ADSD provides Elder Protective Services for persons 60 years of age or older who may experience abuse, neglect, exploitation, or isolation. Elder Protective Services include:

- Investigation, which begins within three working days of being reported
- Evaluation
- Counseling
- Arrangement/Referral for other services

Any person may report an incident of abuse if they have reasonable cause to believe that an elderly person has been abused, neglected, exploited or isolated. All information received as a result of a report is kept confidential. Reports are made to ADSD or a local police department or sheriff's office. ADSD offices are open Monday through Friday, 8 a.m. – 5 p.m., excluding holidays. A Crisis Call Center receives reports after hours, weekends and holidays. Those wishing to make a report are reminded to call 911 when an older person may be in imminent danger.

ADSD has developed a brochure that can be made available to MFP participants and

involved family/caregivers. The care plan and service plan will also include: the case manager contact information for follow-up during work hours, phone numbers for the Elder Protective Services - Aging and Disability Services Division (ADSD) Las Vegas/Clark County (702) 486-6930 and Statewide/other areas (888) 729-0571, as well as the Crisis Call Center 1-800-273-8255. Additionally, ADSD has developed an on-line training program that can be accessed over the Internet at <http://www.nvaging.net/epstraining.htm>.

An existing brochure developed by the Division for Aging and Disability Services, targeting the elderly, will be revised for non-elderly MFP participants, and will include contact information for reporting any concerns about abuse, neglect or exploitation. The State will revise any forms used to determine readiness for transition and service planning to ensure the inclusion of risk assessment and mitigation.

The State also has an effective Serious Occurrence Reporting process that ensures that State staff can follow up on any concerns about abuse, neglect or exploitation. Additionally, any person may report an incident of abuse, neglect, exploitation, or isolation of a vulnerable person to their local law enforcement agency at any time.

NRS 200.5092 states:

“Vulnerable person” means 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 activities of daily living.

2. Informed Consent and Guardianship

a. Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State’s criteria

for who can provide informed consent and what the requirements are to “represent” an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.

Nevada will continue current procedures, which have been effective in obtaining the consent of FOCIS program participants. The process used is as follows: informed consent is obtained from the participant during the initial face-to-face visit. During this visit, the program’s goals and the MFP participant’s rights and responsibilities are explained to the participant and/or representatives. The participant and/or representative also receive information on services and authorization periods at this time. Attachments included in Appendix B include the following: “Referral Form,” “Statement of Understanding,” “Setting Neutral Assessment,” “Diversion/Transition Plan,” and “Recipient’s Bill of Rights.” The “Statement of Understanding” is particularly salient to informed consent, since it is the formal acknowledgement of consent and is signed by the recipient or guardian, as appropriate.

For those MFP participants being reviewed for transition from an ICF/MR to the community, an appropriate representative must be identified. The Division of Mental Health and Developmental Services Regional Centers do not determine who represents the individual. Often, a family member or friend approaches the team with a request to become the guardian. Guardianship appointments are made by the courts. The Regional Centers will at times refer the interested party to an attorney and may pay for the cost of the guardianship. The Regional Centers can also refer individuals to the public guardian’s office if the team has concerns. If a person claims to be the guardian, the Regional Center will request a copy of the court order, which must be renewed on an annual basis.

Informed consent procedures are broadly spread through many health-related statutes and rules. For example, the attachments in this Operational Protocol contain references to informed consent in the FOCIS program, but there are other examples when informed consent is required. The policies of the Elderly in Adult Residential Care waiver in Chapter 3900 of the State Medicaid Services Manual, for example, require the consent of persons before living units can be shared by another person. Other examples are in Chapters 2100, 2200, 2300, , and 3900 of the State's Medicaid Services Manual, which are clear in requiring consent before information can be released about a person applying for a 1915(c) HCBS waiver. Yet another example is in the Aging and Disability Resource Center (ADRC) program, where informed consent is obtained from the person requesting assistance and advocacy and/or eligibility and access to service(s).

b. Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants' guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants' welfare if the guardians are making decisions on behalf of these participants. The policy should specify the level of interaction that is required by the State.

Currently, Nevada does not have a statutory or regulatory requirement stating that the guardians must have a known relationship or interact with the participants on an ongoing basis; however, the current process used in the FOCIS program provides multiple opportunities for guardians, staff and potential MFP Demonstration participants to share information. In addition to the completion of the Statement of Understanding and Setting Neutral Assessment, the Consent for Release of Information is explained and completed by the MFP/FOCIS Health Care Coordinator, who is working with the participant. The person or their legal representative signs and dates the form.

For disclosures of Protected Health Information (PHI), other than in the usual course of treatment, payment, or health care operations, the MFP/FOCIS Health Care Coordinator must

obtain the person's authorization before using or disclosing their PHI. The Authorization for the Use and Disclosure of Protected Health Information (NMH 3804) is used in these instances. The person or their legal representative signs and dates the form and copies are provided to the person or their legal representative. The original is placed in the case file in the appropriate section. The use of the current Consent for Release of Information form (NMH 3811) will continue under the Demonstration.

The following forms are available in Appendix B:

- Referral Form – When a recipient is referred to FOCIS. This form is also used to electronically input recipients' information into the database, and assign to Health Care Coordinator.
- Statement of Understanding - When a recipient has a legal guardian or durable power of attorney, the Health Care Coordinator must contact that representative. This form asks for the authorized or legal representative's signature and their relationship to the recipient.
- Setting Neutral Assessment – Durable power of attorney/health, legal guardian, name, relationship, address, phone; authorized representative/representative payee, name, phone, relationship.
- Diversion/Transition Plan – includes client's needs, goals, actions/approaches, person & program responsible, target date, outcome.
- Recipient Bill of Rights/Responsibilities.

3. Outreach, Marketing and Education

Submit the State's outreach, marketing, education, and staff training strategy. NOTE: The OP Draft required in this application does not require a State to submit marketing

materials at this time. All marketing materials will be submitted during the final approval process for the Operational Protocol. Please provide:

a. The information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers);

For close to a decade, Nevada has been successful in transitioning institutional residents into community life, and the state will continue to expand transition activities under the MFP Demonstration. This prior success has been due in part to the following factors: proactive outreach to potential enrollees and their families, training of providers, education of state staff, and the provision of information to the general public.

The FOCIS program works closely with institutional providers on a daily basis, having done so since 2003. Facilities have been actively involved in transition activities since that time. Approximately 10% of all referrals to FOCIS come from institutional providers, evidencing support and commitment. Additionally, FOCIS staff provide in-service training annually to all long-term care facilities, rehabilitation facilities, and acute hospitals. The presentation includes information about participation by recipients, how to make referrals, the role of the Health Care Coordinator, the assessment, and the transition process. These institutional providers are receptive to working collaboratively to assist the Medicaid recipient, and view FOCIS staff as partners when developing discharge plans.

The type of information to be disseminated to potential participants, providers, and other stakeholders is discussed further below.

b. Types of media to be used;

Nevada will use brochures, letters, web content, and other informational material to inform stakeholders of the MFP Demonstration. The outreach process begins with providing information regarding the MFP Demonstration and available services to providers, potential participants and

community stakeholders. DHCFP mails a letter of interest and brochures to facility staff annually for its FOCIS effort. Nevada only has 48 nursing facilities that participate in the Medicaid program. State staff have worked with these facilities for years. Current outreach practices to the nursing facilities will continue under the MFP Demonstration. The brochures and referral forms are distributed to staff, residents and families, and are also provided to the community and other agencies.

During the initial contact with an MFP candidate, a brochure is provided. Brochures may also be distributed by mail or by leaving the brochure with the candidate, the candidate's family member or a legally responsible individual. The current FOCIS brochure has been developed over the years. Nevada will review this brochure and other educational material during the second year of the MFP Demonstration to improve the current method of educational and informational outreach. The current FOCIS brochure is provided in Appendix A.

Nevada staff have also developed an information packet. Information is written in a consumer friendly style and presented in either a stand-alone format or included with the Participant Information Packet, which contains: Statement of Understanding, Setting Neutral Assessment, Diversion/Transition Plan, and Recipient Bill of Rights/Responsibilities. Examples of these materials are provided in Appendix B. The current materials will be reviewed in the first year of the MFP Demonstration to improve the materials and increase educational efforts.

Based on input from stakeholders, DHCFP will develop an MFP Demonstration Fact Sheet and disseminate Frequently Asked Questions through the MFP Demonstration implementation process. The Demonstration will also rely on the brochures and information developed by Nevada's ADRCs. These materials will be provided to CMS upon completion.

Outreach to facility staff will be provided through marketing materials developed by DHCFP and will be disseminated through letters to institutional providers, educational articles in industry publications, facility-specific newsletters, and through sponsored trainings for providers.

The MFP Demonstration will develop a website for information about nursing home transitions. When operational, the MFP website will provide information regarding who is eligible to participate in the program, describe the Qualified HCBS and Demonstration Services that may be available to MFP participants, list referral contact information, contain case studies so that potential families and participants can read about the experiences of previous persons who have transitioned, and contain the minutes of stakeholder and advisory group meetings.

The website will also be targeted to help persons who are participating in transitions and will contain a “toolbox” of procedures and ideas. For example, information about how to obtain a birth certificate and how to get a Supplemental Security Insurance payment restarted will be included. The website address will be provided on the MFP brochure to encourage a more in-depth review of the ways in which the MFP Demonstration can provide help to participants. The website will also be linked to the ADRCs, CILs and other helpful existing websites – such as www.nevadacareconnection.org; <http://www.lasvegasseniorguide.com>; and <http://www.aarp.org/states/nv> – which enable persons to identify and access community resources.

c. Specific geographical areas to be targeted;

There will be no specific geographical targeting for this outreach as Nevada intends to transition individuals statewide. Therefore, outreach for the MFP Demonstration will occur statewide. DHCFP does intend to collaborate with select counties to participate in a pilot project to fund additional HCBS waiver slots in lieu of nursing facility placements. It is expected that

outreach efforts in specific participating counties may coincide with the implementation of the pilot project.

d. Locations where such information will be disseminated;

Information regarding the MFP Demonstration will be disseminated during in-service presentations. DHCFP will also continue hosting community forums to educate stakeholders about the MFP Demonstration. Family members, guardians, community providers, and the general community will be targets for this outreach. These presentations are primarily intended for facility staff and residents, but may occur throughout the community. Presentations are formal or informal and include recipients, their representatives and facility staff. Brochures and referral forms are provided to participant attendees. Currently, in-service presentations are provided annually for the following:

- Long Term Care Facilities
- Rehabilitation Facilities
- Acute Hospitals
- Mental Health and Developmental Services Facilities
- Centers for Independent Living (CILs)

In addition to the listing above, MFP project staff may also be asked (or invite themselves) to respond to other opportunities to present information. In addition to nursing facilities, the MFP Demonstration is interested in working with discharge planning staff at Nevada's 50 hospitals. Hospital nurses and social work staff are key players in helping families and patients consider their post-acute care options. These other outreach activities will be completed as requested and appropriate.

Dissemination of printed materials will be statewide to targeted groups for distribution at the

community level and to individuals based on personal requests. For example, there are currently 67 senior centers in Nevada and the Demonstration will provide literature to each one of these centers.¹⁸ About a dozen of these senior centers are operated for tribal populations and working through them will likely be a good way of reaching out to an elderly tribal population. The types of locations where literature would be distributed include:

- Division of Aging Services Offices (four locations)
- Offices of HCBS waiver providers
- Centers for Independent Living (five offices)
- Long Term Care Ombudsman's state and local offices
- Legislative offices
- Community Mental Health Centers (32 locations)¹⁹
- Meals on Wheels providers
- Adult Day Health Care Centers (11 locations)²⁰
- Physical therapy offices
- Hospitals
- AARP offices
- Residential Senior Programs (380 locations)²¹
- Senior housing centers
- 2-1-1 offices (two offices)
- Nevada state and county offices

¹⁸ A list of Senior Centers in Nevada is available at, retrieved on 12-6-10,
<http://www.nvaging.net/nvseniorcenters.htm#Carson City>

¹⁹ A list of community mental health programs is available at, retrieved on 12.6-10,
<http://www.unlv.edu/centers/cdclv/healthnv/mentalhealth.html>

²⁰ A list of adult day health centers is available at, retrieved on 12.6-10,
http://www.carenevada.org/list06_nv_adult_day_care.htm

²¹ A list of residential programs for the elderly is available at, retrieved on 12.6-10,
http://www.carenevada.org/list05_nv_assisted_living_facilities.htm

- Tribal offices
- Other types of offices or locales where seniors and individuals with disabilities are known to visit.

e. Staff training plans, plans for State forums or seminars to educate the public;

Within DHHS, ongoing communication and education has been occurring through a Core Work Group that was established under the MFP planning grant. The MFP Core Work Group includes DHCFP, ADSD, MHDS, CILs, and representation from urban and rural Nevada counties. Nevada's MFP Demonstration will encompass three target populations, and it will be critical for these groups to continue collaborating in every aspect of the MFP Demonstration. To this end, joint staff training plans will be developed and it is anticipated that there will be a series of training sessions, which will be held around the state, targeted to relevant DHHS staff and contracted partner agencies.

For the general public, outreach has already begun and will continue with seniors, individuals with disabilities, service providers, advocacy organizations and other stakeholders. Outreach to date has included presentations at Stakeholder Forums held in both northern and southern Nevada to solicit input into the development of the draft Operational Protocol, as well as a survey of individuals and interested parties. Key stakeholders include, but are not limited to: nursing facilities and their professional association, Centers for Independent Living, the state Long Term Care Ombudsman's office, and service providers and consumers. Additional forums or seminars will be scheduled and are anticipated to resume in early spring 2012. Additionally, nursing facilities have regularly participated via teleconference in Long Term Care Task Force meetings hosted by DHCFP to discuss issues relating to nursing facilities, and MFP staff will avail themselves of this outreach and education opportunity.

f. The availability of bilingual materials/interpretation services and services for individuals with special needs; and

DHCFP anticipates that additional material will be developed under Nevada's MFP Demonstration. In particular, Nevada is particularly interested in obtaining educational materials in Spanish. Nevada is hopeful that CMS will create a library or repository of educational information used by participating states so that the literature developed in other states can be examined and, if appropriate, used in Nevada. Nevada will develop alternative formats for all MFP Demonstration outreach materials and other MFP materials as requested, which may include audio recordings, captioning, large print, and electronic versions.

g. A description of how eligible individuals will be informed of cost sharing responsibilities.

This section is not applicable to Nevada's MFP Demonstration as there are no cost-sharing responsibilities.

4. Stakeholder Involvement

Describe how the State will involve stakeholders including consumer representatives in the Implementation Phase of this demonstration, and how these stakeholders will be meaningfully involved throughout the life of the demonstration grant. Please include:

a. A chart that reflects how the stakeholders relate to the organizational structure of the grant and how they influence the project.

Stakeholders include any person or entity with an interest in the MFP Demonstration, including consumers, family members, advocacy groups, nursing facility owners and administrators, and provider organizations. DHCFP has engaged stakeholders related to Money Follows the Person since it began the FOCIS program. In 2008, for example, DHCFP conducted a series of stakeholder focus groups for the purpose of developing the State Profile Tool. DHCFP recognizes the importance of stakeholder involvement in developing the Operational Protocol for the current MFP grant solicitation, and has again requested stakeholder input. DHCFP reached

out to previously involved stakeholders to obtain input into the Operational Protocol and help communicate the MFP Demonstration's goals and methods to the larger Nevada community.

Stakeholders hold an influential role through the Nevada Commission on Services for Persons with Disabilities (CSPD). In Nevada, the CSPD exists through state statute for the purpose of identifying and creating solutions to barriers and gaps in services for persons with disabilities, providing one method for ensuring stakeholder input to MFP activities. DHCFP staff are working with CSPD to identify clear and comprehensive collaboration opportunities between CSPD and the MFP Demonstration. It is anticipated that the CSPD will serve as an important advisory mechanism for the MFP Demonstration, and will assist with project planning during the second year of the MFP Demonstration. Significant strategies that shape the architecture of program development, rebalancing, and systems change will be reviewed by the CSPD, and its help will be sought in understanding the impacts of operational choices.

In addition to stakeholders previously involved with the Real Choice Systems Change Grant, DHCFP is also seeking input from the Governor's Office for Consumer Health Assistance, Nevada Legal Services, state medical associations and societies, and members of the following advisory boards and commissions:

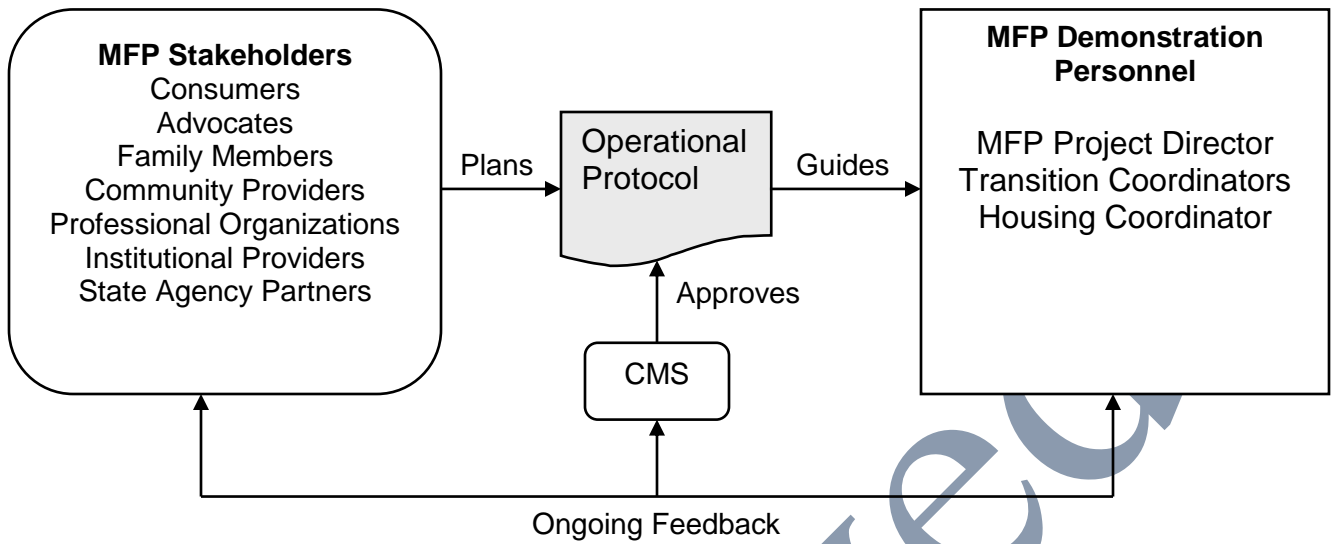
- Commission on Aging
- Senior Strategic Plan Accountability Committee
- Mental Health and Developmental Services Commission
- Assistive Technology Council
- Subcommittee on Communication Services for Persons Who Are Deaf or Hard of Hearing and Persons With Speech Disabilities
- Governor's Council on Developmental Disabilities

- Statewide Independent Living Council
- Interagency Transition Advisory Board
- Subcommittee on Personal Assistance for Persons with Severe Functional Disabilities
- Subcommittee on Traumatic Brain Injuries

Once hired, the MFP Project Director will work closely with all stakeholder groups to identify needs and resolve issues as they arise. The Project Director will also be responsible for outlining a list of additional supports that will be provided to consumers and families to enable their participation in the CSPD meetings. Meetings in which stakeholders may participate are public, appropriate advanced notice is posted for scheduled meetings, venues are accessible for individuals with disabilities, and teleconferencing is available for those that cannot attend in person.

Stakeholders' involvement is evident in the development of critical components of the Operational Protocol. These include, but are not limited to, project goals and benchmarks, target populations, benefits and services, and ongoing communication. In public forums to discuss the new MFP project, stakeholders offered valuable perspectives on specific areas of the Operational Protocol. The chart below illustrates the relationship between stakeholders and the Operational Protocol that will guide MFP Demonstration personnel throughout the grant period.

Figure 2. Stakeholders Relationship to MFP Organization



Nevada’s MFP Demonstration will ensure that stakeholders and consumers continue to play an active role in the development and implementation of the MFP Demonstration project through public forums, meetings with existing advisory groups, and other ongoing written, electronic, and verbal communication mechanisms.

b. A brief description of how consumers will be involved in the demonstration.

Consumers are effective in identifying service needs, gaps in services and recommendations for the development of more responsive consumer-focused programs. Specific to the development of the Operational Protocol, consumers provided assistance to DHCFP in recommending protocol components and describing services that persons need when they return to the community.

As part the draft Operational Protocol development, interviews with nursing facility residents were conducted to obtain the first-hand experiences of residents, including their perceptions of why persons would want to leave the nursing facility and the challenges of doing so. DHCFP and ADSD staff participated in these interviews with nursing home residents and staff. Consumers

and other interested parties were also asked to help design and plan the MFP Demonstration by completing an on-line questionnaire, and were also invited to participate in stakeholder forums to review the MFP Demonstration's goals and allow DHCFP to obtain input into the design of the project.

In November 2010, DHCFP held stakeholder forums related to the MFP Demonstration grant in both northern and southern Nevada. At these meetings, stakeholders were provided with information related to the MFP grant and were asked to assist in identifying current gaps in services and to identify needed services to support individuals transitioning to the community. Consumers and families were also involved in these MFP stakeholder forums.

Consumers had a significant role in the design and development of the draft Operational Protocol. The concept of what Nevada has termed "Transition Navigation," for example, was heavily influenced by consumer experience. One family member of a person with a disability shared, "we really need...coordinated care so that you have one case manager rather than three case managers...[individuals are] dealing with so many case managers that it becomes a real obstacle to even get anything done."

As one nursing facility resident put it, "there should be some sort of agency that coordinates all the things that are available to people without going here, and going there." Another individual expressed the importance of a single point of contact who could help participants navigate through the various services that may be available as part of the transition; "There should be A person...I want to talk to you about everything...I don't want to go to 17 different numbers." Transition Navigation has consequently been incorporated into the role of MFP/FOCIS Health Care Coordinators.

Consumers will continue to have an important role throughout the MFP Demonstration. Consumer involvement will continue using similar methods to actively engage institutional residents, HCBS waiver participants, family members and caregivers. Consumers will be asked to provide input using forums, work groups, surveys, interviews, observations and trainings. During implementation, successfully transitioned MFP participants, family members and caregivers will be asked to provide encouragement and support, such as sharing experiences, to other MFP participants transitioning to the community.

For example, Pennsylvania sought consumer help in working with hospital staff. Pennsylvania arranged meetings between hospital administrators and persons who had transitioned. At these meetings, the participants described the profound impact that leaving the nursing home had in their lives. This consumer involvement was successful in demonstrating to hospital administrators the importance of good discharge planning. Nevada will search for similar methods by which consumers can help the state improve its rebalancing work.

c. A brief description of community and institutional providers' involvement in the demonstration.

As mentioned above, in November 2010, DHCFP held stakeholder forums related to the MFP Demonstration grant. At these meetings, stakeholders were provided with information related to the MFP grant and were asked to assist in identifying current gaps in services and to identify needed services to support individuals transitioning. A listing of community and institutional providers represented in these MFP stakeholder meetings is provided in Appendix C.

Stakeholder forum participants, including providers, identified numerous barriers to effective systems for transitioning MFP participants and explored ways to eliminate these barriers. Respondents to the on-line stakeholder questionnaire also identified barriers the MFP

Demonstration should address. Chief among the identified barriers are funding for community services (92% strongly agreed that this is a barrier) and lack of housing (81% strongly agreed that this is a barrier).

DHCFP also conducted interviews with nursing facility staff during the development of the Operational Protocol. This demonstrated the opportunity to build on existing relationships between DHCFP's FOCIS program and nursing facility administrators and staff involved in the resident discharge process.

Social workers at visited facilities were involved in assisting with transitioning residents with all types of housing options. One nursing home social worker conveyed the facility's dependency on FOCIS involvement in the discharge process by stating that, "we have a problem getting that [housing] set up for them and to find an appropriate placement for them to live. So that's some of the barriers there (are) in discharging, finding the appropriate place we want them to go to." It was clear that more intense, individualized assistance with housing assistance would be beneficial under the MFP Demonstration.

As another nursing home social worker put it, "it's not like there's a general application that all of these different homes will accept. It's individual applications, and it's pretty daunting for the disabled." Other common referrals by nursing facility staff included home health services, Meals on Wheels, and para-transit services.

The MFP Demonstration will continue to contact the nursing facilities and work with facility staff in the same cooperative manner that the FOCIS program has used. Nevada does not anticipate any new or different problems. FOCIS staff have worked with the state's nursing facilities for almost a decade and have easy and cooperative relationships with the staff and administrators at the nursing facilities.

d. A description of the consumers' and community and institutional providers' roles and responsibilities throughout the demonstration.

Stakeholders will continue to provide advice and recommendations during the implementation phase. Once the MFP Demonstration begins, Nevada will seek to have stakeholders participate in the MFP Demonstration. The purpose of consumers' and providers' participation in Nevada's MFP Demonstration is to participate in the implementation of the Operational Protocol, and to monitor the MFP Demonstration throughout the grant period. This input would include providing advice and sharing experiences on specific matters related to MFP, reviewing progress relating to benchmarks and implementation of project policies and procedures, and participating in forums to review MFP activities and making recommendations for improvements.

In addition to serving on various advisory boards and subcommittees, stakeholders already involved in the development of the MFP project will help to promote the project throughout the demonstration period. Printed material will be disseminated to each stakeholder and/or organization to be used to further acquaint and familiarize consumers and providers with the MFP Demonstration. Consumer and provider organizations may assist the process by including advertisements and articles in their publications regarding the MFP Demonstration. These publications will help to educate consumers and families while promoting the goals of the Demonstration. The professional organizations representing institutional providers will also help support MFP Demonstration by including advertisements and informational articles in their trade publications and websites.

e. The operational activities in which the consumers and community and institutional providers are involved.

It is anticipated that consumers will play a role in assisting individuals during their transition

into the community. Consumers may also be identified by institutional residents and participate in the transition process as peer mentors. Those consumers with experience in transitioning and/or the waiver programs will be ideal candidates to act as peer mentors. This will provide an avenue for consumers to directly influence the process and better inform the MFP project staff of transition challenges and successes. In addition, consumers will continue to be involved through the CSPD.

Institutional providers play an essential role in the MFP Demonstration. These partners will continue to provide care for their residents as well as play an important role in the transition process for those individuals who pursue community living. Facility staff will be involved in the transition planning process for MFP participants. Direct care staff at facilities will work with residents and inform MFP/FOCIS Health Care Coordinators about elements of care that will be needed in the community.

Social workers at the facilities will provide direct assistance to the residents in the transition process by helping to secure needed documentation, such as prescriptions from doctors and copies of medical records. The cooperation of all staff working with residents in institutions will be required to facilitate an effective transition and continuity of care between residential settings. Institutional administrators need to understand and support the MFP Demonstration goals in order to assist with information dissemination and consumer education efforts. MFP project staff will host regular meetings with representatives from all provider groups, including institutional providers, to facilitate communication and support implementation efforts.

Community providers also play an essential role in the MFP Demonstration. Nevada will leverage existing provider networks to provide qualified HCBS and Demonstration services. Contact information for relevant providers will be given to the MFP participant to allow them to

select the provider of their choice. Community providers will be invited to take part in the transition process to assist participants with community arrangements needed to return to the community. This could include assisting participants in obtaining durable medical equipment, assistive technology, and medical supplies or arranging for home modifications. After MFP participants transition into the community, the MFP/FOCIS Health Care Coordinators will coordinate with participants and community providers to ensure that all community-based services are addressed and revisions to the Service Plan, if necessary, are made to maintain successful community placement.

5. Benefits and Services

- a. **Provide a description of the service delivery system(s) used for each population that the State will serve through the Money Follows the Person Rebalancing Demonstration. Include both the delivery mechanism (fee-for-service, managed care, self-directed, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration period (1915 a, b, c or combination waiver, 1115 demonstration, Medicaid State Plan, 1915i and 1915j, etc.). For all HCBS demonstration services and supplemental demonstration services State must detail the plan for providers or the network used to deliver these services. Some demonstration services may be added to existing 1915 waivers during the MFP program period, but the services that are not added and the supplemental services not paid for through Medicaid will end at the 365th day for each individual participant.**

The MFP Demonstration will be operated through the coordinated efforts of the Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP), Aging and Disability Services Division (ADSD), and Division of Mental Health and Developmental Services (MHDS). DHHS is the designated single state agency under Title XIX of the Social Security Act. DHHS delivers services and policy through its six divisions. DHCFP is the designated entity within DHHS responsible for oversight of the Medicaid program. Home and Community Based Services (HCBS) and supports are provided under both the Medicaid

State Plan and four 1915(c) Home and Community Based Waiver programs.

Medicaid State Plan Services

All MFP Demonstration participants will also have access to Medicaid State Plan services. This includes both acute and non-acute care services available through the regular Medicaid program. Such Medicaid State Plan services are provided under fee-for-service arrangements with enrolled Medicaid providers. Each MFP Demonstration participant transitioned from an institution will have access to the following HCBS services under the Medicaid State Plan. The most highly utilized HCBS program under the Medicaid State Plan is PCS, administered through DHCFP. Nearly all MFP participants are expected to utilize PCS under the MFP Demonstration.

Personal Care Services (PCS) are provided to eligible recipients whose chronic health problems cause them to be functionally limited in performing Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). The objective is to assist, support, and maintain recipients living independently in their homes. PCS are also provided in settings outside the home, including employment sites. These services are provided where appropriate, medically necessary and within service limitations under the Medicaid State Plan. PCS include a range of human assistance provided to persons with disabilities and chronic conditions of all ages, which enables accomplishment of tasks that persons with disabilities and chronic conditions would normally do for themselves if they did not have a disability or chronic condition. Personal care services may be provided by any willing and qualified provider through a Provider Agency utilizing the standard delivery model or through an Intermediary Service Organization (ISO) when accessing the self-directed model for services. The ISO model allows participants to retain responsibility for hiring, training, scheduling, and supervising the personal assistant. The ISO is responsible for ensuring the direct service provider qualifications - background investigation,

training and health clearance testing - are completed, and handling administrative functions such as payroll and tax withholding. The majority of the current PCS recipients choose the Provider Agency model of service delivery. This model places responsibility for hiring, training, supervision and scheduling of PCS providers on the agency, rather than the recipient. All providers must be enrolled with the Nevada fiscal agent as a Medicaid provider.

Adult Day Health Care (ADHC) services are available under the Medicaid State Plan to Medicaid eligible recipients age 18 or older. ADHC consists of structured, comprehensive and continually supervised components that are provided in a protective setting. An ADHC provides medical services and oversight in addition to social, health and nutrition services. These establishments are licensed as an Adult Day Care Facility and meet the criteria set forth by DHCFP for reimbursement for ADHC services. ADHC recipients receive services and participate on a regular basis during specified hours. The individual must meet the appropriate Level of Care criteria and must require the medical and social services provided by the ADHC under a physician's order. The prior authorization of such individuals must include a rehabilitation goal to be met by the ADHC services.

Targeted Case Management (TCM) is a Medicaid State Plan service that provides case management to specific target groups of Medicaid recipients. The intent of TCM services is to assist recipients eligible under the Medicaid State Plan gain access to needed medical, social, educational, and other support services, including housing and transportation needs. TCM services do not include the direct delivery of medical, clinical or other direct services. Components of the service include assessment, care planning, referral/linkage and monitoring/follow-up. TCM services are provided to eligible recipients who are residing in a community setting or transitioning to a community setting following an institutional stay. There

are eight target groups eligible to receive this service. These groups are:

- (1) Children and adolescents who are non-severely emotionally disturbed (Non-SED) with a mental illness;
- (2) Children and adolescents who are severely emotionally disturbed (SED);
- (3) Adults who are non-seriously mentally ill (Non-SMI) with a mental illness;
- (4) Adults who are seriously mentally ill (SMI);
- (5) Persons with mental retardation and related conditions;
- (6) Developmentally delayed infants and toddlers;
- (7) Juveniles on probation (JPS); and
- (8) Child protective services (CPS).

Durable Medical Equipment (DME), prosthetics, orthotics, and disposable medical supplies are also provided to Medicaid recipients under the Medicaid State Plan. DME is equipment which can stand repeated use, is used to serve a medical purpose and is appropriate for use within the home. Prosthetic and orthotic devices are replacement, corrective, or supportive devices used to artificially replace a missing portion of the body, or to prevent or correct a physical deformity or malfunction, or used to support a weak or deformed portion of the body. Medical supplies are disposable supplies or items which are not reusable and are used to serve a medical purpose.

Home Health Agency (HHA) services are the home health care benefit under the Medicaid State Plan. HHA services are a component in the continuum of care which allows a recipient to remain in his or her home. HHA services may be provided to eligible recipients, based on medical necessity, program criteria, and utilization control measures to meet recipient's needs. HHA services are provided on an intermittent basis, certified by a physician and provided under

a physician-approved Plan of Care (POC). The Home Health Agency (HHA) service benefit provides Skilled Nursing (SN) services, and other therapeutic services such as Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), and Home Health Aides or Certified Nursing Aides (CNAs). Respiratory Therapists (RT) and Registered Dieticians (RD) are also a benefit with limitations under the Medicaid State Plan.

Private duty nursing is an optional benefit under the Medicaid State Plan. Chapter 42 CFR 440.80 defines private duty nursing services as nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or nursing facility, and are provided through an agency by a registered nurse or a licensed practical nurse, under the direction of the individual's physician.

Hospice is an optional benefit provided under the Medicaid State Plan. A hospice is a public agency or private organization, or a subdivision of either, that is primarily engaged in providing care to terminally ill individuals. A participating hospice must meet the Medicare conditions of participation for hospices and have a valid provider agreement. In order to be eligible to elect hospice care under Nevada Medicaid, an individual must be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less.

Roughly 15% of MFP Demonstration participants transitioning into the community from institutional care settings are expected to be enrolled in an HCBS waiver program. Nevada's MFP Demonstration will leverage the service delivery system for these waiver programs. ADSD is responsible for day to day operations of the three 1915(c) Medicaid waiver programs for older adults. MHDS is responsible for the day to day operations of the 1915(c) Medicaid Waiver for Persons with Mental Retardation and Related Conditions. DHCFP maintains day to day

operational responsibility for the 1915(c) waiver program for persons with physical disabilities, and exercises administrative authority for all five 1915(c) waiver programs. All services under 1915(c) waiver programs are provided on a fee-for-services basis. Below is a summary of the 1915(c) waiver programs that MFP Demonstration participants may have access to, depending on their individual needs and whether they meet the applicable eligibility criteria.

Home and Community Based Waivers for Older Adults

Waiver for the Frail Elderly (CHIP)

Waiver Number: NV.0152.90

Target Population: Persons aged 65 and older

Level of Care: Nursing Facility

Services: Case Management, Chore, Adult Companion, Homemaker, Personal Emergency Response System (PERS), Respite, and Social Adult Day Care.

Case Management: Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case Management services can be provided by the Division for Aging Services, Agencies or Independent Private Providers.

Chore: Services needed to maintain a clean, sanitary and safe home environment. This service includes heavy household chores such as cleaning windows and walls, shampooing carpets, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress, minor home repairs and removing trash and debris from the yard.

Adult Companion: Non-medical care, supervision and socialization, provided to a

functionally impaired adult in his/her own home, which would provide temporary relief for the primary caregiver. Adult companions may assist or supervise the individual with such tasks as meal preparation and clean up, light housekeeping, shopping and transportation/escort, but do not perform these activities as discrete services. The provision of adult companion services does not entail hands-on medical care. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the recipient. This service is provided in accordance with a goal in the plan of care, and is not purely diversional in nature.

Homemaker: Services consisting of light housekeeping, meal preparation, shopping, transportation and laundry. These services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home.

Personal Emergency Response System (PERS): PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Respite: Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

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Social Adult Day Care: Social adult day care is a service provided 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing social services needed to ensure the optimal functions of the recipient. Meals provided as part of these services shall not constitute a “full nutritional regime” (three meals per day). This service is provided in accordance with the goals in a plan of care and is not merely diversional in nature. Transportation between the recipient’s residence and the social adult day care center is not provided as a component part of social adult day care. The cost of this transportation is not included in the rate paid to providers of social adult day care services.

Waiver for the Elderly in Adult Residential Care (WEARC) – Now known as CHIP

Waiver Number: NV.0267

Target Population: Persons aged (age 65 and older)

Level of Care: Nursing Facility

Services: Case Management and Attendant Care.

Case management is offered as a waiver service that may be offered by any qualified provider. Case Management services can be provided by the Division for Aging Services, Agencies or Independent Private Providers.

Attendant Care includes personal care services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, and services which will ensure that the residents of the facility are safe, secure, and adequately supervised. This care is over and above the mandatory service provision required by regulation for residential facilities for groups. There are 3 levels of attendant care based on the recipient’s functional status.

Level One: Provides supervision and cueing to monitor the quality and completion of basic

self-care and activities of daily living. Some basic self-care services may require minimum hands-on assistance. This service level provides laundry services to meet the recipient's needs. If needed, this service provides in-home supervision when direct care tasks are not being completed.

Level Two: Provides minimal physical assistance with completion of basic self-care and activities of daily living. Some basic self-care may require a moderate level of assistance. This service level provides laundry services to meet the recipient's needs. If needed, this service provides in-home supervision with regularly scheduled checks if needed.

Level Three: Provides moderate physical assistance with completion of basic self-care and activities of daily living. Some basic self-care may require a maximal level of assistance. This service level provides laundry service to meet the recipient's needs. If needed, this service provides direct visual supervision or safety systems to ensure recipient safety when supervision is not direct.

Assisted Living Waiver (AL)

Waiver Number: NV.0452

Target Population: Persons aged (age 65 and older)

Level of Care: Nursing Facility

Services: Case Management and Augmented Personal Care

Case Management: Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case Management services can be provided by

the Division for Aging Services or provider agencies.

Augmented Personal Care: There are three levels of augmented personal care covered in this waiver. The service level provided is based on the recipient's functional needs to ensure his or her health, safety and welfare in the community. Qualified staff with DAS determines the service level and prior authorization for services as an administrative function of the waiver.

Level One: Provides supervision and cueing to monitor the quality and completion of basic self-care and activities of daily living. Some basic self-care services may require minimum hands-on assistance. This is not a skilled level service, so swallowing ability must be intact. This service level provides laundry services once a week, basic weekly homemaking, assistance with grocery shopping and community access. This service also provides access to social and recreational programs. This service provides indirect supervision when direct care tasks are not being completed.

Level Two: Provides minimal physical assistance with completion of basic self-care and activities of daily living. Some basic self-care may require a moderate level of assistance. This service level provides laundry services twice a week if needed, daily assistance with homemaking related to self-care, assistance with grocery shopping and community access. This service provides once daily assistance with in-apartment meal preparation if requested. This service provides access to and physical assistance with the social and recreational programs. This service provides indirect supervision with regularly scheduled checks when direct care tasks are not being completed.

Level Three: Provides moderate physical assistance with all basic self-care needs. Some basic self-care may require a maximal level of assistance. This service includes assistance with feeding, if needed. This is not a skilled level service so swallowing ability must be intact. This

service level provides laundry service, including changing of linens daily if needed. It includes daily homemaking for clean up after basic self care tasks and weekly homemaking for general cleaning. This service provides completion of or assistance with grocery shopping and community access. This service provides up to twice daily assistance with in-apartment meal preparation if requested. This service provides access to and physical assistance with the social and recreational programs. This service provides direct supervision or safety systems to ensure recipient safety when supervision is not direct.

Facility staff are available 24 hours per day x 7 days per week to assist with planned and unplanned needs and provide supervision.

Home and Community Based Waiver for Persons with Physical Disabilities

Waiver for Persons with Physical Disabilities (WIN)

Waiver Number: NV.4150

Target Population: Persons who are Physically Disabled (no age-based limits or restrictions)

Level of Care: Nursing Facility

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

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

plans of care.

Homemaker Services consist of the performance of general household tasks (e.g., meal planning and preparation and routine household care), laundry, shopping, assistance in learning homemaker skills, accompanying the recipient to homemaker activities, and routine cleanup after up to two household pets. Homemaker services are provided by a qualified homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

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

Respite Services are provided to participants unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing care for the participant. Services are provided in the participant's home or place of residence. FFP will not be claimed for the cost of room and board, except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

Attendant Care services may include assistance with eating, bathing, dressing, personal hygiene, activities of daily living, shopping, laundry, meal preparation, and accompanying the

recipient to appointments as necessary to enable the individual to remain in the community. The services may include hands-on care of both a supportive and health-related nature specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law, and may include an extension of task completion time greater than that allowed under the State Plan, with documentation of medical necessity provided. These services are provided under the State Plan until State Plan limitations have been reached.

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and nondurable equipment not available under the State Plan that is necessary to address participant functional limitations; and (e) necessary medical supplies not available under the State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation and where indicated, will be purchased from and installed by authorized dealers.

Environmental Accessibility Adaptations are physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant

to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Assisted Living services are personal care and supportive services (homemaker, chore, attendant services, meal preparation, companion, transportation, diet and nutrition, orientation and mobility,) that are furnished to waiver participants who reside in a homelike, non-institutional setting that includes 24-hour onsite response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, community mobility/transportation training, advocacy for related social services, health maintenance, home and community safety training, and medication assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with the assisted living provider. Nursing and skilled therapy services are incidental, rather than integral, to the provision of assisted living services. Payment is not to be made for 24-hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The costs of room and board are excluded from payments for assisted living services.

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Home Delivered Meals is the provision of meals to persons at risk of institutional care because of inadequate nutrition. Home Delivered Meals includes meal planning, purchase of food, supplies, equipment and labor, as well as the transportation costs of delivering the meals to a person's home. Persons who receive this service are unable to manage a special diet recommended by their physicians.

PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This waiver service purchases the device and funds ongoing monitoring at a monthly service cost.

Home and Community Based Waiver for Persons with Mental Retardation and Related Conditions

Waiver for Persons with Mental Retardation and Related Conditions (MRRC)

Waiver Number: NV.0125

Target Population: Persons with Mental Retardation and Related Conditions

Level of Care: ICF/MR

Services: Behavioral Consultation, Training and Intervention, Community Integration Services, Counseling (Individual and Group), Day Habilitation, Non-Medical Transportation, Nursing Services, Nutrition Counseling Services, Prevocational Services, Residential Habilitation – Direct Services and Support, Residential Habilitation – Direct Support Management, and Supported Employment.

Behavioral consultation, training and intervention services are behavior analytic therapeutic services that assist unpaid caregivers and/or paid direct services and support or day habilitation staff in carrying out individual treatment/support plans that are not covered by State

Plan services and are necessary to improve the individual's independence and inclusion in their community. Consultation activities are provided by professionals in psychology and behaviorally-based therapies. Services may be provided in the person's home, school or workplace and in the community. Applied behavioral analysis-based services are not covered.

This service may include:

- Assessment of the environmental factors that are precipitating a problem behavior;
- Development of a behavioral support plan in coordination with the ISP team;
- Consultation or training on how to implement positive behavior support strategies and/or the behavior support plan;
- Consultation or training on data collection strategies to monitor progress;
- Monitoring of the individual and the provider in the implementation of the plan and updating the plan as necessary.

Community integration services are based on a comprehensive assessment of the individual's needs and desires related to community participation and the existing circle of support. This service focuses on assisting the individual to join clubs, organizations, teams or groups that are not specifically affiliated with the disability community. 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:

- Thorough assessment of individual skills, interests, and preferences;
- Based on the assessment, identification of integrated community resources, groups, clubs, teams or organizations where the person's interests, skills and preferences

would be valued and shared;

- Development of a community inclusion plan within the ISP;
- Method of evaluating the success of the community inclusion plan.

The goal of community inclusion services is for the person to develop sources of natural support so the paid community integration provider is no longer needed for the person to continue their participation and maintain relationships within the context of the group or organization.

Day Habilitation services are intended to provide meaningful day and individualized activities that support the participant's definition of a meaningful day. Day Habilitation services enable the participant to increase or maintain their capacity for independent functioning and decision making. Day Habilitation services consist of a daily program of functional and meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a variety of day habilitation settings, including facilities or settings separate from the participant's private residence or other residential living arrangement. Services may be authorized by MHDS to be provided in the person's home only under special circumstances that include risk to the person or others if habilitation occurs in an alternative setting. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice.

A person who receives day habilitation services may also receive supported employment, and prevocational services. A person's service 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.

Services may include transportation provided between the individual's place of residence and the site(s) of the habilitation services or between habilitation sites as a component of habilitation

services as described in the Individual Support Plan.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Non-Medical Transportation Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified in their individual service plan. 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 that can provide this service without charge are utilized.

This service is offered in addition to medical transportation services under the State plan which includes transportation to medical appointments which can be arranged at least 48 hours in advance and emergency medical transportation. This service will not duplicate or impact the amount, duration and scope of the emergency transportation benefit provided under the Medicaid State Plan.

Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends or community agencies which can provide this service without charge are utilized.

Nursing Services provide routine medical and health care services that are integral to meeting the daily needs of residents (e.g., routine administration of medications by nurses or tending to the needs of residents who are ill or require attention to their medical needs on an ongoing basis). Routine nursing services are within the scope of the State's Nurse Practice Act

and are provided by a registered professional nurse, or licensed practical nurse under the supervision of the registered nurse, licensed to practice in the State. These services are long-term, occur at least once monthly, and are necessary to maintain or improve the individual's general health and welfare in the community. The service may include medication administration, assessment (including annual nursing assessment), the development of a treatment/support plan, training and technical assistance for paid support staff to carry out the plan, monitoring the individual and provider in the implementation of the plan, and documentation of outcomes. The service may be delivered in the individual's home, day program, or in other community settings as described in the service plan.

The service also includes referrals to Home Health Care or other medical providers for specific action or treatment under the Medicaid State Plan.

The provision of such routine health services is not considered to violate the requirement that a waiver cannot cover services that are available through the State plan. Medical and Health care services such as physician services that are not routinely provided to meet the daily needs of residents are not included.

Nutrition Counseling Services include assessment of an individual's nutritional needs, development and/or revision of individual's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to the successful implementation of the nutritional plan. The services include:

- Training, education and consultation for individuals and their family members or support staff involved in the day to day support of the person
- Comprehensive assessment of nutritional needs
- Development, implementation and monitoring of nutritional plan incorporated into the

person's ISP, including updating and making changes in the plan as needed

- Aid in menu planning and healthy options
- Nutritional education and consultation
- Quarterly summaries of progress on the nutritional plan

The waiver-covered dietitian duties, as outlined above, are above and beyond those approved and covered under the state plan services. This service does not include the cost of meals or food items.

Prevocational Services that prepare a participant for paid or unpaid employment. Services include teaching skills such as self care, social skills, attendance, mobility training, task completion, self direction, problem solving and safety. Services are not job or task oriented, but instead, aimed at a generalized result. Services are reflected in the participant's ISP and are directed to habilitation rather than explicit employment objectives.

A person who receives prevocational services may also receive supported employment services. A person's service 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.

Services may include transportation provided between the individual's place of residence and the site(s) of the habilitation services or between habilitation sites as a component of habilitation services as described in the Individual Support Plan.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Residential Habilitation Direct Services and Support are designed to ensure the health and safety of the individual, and to assist in the acquisition, retention and improvement in skills

necessary to support the person to successfully reside in their community. These services are individually planned and coordinated and described in the Individual Support Plan (ISP).

Direct Services and Support staff are responsible to implement ISP goals related to residential and community living. These supports include adaptive skill development, facilitation of activities of daily living, facilitation of community inclusion, teaching community living skills, interpersonal and relationship skills, choice making skills, social and leisure skills, budgeting and money management skills, providing assistance with self administration of medication, and medication administration (including the use of certified medication aides) that assist the participant to reside in the most integrated setting appropriate to his/her needs. Direct Services and Support may be provided up to 24 hours a day based on the assessed needs of the individual to ensure the individual's health and welfare. Direct Services and Support also includes protective oversight and supervision to assure health and welfare and personal care as an extension of State Plan services. (i.e. support is any assistance provided to the recipient, where learning is secondary or incidental to the task itself or an adaption is provided) which is essential to community living.

Individuals who have chosen the self directed pilot in the Rural Region of Nevada and are receiving Residential Habilitation direct services and support will have the ability to utilize provider-managed agency direct services and support staff if their designed service provider is unable to fulfill their responsibilities. This back up service must be necessary to protect health and welfare and prevent costly institutional placement. These services are immediate and time limited and must be designated in the participant's Individual Support Plan.

Under Residential Habilitation Direct Services and Supports, the responsibility for the living

environment rests with the service agency and encompasses a variety of Supportive Living Arrangements. Supportive Living Arrangements are typically provided in a home setting of four or fewer individuals and are based on the individual level of care needs. Intensive Supportive Living Arrangements provides support and training 24 hours with awake and/or sleep staff. Individuals using SLA services live in their own home or apartment and/or may share with roommates.

Supportive Living Arrangements allow individuals to live in a home of a family member if they choose. Services are provided in the person's home or community with the goal of enhancing the individual ability to be as self-sufficient as possible and utilize available community options. Additionally, Host Home providers may be utilized and typically serve up to two individuals who are usually younger or more dependent individuals who desire or need a family living situation. These providers are private people who choose to have their home licensed and/or certified to care for individuals with mental retardation and related conditions. The people who live in these homes are included in all the provider family's life and activities.

Supportive Living Arrangements do not require state licensure; however, the Division of Mental Health and Developmental Services must approve the service agencies through their certification process in order to provide such services.

Direct support management is designed to ensure the health and welfare of individuals receiving direct services and support from agencies and that assure those services and supports are planned, scheduled, implemented and monitored as the individual prefers and as needed depending on the frequency and duration of approved services. Direct support management staff assists the person to manage their supports within home and community settings. This service includes:

- Assist the person to develop his or her goals;
- Schedule and attend Individual Support Planning Meetings;
- Develop action/service plans as determined in the person's ISP and train residential habilitation direct service and support staff in their implementation and data collection;
- Assist the person to apply for and obtain community resources and benefits such as: Medicaid, SSI, SSDI, HUD, Food Stamps, Housing, etc.
- Assist the person with locating residences;
- Assist the person in arranging for and effectively managing generic community resources and informal supports;
- Assist the person to identify and sustain a personal support network of family, friends, and associates;
- Provide problem solving and support with crisis management;
- Support the person with budgeting, bill paying, and with scheduling and keeping appointments;
- Observe, coach, train and provide feedback of waiver services provided by the direct service and support staff in the person home to assure they have the necessary and adequate training to carry out the supports and services identified in the ISP;
- Follow up with health and welfare concerns and remediation with deficiencies;
- Complete required paperwork on behalf of the person served;
- Make home visits to observe the person's living environment to assure health and welfare; and
- Provide 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 person to reach his or her goals.

Direct Support Managers must work collaboratively with the person's service coordinator (TCM). Mandated TCM functions of locating, coordinating, and monitoring of waiver services are excluded from Federal and State Participation under the Waiver. Direct Support Management services are different from TCM and no duplicate payments will be made.

Supported employment is a combination of intensive ongoing supports and services that enable participants for whom competitive employment at or above the 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 where persons without disabilities are employed. Supported employment activities are designed to increase or maintain the individual's skill and independence, and may include: supervision and training, career exploration and job development, job coaching, follow along services, and transportation between the individual's place of residence and the site of the services or between habilitation sites.

When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations (i.e. supervision and training required by participants receiving waiver services as a result of their disabilities) but does not include payment for the supervisory activities rendered as an ordinary part of the business setting.

A person who receives supported employment services may also receive prevocational or day habilitation services. A person's service 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.

Services may include transportation provided between the individual's place of residence and the site(s) of the supported employment services or between habilitation sites as a component of habilitation services as described in the Individual Support Plan.

Documentation is maintained on the service agreement of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
- 2) Payments that are passed through to users of supported employment programs; or
- 3) Payments for vocational training that is not directly related to an individual's supported employment program.

After the 365 days following the transition back to the community, individuals will continue to receive medically necessary Medicaid State Plan services, subject to any limitations under the Medicaid State Plan, as long as they remain Medicaid eligible. An exception to Medicaid State Plan service coverage is that WEARC and AL Waiver recipients cannot receive PCS or ADHC services for additional Medicaid reimbursement, because the costs of all services are included in the provider payment for WEARC or AL waiver services. This exclusion also applies to WIN waiver recipients using the assisted living service under that HCBS waiver.

Those MFP participants that have been enrolled in a Medicaid 1915(c) HCBS waiver program during the 365 days following transition will continue enrollment under the specific 1915(c) waiver program so long as they continue to meet eligibility criteria for the program.

Decisions to include or not include additional services as current waiver and Medicaid State Plan services will be made in the future after careful analysis and further consultation with stakeholders. Whether such waiver or Medicaid State Plan authorities can be added or amended during or after the conclusion of the demonstration period will be made after data collection and cost analysis about the frequency of particular service needs for the populations under the MFP Demonstration. This analysis will address the impact of services in light of the overall demand for services, progress toward flexible funding mechanisms, non-federal share of the costs for certain Medicaid recipients with incomes between 157 percent and 300 percent of SSI, and Nevada's exploration of new long-term care services options – like the Community First Choice Option. In this sense, DHHS sees the MFP Demonstration as an evolutionary process as Nevada continues to make progress in rebalancing its system of long-term care services and supports.

b. List the service package that will be available to each population served by the Demonstration program. Include only services that are provided through the demonstration (home and community-based long-term care services and supplemental services). Do not include acute care service or institutional services that will be paid for through the regular Medicaid program. In a chart, divide the service list(s) into Qualified Home and Community-Based Program Services, HCBS demonstration services, and supplemental demonstration services reflecting the categories of services that are listed in the solicitation. If any qualified Home and Community-based Services are not currently available to Medicaid recipients in the State (and are, therefore, not included in the State's maintenance of effort calculations), provide a detailed account of when and how they will be added to the Medicaid program. For HCBS demonstration services and supplemental demonstration services, indicate the billable unit of service and the rate proposed by the State. For supplemental demonstration services, provide any medical necessity criteria that will be applied as well as the provider qualifications.

Nevada engaged in an extensive stakeholder involvement process in the course of developing

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this draft Operational Protocol. A key aspect of this engagement was working with stakeholders to assess barriers to individuals transitioning back to the community, and to identify services that could assist in overcoming those barriers. This input was invaluable in the design of the MFP Demonstration benefits package. All MFP participants will be eligible for services contained within the MFP Demonstration benefits package. The MFP Demonstration services provided to individuals will vary, based on the needs of the individual for services identified through the transition planning process.

One consistent theme emerging from stakeholder involvement was the need for transition coordination to provide relocation assistance and intensive service coordination activities to MFP participants as they transition to community settings of their choice. Too often, multiple agencies and contacts are involved with residents. This can create duplication, fragmentation and confusion about needed services and how to access them. As one nursing facility resident put it, “there ought to be some agency to coordinate all the things available.” Nevada stakeholders envisioned a single case manager, or point person, to “navigate” participants through the transition process. Therefore, all MFP participants transitioning to the community will be offered Transition Navigation from an MFP/Health Care Coordinator at the participant’s local Division of Health Care Financing and Policy District Office. The MFP/FOCIS Health Care Coordinators will be trained (in some instances, re-trained), to have a “person-centered” orientation, coupled with strong program knowledge that facilitates coordination across multiple programs and services. The MFP/FOCIS Health Care Coordinators associated with the FOCIS program will serve as Transition Navigators, and will work with the resident in pre-transition planning to evaluate eligibility and suitability for the MFP Demonstration.

The MFP/FOCIS Health Care Coordinators will identify the individual’s needs and work to

assist the individual in realizing their goal of moving into a community-based setting. Activities may include helping the participant identify and eliminate potential barriers that would prohibit transitioning to the community, helping to facilitate and develop natural support systems, informing and educating the individual about the choice to participate in the MFP Demonstration, and providing technical information to concerned family and friends upon the participant's request, pursuant to an approved release of information. In addition, pre-transition coordination services are provided to persons residing in institutional settings prior to their transition to a 1915(c) waiver program or other HCBS services. Furthermore, the MFP/FOCIS Health Care Coordinators will continue post-transition to provide MFP participants with assistance during the 365-day period following discharge from an institution.

Pre-Transition activities may include, but are not limited to, the following:

- Conduct outreach to facility staff and administrators to explain the MFP Demonstration.
- Provide information to institutional residents to ensure an understanding of the MFP Demonstration Grant project, Medicaid 1915(c) Waiver HCBS, and non-waiver services and supports.
- Confirm participant eligibility for the MFP Demonstration.
- Conduct a thorough assessment to collect more information about the person's desires, needs, current services, housing preferences, and available support resources in their home/target community.
- Assist an institutional resident in completing a self-assessment.
- Develop a transition plan together with participant/family/legal representative, and appropriate facility staff.

- Coordinate planning team.
- Coordinate agencies responsible for HCBS service delivery.
- Assist participant and facility staff to identify facility tasks to accomplish in order to transition prior to the transition.
 - Medication revisions
 - Changes in therapies to increase independence/participation in self care, mobility and other required functional capability
 - Diet revision, exercise, or weight loss plans
 - Knowledge about own needs and self care
 - Caregiver training and skills competency evaluation
- Develop housing options with each participant.
 - Assist with housing choices, applications, wait-lists follow-up, roommates and trial visits
 - Secure housing for all participants
 - Coordination of housing resources, including accessibility modifications.
- Coordinate with HCBS waiver case manager, participant/family/legal representative and other requested individuals/clinicians to both develop the HCBS waiver Service Plan for community living and identify service providers.
 - Arrange for the services in the Service Plan.
 - Ensure services/equipment/supplies are in place prior to facility discharge.
- Assist participant with community arrangements needed to transition.
 - Obtain durable medical equipment, assistive technology, and medical supplies
 - Arrange for home modifications

- Identify medically necessary medical, dental, specialty, and pharmacy providers
- Secure financial assistance, food stamps, and Medicaid eligibility updates
- Describe transportation options and how to access these services
- Schedule moving arrangements on discharge day.
- Assist participant with any required paperwork.
- Conduct initial MFP Quality of Life survey.

Post-transition activities include, but are not limited to, the following:

- Conduct post-transition monitoring visits or contacts for assessment of health, social and housing needs.
- Assist participant with problem solving dependency and isolation issues/consumer directed services/supports/community inclusion.
- Monitor the eligibility process.
- Assess caregiver status and assist with problem solving/needed training.
- Coordinate with providers for all community-based services to address needed revisions to the Service Plan.
- Maintain accurate, comprehensive, confidential program records and case files.
- Participate in team meetings to identify successful strategies and barriers for improvement.
- Conduct follow up Quality of Life surveys.
- Other activities necessary to maintain the participant in the community.

Another service need clearly articulated from stakeholders involved funds to secure needed

goods related to the transition. During interviews with nursing facility residents, it was not uncommon to hear “moving will take all my money” or “how do I get furniture?” or other similar comments. In response, Nevada will include Community Transition Services in its MFP Demonstration as a Demonstration Service. Community Transition Services will assist MFP participants in arranging housing payments, including rental deposits or payments, security, utility, and phone deposits. Community Transition Services may also include preparing the household, including cleaning, moving property, purchasing furniture, necessary household items, and food, as well as establishing a bank account for the participant.

Community Transition Services include items, goods or services necessary to allow an institutionalized individual to transfer into a community setting and enable a person to establish a household. Items, goods or services may include, but are not limited to, the following:

- Housing deposits
- Set-up fees or deposits for essential services
 - Telephone
 - Electricity
 - Heating
 - Water
 - Other utilities
- Moving assistance expenses
- Essential household items
 - Furniture
 - Appliances
 - Window coverings

- Bed/bath linens
- Food preparation items
- Other essential household items
- Initial essential groceries
- Financial Services/Bank Fees
- Services necessary for health and safety prior to occupancy, as appropriate
 - One-time cleaning
 - Pest eradication
 - Allergen control

Community Transition Services will be provided by the MFP/FOCIS Health Care Coordinators in collaboration with MFP staff. After an individual is found eligible for the MFP Demonstration the MFP/FOCIS Health Care Coordinator will be responsible for identifying the need for Community Transition Services. DHCFP will establish a pool of flexible funds under the MFP Demonstration. This pool will be established at an average anticipated expenditure of \$2,500 per person, and the fund will be managed on an aggregate basis.

Another strong sentiment expressed by stakeholders was the need to ensure a safe and adequate environment for MFP participants. Nevada will include Environmental Accessibility Adaptation in its MFP Demonstration as a Demonstration Service. Environmental Accessibility Adaptations are physical adaptations to the private residence of the participant or the participant's family, required by the participant's Service Plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized

electric and/or plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

All MFP participants will also have Housing Coordination services available as a Demonstration Service to provide the individual assistance each MFP consumer will need related to housing navigation. As the MFP consumer begins to work towards leaving the institutional setting, it can be very overwhelming for the consumer to know where to start. Housing Coordinator services will play a vital role in assisting the MFP consumer as he navigates through the housing process of returning to the community.

Housing Coordinator Services may include the following:

- Assist in providing an extensive list of housing options for each MFP consumer.
- Assist in the application for federal rental assistance (Public Housing units and Public Housing Authority's (PHA) voucher program)
- Assist the consumer to obtain appropriate documentation required by PHA/ public housing units
- Assist the MFP consumer in applications for each individual apartment complex
- Assist in the coordination of transportation for each MFP consumer to appointments for housing

- Coordinate with the Health Care Coordinator in the use of Community Transition funds to pay back bad credit issues related to past rental history
- Accompany MFP consumer to each unit/home for inspection
- Assist consumer in communication with property manager/landlord
- Mediate any denial of application of unit.
- Coordinate with local fair housing organization when consumer feels discriminated based off of disability.

MFP participants will have access to the core set of benefits described above considered essential for successful transition into the community. These services are currently available only to certain waiver populations. As needed, these services will be made available to an MFP participant when they move to a community-based residence.

The service package provided to MFP participants will vary by individual need. All MFP participants will be eligible for Medicaid State Plan services. All MFP participants, with few exceptions, are expected to utilize PCS. Each targeted population group will have access to different 1915(c) waiver services, if enrolled in an HCBS waiver following transitions. MFP/FOCIS Health Care Coordinators will work with MFP participants, support networks and providers to assess the scope, intensity and duration of the participant need.

Services may be offered as either Demonstration Service or “Qualified Home and Community Based Services.” Qualified HCBS includes Medicaid State Plan covered HCBS, and 1915(c) waiver services if enrolled, which the MFP participant may utilize after transition to the community.

The following charts segment MFP services into Qualified HCBS and Demonstration Services for each targeted population. Nevada will continue the provision of Qualified HCBS

Services after the conclusion of the MFP Demonstration program. Demonstration Services will also be claimed at an enhanced match rate for the first 365-day post-transition period for MFP participants. Because the Demonstration Services are focused on time-limited transition supports such services are not expected to continue after the 365-day post-transition period. No Supplemental Services are proposed for Nevada's MFP Demonstration.

Approved

Table 7. Older Adults MFP Demonstration Benefits Package

Qualified HCBS
Personal Care Services
Adult Day Health Care
Targeted Case Management
Community-Based Mental Health Services
Durable Medical Equipment
Prosthetics/Orthotics
Disposable Medical Supplies
Skilled Nursing Services
Home Health Aides/Certified Nursing Aides
Physical Therapy
Occupational Therapy
Speech Therapy
Respiratory Therapy
Registered Dietician Services
Adult Companion*
Assisted Living*
Chore*
Homemaker*
Personal Emergency Response Systems* ⁺
Respite Care*
Social Adult Day Care*
Demonstration HCBS
Transition Navigation
Community Transition Services
Environmental Accessibility Adaptation
Housing Coordination

*Available to older adults enrolled in CHIP waiver.

+ PERS will be provided to all MFP participants to serve as a 24-hour back-up system.

Table 8. Persons with Physical Disabilities MFP Demonstration Benefits Package

Qualified HCBS
Personal Care Services
Adult Day Health Care
Targeted Case Management
Community-Based Mental Health Services
Durable Medical Equipment
Prosthetics/Orthotics
Disposable Medical Supplies
Skilled Nursing Services
Home Health Aides/Certified Nursing Aides
Physical Therapy
Occupational Therapy
Speech Therapy
Respiratory Therapy
Registered Dietician Services
Attendant Care*
Chore*
Environmental Accessibility Adaptations* ⁺
Homemaker*
Home Delivered Meals*
Personal Emergency Response Systems* ⁺
Respite Care*
Specialized Medical Equipment & Supplies*
Demonstration HCBS
Transition Navigation
Community Transition Services
Environmental Accessibility Adaptation ⁺
Housing Coordination

*Available to persons with physical disabilities enrolled in WIN waiver.

⁺May be provided as Qualified HCBS to WIN waiver recipients. Services in the WIN waiver and the Demonstration Services can complement one another, but cannot duplicate services. For example, the WIN waiver service of environmental accessibility is limited to a maximum of \$3,230. If a MFP recipient participating in the WIN waiver needed environmental adaptations to ensure success in a community placement that cost more than \$3,230, MFP funding could assist with the difference. PERS will be provided to all MFP participants to serve as a 24-hour back-up system.

Table 9. Persons with Intellectual Disabilities MFP Demonstration Benefits Package

Qualified HCBS
Personal Care Services
Adult Day Health Care
Targeted Case Management
Community-Based Mental Health Services
Durable Medical Equipment
Prosthetics/Orthotics
Disposable Medical Supplies
Skilled Nursing SN services
Home Health Aides/Certified Nursing Aides
Physical Therapy
Occupational Therapy
Speech Therapy
Respiratory Therapy
Registered Dietician Services
Behavioral Consult, Training & Intervention*
Community Integration*
Counseling Services*
Day Habilitation*
Nursing Services*
Prevocational Services*
Residential Habilitation*
Supported Employment*
Transportation: Non-Medical*
Demonstration HCBS
Transition Navigation
Community Transition Services
Environmental Accessibility Adaptation
Personal Emergency Response Systems ⁺
Housing Coordination

*Available to persons with intellectual disabilities enrolled in MRRC waiver.

⁺PERS will be provided to all MFP participants to serve as a 24-hour back-up system.

Billable units of service and proposed rates for all Demonstration Services are provided on the following table.

Table 10. Billable Rates for MFP Demonstration Services

Demonstration Service	Proc Code	Rate
Transition Navigation	TBD	TBD
Environmental Accessibility Adaptations	S5165	\$3230.00
PERS Installation	S5160	\$45.00
PERS Monthly Monitoring	S5161	\$40.00
Housing Coordination	TBD	TBD

DHCFP uses structured methodologies for the development of rates for covered services. Rates for Transition Navigation will be developed by DHCFP as part of the implementation of these services. DHCFP will amend its Operation Protocol after a rate setting methodology has been established. The rate proposed for Environmental Accessibility Adaptation is the Provider Type 58 Physically Disabled Waiver (WIN) reimbursement rate for Home Modification as of October 2010.

6. Consumer Supports

Describe the process and activities that the state will implement to ensure that the participants have access to the assistance and support that is available under the demonstration including back-up systems and supports, and supplemental support services that are in addition to the usual HCBS package of services. Please provide:

- a. A description of the educational materials used to convey procedures the State will implement in order for demonstration participants to have needed assistance and supports and how they can get the assistance and support that is available;**

DHCFP has developed educational material for the FOCIS program over the years, and this

material is currently in use. The FOCIS brochure is provided in Appendix A. Nevada will review this and other educational materials during the second year of the MFP Demonstration to determine whether the content and dissemination methods can be improved. Nevada is hopeful that CMS will create a library or repository of educational information used by other states, so that this literature can be examined, and if appropriate, used in Nevada. Nevada would also be willing to contribute its own literature to any such library or repository.

Given that persons of Hispanic descent comprise a quarter of the state's population, and represent over one-third of the Medicaid population, Nevada is particularly interested in obtaining culturally appropriate educational materials and developing MFP Demonstration educational material in Spanish.²²

- b. A description of any 24 hour backup systems accessible by demonstration participants including critical services and supports that are available and how the demonstration participants can access the information (such as a toll free telephone number and/or website). Include information for back-up systems including but not limited to:**
 - i. Transportation**
 - ii. Direct service workers;**
 - iii. Repair and replacement for durable medical and other equipment (and provision of loan equipment while repairs are made); and**
 - iv. Access to medical care: individual is assisted with initial appointments, how to make appointments and deal with problems and issues with appointments and how to get care issues resolved.**

Back-up systems will be individualized and listed in the Plan of Care and Service Plan. At a minimum, all MFP participants will be provided with a Personal Emergency Response System (PERS). The Plan of Care and Service Plan will specify alternate providers for additional support in circumstances in which the recipient is unable to contact the primary provider. The assigned primary agency/provider is required to answer the phones 24 hours per day and provide assistance to the recipient when critical issues arise. The Plan of Care/Service Plan will also

²² See <http://quickfacts.census.gov/qfd/states/32000.html>, retrieved on 11-30-10.

include: the case manager contact information for follow-up during work hours, phone numbers for the Elder Protective Services - Aging and Disability Services Division (ADSD) Las Vegas/Clark County (702) 486-6930 and Statewide/other areas (888) 729-0571, as well as the Crisis Call Center 1-800-273-8255. The Plan of Care/Service Plan may be updated as necessary to ensure the system outlined is appropriate for the individual recipient.

PCS agencies are required to work with other DHCFP-contracted PCS provider agencies or home health agencies to ensure that there is after-hours coverage for all recipients. The contact name and numbers are noted on the Plan of Care and Service Plan. For MFP participants receiving PCS under the self-directed option, the ISO shall maintain and make available to the recipient or PCR, on request, a list of qualified personal care assistants that may be able to provide back-up services. The ISO is not responsible for arranging or ensuring back-up care is provided.

Durable Medical Equipment (DME) providers are accommodated in emergency situations by a retroactive prior authorization approval process available through DHCFP's QIO-like vendor for Nevada Medicaid reimbursable DME. As set forth in the Nevada Administrative Code, life sustaining equipment service or repair calls must be responded to within one hour of such a call, whether during business hours or during after-hours, by the medical products providers of such life-sustaining equipment.

The MFP/FOCIS Health Care Coordinator will assist the MFP participant in obtaining initial appointments, teaching the recipient how to make subsequent appointments, and in dealing with problems and achieving acceptable resolution. This includes assisting the MFP participant with accessing Non-Emergency Transportation (NET) through the Medicaid NET broker. Emergency transportation is provided as needed by calling 9-1-1.

During the initial year of the MFP Demonstration, Nevada will explore other potentially cost-effective back-up systems or mechanisms, such as the use of a 24-hour help line. Any new back-up system available to MFP participants during the 365-day period following transition will supplement those service types that require the provider to be available 24/7 and the PERS provided to each MFP participant. Over the long term, Nevada will be exploring how best to structure intensive medical care coordination through Patient Centered Medical Homes to assist Medicaid recipients with accessing the right care at the right time in the right setting.

c. A copy of the complaint and resolution process when the back-up systems and supports do not work and how remediation to address such issues will occur.

It is expected that nearly all MFP participants will receive PCS as a Qualified HCBS service. Nevada has well-prescribed complaint and resolution procedures. The PCS provider must respond to all complaints in a reasonable and prompt manner. The PCS provider must maintain records that identify the complaint, the date received, the response, and the outcome of the incident. The PCS provider must investigate and respond in writing to all written complaints within 10 calendar days of receipt. The PCS provider will provide the MFP participant and DHCFP written notification of the complaint and its outcome.

The PCS provider must also provide the DHCFP District Office Care Coordination Unit with written notification of serious occurrences involving the recipient, the personal care assistant, or affecting the provider's ability to deliver services. The DHCFP District Office Care Coordination Unit must be notified of serious occurrences by fax within 24 hours of discovery.

For MFP participants also receiving HCBS waiver services, written notification must also be provided to the DHCFP Care Coordination Unit and the appropriate waiver case manager at the local ADSD or DHCFP District Office as appropriate.

Serious occurrences may include, but are not limited to, the following:

- Suspected physical or verbal abuse;
- Unplanned hospitalization;
- Neglect of the participant;
- Exploitation;
- Sexual harassment or sexual abuse;
- Injuries requiring medical intervention;
- Unsafe working environment;
- Any event which is reported to Child or Elder Protective Services or law enforcement agencies;
- Death of the recipient during the provision of PCS; or
- Loss of contact with the participant for three consecutive scheduled days.

The summary report of serious occurrences from the PCA agency is required to be submitted in January and July of each year to the DHCFP Central Office PCS Program Specialist. DHCFP plans to enhance its quality assurance processes to develop a more person-centered, rather than programmatic, orientation to ensure appropriate action has been taken to correct the issue and prevent further occurrences.

The section on Quality in this Operational Protocol further explains the state's procedures and policies to provide appropriate levels of support to participants.

7. Self-Direction

Sub-Appendix I is considered part of the Operational Protocol and is required for States using self-direction for MFP demonstration participants. An electronic copy of the form will be made available to applicants. CMS requires that adequate and effective self-directed supports are in place. Provide a description of the self-

direction opportunities under the demonstration before the Institutional Review Board (IRB) approval.

Nevada recognizes the need to offer Medicaid recipients the opportunity to self-direct and self-determine their care, as appropriate. The terms are often used interchangeably, but the fundamental shift in power allows individuals to control their own services and supports, while at the same time maintaining an appropriate level of accountability. The State of Nevada has defined self determination as freedom for individuals, who as a result of their disability and vulnerability have often been oppressed, segregated and isolated within society. It is defined by a set of guiding principles that assure freedom, choice and self-direction in their lives.

Nevada offers a self-direction option for PCS, a delivery option designed to allow recipients more autonomy and responsibility in the provision of PCS. The option is utilized by accessing services through an ISO. An ISO is an entity acting as an intermediary between Medicaid recipients who elect the self-directed service delivery model, and the personal care assistants. ISO services must be provided in a manner that affords individuals and their representatives choice and control over the services they receive and the qualified providers of those services.

The 1915(c) HCBS Waiver for Persons with Mental Retardation and Related Conditions, operated by MHDS, also has a self-directed pilot program for waiver services. This pilot is currently limited to participants residing in the rural regions of Nevada served by the MHDS Rural Regional Center. Based on the outcomes and evaluation of this pilot, the service delivery model may be phased in throughout the state at a later time by amending the current, approved waiver. MFP participants residing in a region served by the Rural Regional Center that are eligible for this waiver will be able to avail themselves of this opportunity for self-direction. Tracking of MFP participants choosing self-direction will be done manually by the Health Care Coordinators, and a reporting methodology will be developed. When the service areas for self-

direction are expanded by amending the waiver, MFP participants residing in other areas of Nevada will be able to choose a self-directed option for waiver services.

The Self-Direction Submittal Form (see Appendix D) discusses the characteristics of Nevada's self-direction opportunities at length. The discussion in the Self-Direction Submittal Form references activities of the MHDS pilot when responses are restricted to waiver services. In other cases, the discussion addresses the ISO option for PCS, where appropriate.

a. Describe how the State accommodates a participant who voluntarily terminates self-direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method.

An MFP participant may terminate the ISO model for PCS at any time. The state uses the same Quality Improvement Organization (QIO)-like vendor for HCBS, Medicaid State Plan services, and self-directed services; therefore, with appropriate notice and planning, there should not be any lapse in service. After appropriate notice, authorizations can end one day and a new authorization can begin the next day to have the services provided through a PCS agency.

A participant may request termination of self-directed services under the HCBS Waiver for Persons with Mental Retardation or Related Conditions (MRRC) at any time through notification to their support broker or service coordinator. After the participant's request to voluntarily terminate self-direction, a special care planning meeting is held. At this meeting, the support team will develop a new person-centered plan to ensure continuity of care and that health and welfare needs are met during the transition from self-direction to provider-managed services. The team will discuss timelines and options. By participating in appropriate planning sessions, participants can change between self-directed and provider-managed models without service interruptions.

b. Specify the circumstances under which the State will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Please include information describing how continuity of services and participant health and welfare will be assured during the transition.

A participant must be terminated from the ISO option and offered services through traditional providers if there are immediate health and safety risks to the person associated with self-direction or their ability to understand what it means to self-direct. It is the responsibility of the ISO to monitor the person throughout the year. A DHCFP Care Coordinator will complete an annual contact to determine if a person continues to meet the criteria for the ISO option. The Care Coordinator assesses the recipient's ability to understand self-direction by explaining the option and having the recipient explain the option back to the Care Coordinator. The Social Health Assessment also assesses risks. If risks are identified, the Care Coordinator identifies resources and makes referrals on behalf of the ISO recipient to address those risks. If the recipient does not have the ability to understand the ISO option, or there are immediate health and safety risks, the ISO option will not be approved. In that case, the Care Coordinator facilitates access to traditional PCS services if the participant is involuntarily terminated from the ISO option.

Involuntary termination of self-direction under the MR/RC waiver will not take place until other interventions and support resources are exhausted. The state will involuntarily terminate a participant from the self-directed service model under the MR/RC waiver if he or she is determined to be at risk due to lack of ability to direct services as defined in the Individual Support Plan (ISP). This will be identified through the service coordinator's monitoring, the support broker's input, or other quality assurance activities assessing the participant's health and welfare.

c. Specify the State's goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration's self-direction opportunities.

At the present time, fewer than 5% of waiver and State Plan recipients who have PCS utilize the ISO option. It is unclear how many recipients may choose this option when transitioning from a nursing home to the community. The participation in the MR/RC waiver self-directed pilot is about 1% of the total waiver population for the MHDS Rural Regional Center. MFP Demonstration project staff will include information about the MR/RC waiver self-directed pilot program option for those MFP participants residing in an area covered by MHDS Rural Regional Center.

Through information provided at national conferences, Nevada understands this low uptake of self-directed service utilization is not present in all states. In order to address this, the MFP Demonstration project staff will work with DHCFP and MHDS staff to determine if current administrative or staff cultural processes and beliefs might be impeding utilization of self-directed options. This activity will also include information about PCS self-direction options in education and outreach opportunities to MFP/FOCIS Health Care Coordinators, 1915(c) waiver case managers, participants, institutional facility staff, legally responsible individuals, and other stakeholders. We expect the number of MFP Demonstration participants to avail themselves of self-direction opportunities will be equal or greater to the proportion of current recipients that select self-directed options. Tracking of MFP participants choosing self-direction will be done manually by the Health Care Coordinators, and a reporting methodology will be developed.

8. Quality

a. If the State plans to integrate the MFP demonstration into a new or existing 1915(c) waiver or HCBS SPA, the State must provide written assurance that the MFP demonstration program will incorporate, at a minimum, the same level of quality

assurance and improvement activities articulated in Appendix H of the existing 1915(c) HCBS waiver application during the transition and during the 12 month demonstration period in the community.

Through utilization of the Centers for Medicare and Medicaid Services HCBS Quality Framework, Nevada desires to transition its current HCBS quality management program from one that completes multiple, repetitive separate reviews of service providers for each service program into one coordinated yearly review that allows for a comprehensive scope and a single improvement tracking mechanism. This will integrate the existing 1915(c) HCBS Waiver Quality Management Strategy with the MFP Demonstration quality management review and the State Plan PCS and 1915 (i) program reviews.

Assurance for HCBS waivers are contained in Appendix H of the approved waivers. These existing waivers include: HCBS Waivers for the Elderly in Adult Residential Care (0267.90.R.01), the Waiver for Persons with Physical Disabilities (4150.R04.00), the Waiver for the Frail Elderly (0152.90.R3), and the Waiver for Persons with Mental Retardation and Related Conditions (0125.R05.00). All of these waivers have Quality Improvement Systems (QIS) that have been approved by CMS.

Assurances are measured by conducting periodic reviews, which include reviewing the participant's case files, onsite provider reviews to verify both provider qualifications and that the providers are effectively serving participants, participant face-to-face interviews, and financial reviews of claims paid against service delivery documentation and plan of care documentation (financial accountability). At a minimum, reviews are completed annually. Participants will have monthly contacts with MFP/FOCIS Health Care Coordinators or waiver case managers. These monthly contacts aid in determining that assurances are met.

While this application describes substantially the adaptation of the current 1915(c) Waiver Quality Management Strategy, it is anticipated that MFP will offer the impetus for a collaborative effort to improve interagency collaboration and cooperation with quality assurance reviews. The state wishes to take advantage of the MFP Demonstration collaboration opportunities to streamline and make more efficient the quality management process across DHHS Divisions.

All MFP participants will benefit from the same high level of quality management that 1915(c) waiver participants receive. These quality assurance and improvement activities will be available to MFP participants both during the transition period and during the 365-day demonstration period in the community. This is expected to be a multi-year effort that would first involve data collection and then move to implementation and operational phases.

b. If the State plans to utilize existing 1915(b), State Plan Amendment (SPA) or an 1115 waiver to serve individuals during and after the MFP transition year, the State must provide a written assurance that the MFP demonstration program will incorporate the same level of quality assurance and improvement activities required under the 1915(c) waiver program during the individual's transition and for the first year the individual is in the community. The state must provide a written narrative in this section of the OP regarding how the proposed service delivery structure (1915(b), State Plan Amendment, or 1115) will address the items in section (c) below.

The state does not plan to use 1915(b) or 1115 waivers to support the MFP Demonstration. Nevada may consider the possibility of implementing a 1915(b) or 1115 waiver for the aged and disabled. Such changes would be carefully considered in light of the goals of the MFP Demonstration.

c. The Quality Improvement System under the MFP demonstration must address the waiver assurances articulated in version 3.5 of the 1915(c) HCBS waiver application and include:

- i. Level of care determinations;**
- ii. Service plan description;**
- iii. Identification of qualified HCBS providers for those participants being**

transitioned;
iv. Health and welfare;
v. Administrative authority; and
vi. Financial accountability.

MFP Transition Services

Along with MFP/FOCIS Health Care Coordinators monitoring and documenting the quality of care through regular contacts and home visits, quality assurance reviews will be completed to assure participants are receiving desired MFP Demonstration outcomes. MFP/FOCIS Health Care Coordinators are experienced social workers, nurses, or other licensed health care professionals, and will work diligently to ensure the needs of MFP participants are appropriately met.

Services provided by MFP/FOCIS Health Care Coordinators will include, but are not be limited to:

1. Assist participants in accessing needed MFP services, as well as medical, social, and educational services that contribute to successful transition and community living.
2. Monitor the overall provision of services, including documentation of services provided to ensure the health and welfare of the participant.
3. Monitor and document the quality of care.
4. Determine if there are any issues with service provision or the participant's satisfaction with services, assess the need for any changes in services or providers, and determine whether the services are promoting the goals stated on the participant's POC.

The state will use the existing quality assurance and monitoring systems for Nevada's HCBS waivers, which include the services of the DHCFP Continuum of Care Quality Assurance Unit, to review program quality for multiple Continuum of Care programs. In addition, the state will implement a coordinated effort through information technology infrastructure improvements,

data gathering methods, and program review efficiency implementation to ensure necessary information regarding quality management is shared with essential MFP stakeholders focusing on improvements made to the quality of services provided under the MFP Demonstration. Information acquired during the review process will be used to identify areas of concern, additional training needs, and corrective actions required.

Quality Management Strategy and Assurances

The state ensures through its review process the following assurances:

1. Level of care determinations will be conducted

MFP/FOCIS Health Care Coordinators are responsible for conducting the MFP participants' Level of Care determinations. Each participant must meet and maintain a level of care supporting institutional placement if community based services or supports are not available.

Supervisors will complete a 100% review of all Level of Care determinations completed upon admission to the MFP Demonstration. Supervisors will also work with the MFP/FOCIS Health Care Coordinators to correct any issues as they occur.

A retrospective statistical sample review will be completed by the Quality Assurance Unit, including reviewing the MFP participants' Level of Care documentation. The results of the retrospective reviews and any necessary plans for improvement will be reported. The review report and any other pertinent reports will be reviewed and disseminated as needed

2. Plans of Care (POC) are responsive to participant needs

The POC is a written document which identifies all of the participant's care and service

needs. The POC is based on an assessment of the participant's health and welfare needs, and is developed by the MFP/FOCIS Health Care Coordinators in conjunction with each participant and his/her authorized representative using a person-centered planning process.

MFP/FOCIS Health Care Coordinators are responsible for development and implementation of the POC for each MFP participant. This responsibility includes determining the amount, duration, frequency, and provider type for services that participants require. Updates to the POC are accomplished through telephone contacts, and face to face visits.

During the contacts, information such as: changes since last contact, medical appointments, new medications or treatments, hospitalizations, falls, services meeting needs, any new or unmet needs, satisfaction with services, any equipment or supplies needed, or other information is gathered from the participant. Service authorizations are reviewed and updated to facilitate payment. If the participant requires increased or additional services, the MFP/FOCIS Health Care Coordinators discuss these needs with the participant and/or designated representative for inclusion in the POC. If a new service need is identified, the POC will be updated and the participant and/or designated representative are given a choice of enrolled Medicaid providers.

MFP/FOCIS Health Care Coordinators encourage family members, a designated representative, or members of the participant's circle of support to attend face-to-face meetings with the participant. Participants who have cognitive or communication disabilities can be assisted by family members, a designated representative, or a member of the participant's circle of support. MFP/FOCIS Health Care Coordinators can also assist the participant with tasks such as filling out paperwork, locating information needed for

applications, or other tasks that might prove daunting to the participant.

3. Qualified providers serve participants

Providers may only provide services that have been identified in the participant POC and which have been previously authorized. Providers must be enrolled as a Medicaid provider in order to receive reimbursement for services rendered, meet the participation standards specified for the program service area for which they are applying, and comply with all federal, state, and local statutes, rules and regulations relating to the services being provided. MFP reviews will determine that provider requirements are current and identify any need for corrective action plans and remediation.

Provider site reviews of provider qualifications will be conducted. Findings regarding the reviews will be reported and corrective action plans and remediation will be required. The results of these reviews will also be discussed at Quality Management Committee meetings. The Quality Management Committee has identified a standard system for provider approval prior to enrollment, a policy for annual provider reviews when other reviews are necessary, and a system for the process of provider sanctions progressing to termination if warranted.

An example of how provider quality is maintained is seen in the rigor of criminal history requirements. All providers who have contact with participants are required to undergo a criminal history check. The 1997 Nevada Legislature enacted NRS 449.176 et seq. that requires a check of the criminal history of an applicant for a license to operate, and employees of agencies that provide care in the home and certain facilities.

DHCFP ensures this screening has been conducted through Provider Quality Assurance Reviews and employment record reviews. The Health Division, Bureau of Health Care

Quality and Compliance (HCQC) upon initial certification and during subsequent reviews pursuant to NRS 449.176-449.188, also monitors this for providers under its purview.

4. The health and welfare of participants is maintained

The MFP participant has multiple opportunities to express or evaluate his or her satisfaction (or dissatisfaction) with services and to help shape individual and system quality improvements. A sample of participants will be asked to respond to their personal satisfaction with their providers, services and service outcomes. In addition, a random participant may be visited in-person and invited to respond to a Participant Experience Survey (PES).

In order to assure participants health and welfare, participants are interviewed regarding their experiences, satisfaction with their services, and whether desired outcomes are being achieved. Key factors include:

- a. Access to Care: What services are the participants receiving? Is he/she getting the help that is needed related to personal assistance, adaptive equipment, and MFP/FOCIS Health Care Coordinator access? Are MFP goals being achieved?
- b. Choice and Control: Do program participants have input into the types of services they receive and who provides them?
- c. Respect and Dignity: Are program participants treated with respect by providers?
- d. Community Integration/Inclusion: Do program participants participate in activities and events of their choice outside their homes when they want to?

The MFP participant may contact the MFP/FOCIS Health Care Coordinators at any time during regular business hours to ask questions, receive clarifications on the program or services, or to provide feedback regarding services.

5. DHCFP retains administrative authority over the program

In the HCBS review process, providers, MFP participant files, and participants will be reviewed. Findings from these reviews along with corrective action plans will be available. Participants will be monitored for timely notice of eligibility as well as for denial, suspension, reduction and termination of services. Participants will be tracked through the eligibility process in a timely manner. DHCFP will monitor timeliness of eligibility notices as well as notices for denial, suspension, reduction and terminations.

The HCBS quality review team will complete reviews for the MFP participant's program intake and the intake authorization that was completed by the MFP/FOCIS Health Care Coordinator. A statistical sample review of the participants will be completed in the review process.

6. The state provides financial accountability.

Nevada will apply the same quality review of financial accountability to the MFP Demonstration that it customarily uses for its 1915(c) waiver programs. The HCBS quality review team will review a sample of MFP provider claims to justify payment accuracy. Findings and reports will be used to determine any necessary corrective action plans.

The review is structured as a look-behind review of all authorized services and confirmation of data on performance measures provided. DHCFP has the ability to break out the findings by specific policy area(s). During the review, the HCBS quality review team will review policies related to the operation of the MFP Demonstration and assure such policies are correctly administered.

Additional MFP Quality Requirements

The MFP Demonstration has three additional quality requirements in addition to the assurances made for 1915(c) waivers:

1. 24-Hour Backup

Three of Nevada's four waivers have a residential component. These three are the Assisted Living Waiver, the Waiver for the Elderly in Adult Residential Care (WEARC), and the Waiver for Persons with Mental Retardation and Related Conditions. A 24/7 monitoring of care is required of providers that provide residential care.

The Waiver for the Frail Elderly and the Waiver for Persons with Physical Disabilities encourage care in the person's own home or apartment. Persons participating in these two waivers have the opportunity to obtain Personal Emergency Response System (PERS) units. A substantial number of persons currently take advantage of this service, and PERS will be made available to all MFP participants.

Nevada launched Nevada 2-1-1 in 2006 and has assisted over 260,000 Nevadans with basic needs to health and human services programs. The hours are 8:00 am to midnight Monday – Friday and 8:00 am – 4:00 pm Saturday and Sunday, excluding Holidays.

Provider agencies have internal processes in place for recipients to access care when a caregiver does not show up.

2. Risk assessment and mitigation process

Potential risks to MFP participants are assessed during the initial assessment process by addressing ADL and IADL needs and identifying the amount of assistance needed to safely complete these activities. Factors addressed to assess risk include the participant's ability to

manage medication, potential to wander, resist care, and/or exhibit cognitive and behavioral problems. The level of assistance required is identified along with equipment needs and methods of safely providing the services on the plan. As safety concerns are identified, referrals are made to appropriate resources to address and mitigate those concerns.

MFP/FOCIS Health Care Coordinators are responsible for the initial assessment and POC development and implementation. If there are identified risks, they will be indicated on the POC.

In the Nevada HCBS program, a participant's Plan of Care is reviewed at multiple levels and risk assessment is an explicit criterion of these reviews. At all levels of review, including the supervisor's review, and the statewide program review, reviewers evaluate the Plan of Care in conjunction with assessments to determine whether the plan reflects assessed needs, risks and personal goals. All levels of review verify that the plan is based on social, health and functional assessments.

MFP participants who transition to a HCBS waiver will be assigned a waiver case manager who will conduct the same services as the MFP/FOCIS Health Care Coordinator on an ongoing basis. For those MFP participants who do not transition to a HCBS waiver, the MFP/FOCIS Health Care Coordinator will continue to be assigned to the participant while they remain in the community and continue to conduct the same services while they were in their initial 365 of the MFP Demonstration.

3. Incident management system

The State of Nevada has established mandatory reporting requirements of suspected incidents of Elder Abuse and has a database of other critical incidents. ADSD and local law enforcement are the receivers of incident reports. Reports must be made within 24 hours of

identification/suspicion.

The Elder Abuse Policy

NRS 200.5093 states that anyone “who, in his professional or occupational capacity, knows or has reasonable cause to believe that an older person has been abused, neglected, exploited or isolated...” must report the abuse, exploitation, neglect (including self-neglect), or isolation to the Elder Rights unit of the ADSD, the local police department or the county’s protective services unit in Clark County (if the suspected action occurred in Clark County).

Abuse

For the purposes of elder protective services, the following definition applies. Abuse means willful:

- A. Infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish
- B. Deprivation of food, shelter, clothing or services, which are necessary to maintain the physical or mental health of an older person.

Neglect

Neglect means the failure of:

- A. A person who has assumed legal responsibility or a contractual obligation for caring for an older person or who has voluntarily assumed responsibility for his care to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the older person, or
- B. An older person to provide for his own needs because of inability to do so. (NRS 200.5091-200.50995, et seq.)

Exploitation

Exploitation means any act taken by a person who has the trust and confidence of an older person or any use of the power of attorney or guardianship of an older person to obtain control, through deception, intimidation or undue influence, over the older person's money, assets or property with the intention of permanently depriving the older person of the ownership, use, benefit or possession of his money, assets or property. As used in this subsection, undue influence does not include the normal influence that one member of a family has over another. (NRS 200.5091-200.50995, et seq.)

Isolation

Isolation means willfully, maliciously and intentionally preventing an older person from having contact with another person by:

- A. Intentionally preventing the older person from receiving his visitors, mail or telephone calls, including, without limitation, communicating to a person who comes to visit the older person or a person who telephones the older person that the older person is not present or does not want to meet with or talk to the visitor or caller knowing that the statement is false, contrary to the express wishes of the older person and intended to prevent the older person from having contact with the visitor; or,
- B. Physically restraining the older person to prevent the older person from meeting with a person who comes to visit the older person. The term does not include an act intended to protect the property or physical or mental welfare of the older person or an act performed pursuant to the instructions of a physician who is treating the older person.

(NRS 200.5091-200.50995)

NRS 200.5093 (9) provides that anyone who knowingly and willfully violates the mandatory reporting law is guilty of a misdemeanor.

Participant safeguards include initiation of investigation by local law enforcement and/or Elder Protective agency, provision of protective services to the older person if they are able and willing to accept them. If the person who is reported to have abused, neglected, exploited or isolated an older person or a vulnerable person is the holder of a license or certificate issued pursuant to chapters 449, 630 to 641B, inclusive, or 654 of NRS, information contained in the report must be submitted to the board that issued the license.

Other Critical Incident Reporting

Medicaid providers are expected to have internal policies in place to handle incident reports. Providers who provide services to waiver recipients must report concerns with care supervision and delivery of services to the waiver case manager. This is expected to occur within a reasonable time frame. Providers who provide services to MFP participants will be required to report concerns to the MFP/FOCIS Health Care Coordinator.

DHCFP, MHDS and ADSD have internal policies for tracking and trending of serious occurrences.

Serious Occurrences include, but are not limited to:

- a. Sexual harassment or sexual abuse;
- b. Injuries requiring medical intervention;
- c. An unsafe working environment;
- d. Any event which is reported to Child and Elder Protective Services or law enforcement agencies;
- e. Death of the participant: and
- f. Loss of contact with the participant for three consecutive scheduled days.

Providers must report any serious occurrence by telephone within 1 working day and in writing within 5 working days. Action as appropriate, including supervisory review, will be taken. Based on the outcome of the analysis, the occurrence will be reported to the oversight agency or law enforcement and the participant will be offered protective services as appropriate. The trends of the reports are reviewed by supervisor and management staff and program/policy modifications are recommended if possible.

MFP/FOCIS Health Care Coordinators receive, track and trend Serious Occurrences for MFP participants using the same system as HCBS waiver case managers. For those MFP participants who transition to an HCBS waiver, the waiver case manager will continue to receive, track and trend serious occurrences. For those MFP participants who do not transition to an HCBS waiver, the MFP/FOCIS Health Care Coordinator will continue to receive, track and trend serious occurrences.

Reports received by any Division office must be investigated by the local office which is required to commence an investigation within three working days of receiving the report.

DHCFP's Quality Assurance Unit recently created a statewide tracking system for serious occurrences for all five (5) waivers. The operating agency (DHCFP District Office, MHDS, and ADSD) send reports to DHCFP Central Office monthly for tracking and trending. This same level of administrative oversight will be conducted with MFP participants.

- d. If the State provides supplemental demonstration services (SDS), the State must provide:**
- 1. A description of the quality assurance process for monitoring and evaluating the adequacy of SDS service(s) to manage the barrier it was selected to address; and,**
 - 2. A description of the remediation and improvement process. “**

No supplemental services are proposed for the MFP Demonstration.

9. Housing

- a. Describe the State’s process for documenting the type of residence in which each participant is living (See chart for examples in Sub-Appendix II). The process should categorize each setting in which an MFP participant resides by its type of “qualified residence” and by how the State defines the supported housing setting, such as:**
- i. Owned or rented by individual,**
 - ii. Group home,**
 - iii. Adult foster care home,**
 - iv. Assisted living facility, etc. (Please see the Policy Guidance in Sub-Appendix VI)**
- If appropriate, identify how each setting is regulated.**

Nevada will manually track of the types of community residences utilized by MFP participants. As shown in the benchmark and budget narratives, the IT system infrastructure needs to be upgraded and linked to other systems used by the state, such as the state’s eligibility system – the Nevada Operations of Multi-Automated Data Systems (NOMADS) – and its Medicaid Management Information System (MMIS), and plan for the reporting requirements of MFP. Currently, the FOCIS program collects residential information for FOCIS participants transitioned, but does so in a stand-alone manner and needs data retrieval upgrades.

The following table shows the types of residences that persons receiving Medicaid home and community-based services currently reside in.

Table 11. Residence Types by Persons Receiving HCBS Waiver Services, 2010

Name of Waiver	Use of Qualified Residences	Licensing	State Regulation and Qualified Housing
Assisted Living	No, the assisted living provider has a 90-unit building	Yes	Regulated by NAC 449.2751. The provider in the assisted living waiver does not have a qualifiable residence for MFP purposes.

Name of Waiver	Use of Qualified Residences	Licensing	State Regulation and Qualified Housing
Frail Elderly (CHIP)	Yes, these are almost all homes and apartments.	Homes and apartments are not licensed	Certification of service providers is required.
Persons with Physical Disabilities (WIN)	Yes, these are almost all homes and apartments.	Homes and apartments are not licensed	Certification of service providers is required.
Elderly in Adult Residential Care (WEARC)	No, these are typically homes with six or more residents.	Yes	Regulated by NAC 449.156. There are 228 waiver providers with 3,754 beds, but only eight providers have four or fewer beds
Persons with Mental Retardation and Related Conditions (MRRC)	Nevada serves 5,334 individuals with mental retardation or related conditions statewide. Of the 5,334 individuals receiving services, 1,639 individuals are supported in home and community-based waiver placements. Nevada also supports individuals in supportive living arrangements outside of the MR/DDRC waiver. Most of the community-based living arrangements support four or fewer recipients and are qualified residences under MFP.	Licensing of supportive living arrangements is not required.	Certification of service providers is required as per MHDS Policy DS 1.1. Personal Care Agencies are defined in Nevada statutes at NAS 449.0021

- b. Describe how the State will plan to achieve a supply of qualified residences so that each eligible individual or the individual’s authorized representative can choose a qualified residence prior to transitioning. This narrative must:**
- i. Describe existing or planned inventories and/or needs assessments of accessible and affordable community housing for persons with disabilities/chronic conditions;**
 - ii. Explain how the State will plan to address any identified housing shortages for persons transitioning under the MFP demonstration grant,**
 - iii. Address how the State Medicaid Agency and other MFP stakeholders will work with Housing Finance Agencies, Public Housing Authorities and the various housing programs they fund to meet these needs;**
 - iv. Identify the strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants.**

Nevada has only five housing authorities.²³ On January 1, 2010, the housing authorities of the City of Las Vegas and Clark County merged, creating the largest housing authority in the state, with more than 70% of the state's population residing in Clark County (i.e., greater Las Vegas). The new Southern Regional Housing Authority has a 1,692 page, five-year plan that extensively lays out goals and strategies for affordable housing and contains inventories of existing housing units and estimates of unmet need. The table below shows the number of persons in the Clark County area that need affordable housing.

Approved

²³ City of Reno Housing Authority, Nevada Rural Housing Authority, Southern Nevada Regional Housing Authority, the Housing Authority of the City of North Las Vegas, and Accessible Space Inc. (ASI). The Nevada Rural Housing Authority and ASI only provide Section 8 vouchers, while the other authorities provide both Section 8 vouchers and public housing authority dwelling units.

Table 12. Number of Families with Housing Needs in Clark County, 2010

Number of Families with Housing Needs	
Income by Area Median Income (AMI)	
Income <= 30% of AMI	13,290
Income >30% but <=50% of AMI	11,503
Income >50% but <80% of AMI	16,433
Age and Disabilities	
Elderly	11,322
Families with Disabilities	7,543
Race/Ethnicity	
White	17,745
Black	6,214
Hispanic	9,976

Data Source: Southern Nevada Regional Housing Authority Five-Year Plan 2011-2015. p. 1586

The five-year plan also provides information regarding the number of people on the waiting lists and the length of wait times for Section 8 vouchers and public housing units. For example, on April 19, 2010 there were 1,620 families on the waiting list for Section 8 vouchers, of whom 380 were families that included a person with a disability. Also as of this date, the waiting list for public housing authority units was comprised of 1,286 families, of which 133 were families that included a person with a disability.²⁴

The State Division of Housing conducts frequent studies of housing stock in Nevada and publishes periodic studies. For example, it publishes quarterly apartment studies that, among other data, identify how many apartments have rental levels that are affordable, are at market

²⁴ Southern Nevada Regional Housing Authority, (2010) *Annual Agency Plan Update FY 2011-FY2015 Five Year Plan*, Las Vegas, NV: pp. 1587-1588. Retrieved on 11-26-10 from <http://www.haclv.org/bulletins.htm>

rate or can be afforded by persons with special needs. The Division of Housing has also published housing analyses for persons with special needs.²⁵

The MFP Demonstration will use a four-part strategy with regard to housing:

1. Provide MFP sub-grant or contractual funds for a community non-profit agency or create a grant position to provide Housing Coordination as a Demonstration Service;
2. Build upon existing websites/housing registries;
3. Learn from other states; and
4. Nurture relationships with the public housing authorities.

Housing Coordination Service

Nevada has included Housing Coordination as a Demonstration Service for the MFP Demonstration. DHCFP intends to sub-grant or contract with a community non-profit agency or create a grant position to provide Housing Coordination services. Housing Coordination has two initiatives as part. First, is the individual assistance each MFP consumer will need related to housing navigation. As the MFP consumer begins to work towards leaving the institutional setting, it can be very overwhelming for the consumer to know where to start. The Housing Coordinator will play a vital role in assisting the MFP consumer as he navigates through the housing process of returning to the community.

Housing Coordination services may include the following:

- Assist in providing an extensive list of housing options for each MFP consumer.
- Assist in the application for federal rental assistance (Public Housing units and Public Housing Authority's (PHA) voucher program)

²⁵ For example, see the studies at, retrieved on 11-26-10 from <http://www.nvhousing.state.nv.us/pr/apartment%20studies.htm>

- Assist the consumer to obtain appropriate documentation required by PHA/ public housing units
- Assist the MFP consumer in applications for each individual apartment complex
- Assist in the coordination of transportation for each MFP consumer to appointments for housing
- Coordinate with the Health Care Coordinator in the use of Community Transition funds to pay back bad credit issues related to past rental history
- Accompany MFP consumer to each unit/home for inspection
- Assist consumer in communication with property manager/landlord
- Mediate any denial of application of unit.
- Coordinate with local fair housing organization when consumer feels discriminated based off of disability.

Second, we know housing is the main barrier for people with disabilities returning to the community. Providers of Housing Coordination must be innovative as he finds available housing options for MFP consumers. Therefore, it will be the responsibility of the contracted provider or identified staff to create the Local Housing Committee (LHC) in order to gain buy-in with the local housing professionals and the Public Housing Authority. The local DHCFP District Office (DO) will monitor the progress of the Housing Coordinator provider responsible for the LHC. The LHC must include:

- Local Public Housing Authority
- Local Housing Developer
- Local Fair Housing Agency
- Local MFP/FOCIS Health Care Coordinator

- Local Aging and Disability representative
- Local Center for Independent Living
- Local Department of Mental Health and Developmental Services Agency
- Local Community Development Agency
- Local MFP consumer
- Local Housing Advocates
- Local Service provider Agency
- Various other organizations suggested by LHC or DO

The LHC will meet regularly to discuss the success of the MFP Demonstration program and the coordination of housing initiatives at the local level. The group will formulate a mission statement in addition to goals to help achieve success of MFP consumers.

Build upon existing websites/housing registries

Nevada believes that one component of a durable housing program is the use of technology to organize information. The state built a housing website eight years ago when it began its nursing facility diversion and transition work. When the nursing home transition grant ended, the website maintenance costs were picked up by Developmental Disabilities Council and United Way of Southern Nevada. Support for the website and its housing registry was part of the DD Council's five-year plan (2006-2011). As the state budget tightened, it became difficult to find resources to continue the effort and work on the website lapsed. However, persons recognized the need for such a site and the legislature provided some funds to the Division of Housing to work with the Aging and Disability Services Division to restore the housing website.

Essential activities necessary for progress are to clearly identify the number of affordable

housing units as well as the number of housing vouchers currently available and the number of vouchers dedicated to individuals with disabilities.

While there are readily available lists of the properties owned by public housing authorities, there are other low-income, affordable housing opportunities that are less visible, such as properties that are developed through the state's Low Income Trust Fund and properties developed through the Low-Income Housing Tax Credit Program. What is needed to develop a website and housing registry is to link together information from all housing programs as well as from existing web sites such as:

- the Western Nevada Home Consortium
<http://www.cityoffernley.org/index.aspx?NID=397>,
- the Washoe Affordable Housing Corporation (WAHC), <http://www.wahc.info/>,
<http://www.gosection8.com/> and
- the US Department of Housing and Urban Development
<http://www.hud.gov/local/nv/renting/phwaitinglist.pdf>.

ADSD has a mandate to collect and provide information on affordable housing from AB 139 passed by the 2009 Nevada Legislature. Section 4 of AB 139 reads as follows:

1. If an owner of residential housing that is offered for rent or lease in this State and is:

- (a) Accessible to persons with disabilities; or*
- (b) Affordable housing,*

has received any loan, grant or contribution for the residential housing from the Federal Government, the State or any public body, the owner shall, not less than quarterly, report to the Office of Disability Services of the Department of Health and Human Services information concerning each unit of the residential housing that is available and suitable for use by a person with a disability.

2. *The Department of Health and Human Services shall adopt regulations to carry out the provisions of this section.* 3. *As used in this section, “affordable housing” has the meaning ascribed to it in NRS 278.0105.*

Before a housing registry can be fully operationalized, regulations must be adopted to outline the applicability and compliance structure of the registry. ADSD staff will develop such regulations and present them at workshops and hearings along with the unit's other proposed regulations. It is contemplated that the housing registry regulations will outline:

- Housing units to which the regulations apply;
- Data which must be provided;
- Parties responsible for providing the data and ensuring its accuracy;
- Timelines required for providing the data; and
- Penalties for noncompliance.

Learn from Other States

States such as Ohio, Pennsylvania, and Texas have spent a considerable amount of energy developing their housing programs. Nevada can learn from the experience of other states through phone calls and possibly site visits to other states to study their housing efforts. A number of states have proposed interesting ideas, and Nevada would like to see how they have been implemented, the lessons learned and best practices.

For example, Ohio has proposed the development of regional housing collaboratives, which consist of groups of people led by persons with disabilities and include providers of affordable housing, service, and transportation. The collaborative works together to address the needs of people with disabilities in their regions and communicates with local elected officials about the MFP Demonstration and the role housing plays in the success of the project.

Texas has proposed a deliberate schema for involving state housing agencies and human service agencies in joint planning arrangements and has proposed systematic procedures for working with public housing authorities. These procedures extend to targeting authorities that are out of compliance with HUD performance standards, visiting the larger authorities, and providing input into their five-year plans.

Pennsylvania funded both a statewide housing director and ten regional housing coordinators to work with state and local staff/partners to identify housing resources at the local level and build local level capacity. The Pennsylvania housing coordinators work with public housing authorities, private developers, property managers, and "Local Housing Options Teams" (LHOT).

In addition to examining these innovative state practices, Nevada wishes to avail itself of as much technical assistance from CMS as possible around housing issues. Nevada is aware that the CMS MFP technical assistance effort includes housing consultation, and Nevada plans to access this expertise. If possible, Nevada would like to participate in CMS's Housing Capacity Building Initiative for Community Living.

Nurture Relationships with the Housing Authorities

The envisioned process would be to first establish a constructive and collaborative relationship with the state's Division of Housing and then, using that relationship as a platform, expand the housing initiative to include the local/regional public housing authorities.

A key player in housing is the state's Division of Housing, located within the Department of Business and Industry. The MFP Demonstration will work with the Division of Housing to decide how to build a durable relationship so that the experience of the Housing Division can be leveraged to support the MFP Demonstration. This is a fundamental relationship and may

require leadership of DHHS and the Department of Business and Industry to establish.

The Division of Housing has considerable experience with housing resources and data about housing. The MFP Demonstration needs to work with housing staff to learn which resources should be accessed and the most effective ways to access them. This is an important relationship and needs to be well-grounded and well-maintained if a successful housing program for MFP participants is to be sustained.

MFP project staff and Housing Division staff will collaborate on plans for working with the public housing authorities. As previously stated, Nevada has only five Housing Authorities: City of Reno Housing Authority, Nevada Rural Housing Authority, Southern Nevada Regional Housing Authority, the Housing Authority of the City of North Las Vegas, and Accessible Spaces Inc, making this goal manageable compared to other states.

For example, Nevada wants to be sure that when federal housing opportunities become available, such as the April 7, 2009 Notice of Funding Availability (NOFA) for 5,300 housing vouchers for non-elderly persons with disabilities, that the local/regional housing authorities take advantage of them, if possible. These opportunities are not automatically distributed to housing authorities; rather, Authorities have to apply for them. The MFP Demonstration wants to ensure that Nevada avails itself of the aforementioned Category 2 vouchers.

Nevada's MFP Demonstration would first use a fact-gathering approach with the housing authorities and meet with staff to learn about opportunities and the policies and priorities of the Housing Authorities. There are policy differences that need to be addressed. For example, what is the policy rational for prioritizing housing assistance for someone voluntarily leaving a nursing home when there are homeless families that need a home? Based on this initial round of fact gathering and policy clarification, it is likely that a coordinating mechanism of some

kind could be established.

After relationships with the housing authorities are established, the HUD Reno field office, the HUD Regional Office in San Francisco, and the USDA Rural Development Office in Carson City would be contacted and relationships established with them. The MFP Demonstration would also seek relationships with non-profit, non-public agencies with proven housing experience, such as the Nevada Affordable Housing Assistance Corporation.

Housing for MFP participants is heavily dependent on the efficiency with which state agencies and public housing authorities operate. Public agencies within Nevada make serious efforts to establish adequate levels of affordable housing.

The state's Division of Housing is responsible for the following programs:

- Low Income Housing Tax Credit (LIHTC) Program;
- Multi-Family Project Bond Financing;
- HOME Program; and
- Low income Housing Trust Fund.

In addition to these direct programs, there are other programs such as the Employer-Assisted Housing Program (EAHP), Deferred Loan Program, the First Time Homebuyer's Program, the Weatherization Program, and the Hardest Hit Program that make it possible to purchase a home more cheaply, make it easier to afford, or make it easier to stay in the house if mortgage problems arise.

The public housing authorities operate large and diverse programs. For example, the Southern Nevada Regional Housing Authority serving the Las Vegas and Clark County area is the largest in the state. As of January 1, 2010 it was managing 4,937 units and was under

contract to manage 120 public housing units with the City of North Las Vegas.²⁶ This authority also:

- Acquires or build units or developments;
- Has initiatives to expand home ownership;
- Promotes a Section 32 Homeownership Program;
- Promotes the self-sufficiency and economic independence of assisted households;
- Enhances educational opportunities and prevention programs for youth;
- Works with the realty industry on the REALTOR Security Deposit Program;
- Operates the Scattered Site Homeownership Program;
- Uses Bureau of Land Management land to develop mixed income, mixed use properties using various financing strategies (i.e., tax credit, bonds, project based Section 8);
- Works with the HUD programs, such as Section 236 rental assistance payments, Section 202 projects for non-elderly with disabilities, Section 236 interest reduction payments, and Section 811 project-based supportive housing for persons with disabilities;
- Has extensive marketing activities in Spanish to reach Hispanic populations;
- Works with charitable 501(c)(3) entities, such as Help of Southern Nevada (HELP);
- Provides or finds supportive services to improve assisted recipients' employability; and
- Provides or finds supportive services to increase independence for the elderly or families with disabilities.

To the extent that the housing authorities are successful in these activities, there will be more affordable housing units available. The task of the MFP Demonstration is to leverage

²⁶ Southern Nevada Regional Housing Authority, (2010) *Annual Agency Plan Update FY 2011-FY2015 Five Year Plan*, Las Vegas, NV: pp. 1555. Retrieved on 11-27-10 from <http://www.haclv.org/bulletins.htm>

these housing opportunities. The current preferences for housing opportunities do not include persons transitioned from institutions. The current preferences for Section 8 vouchers of the Southern Nevada Regional Housing Authority are:²⁷

- Involuntary displacement – federally declared disasters;
- Foster youth aging out of the foster care system – limited to ten per year;
- Family unification referrals;
- Working preference, which includes elderly and disabled and those applicants enrolled in a training program; and
- Veteran preference.
- Resident preference

The challenge of the MFP Demonstration is to build a process, as outlined above, that will lead to a continuous and influential relationship with the authorities that will result in some aid being given to persons transitioning out of institutions. Nevada believes this is possible given the strategies outlined above.

10. Continuity of Care Post the Demonstration

To the extent necessary to enable a State initiative to meet the demonstration requirements and accomplish the purposes of the demonstration, provide a description of how the following waiver provisions or amendments to the State plan will be utilized to promote effective outcomes from the demonstration and to ensure continuity of care:

- a. **Managed Care/Freedom of Choice (Section 1915(b)) – for participants eligible for managed care/freedom of choice services, provides evidence that:**
 - i. **1915(b) waivers and managed care contracts are amended to include the necessary services**
 - ii. **Appropriate HCBS are ensured for the eligible participants; or**
 - ii. **A new waiver will be created.**

²⁷ Southern Nevada Regional Housing Authority, (2010) *Annual Agency Plan Update FY 2011-FY2015 Five Year Plan*, Las Vegas, NV: pp. 1562. Retrieved on 11-27-10 from <http://www.haclv.org/bulletins.htm>

Nevada does not currently use any 1915(b) waivers that would support the MFP Demonstration. Nevada does have a carefully planned and thoughtful array of 1915(c) waivers, whose services are tailored to meet the needs of the populations that utilize these waivers. Nevada may consider the possibility of implementing a 1915(b) waiver for the aged and disabled. Such changes would be carefully considered in light of the goals of the MFP Demonstration.

- b. Home and Community-Based (Section 1915(c)) – for participants eligible for “qualified home and community-based program” services, provide evidence that:**
- i. capacity is available under the cap;**
 - ii. A new waiver will be created; or**
 - iii. There is a mechanism to reserve a specified capacity for people via an amendment to the current 1915(c) waiver.**

Persons on the MFP Demonstration who were enrolled in an existing HCBS waiver will continue on the waiver so long as they meet eligibility requirements. Nevada has considered its capacity in existing waivers and has determined that it may not be necessary to modify those waivers for purposes of the MFP Demonstration. DHCFP will reassess waiver capacity annually to ensure that any waiver caps, including funding limitations, are not exceeded. If necessary, DHCFP will submit waiver amendments to increase capacity. However, should the waiver enrollment necessary to accomplish the goals of the MFP Demonstration exceed legislatively approved budget authority, appropriate state approval and revisions of waiver budget authority will be submitted.

The initial transition planning will include preliminary identification of the waiver and/or State Plan service options the MFP participant will need, and documentation in the case narrative. MFP/FOCIS Health Care Coordinators and local office case management staff will begin the transition process no later than the ninth month of MFP participation by identifying the

on-going HCBS services necessary to ensure success in the community. Local DHCFP, ADSD and MHDS staff will reassess the participant's eligibility for on-going Medicaid-funded home and community-based services. The case manager will update the participant's person-centered planning tools to reflect the transition from MFP status. If necessary, individual Service Plans will be updated to conform to the person's reassessed needs and to the specifications of the benefit package available to the person. In the rare circumstance that an MFP participant no longer meets Medicaid financial and/or functional eligibility criteria to receive Medicaid-funded long-term care services, they will be afforded the same fair hearing and appeals rights as other Medicaid recipients in the same circumstance.

It is the Department's intent that the transition from day 365 to day 366 and beyond be a seamless transition for the participant and the case manager. Administrative staff will need to make coding changes for purposes of reporting costs after day 365, but the respective Divisions will provide tickler notices to ensure that those changes occur. Other changes that will take place regarding the source of funding will occur at the state level in fiscal management and tracking systems.

With the exception of Demonstration Services for the transition (i.e., Community Transition Services and Environmental Accessibility Adaptations), all HCBS, including Medicaid State Plan services, provided as Qualified HCBS under the MFP Demonstration to an individual in the first year following transition from the institution will be available in subsequent years of the MFP Demonstration grant, contingent upon program eligibility requirements and legislative authorization.

Table 13. Current HCBS Waiver Services

Home and Community-Based Waiver	Waiver Services
<p>Persons with Physical Disabilities (WIN) Targeted population: Physically disabled, nursing facility level of care, waiver service need.</p>	<ul style="list-style-type: none"> • Case management • Attendant Care • Homemaker • Chores • Respite Care • Home Adaptations • Personal Emergency Response Systems • Assisted Living • Home Delivered Meals • Specialized Medical Equipment
<p>Elderly in Adult Residential Care (WEARC) Targeted population: 65 and over, nursing facility level of care, waiver service need.</p>	<ul style="list-style-type: none"> • Case Management • Attendant Care
<p>Frail Elderly at Home (CHIP) Targeted population: 65 and over, nursing facility level of care, waiver service need.</p>	<ul style="list-style-type: none"> • Case Management • Attendant Care (through State Plan PCS) • Homemaker • Chores • Respite Care • Personal Emergency Response Systems • Adult Companion • Social Adult Day Care (out of home)
<p>Assisted Living (AL) Targeted population: 65 and over, nursing facility level of care, waiver service need.</p>	<ul style="list-style-type: none"> • Case Management • Augmented Personal Care
<p>Persons with Mental Retardation or Related Conditions (MR/RC) Targeted population: Intellectual disability or related condition, ICF/MR level of care, waiver service need.</p>	<ul style="list-style-type: none"> • State Plan Targeted Case Management • Attendant Care (provided under State Plan PCS) • Counseling Services • Day Habilitation • Prevocational Services • Supported Employment • Counseling • Residential Habilitation: Direct Support Management • Behavioral Consultation, Training and Intervention • Community Integration • Non-medical Transportation • Nursing Services

Given the complex needs of these MFP participants who do enroll in an HCBS waiver, we anticipate some may use more than the average number of HCBS waiver services. Since waiver costs are reported in an aggregate average, Nevada does not anticipate a problem with the waiver requirements for cost neutrality.

- c. Research and Demonstration (Section 1115) – for participants eligible for the research and demonstration waiver services, provide evidence that:**
- i. Slots are available under the cap;**
 - ii. A new waiver will be created; or**
 - iii. There is a mechanism to reserve a specified number of slots via an amendment to the current Section 1115 waiver.**

Nevada does not currently utilize any 1115 research demonstration waivers. Nevada does have a carefully planned and thoughtful array of 1915(c) waivers, whose services are tailored to meet the needs of the populations that use them. Nevada may consider the possibility of implementing an 1115 waiver for the aged and disabled. Such changes would be carefully considered in light of the goals of the MFP Demonstration.

- d. State Plan and Plan Amendments - – for participants eligible for the State plan optional HCBS services, provide evidence that there is a mechanism where there would be no disruption of services when transitioning eligible participants from the demonstration program**

Nevada currently offers personal care services as a State Plan option, with both a traditional agency service delivery model and a self-directed model available as the recipient chooses. The self-directed model is available to recipients through an Intermediary Service Organization (ISO). Nevada's ISO model allows participants to retain responsibility for hiring, training, scheduling, and supervising the personal care assistant and the services delivered. In addition, DHCFP will explore the feasibility of implementing the Community First Choice Option (1915(k)). To do so, the state will need to have sufficient numbers of Medicaid recipients who

both meet a nursing facility level of care and who are interested in the self-directed service delivery option. DHCFP views its proposed MFP Demonstration as an important building block for the possible future implementation of a 1915(k) State Plan option for home and community-based services.

In addition to personal care services, Nevada offers optional State Plan services to assist recipients with their needs to remain in the community. These services are available to all Medicaid-eligible recipients. There is currently no waiting list for the services identified below:

- Adult Day Health Care;
- Durable Medical Equipment, prosthetics, orthotics, and disposable medical supplies;
- Home Health Agency services;
- Physical, occupational, and speech therapies;
- Pharmacy;
- Dental;
- Optometry;
- Psychologist;
- Community-based mental health services;
- Podiatry for those under 21 years of age and QMB eligibles;
- Chiropractic for those under 21 years of age and QMB eligibles;
- Private Duty Nursing; and
- Hospice.

Additionally, Nevada will seek to integrate State Plan benefits with other potential opportunities to provide comprehensive and timely high quality services to participants in need of long-term care. This will include developing comprehensive care planning and intensive care

coordination programs. DHCFP is exploring the feasibility of implementing Patient Centered Medical Homes (PCMHs) under the Section 1945 State Option to Provide Health Homes for Enrollees with Chronic Conditions. These PCMHs would provide comprehensive transitional care from inpatient to other settings, including appropriate follow-up, and the use of health information technology to link the services provided to individuals by multiple clinicians within an accessible claims data system. Nevada views the broader infrastructure investments accomplished under the MFP Demonstration as part of a larger effort to better coordinate acute medical, behavioral, and long-term care, with social supports. The Money Follows the Person Rebalancing Demonstration and other new authorities in the Affordable Care Act can be coordinated to provide essential building blocks to improve the availability of comprehensive care planning and coordination under a rebalanced system.

APPROVED

C. Project Administration

Provide a description of the day to day organizational and structural project administration that will be in place to implement, monitor, and operate the demonstration. Please include the following:

1. Organizational Chart

1. Organizational Chart: Provide an organizational chart that describes the entity that is responsible for the day to day management of this grant and how that entity relates to all other departments, agencies and service systems that will provide care and supports and have interface with the eligible beneficiaries under this grant. Show specifically the relationship of the organizational structure to the Medicaid Director and Medicaid agency.

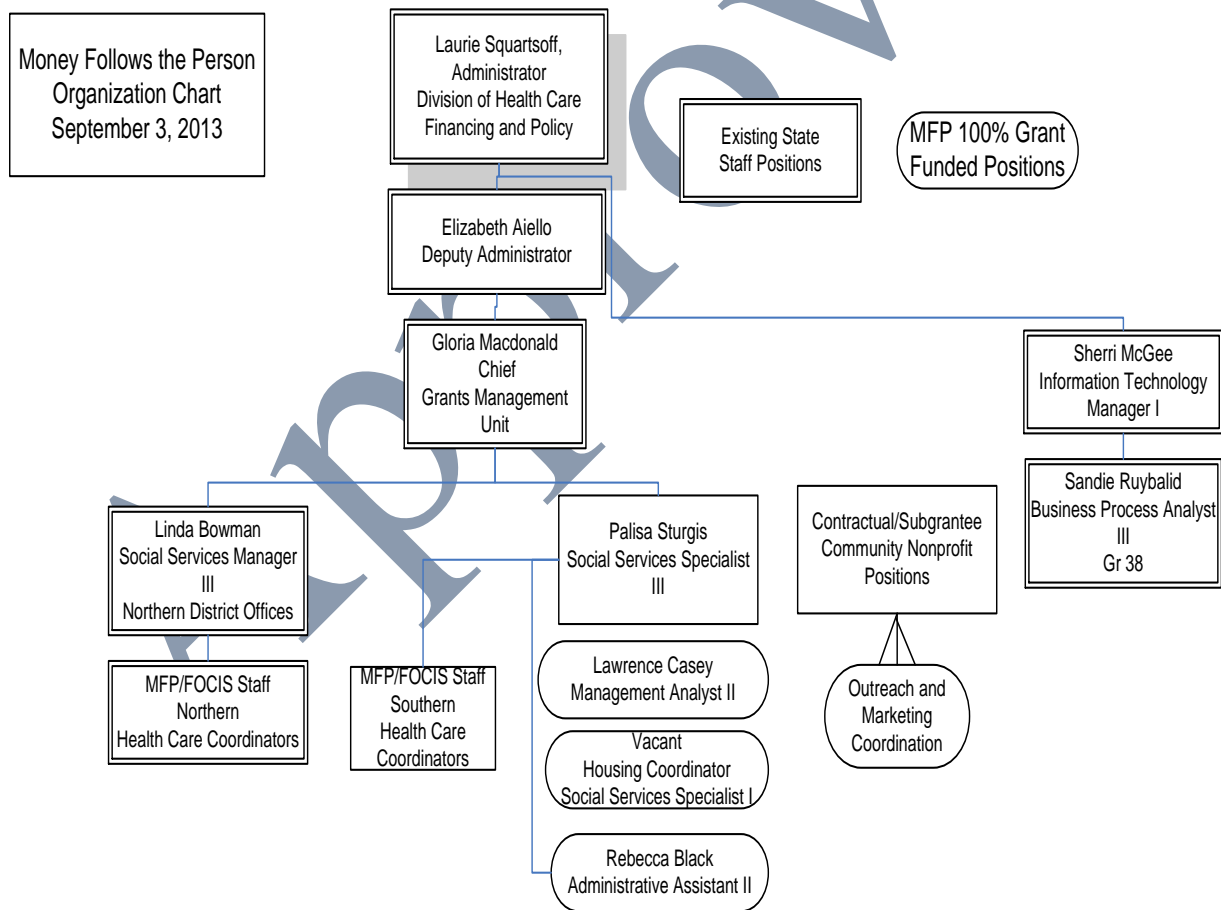
The Draft Operational Protocol is submitted by the single state Medicaid agency, the Department of Health and Human Services (DHHS). The Division of Health Care Financing and Policy (DHCFP) will be responsible for the day to day management of the MFP Demonstration grant. DHCFP is responsible for administering State Plan services accessible to MFP Demonstration participants. DHCFP provides assurances to CMS for all Medicaid-funded programs. Program operation for HCBS waivers may be delegated to other DHHS offices, with DHCFP retaining administrative authority. ADSD is responsible for day to day operations of the Waiver for the Frail Elderly, the Waiver for Elderly in Adult Residential Care, and the Assisted Living Waiver. MHDS is responsible for day to day operations of the Waiver for Persons with Mental Retardation and Related Conditions. The Waiver for Persons with Physical Disabilities is operated directly by DHCFP.

Laurie Squartsoff, DHCFP Administrator, is the Medicaid Director and will provide direct oversight for Nevada's MFP Demonstration. Elizabeth Aiello is the Deputy Administrator, who will also provide oversight for Nevada's MFP Demonstration. Gloria Macdonald is the Chief of DHCFP's Grant Management Unit. Continuum of Care will hire an MFP Project Director.

The Project Director will be responsible for coordinating the MFP Core Work Group to complete the design development of the Operational Protocol. The MFP Core Work Group, under the coordination of the MFP Project Director, will also lead the implementation of the Operational Protocol and activities for sustaining the MFP Demonstration.

Ms. Macdonald has overall responsibility for the MFP Demonstration and will assess the performance of staff involved in the MFP Demonstration. The MFP Organization Chart below identifies the people already in place and the new positions to be added to support MFP Demonstration activities.

Figure 3. MFP Demonstration Table of Organization



2. Staffing Plan

- 2. Staffing Plan: Provide a staffing plan that includes:**
 - a. A written assurance that the Project Director for the demonstration will be a full-time position and provide the Project Director's resume or Job Description including performance evaluation criteria (CMS pays 100% of the cost of this position, CMS will have input into the approval of the person hired. At any time CMS feels that the individual is not performing up to our expectations, CMS may request that a new Project Officer be assigned.)**
 - b. The number and title of dedicated positions paid for by the grant and a justification of need. Please indicate the key staff assigned to the grant, if they have been identified.**
 - c. Percentage of time each individual/position is dedicated to the grant.**
 - d. Brief description of role/responsibilities of each position.**
 - e. Identify any positions providing in-kind support to the grant.**
 - f. Number of contracted individuals supporting the grant.**
 - g. Provide a detailed staffing timeline.**
 - h. Specify the entity that is responsible for the assessment of performance of the staff involved in the demonstration.**

Authority for the administration and supervision of the MFP Demonstration project staff will reside in DHCFP. The MFP Project Director and other MFP project staff, including contracted resources, will be responsible for carrying out the responsibilities residing within DHCFP and for interagency coordination in the implementation of the MFP Demonstration.

The *MFP Project Director* will be a full-time position responsible for the overall management and coordination of the MFP Demonstration, including providing oversight of MFP project staff. The MFP Project Director MFP demonstration is also expected to:

- Participate in hiring and assessment of performance of the MFP project staff
- Identify appropriate information, resources and technical assistance necessary for the awarded contractors to complete assigned tasks
- Provide on-going guidance and project coordination within DHCFP and DHHS
- Participate in policy and planning that involves multiple administrative units within DHHS and across multiple state agencies

- Engage stakeholders in the implementation of the Operational Protocol
- Collaborate with county staff in the development and implementation of a pilot project to test flexible funding mechanisms
- Develop and implement evaluation plans of the county pilot project
- Oversee the development of outreach and marketing materials related to the demonstration
- Review and approve the outreach and marketing coordination vendor's contract deliverables
- Coordinate ongoing stakeholder forums and regular meetings with consumer and provider groups
- Participate in housing initiatives with Division of Housing local housing authorities and the contracted housing coordination
- Review and approve the housing coordination vendor's contract deliverables

The ***MFP Management Analyst*** will be a full-time position responsible for management and administrative areas such as budgeting and financial analysis, management research; and statistical and informational analysis. This position will also assist in implementation of new or revised procedures and systems for Operational Protocol issues focused on collaborative relationships with external entities. The MFP Management Analyst is expected to:

- Participate in the preparation, monitoring and maintenance of the demonstration project;
- Monitor grant expenditures against approved limits;
- Conduct and/or assist in conducting financial, statistical or investigative studies;
- Compile and analyze data for required programmatic and fiscal reports related to the demonstration project; and

- Conducts programmatic reviews and audits, monitoring, quality assurance and quality improvement.

The *Housing Coordinator* will be a full-time position responsible for assisting the MFP consumer as he navigates through the housing process of returning to the community. The MFP Housing Coordinator is expected to:

- Assist in providing an extensive list of housing options for each MFP consumer.
- Assist in the application for federal rental assistance (Public Housing units and Public Housing authority's (PHA) voucher program);
- Assist the consumer to obtain appropriate documentation required by PHA/ public housing units;
- Assist the MFP consumer in applications for each individual apartment complex;
- Assist in the coordination of transportation for each MFP consumer to appointments; Accompany MFP consumer to each unit/home for inspection;
- Assist consumer in communication with property manager/landlord;
- Medicate any denial of application of unit;
- Coordinate with local fair housing organization when consumer feels discriminated based off of disability;
- Create a Local Housing Committee with local housing professionals and the Public Housing Authority;
- Assist Health Care Coordinator and MFP staff with the purchase and delivery of items required by the consumer to occupy their new residence;
- Perform other duties for Community Transition Services as necessary

The *MFP Administrative Assistant* will be responsible for providing administrative program

support to the MFP Demonstration program staff and the DHCFP staff.

Table 13. 100% Dedicated MFP Demonstration Project Staff

Title	Class Specification	Grade	Projected Hire Date
Project Director	Social Services Program Spec. III	37	May 2011
Management Analyst	Management Analyst II	36	June 2011
Housing Coordinator	Social Services Program Specialist I	33	November 2013
Administrative Assistant	Administrative Assistant II	25	June 2011

In addition to the full-time MFP project staff listed above, Nevada will subgrant or contract with community organizations for outreach and marketing coordination to develop and implement the outreach, education and training materials for the MFP Demonstration.

Community Transition Services are provided by MFP/FOCIS staff and Housing Coordination will be provided either by contract, utilizing sub-grants with community non-profit agencies, such as Centers for Independent Living (CILs), or by MFP/FOCIS staff. MFP/FOCIS Health Care Coordinators will provide Transition Navigation. These DHCFP staff will be responsible for coordination, facilitation, and monitoring of participant transition per guidelines established in the Operational Protocol. Because Transition Navigation, Community Transition Services and Housing Coordination will be provided as Demonstration Services, these services are not detailed in the administrative budget or staffing plan, along with supervision of the MFP/FOCIS Health Care Coordinator positions from their respective District Offices.

3. Billing and Reimbursement Procedures

3. Billing and Reimbursement Procedures. Describe procedures for insuring against duplication of payment for the demonstration and Medicaid programs; and fraud control provisions and monitoring.

DHCFP is responsible for the fiscal integrity of all Medicaid services and is committed to a program that minimizes fraud, waste, abuse and improper payments. Federal regulations require

DHCFP to operate a statewide Surveillance and Utilization Review (SUR) program to safeguard against unnecessary or inappropriate use of services and prevent excess payments in an efficient, economical and effective manner. DHCFP has methods in place to identify, investigate and refer suspected cases of provider and recipient fraud and abuse. DHCFP refers all cases of suspected fraud and abuse, pursuant to Nevada Revised Statutes (NRS) 422.540 to 422.570, to the Office of the Attorney General, Medicaid Fraud Control Unit (MFCU). The MFCU has the primary authority and responsibility to fully investigate and prosecute, for civil and/or criminal action, violations of fraud and abuse in the Medicaid program.

DHCFP has methods and processes to review duplication of services to prevent and/or recover improper payments. For Qualified HCBS, billing and reimbursement will be managed through the systems currently used for HCBS Waiver and State Plan services. DHCFP has extensive fraud control and financial monitoring systems in place. The current Medicaid MMIS system is set up to deny duplicate claims for waiver and State Plan services that will be utilized under the MFP Demonstration.

The Medicaid Fiscal Agent will screen each claim for existence and/or application of prior resources, correct coding of services, and appropriate authorization form, if applicable. In addition, each claim is screened for accuracy in computation and compliance with published procedures. DHCFP also conducts reviews to determine if services are billed in accordance with applicable policies and/or regulations. Providers are selected for review based on complaints, referrals and through the use of fraud detection and other analysis. All providers are subject to review.

Pending final cost and time estimates for systems changes and the availability of funding, DHCFP will determine whether claims for the Demonstration Services will be processed through

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its existing MMIS system or by a manual invoicing process. Irrespective of the decision, monitoring procedures will be in place to protect against duplication of payment and fraud.

All providers offering services to Medicaid recipients are subject to post-payment review. The Medicaid Program Integrity Section is responsible for review of any improper, abusive, or fraudulent practices. Definition of abuse and the sanctions to be imposed are delineated in the Nevada MSM, Chapter 100.

Approved

D. Evaluation

Although not required as a component of the MFP demonstration, States may propose to evaluate unique design elements from their proposed MFP program. If these activities are undertaken by the State, the following information must be provided to CMS:

- 1. Evaluator**
- 2. Evaluation Design**
- 3. Variables**
- 4. Process Evaluation**

Nevada is not proposing an additional formal evaluation separate from the national evaluation at this time. MFP Demonstration participants will participate in the federally required Quality of Life Survey and in quality improvement activities that DHCFP carries out in the course of overseeing the provision of Medicaid services, including home and community-based services (HCBS). Nevada will strengthen the existing quality assurance and monitoring systems for Nevada's HCBS waivers. This will include moving to a person-centered approach that consolidates continuous quality improvement activities and performance oversight across multiple HCBS waivers and other State Plan programs. In addition, the state will implement a coordinated effort to ensure necessary information regarding quality management strategy is shared with stakeholders, focusing on improvements made to the delivery of community-based long-term care services and supports. DHHS is interested in completing a process evaluation and assessing the impact of these improvements to the quality management system departmentwide.

Additionally, a primary goal of the MFP Demonstration is to eliminate barriers that prevent the flexible use of Medicaid funds to enable individuals to receive long-term care services and supports in the settings of their choice. Nevada Medicaid covers the optional special income group for institutionalized individuals and those qualifying for HCBS waivers. In Nevada, counties are responsible for the non-federal share of medical costs of nursing facility residents with income between 157 and 300 percent of the Federal Benefit Rate (FBR). Historically,

counties have been reluctant to shift this funding when individuals above 157 percent of the FBR transition from nursing home to HCBS. This is due to concerns that beds would be filled with new Medicaid recipients, resulting in additional costs to the counties. To address these concerns, DHHS will collaborate with counties to design a pilot project that will permit select counties to voluntarily fund HCBS services for individuals above 157 percent of the FBR who transfer from nursing facilities to the MFP Demonstration. It will be critically important to measure and monitor the fiscal impact of shifts in expenditures between the counties and the state. Collection of baseline data and further collaboration of project design is needed during the initial year of the MFP Demonstration, anticipating actual implementation of the pilot in the second year of the demonstration period.

Over the second year of the demonstration period, DHCFP will be developing plans for the consolidated HCBS system and the pilot program for counties to fund HCBS in lieu of institutional placements. DHCFP will be meeting with advisory boards and stakeholders to determine the unmet evaluation needs for these aspects of the MFP Demonstration. As specific areas of focus for formal evaluation in Nevada are identified, a complete evaluation plan will be developed. Before DHCFP initiates a formal evaluation on the implementation and impact of these state-specific features of Nevada's MFP Demonstration, we will submit an amendment to this Operational Protocol.

E. Budget

INSERT INSTRUCTIONS OR A SUMMARY OF THE FINANCIAL FORM WORKSHEET FOR PROPOSED BUDGET (WPB)

Nevada's MFP Demonstration Worksheet for Proposed Budget is provided in Appendix E.

Below is a summary of the MFP Demonstration budget for the entire grant period.

Table 14. MFP Demonstration Budget Summary

Total Expenditures	Total Costs	Federal	State
Qualified HCBS	\$ 7,062,594	\$ 5,573,250	\$ 1,489,344
Demonstration HCBS	\$ 2,479,064	\$ 1,955,000	\$ 524,064
Supplemental	\$ -	\$ -	\$ -
Administrative - Normal	\$ -	\$ -	\$ -
Administrative - 75%	\$ -	\$ -	\$ -
Administrative - 90%	\$ -	\$ -	\$ -
Federal Evaluation Supports	\$ -	\$ -	\$ -
Administrative (Other) - 100%	\$ 2,737,369	\$ 2,373,369	\$ -
State Evaluation	\$ -	\$ -	\$ -
Total	\$ 11,915,027	\$ 9,901,619	\$ 2,013,408

Per Capita Services Costs under the MFP Demonstration are projected to be \$18,209. Per Capita Administrative Costs under the MFP Demonstration are projected to be \$4,529. Nevada recognizes that MFP is a systemic LTC rebalancing effort and not just a transition program. Nevada intends to enable older adults and persons with disabilities to successfully move from institutional to HCBS systems by creating a systemic rebalancing infrastructure that supports MFP principles. Administrative cost ratios reflect a necessary investment in project infrastructure from the beginning of the grant until the end of calendar year 2012. Administrative cost ratios

decline from 100% of total grant funds in CY 2011 (during which no transitions occur) to 14% in CY 2015.

- 1. Administrative Budget Presentation:**(A electronic submittal form will be provided by CMS) Please address the following items:
- a. Personnel**
 - b. Fringe benefits.**
 - c. Contractual costs, including consultant contracts.**
 - d. Indirect Charges, by federal regulation.**
 - e. Travel**
 - f. Supplies**
 - g. Equipment**
 - h. Other costs**

The State of Nevada is appreciative of the opportunity to receive full reimbursement for specific administrative costs associated with the systems infrastructure development and operations of the MFP Demonstration. A summary of the Budget, inclusive of administrative and direct service costs, requested for Nevada’s MFP Demonstration is provided below. This summary illustrates both Federal and State Funding.

Table 15. Grant Budget Presentation, CY 2011 through 2016

Budget Categories	CY 4/1/11 - 12/31/11	CY 1/1/12 - 12/31/12*	CY 1/1/13 - 12/31/13	CY 1/1/14 - 12/31/14	CY 1/1/15 - 12/31/15	CY 1/1/16 - 3/31/16
A. Personal Services	\$ 118,473	\$ 221,270	\$ 226,246	\$ 226,246	\$ 226,246	\$ 56,561
B. Fringe Benefits	\$ 39,096	\$ 73,019	\$ 74,661	\$ 74,661	\$ 74,661	\$ 18,665
C. Travel	\$ 7,681	\$ 12,346	\$ 12,346	\$ 12,346	\$ 12,346	\$ 4,036
D. Equipment	\$ 57,065	\$ 2,832	\$ 2,832	\$ 2,832	\$ 2,832	\$ 708
E. Supplies	\$ 4,303	\$ 5,713	\$ 5,642	\$ 5,642	\$ 5,642	\$ 1,411
F. Contractual	\$ 504,729	\$ 50,000	\$ 50,000	\$ 50,000	\$ 50,000	\$ 12,500
G. Construction	\$0	\$0	\$0	\$0	\$0	\$0

H. Service Dollars	\$ 0	\$ 1,684,436	\$ 2,244,596	\$ 2,425,102	\$ 2,392,751	\$ 794,773
I. DIRECT COSTS	\$ 731,347	\$ 2,049,616	\$ 2,616,323	\$ 2,769,829	\$ 2,764,478	\$ 888,654
J. Indirect Costs	\$ 10,167	\$ 13,556	\$ 13,556	\$ 13,556	\$ 13,556	\$ 3,389
K. Total	\$ 741,514	\$ 2,063,172	\$ 2,629,879	\$ 2,810,385	\$ 2,778,034	\$ 892,043

A budget narrative detailing all requests to fund administrative cost claims for each budget category reflected above follows below. Nevada is requesting to fund each line item in the Budget, with the exception of Service Dollars, at 100% Federal reimbursement.

2. Administrative Budget: Please include projections for annual costs regarding the routine administration and monitoring activities directly related to the provision of services and benefits under the demonstration. Please indicate any administrative fund request to be reimbursed fully through the grant. Indicate any additional actions that are required to secure State funding (e.g., appropriation by the legislature, etc.), as well as costs associated with participation with the National Evaluation and Quality initiatives implemented by CMS.

The following budget narrative details specific administrative costs that help Nevada build the infrastructure to meet the benchmarks proposed in the Operation Protocol. A staffing plan for the MFP Demonstration was previously provided in the Project Administration section of this Operation Protocol. Below, state personnel costs including salary, fringe benefit and other direct costs (excluding direct service costs) are identified.

A. Personnel Salaries. This category includes salaries for MFP project staff. DHCFP believes that the presence of full time dedicated staff is important to the success of Nevada’s MFP Demonstration. The state is requesting 100% federal funding for the four full time 100% dedicated state employee positions, at the annual salaries indicated below.

- Social Services Program Specialist III (Grade 37): \$65,625.84

- Management Analyst II (Grade 36): \$ 62,723.53
- Social Services Program Specialist I (Grade 33): \$54,893.52
- Administrative Assistant II (Grade 25): \$40,361.04

All salaries include a projected one-time 4.6% increase effective July 1, 2013.

B. Fringe Benefits. This category includes the costs of fringe benefits associated with the full time dedicated MFP project staff. The cost of fringe benefits is calculated as a percentage of salary. The fringe benefits rate is 33% of personnel salaries.

C. Travel. Costs for travel include 59 in-state trips for MFP project staff over the grant period and ten out-of-state trips for up to two staff members. Estimated costs per trip for in-state and out-of-state travel are \$742 and \$1,749, respectively.

D. Equipment. This category includes the cost of new furnishings, telephone equipment, computers, and computer software associated with dedicated MFP project staff. Additionally, costs for server(s) and software intended for hosting software applications essential to the success of the MFP Demonstration are included.

E. Supplies. This category includes operating and miscellaneous supplies, as well as state printing costs.

F. Contractual. Costs in this category include funds requested for several critical elements to support a rebalanced LTC system.

Included costs support the development of a data infrastructure and/or alternative manual systems to support the business needs of identifying, assessing, and tracking persons who have transitioned into the community across various programs and service providers. Costs may include purchase, maintenance and support of necessary software. And hours for enhancements to the Medicaid Management Information System to potentially accommodate the MFP reporting requirements, new payment mechanisms, and other enhancements required to support a more flexible financing structure through the proposed county match pilot project.

Finally, this category includes funds requested for program outreach and marketing, including development of materials, public information, and stakeholder communication initiatives. Funding for a participant call center is also included in this cost category.

G. Construction. No funds for construction are requested.

J. Indirect Charges. Costs in the category include the Department of Information Technology (DOIT) email service, infrastructure and security assessment charges, as well as a variety of costs for state employee support that is apportioned to state agencies that use those services. Postage is also included in this category.

3. Evaluation Budget: Please include annual estimated costs of the evaluation activities the State is proposing.

At this time, Nevada is not proposing an additional formal evaluation separate from the national evaluation. Over the second year of the demonstration period, DHCFP will be developing plans for the consolidated HCBS system and the pilot program for counties to fund HCBS in lieu of institutional placements. Anticipating a complete evaluation plan will be

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developed, it is also anticipated that a request for funding state evaluation activities will be submitted with a subsequent amendment to this Operational Protocol.

Approved

Appendices

Approved

Appendix A

Revised 12/29/09

**Division of Health Care Financing
and Policy
Nevada Medicaid**

**Facility Outreach and
Community Integration Services**

FOCIS



The Bridge to Community Living

Approved

FACILITY OUTREACH AND COMMUNITY INTEGRATION SERVICES (FOCIS)

WHAT IS FOCIS?

FOCIS is a Medicaid program staffed by social workers, nurses and other licensed health care professionals. Their role is to assist individuals to live in community settings by accessing Medicaid services and resources.

FOCIS is a voluntary program intended to provide Medicaid recipients with an alternative to institutional living.

WHO CAN WE HELP?

Any Nevada Medicaid recipient who is:

- **At risk of admission to,**
- **Pending discharge from, or**
- **Currently residing in a**
medical or long term care facility

HOW CAN WE HELP?

FOCIS staff advocates for recipients by:

- Working together with the recipient, legal guardian, facility staff and others as requested by the recipient to coordinate a discharge plan
- Providing information on available services
- Assisting with applications
- Making appropriate referrals
- Conducting follow-up visits after discharge

If you are interested, have questions or know someone who may benefit from this service, please call:

DISTRICT OFFICE TELEPHONE

Carson City.....	(775) 684-3651
Elko.....	(775) 753-1191
Las Vegas.....	(702) 668-4200
Reno.....	(775) 687-1900

Appendix B

Approved

[Type text]

STATE OF NEVADA
DIVISION OF HEALTH CARE FINANCING AND POLICY
Facility Outreach and Community Integration Services (FOCIS) and
Local Contact Agency Referral MDS 3.0 Section Q Referral Form

A. REFERRAL INFORMATION

. Date of Referral:		2. Referral Type: <input type="checkbox"/> Initial <input type="checkbox"/> MDS <input type="checkbox"/> LOC <input type="checkbox"/> Other: (specify)	
. Referral Made By (name and title):		4. Phone Number/Fax	
. Individual's Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify):			
. Last Name:	First:	MI:	7. DOB:
. SSN:	9. Gender: <input type="checkbox"/> M <input type="checkbox"/> F	10. Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
1. Current Location (Facility name and address):			
2. Room number:			
3. Telephone number:			
4. Reason(s) for referral:			
5. Other programs referred to:			
6. Diagnosis:			

B. CONTACT INFORMATION

Include social workers, case managers, legal guardian, power of attorney, spouse, relatives or friends.

Name	Relationship	Phone #

C. MEDICAID INFORMATION

. Does recipient have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Medicaid
. Other Insurance (name) and ID #'s:		

Please return form to:

RENO District Office	CARSON CITY District Office	ELKO District Office	LAS VEGAS District Office
030 Bible Way	1100 E William Ste 101	1010 Ruby Vista Dr. Ste 103	1210 S Valley View Blvd. Ste 104
reno, NV 89502	Carson City, NV 89701	Elko, NV 89801	Las Vegas, NV 89102
ax: (775) 687-1901	Fax: (775) 684-3663	Fax: (775) 753-1101	Fax: (702) 668-4279

D. FOR MEDICAID USE ONLY

Assigned to HCC:		Date Assigned:
Assigned By:		
Date Individual Contacted:	Method of Contact: <input type="checkbox"/> Face to Face <input type="checkbox"/> By Phone <input type="checkbox"/> By Letter	

[Type text]

STATE OF NEVADA

DIVISION OF HEALTH CARE FINANCING AND POLICY
Facility Outreach and Community Integration Services (FOCIS)

Statement of Understanding

RECIPIENT NAME: _____ **MEDICAID #:** _____

Facility Outreach and Community Integration Services (FOCIS) is a voluntary Nevada Medicaid Program providing Medicaid recipients a choice to remain or seek placement in a community setting. Health Care Coordinators (HCC) who work for the Division of Health Care Financing and Policy (DHCFP), also known as Medicaid, staffs FOCIS. The Health Care Coordinator assesses your needs so that appropriate Medicaid services and community resources can be identified and accessed as a means for you to live in the community.

I have been advised that I have a choice to remain in a medical facility or to pursue opportunities to live in a less restrictive environment in the community.

- I choose to pursue opportunities to leave the medical facility** and return to a community setting. I also choose to participate in an assessment in order to develop and implement a plan that addresses my needs in returning to a community setting. I understand some services may not be covered under Medicaid. Further, I agree to advise my Health Care Coordinator of the following:
 - Any change in my living situation, including moving to another facility or becoming hospitalized;
 - If I become ineligible for Medicaid and/or if I have any changes/issues in finances/debt that may arise and affect my plan;
 - I choose to have a representative present during assessments, conferences, and meetings.

- I am presently in a community setting** and agree to participate in an assessment that addresses my needs and available services in order to remain in the community.

- I am presently in a community setting or medical facility** and I decline any further FOCIS services at this time. I understand my Medicaid benefits will NOT be affected by this decision. I also understand I may request assistance with returning to a community setting at any time in the future by calling DHCFP, FOCIS Program at:

- Las Vegas (702) 668-4200 Reno (775) 687-1900
- Elko (775) 753-1191 Carson City (775) 684-3651

- This form was read to the recipient and/or their legal representative and their choice is indicated above.

- Obtained verbal agreement from _____.

Recipient Signature Date

Authorized or Legal Representative Signature (if applicable) Date

Authorized/Legal Representative's Relationship to Recipient: _____

Health Care Coordinator Signature Date

[Type text]

Able to Administer Own Meds Yes No

Needs Assistance w/Administration Yes No

Speech: Good Limited Unable to communicate Communicates by: _____

Hearing: Good Poor Deaf Hearing Aid **Dental:** Good Poor Dentures

Vision: Good Poor Blind Corrected

Diet: _____

Allergies: _____

Comments: _____

C. Cognition/Behavior/Emotional/Mental Status (Check if Applicable)

- Oriented Functional/Calm/Appropriate
- Disoriented Cooperative/Motivated
- Intermittent Disorientation Assertive/Outspoken
- Minor Forgetfulness/Poor Historian Restless/Agitated/Anxious
- Non-Responsive Verbally/Physically Aggressive
- Appropriate Social Behavior Apprehensive/Discouraged/Depressed
- Inappropriate Social Behavior Wanders
- Able to Call/Report a Problem/Emergency Safety Risk

Comments: _____

D. Function/Equipment/Services (Check Appropriate Box)

1. Function	Indep.	Assist	Dependent	Indep.	Assist	Dependent
Bed Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder:	<input type="checkbox"/>	<input type="checkbox"/>
Transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Continent		
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Incontinent		
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel:	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Continent		
Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Incontinent		
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stairs	<input type="checkbox"/>	<input type="checkbox"/>
				Phone Use	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

2. **Equipment** (Indicate if recipient (N) Needs or (H) Has or (R) Requests)

- ___ Braces ___ Manual Wheelchair ___ Incontinent Supplies
- ___ Cane ___ Motorized Wheelchair ___ Ostomy Appliances
- ___ Prostheses ___ Ramp ___ Glucometer & Supplies
- ___ Splints ___ Grab Bars ___ Oxygen
- ___ Walker ___ 3 in 1 Commode ___ Service Animal
- ___ Hospital Bed/side rails ___ Catheter/supplies ___ Slide Board
- ___ Hoyer Lift ___ Bedpan/Urinal ___ Other
- ___ Overhead Trapeze ___ Telephone Use

[Type text]

Comments: _____

3. **Services** (Indicate if recipient (N) Needs or (H) Has or (R) Requests)

- Personal Care Service Home Health Mental Health
- Shopping Occupational Therapy Counseling
- Light Housekeeping Physical Therapy Alcohol/Substance Abuse
- Laundry Speech Therapy Group Home
- Transportation Respiratory Companion
- SNAP (Food Stamps) Dialysis Case Management
- Nutritional Ocular Other
- Home Delivered Meals Dental AL
- Meal Preparation Hearing CHIP
- Medication Delivery Assistive Technology MR and Related Conditions
- PERS Hospice WEARC
- _____ _____ WIN

Comments: _____

E. Environment/Housing/Energy Assistance (Check Appropriate Boxes)

1. Housing: Situation and/or Options

- Accessible Space Inc. Assisted Living Board & Care Group Home
- Halfway House Live with Family Live with a Friend Own Residence Section 8

2. Energy Assistance: EAP Yes No

3. Evictions: Yes No

Comments: _____

F. Finances

1. Source and Amount of Income (Check all that apply and indicate amount)

- | <u>Type</u> | <u>Amount</u> | <u>Type</u> | <u>Amount</u> |
|-------------------------------|---------------|--|---------------|
| <input type="checkbox"/> SSA | \$ _____ | <input type="checkbox"/> Veterans | \$ _____ |
| <input type="checkbox"/> SSI | \$ _____ | <input type="checkbox"/> Railroad Retirement | \$ _____ |
| <input type="checkbox"/> RSDI | \$ _____ | <input type="checkbox"/> Other | \$ _____ |

Type: _____

2. Other Insurance, e.g. Medicare: _____

3. Outstanding Debt (Check all that applies and indicate amount)

- Utilities Amount \$ _____ Overpayment Amount \$ _____
- Other Type _____ Amount \$ _____

4. Warrants: Yes No

Comments: _____

| [Type text]

HCC Signature: _____ Date: _____

Approved

PERSONAL CARE AIDE SERVICES RECIPIENT BILL OF RIGHTS

The Recipient's rights are to:

Receive considerate and respectful care at all times, and have property treated with respect;

- Participate in the development of the Service Plan and receive an explanation of services proposed. Receive a written list of alternative resources and referrals that may be available;
- Receive a copy of the service plan;
- Receive the name of the PCA case manager and the Nevada Medicaid district office supervisor's number to be contacted for complaints about caregiver, provider or DHCFP employees;
- Receive assurance that privacy and confidentiality about one's health, social, domestic and financial circumstances will be maintained pursuant to law;
- Know all communications and records will be treated confidentially;
- Expect all providers, within the limits set by the service plan and within program criteria, will respond in good faith to the recipient's reasonable requests for assistance;
- Receive information upon request on Nevada Medicaid's policies and procedures, including information on charges, reimbursements, and service plan determinations;
- Request a change of provider agency or ISO;
- Participate in the plan for discontinuation of service;

- Have access, upon request, to Medicaid payment history;

Receive a written explanation of the hearing process;

Request a hearing when disagreeing with Nevada Medicaid's action to deny, terminate, reduce, or suspend services;

- Receive in writing the name and contact number of an official of Nevada Medicaid and the state ombudsman telephone number.

Recipient/Personal Representative Signature

Date

Service Worker Signature

Date

PERSONAL CARE AIDE (PCA) SERVICES RECIPIENT RESPONSIBILITIES

The Recipient's responsibilities are to:

- Notify the provider and PCA case manager of changes in Medicaid eligibility.
- Notify the provider of current insurance information, including the name of other insurance coverage, such as Medicare.
- Notify the provider and PCA case manager of changes in medical status, service needs, address location (if you go on vacation or into a hospital or other facility) or in changes of status of legally responsible family member(s).
- Not request your PCA work more than the hours authorized on your service plan.
- Not request your PCA work or clean for non-recipient family or household members.

Not request your PCA provide services not on the service plan.

Contact the district office PCA case manager to request a change of provider agency or ISO.

Treat all staff appropriately.

Sign the PCA delivery record to verify services were provided.

Notify the provider when scheduled visits cannot be kept or services are no longer required.

- Notify the provider agency of missed visits by provider agency staff.
- Notify the provider agency of unusual occurrences, complaints regarding delivery of services, specific staff and/or requests for a change in caregivers.

Supply the provider agency with a copy of advance directives.

Establish a backup plan in the event a PCA is unable to work at the scheduled time.

Recipient/Personal Representative Signature Date

Service Worker Signature Date

[Type text]

STATE OF NEVADA
DIVISION OF HEALTH CARE FINANCING POLICY
Facility Outreach and Community Integration Services (FOCIS)

Diversion/Transition Plan					
1. Recipient Name:			2. Medicaid#:		
3. Date of Plan:		4. Physician:			
5. Health Care Coordinator:			6. Anticipated Date of Discharge:		
<i>Setting Neutral Assessment is used in conjunction with developing a plan, follow key listed below:</i>					
Key: A. Recipient Information B. Health C. Mental/Emotional D. Function/DME E. Housing F. Finances G. Other					
Recipient Needs:	Recipient Goals:	Actions/Approaches:	Person & Program Responsible	Target Date:	Outcome:

| [Type text]

Appendix C

Approved

**Organizations Participating in Stakeholder Forums
November 2010**

- AARP Nevada
- Access to Healthcare Network
- Aging and Disabilities Service Division
- Clark County Social Services
- Consumer Direct
- High Sierra Industries
- Nevada Center for Excellence in Disabilities, University of Nevada, Reno
- Nevada Disability Advocacy & Law Center
- Nevada Parents Encouraging Parents (PEP)
- Nevada Senior Services
- Northern Nevada Autism Network
- Northern Nevada Center for Independent Living
- Rebuilding All Goals Efficiently (RAGE)
- Southern Nevada Adult Mental Health Outreach
- Southwest Medical Associates Lifestyle Center
- Southwest Medical Associates/United HealthCare
- The Continuum
- University of Nevada, Reno Sanford Center for Aging
- Washoe Legal Services
- Washoe County Social Services

| [Type text]

Appendix D

Approved

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Self-Direction Submittal Form

I. Participant Centered Service Plan Development

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b) (2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input type="checkbox"/>	Case Manager (qualifications specified in Appendix C-3)
<input type="checkbox"/>	Case Manager (qualifications not specified in Appendix C-3). <i>Specify qualifications:</i>
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input checked="" type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>): Each recipient enrolled in the MR/RC waiver has a service coordinator who is a Qualified Mental Retardation Professional (QMRP) as defined in CFR 483.430 (a). The Service Coordinator has responsibility for Service Plan development. Each individual who participates in an ISO, Nevada's self-direction option for Personal Care Services (PCS), is assigned a DHCFP District Office Care Coordinator. The qualifications of a Care Coordinator are to have a current Nevada state licensure as a social worker or nurse. The ISO has the ultimate responsibility for service plan development.

b. Service Plan Development Safeguards. *Select one:*

<input checked="" type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

For the MR/RC waiver, the service coordinator receives initial and ongoing training in the person-directed planning process and provides information and education to the participant

(and family or guardian, as appropriate) on the person-directed planning process, the options available and how to exercise his/her rights. The service coordinator provides activities related to targeted case management only, which includes service plan development.

If an individual chooses an ISO for Personal Care Services, the ISO is responsible for service plan development. The ISO must review and document with the recipient or PCR their approved service plan. This must be done each time a new service plan is implemented. The ISO has an individual agreement with the recipient, which outlines the responsibilities of the ISO.

d. **Service Plan Development Process** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Nevada uses a person-directed planning process for the MR/RC waiver. The service coordinator facilitates the development of the ISP. At the initial planning meeting the differences between the participant's preferred future (vision) and the current situation are considered in order to provide direction for the identification of desired outcomes and goals.

The ISP is developed using applicable assessments that may include: a social assessment, medical/health assessment, assessment of the participant's functional skills, assessment of the participant's social network, and an assessment of the participant's desired life outcomes. Information for the completion of assessments is provided by the participant, support staff, health professionals, and may also include information from others who know the person well.

Support plans include timelines for the implementation of specific goals and objectives, as well as assignments of responsibilities to specific team members (or others) for the implementation of those goals and objectives. The ISP identifies the person responsible for providing each service/support as well as the action steps needed to be taken. The support plan is inclusive of all the services and supports that are furnished to meet the assessed needs of the participant. The service coordinator is responsible for gathering assessment information, developing the ISP based on team recommendations, facilitating plans for needed referrals, and monitoring all services as part of the support plan implementation. If the waiver participant receives other State Plan services (e.g., Personal Care Services), these services are coordinated with the waiver services in the ISP to avoid duplication. For self-directed PCS, a physical or occupational therapist will complete the functional assessment and forward to DHCFP's QIO-like vendor for authorization of services. The

ISO is responsible for developing the service plan. The ISO must review with the recipient the service plan, allowable hours, tasks and required paperwork. Recertification is needed annually or when a significant change occurs.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk assessment in the MR/RC waiver is conducted by the service coordinator as a part of the assessment and service plan development. The service coordinator takes into account both the services and supports needed as well as the supports that are already in place to mitigate risk. If there are identified health or community risks, the service coordinator may make referrals to specialists who can assess the situation and consult with the team on how to mitigate the risk. These may include psychologists, counselors, behavioral consultants, nurses, dietitians, allied therapists, and others. Once the risk has been evaluated, the team develops a safety plan to address those risks, and the plan is incorporated into the ISP. All support plans include detailed information on the service participant's health care needs: physicians, medications and the person responsible for assuring specific and routine health care needs are met.

For both agency-directed and consumer-directed care, the individual must have a viable support system (e.g., a family member, neighbor or friend willing, able and available to assist the individual, in the event the service provider is unable to work as expected or terminates employment without prior notice). It is the responsibility of the participant and family to identify this support individual and he or she must be identified in the service plan as well. Individuals who do not have viable support systems are not eligible for services. The service coordinator may assist the individual in identifying and selecting individuals or agencies that will be engaged as a viable back-up.

A DHCFP care coordinator makes an initial and annual home visit to every recipient who is interested in, or currently using, the ISO option. Potential risks are evaluated and discussed. The Care Coordinator must approve or deny this option based on assessed needs, assessed risks and available support plans.

Under the ISO option, the ISO is required to assist the recipient in developing a written back-up plan to address personal care service needs in the event that care is interrupted. The ISO is responsible for documenting the back-up plan that is developed, but is not responsible for arranging or ensuring back-up care is provided, because it is the responsibility of the recipient or PCR to do so.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Prior to enrollment in the MR/RC waiver, all waiver participants must read (or have read to them) and sign the form entitled "Statement of Choice." The Statement of Choice form is used to inform applicants of their right to choose between waiver and institutional services and among service providers. Service coordinators supply a list of qualified waiver service providers and work with people to ensure that opportunities for exploration of options and meetings with potential providers occur. The applicant or his or her designated legal representative then signs the Statement of Choice to document the choice of waiver service.

The Service Coordinator is responsible for assuring that the person has the necessary information to make appropriate choices between self-directed and traditional waiver services. Individuals wishing to elect the self-directed waiver option or obtain information about this option are assisted by the service coordinator and referred to the Support Broker Agency and Fiscal Management Services.

A participant who chooses an ISO to facilitate support services for PCS must be fully informed of his/her role and responsibilities and the role and responsibilities of the ISO, and must also review and sign an agreement with the ISO, which is submitted to DHCFP's Care Coordination Unit. The ISO agreement includes an acknowledgement of choice of ISO agencies. The selected ISO must educate the recipient or PCR in the skills to act as managing employer. This includes tasks related to selecting, managing, and directing the PCA in the delivery of authorized services. Education must begin with an accepted recipient referral and continue throughout the duration of the service provision:

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b) (1) (i):

MHDS sends waiver intake packets to DHCFP for approval. The intake packets include a copy of the ISP, assessment information that documents the need for waiver services, and the level of care consistent with the ISP and assessment information. DHCFP Health Care Coordinator III (a Nevada State Licensed Registered Nurse) reviews a statistically valid sample of the assessments and their accompanying level of care determination and Individual Support Plan (ISP) prior to the start of service provision. During the initial packet review by DHCFP the anticipated services are identified and included in the packet for review. DHCFP reviews 100% of intake packets for approval.

PCS under the ISO option is authorized by DHCFP's QIO-like vendor. The QIO-like vendor reviews and approves 100% of service plans prior to issuing a prior authorization.

- h. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
<input checked="" type="checkbox"/>	Operating agency
<input type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (<i>specify</i>):

II. Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

MHDS service coordinators are ultimately responsible for monitoring and documenting the provision of MR/RC waiver services and participant health and welfare. This monitoring is completed through a multiple-component approach:

Service coordinators:
 Conduct monthly contacts with waiver participants, their legal representatives/family or support

providers;
Make home visits to participants receiving residential supports. Scheduling of these visits is dependent on type or level of support needs with higher supervision having more frequent visits;
Review logs from direct support managers and service brokers on a monthly basis;
Review participant progress reports from individual and agency providers;
Visit participants in their day habilitation settings. Scheduling of these visits is dependent on level of support needs, special concerns or issues, with greater needs resulting in more frequent visits; and
Track and trend serious occurrences.
Service coordinators are responsible for completing assessments and supports within established timelines and documenting follow up activities in an MHDS statewide database. Service coordinators review monthly invoices from residential support providers to ensure the ISP has been implemented and that services provided are consistent with the ISP.
Service coordinators are also responsible for updating the participant's ISP if needs have changed or health and welfare have been compromised. Team members are responsible for planning and arranging for additional support services if needed to ensure the health and welfare of the participant. Regional center quality assurance staff track and trend the reviewing of the participant's support plan through data collection on the HCBS Service Review Form.
Under the ISO option, the ISO is required to assist the recipient in developing a written back-up plan to address personal care service needs in the event that care is interrupted. The ISO is responsible for documenting the back-up plan that is developed, but is not responsible for arranging or ensuring back-up care is provided, as this is ultimately the responsibility of the recipient or PCR.
The ISO must review with the recipient the service plan, allowable hours, tasks and required paperwork. Recertification is needed annually or when a significant change occurs.
A DHCFP care coordinator completes an initial and annual home visit for every recipient who is interested in, or currently using, the ISO option. Potential risks are evaluated and discussed. The Care Coordinator must approve or deny this option based on assessed needs, assessed risks and available support plans.

b. Monitoring Safeguards. *Select one:*

<input checked="" type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
<input type="radio"/>	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>

III. Overview of Self-Direction

a. Description of Self-Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the

entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participants enrolled in the MR/RC waiver in the rural region have the ability to choose waiver services from both provider-managed (traditional) and self-directed models of services. Services that may be self-directed include: direct services and support, counseling, non-medical transportation, nursing, nutrition counseling, community inclusion, and supported employment. Individuals (and their families, as appropriate) expressing an interest in the self-directed model will receive an in-depth orientation prior to enrollment. The ISP documents the choice made between traditional or self-directed services or a combination of both.

Individuals electing the self-directed option have the support of a traditional service coordinator – who develops, manages and monitors the ISP – and the specialized assistance of a support broker -- who develops, manages and monitors the self-directed individual budget. Activities of each support entity works in concert with each other, and program policy, training and job descriptions will ensure non-duplication of roles. The support coordinator oversees and monitors the development, maintenance and quality of the ISP while the support broker supports only the self-directed activity. Quarterly, the service coordinator meets with the person (face-to-face) and the support broker to review the ISP and assess progress. At any time, the individual may request a change in his or her services.

In addition to attending ISP meetings, the support broker is responsible for assisting with developing the individual budget (self-directed portion of the ISP) and updating the individual budget. The support broker also provides assistance with recruiting, hiring, training, managing, evaluating and dismissing independent staff, as well as coordinating activity with the financial management service (FMS), and explaining record keeping and program options under the pilot. Training and education on developing self-directed skills is also a responsibility of the support broker.

The service coordinator contacts the support broker at least monthly to report the outcomes of monitoring the self-directed services and the implementation of the ISP tied to self-direction. Quarterly, the service coordinator meets with the person (face-to-face) and the support broker to review the ISP and assess progress. At any time, the individual may request a change in his or her services. Changes are accomplished through revisions of the ISP. When the ISP is modified, the individual may reallocate his or her budget resources to allow for any changes in services that occur based on changing needs or priorities.

Individuals are assisted by a financial management service (FMS) to access self-directed 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. Monthly reports are sent to each individual electing self-direction with copies to the service coordinator and the support broker detailing payments made and the status of the individual budget. The FMS also is responsible for ensuring service providers employed by the participant meet applicable qualification requirements, receiving required training, submitting background checks, purchasing worker's compensation, and preparing required quality management and utilization reports.

Nevada has a self-directed option for State Plan Personal Care Services (PCS). A recipient may choose to self-direct and hire a fiscal intermediary, which in Nevada is an Intermediary Service Organization (ISO). An ISO provides two primary functions. The

first function is to reduce the individual's employer-related burden through the provision of appropriate fiscal and supportive services. The second function is to assure the state that support services are being provided to an individual in compliance with federal, state and local regulations. This option is available to recipients in need of Personal Care Services (PCS) who have the ability and desire to manage their own care. When the recipient does not have the ability to manage or direct their own care, a Personal Care Representative (PCR) to direct the provider on the recipient's behalf may be selected. The ISO is the employer of record and the recipient is the managing employer.

The recipient or their representative indicates interest in the self-directed PCS model by contacting the DHCFP District Office (DO) directly. All individuals seeking this type of self-directed program will require prior authorization from DHCFP DO staff, normally a Care Coordinator, or in the case of an Aging and Disability Services Division (ADSD) recipient, from the ADSD Care Coordinator.

If an individual chooses an ISO, a DHCFP Care Coordinator makes an initial home visit to verify the individual is able to self-direct. If so, the QIO-like vendor will approve the ISO model for a period of 365 days. An individual may terminate this model at any time. The state uses the same QIO-like vendor for home and community based services, state plan services, and self-directed services; therefore, there will never be a lapse in service. Authorizations can end one day and a new authorization can begin the next day.

An individual who chooses an ISO to facilitate support services must be fully informed of his/her role and responsibilities, the role and responsibilities of the ISO, and must review and sign an agreement with the ISO. The original must be maintained with the ISO. At a minimum, the ISO agreement must include:

Role and responsibilities of the individual;

Role and responsibilities of the ISO;

Acknowledgement the individual has reviewed the information and understands his/her role and responsibilities related to self-directing her/her support services using an ISO;

Acknowledgement the individual accepts her/her role and responsibilities related to using the chosen ISO; and

Acknowledgement of choice of ISO agencies.

The state has established the following financial safeguards to ensure self-direction is conducted in the best interests of the recipient.

An individual agreement with an ISO if used;

Established cost and rate standards;

Enrollment through QIO-like vendor to become a Medicaid provider;

Prior approval process; and

Monthly reporting on expenditures.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

- | | |
|-----------------------|---|
| <input type="radio"/> | Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available |
|-----------------------|---|

[Type text]

	for participants who exercise this authority.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant’s representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
<input checked="" type="radio"/>	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input checked="" type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
<input checked="" type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements (<i>specify</i>): The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual’s family has domain and control.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

<input checked="" type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input type="radio"/>	The waiver is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i> Self-Direction under the MR/RC waiver is limited to rural parts of state. The ISO option for PCS is available statewide.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant’s representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

An informational brochure is provided to each MR/RC waiver participant or new applicant by the service coordinator at the initial visit, subsequent visits or anytime the individual requests the information. The brochure lists the features, responsibilities and potential liabilities inherent in the self-directed service model. Service Coordinators are trained on the self-directed service model and the new role of the participant in self-direction. The Service Coordinator will provide information during the person- centered planning process, and the ISP will coordinate activity with the support
--

[Type text]

broker.
 If the participant is receiving State Plan services only, they may obtain information regarding PCS self-direction from any of the DHCFP district offices or the QIO-like vendor. Participants may also contact an ISO who will explain to them the self-directed model.

f. Participant Direction by a Representative. Specify the State’s policy concerning the direction of waiver services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input checked="" type="radio"/>	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: (<i>check each that applies</i>):
<input checked="" type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.
<input checked="" type="checkbox"/>	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant: When a waiver participant identifies an individual representative that is not a legal representative, the support broker, during routine visits with the participant, ensures: 1) the participant is satisfied with this arrangement; 2) the individual budget is implemented accordingly; and 3) the individual budget is adequate to meet the self-directed needs.

Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. (*Check the opportunity or opportunities available for each service*):

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Nursing Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Supported Employment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Counseling	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-Medical Transportation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Nutrition Counseling Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Community Integration Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Direct Services and Support	<input checked="" type="checkbox"/>	<input type="checkbox"/>

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

<input checked="" type="radio"/>	Yes. Financial Management Services are furnished through a third party entity. (<i>Complete item E-1-i</i>). Specify whether governmental and/or private entities furnish these services. <i>Check each that applies</i> :
<input type="checkbox"/>	Governmental entities
<input checked="" type="checkbox"/>	Private entities
<input type="radio"/>	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i</i> .

i. Provision of Financial Management Services. Financial management services (FMS) may be

[Type text]

furnished as a waiver service or as an administrative activity. *Select one:*

<input type="radio"/>	FMS are covered as the waiver service entitled as specified in Appendix C-3.
<input checked="" type="radio"/>	FMS are provided as an administrative activity. <i>Provide the following information:</i>
i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: FMS is contracted by the State to act as the fiscal agent, assist the employer in payroll management, employment tasks, and track the use of the individual budget. The FMS also assists the employer to ensure 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 is an administrative activity.
ii.	Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform: The FMS monthly administrative fee is a range and is determined by total amount of the contract and is between \$65.00 and \$450.00.
iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide (<i>check each that applies</i>): <i>Supports furnished when the participant is the employer of direct support workers:</i>
<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status
<input checked="" type="checkbox"/>	Collect and process timesheets of support workers
<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
<input checked="" type="checkbox"/>	Other (<i>specify</i>): FBI background check Broker Worker's Compensation Verify provider qualifications Assure required training is completed upon hire and every 12 months
	<i>Supports furnished when the participant exercises budget authority:</i>
<input checked="" type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget
<input checked="" type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds
<input checked="" type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
<input checked="" type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
<input type="checkbox"/>	Other services and supports (<i>specify</i>):
	<i>Additional functions/activities:</i>
<input checked="" type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
<input checked="" type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services

	under an agreement with the Medicaid agency or operating agency
☑	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
☐	Other (<i>specify</i>):
iv.	Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
	<p>Service coordinators at the Regional Centers perform program reviews at least annually and review monthly invoice and backup documentation from the FMS prior to payment to ensure program responsibilities are fulfilled.</p> <p>Program review verifies:</p> <ul style="list-style-type: none"> Ongoing and effective customer services Written policies and procedures are followed Participants are notified of their individual budget amount, at least monthly Verifies provider qualifications of individual workers according to state policy Assists participant to manage the individual budget Compares expenditures with ISP before payment Provides information and assistance with processing timesheets, invoices and payroll checks Executes provider agreements on behalf of the Medicaid agency (under written agreement) <p>The audit review verifies that FMS:</p> <ul style="list-style-type: none"> Verifies citizenship or alien status Operates correctly under IRS Revenue Procedure 70-6 and proposed notice 2003-70 Acts as a “bank” for participant’s individual budget; Invoices the state reimbursement for timesheets and goods and services Disburses and tracks all funds Manages criminal background checks according to state and program requirements Withholds files and pays federal tax, Medicare and Social Security (FICA), federal (FUTA) and state (SUTA) employment, disability insurance taxes, and local taxes, as applicable Prepares and disburses workers' payroll checks Processes judgments, garnishments, tax levies, or any related holds on workers' pay Processes federal advanced earned income credit for workers who are eligible Refunds over-collected FICA, when appropriate Prepares and disburses IRS Forms W-2 and W-3, when appropriate Ensures participants have separate EINs. <p>DHCFP district office staff review 100% of PCS and ISO agencies annually. The review includes examining records to assure arrangements for essential training of all employees and that providers take corrective actions when necessary as indicated above under the assurance component titled “State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.” The</p>

PCS employees must have at least 16 hours basic training prior to initiating services.

Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input type="checkbox"/>	Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i>
<input type="checkbox"/>	Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:
<input checked="" type="checkbox"/>	<p>Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i></p> <p>Information and assistance to individuals electing to self-direct is furnished by a support broker. The entity providing this administrative service is determined through a Request for Proposals (RFP). The support broker is responsible for assisting each person and/or their representative to self-direct services according to the individual budget portion of the ISP. Each broker provides:</p> <p>Assistance and support by ensuring the participant understands the self-direction program; Information on associated policies, procedures and requirements, and Skill teaching self-direction.</p> <p>The support broker also conducts an annual survey to determine level of participant satisfaction. The support broker is an active member of the ISP team and assists the service coordinator and FMS to monitor the adequacy of the ISP and individual budget. The support broker is a critical function of the quality management system.</p> <p>Under the ISO option, a DHCFP Care Coordinator completes an initial and annual home visit for every recipient who is interested in, or currently using, the ISO option. The Care Coordinator must approve or deny this option based on assessed needs, assessed risks and available support plans.</p> <p>The ISO is required to assist the recipient in developing a written back-up plan to address personal care service needs in the event that care is interrupted. The ISO is responsible for documenting the back-up plan that is developed, but is not responsible for arranging or ensuring back-up care is provided, because it is the responsibility of the recipient or PCR to do so.</p>

k. Independent Advocacy (*select one*).

<input type="radio"/>	Yes. Independent advocacy is available to participants who direct their services. <i>Describe</i>
-----------------------	---

	<i>the nature of this independent advocacy and how participants may access this advocacy:</i>
●	No. Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A participant may request termination of self-directed services under the HCBS Waiver for Persons with Mental Retardation or Related Conditions (MR/RC waiver) at any time through notification to their support broker or service coordinator. After the participant's request to voluntarily terminate self-direction, a special care planning meeting is held. At this meeting, the support team will develop a new person-centered plan to ensure continuity of care and that health and welfare needs are met during the transition from self-direction to provider-managed services. The team will discuss timelines and options. By participating in appropriate planning sessions, participants can change between self-directed and provider-managed models without service interruptions.

A participant may terminate the ISO model for PCS at any time. The state uses the same Quality Improvement Organization (QIO)-like vendor for home and community-based services, state plan services, and self-directed services; therefore, with appropriate notice and planning, there should not be any lapse in service. After appropriate notice, authorizations can end one day and a new authorization can begin the next day to have the services provided through a PCS agency.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

.Involuntary termination of self-direction under the MR/RC waiver will not take place until other interventions and support resources are exhausted. The State will involuntarily terminate a participant from the self-directed service model under the MR/RC waiver if he or she is determined to be at risk due to lack of ability to direct services as defined in the Individual Support Plan (ISP). This will be identified through the service coordinator's monitoring, the support broker's input, or other quality assurance activities assessing the participant's health and welfare.

A participant must be terminated from the ISO option and offered services through traditional providers if there are immediate health and safety risks to the person associated with self-direction (e.g., imminent risk of death or irreversible or serious bodily injury related to the self-direction of waiver services). It is the responsibility of the ISO to monitor the person throughout the year. A DHCFP Care Coordinator will conduct an annual home visit to determine if a person continues to meet the criteria for the ISO option.

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Appendix E

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**Money Follows the Person Demonstration
Worksheet for Proposed Budget (revised January 7, 2011)**

Instructions: Please fill in only the cells highlighted in YELLOW. All other cells will autopopulate. **Please DO NOT alter any formulas.**
Please note: The enhance rate for FFY2009 thru FFY2011 is based on the increased FMAP rate related to the implementation of the Recovery Act of 2009 & the Education, Jobs and Medicaid Assistance Act of 2010. Budget calculations for the last quarter of CY2008 thru the first two quarters of CY2011 use these rates.

Date of Report:		Please express FMAP as a decimal, (example: 68.32%=.6832)				
Name of State/Grantee:		State FMAP (9 to 11) (for rates Dec 2008 - Dec 2010)	State Enhanced FMAP	Increased FMAP (Oct 2009 - Jun 2011)	ALLOWED Enhanced FMAP Not to Exceed 90%	Calculated Enhanced FMAP (Oct 2009 - Dec 2010)
Nevada Department of Health and Human Services						
Grant #:		FFY 2007	0.50000		0.50000	
LICMS330822-01-60		FFY 2008	0.50000		0.50000	
Demonstration Program Title:		FFY 2009 Q1	0.50000		0.50000	0.50000
Money Follows the Person (MFP)		FFY 2009 Q2	0.50000		0.50000	0.50000
Demonstration		FFY 2009 Q3	0.50000		0.50000	0.50000
		FFY 2009 Q4	0.50000		0.50000	0.50000
		FFY 2010 Q1	0.50000		0.50000	0.50000
		FFY 2010 Q2	0.50000		0.50000	0.50000
		FFY 2010 Q3	0.50000		0.50000	0.50000
		FFY 2010 Q4	0.50000		0.50000	0.50000
		FFY 2011 Q1	0.50000		0.50000	0.50000
		FFY 2011 Q2	0.50000		0.50000	0.50000
		FFY 2011 Q3	0.51610	0.59220	0.79610	0.79610
		FFY 2011 Q4	0.51610		0.75805	
		FFY 2012	0.56200		0.78100	
		FFY 2013	0.58140		0.79070	
		FFY 2014	0.58140		0.79070	
		FFY 2015	0.58140		0.79070	
		FFY 2016	0.58140		0.79070	

Populations to be Transitioned (unduplicated count)

Unduplicated Count - Each individual is only counted once in the year that they physically transition. All population counts and budget estimates are based on the Calendar Year (CY).

	Elderly	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis	Total per CY
CY 2007						0
CY 2008						0
CY 2009						0
CY 2010						0
CY 2011	0	0	0	0	0	0
CY 2012	58	4	58	0	0	120
CY 2013	58	2	58	0	0	120
CY 2014	61	4	61	0	0	126
CY 2015	63	2	63	0	0	128
CY 2016	15	0	15	0	0	30
Total Count	256	12	256	0	0	
			Total of Populations	524		

Demonstration Budget Summary

Qualified HCBS Services, Demonstration HCBS Services and Supplemental Services are defined in the RFP.
 Administrative - Normal - costs that adhere to CFR Title 42, Sections 433(b)(7), Administrative - 75% - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10), Administrative - 90% - Federal Evaluation Supports - costs related to administering the Quality of Life Survey (reimbursed @ \$100 per survey).
 Rebalancing Fund is a calculation devised by CMS to estimate the amount of State savings attributed to the Enhanced FMAP Rate that could be reinvested into rebalancing benchmarks.
 Other - Other costs reimbursed at a flat rate (to be determined by CMS)

Total Expenditures (2007 - 2016)	Rate	Total Costs	Federal	State
Qualified HCBS		\$ 7,082,594	\$ 5,573,250	\$ 1,489,344
Demonstration HCBS		\$ 2,479,064	\$ 1,955,000	\$ 524,064
Supplemental		\$ -	\$ -	\$ -
Administrative - Normal		\$ -	\$ -	\$ -
Administrative - 75%		\$ -	\$ -	\$ -
Administrative - 90%		\$ -	\$ -	\$ -
Federal Evaluation Supports		\$ -	\$ -	\$ -
Administrative (Other) - 100%		\$ 2,431,855	\$ 2,431,855	\$ -
State Evaluation		\$ -	\$ -	\$ -
Total		\$ 11,973,513	\$ 9,960,105	\$ 2,013,408

Per Capita Service Costs	\$ 18,209
Per Capita Admin Costs	\$ 4,641

Rebalancing Fund Calculation	
CY 2007	\$ -
CY 2008	\$ -
CY 2009	\$ -
CY 2010	\$ -
CY 2011	\$ -
CY 2012	\$ 368,891
CY 2013	\$ 489,794
CY 2014	\$ 507,574
CY 2015	\$ 500,803
CY 2016	\$ 168,346
Rebalancing Fund Total	\$ 2,013,408

CY 2011 (using partial year increased FMAP)	Rate	Total Costs	Federal	State	Summary
Qualified HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Remaining Award Funding \$ 800,000
Qualified HCBS (Apr-Jun increased FMAP)	0.79610	\$ -	\$ -	\$ -	Total Fed Costs \$ 800,000
Qualified HCBS (Jul-Dec)	0.75805	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Demonstration HCBS (Jan-Mar increased FMAP)	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year \$ 1,694,281
Demonstration HCBS (Apr-Jun increased FMAP)	0.79610	\$ -	\$ -	\$ -	Total (Balance + Request) \$ 1,694,281
Demonstration HCBS (Jul-Dec)	0.75805	\$ -	\$ -	\$ -	
Supplemental (Jan-Mar increased FMAP)	0.00000	\$ -	\$ -	\$ -	
Supplemental (Apr-Jun increased FMAP)	0.59220	\$ -	\$ -	\$ -	
Supplemental (Jul-Dec)	0.51610	\$ -	\$ -	\$ -	
Administrative - Normal	0.50000	\$ -	\$ -	\$ -	
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -	
Administrative (Other) - 100%	1.00000	\$ 800,000	\$ 800,000	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ 800,000	\$ 800,000	\$ -	

CY 2012	Rate	Total Costs	Federal	State	Summary
Qualified HCBS	0.78100	\$ 1,148,820	\$ 897,228	\$ 251,592	Remaining Award Funding \$ 1,694,281
Demonstration HCBS	0.78100	\$ 535,616	\$ 418,316	\$ 117,300	Total Fed Costs \$ 1,694,281
Supplemental	0.56200	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Administrative - Normal	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year \$ 2,160,085
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request) \$ 2,160,085
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -	
Administrative (Other) - 100%	1.00000	\$ 378,736	\$ 378,736	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ 2,063,172	\$ 1,694,281	\$ 368,891	

CY 2013	Rate	Total Costs	Federal	State	Summary
Qualified HCBS	0.79070	\$ 1,670,976	\$ 1,321,241	\$ 349,735	Remaining Award Funding \$ 2,302,811
Demonstration HCBS	0.79070	\$ 573,620	\$ 453,561	\$ 120,059	Total Fed Costs \$ 2,302,811
Supplemental	0.58140	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Administrative - Normal	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year \$ 2,302,811
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request) \$ 2,302,811
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -	
Administrative (Other) - 100%	1.00000	\$ 385,283	\$ 385,283	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ 2,629,879	\$ 2,160,085	\$ 469,794	

CY 2014	Rate	Total Costs	Federal	State	Summary
Qualified HCBS	0.79070	\$ 1,818,864	\$ 1,438,176	\$ 380,688	Remaining Award Funding \$ 2,302,811
Demonstration HCBS	0.79070	\$ 606,238	\$ 479,352	\$ 126,886	Total Fed Costs \$ 2,302,811
Supplemental	0.58140	\$ -	\$ -	\$ -	Balance (Carry Over) \$ -
Administrative - Normal	0.50000	\$ -	\$ -	\$ -	Supplemental Award Request for next year \$ 2,277,231
Administrative - 75%	0.75000	\$ -	\$ -	\$ -	Total (Balance + Request) \$ 2,277,231
Administrative - 90%	0.90000	\$ -	\$ -	\$ -	
Federal Evaluation Supports	1.00000	\$ -	\$ -	\$ -	
Administrative (Other) - 100%	1.00000	\$ 385,283	\$ 385,283	\$ -	
State Evaluation (if approved)	0.50000	\$ -	\$ -	\$ -	
Total		\$ 2,810,385	\$ 2,302,811	\$ 507,574	

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Appendix F

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State Department of Human Services

MFP Grant Number 1LICMS330822-01-00 - CY 2012 NV ADRC Supplemental Funding Request

Abstract

The Nevada MFP program along with the Aging and Disability Services Division (ADSD) Nevada ADRC program proposes a partnership that will increase consumer awareness of and access to the existing MFP program and will enhance the ADRC program's ability to provide information and access to consumers and caregivers who are interested in transition services. The partnership will involve agency cross-training, the enhancement of the existing Nevada ADRC portal and the dissemination of information to consumers, caregivers and service providers.

The goal of this project is to build capacity and infrastructure for the Nevada ADRC program to provide support to consumers who want to transition from institutionalization. The project will focus ADRC efforts in marketing and outreach to critical pathway providers, enhancing the existing Nevada ADRC web portal and expanding options counseling to consumers who are not Medicaid eligible.

This funding will provide supply and travel monies as well as yearly attendance at the national conference meeting to further develop core competencies of the project. We envision contracting out 3 part-time outreach and training coordinators statewide within our ADRC network of grantees or stakeholders; 1 person in Northern Nevada, 1 in Southern Nevada and 1 person to concentrate on rural Nevada. These positions will be responsible for increasing the long-term services and support resources on the ADRC web portal, enhancing the information in the existing registry for "housing that is suitable for use by a person with a disability", and educating Critical Pathway Providers on roles and access to the MFP program. This funding will also provide a statewide part-time Content Development Manager responsible for including verbiage on the ADRC Portal that dedicates space to MFP and translates Medicaid policy and program information into an easy to read manner for the general consumer or family caregiver planning for a transition back to the community. This person will work with the contracted IT Consultant responsible for implementation and integration of content into the ADRC portal. The IT Consultant will also be responsible for deploying three training modules submitted by the team to be included on the portal's e-learning solution.

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Current Status

The Nevada ADRC project began in 2005 with an initial ADRC development grant from the Administration on Aging and the Centers for Medicare and Medicaid Services. In 2009, Nevada was granted a three year expansion grant to aid in enhancing the capacity of ADRCs throughout Nevada. Since that time, resources have been dedicated to developing the Nevada ADRC web portal, training through an e-learning solution, recruitment of new ADRC sites, and ongoing program evaluation for improved access to services. These activities have allowed expansion from three local sites to five throughout Nevada. The five-year ADRC plan focuses on the development of more sites to allow for true statewide coverage.

The Nevada ADRC project provides services to seniors, people with disabilities and caregivers to assist them in planning for and accessing long term care services. The sites focus on nursing home diversion and providing options to institutionalization. Each site has developed strong partnerships with community-based service providers, home health agencies and local programs. The Nevada ADRC project has partnered with 12 state programs ranging from Independent Living/Assistive Technology services to Medicaid. The Nevada ADRC program has enhanced relations with the state's two federally recognized Centers for Independent Living, collaborating through cross-referrals to enhance transition efforts. The program has also recently begun collaborating with several community programs seeking partnerships based on Community Based Care Transition Program (CCTP) program application submittals.

Historically, the MFP program has been contained within Medicaid's FOCIS program, with limited involvement with the Nevada ADRC program. The potential for collaboration is evident in the similarity in MFP and ADRC goals, namely diversion or transition and utilization of private resources as possible. This funding opportunity will provide a basis for collaboration that could be maintained within each of our respective agencies. This collaboration will also include the ADSD Ombudsman Program, which has staff assigned to visit every nursing home and licensed residential facility for groups, a.k.a. group homes, in the state quarterly.

Goals, Objectives and Outcomes

The goal of this project is to promote awareness of the Money Follows the Person

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and ADRC projects to better serve consumers who are interested in transitioning from institutions. Nevada's MFP project and the Nevada ADRC project plan to meet the following objectives:

- 1) Create increased awareness of the MFP/FOCIS program through a targeted outreach/marketing campaign to critical pathway providers, consumers and caregivers.
- 2) Enhance the Nevada ADRC portal to include easy to understand information about accessing Medicaid long-term support services.
- 3) Develop cross-training materials for Nevada ADRC and MFP projects to enhance understanding of each person's program and the benefits of collaboration.
- 4) Increase consumers' ability to advocate and navigate long term support services through education and training.

As a result of these objectives, we expect the following outcomes:

- 1) An additional 150 people will be connected to MFP/FOCIS services over the course of the project.
- 2) 50 consumers, who are non-Medicaid eligible, will receive Options Counseling through the ADRC network.
- 3) A formal Community Partner Agreement among Nevada ADRC, Aging & Disability Services Ombudsman Program, and MFP/FOCIS will be established.
- 4) 500 consumers, caregivers, and/or service providers will access training through the Nevada ADRC portal to increase their awareness and access to community supports.

Proposed Project

The focus of this project is statewide. Consumers with disabilities who are Medicaid/Waiver program eligible are the primary targets although the ADRCs will also provide assistance to consumers who are not Medicaid/Waiver program eligible. Specifically, the project will target consumers who are institutionalized but could live independently with minimal community supports.

The Nevada MFP/FOCIS project relies on grassroots, word of mouth outreach. The MFP-ADRC partnership will introduce a targeted outreach plan that incorporates two existing ADRC sites and staff in ADSD's Long-Term Ombudsman program. The focus of the plan is to engage critical pathway providers to refer to MFP/FOCIS. Promoting

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the MFP/FOCIS program to critical pathway providers will also increase awareness of MDS 3.0 Section Q.

Outreach will also be available to the many consumers, caregivers and service providers interested in transition services but unaware of where to start. Education and outreach is needed to expand understanding of the transition process, what services are available and how to access those services. Beyond general outreach, the Nevada ADRC project will develop training modules that cover topics from self-advocacy to benefits planning. Materials must be easy to understand and accessible to a wide audience through the ADRC portal.

Information and assistance to consumers, caregivers and service providers is vital to the success of MFP-ADRC in transitioning individuals from institutions. To enhance the ADRC's ability to provide these services, the Nevada ADRC web portal will be expanded to include an entire section dedicated to transition and Medicaid services. In close coordination with Medicaid, Nevada ADRC will take away the technical jargon and complexity of transition services and Medicaid and put it into layman's terms. By enhancing the Nevada ADRC web portal in this manner, more consumers, caregivers and service providers will be able to access the services they need in order to make a successful transition.

The final element of the proposed MFP-ADRC partnership is increased cross-training opportunities for all program staff involved. Nevada ADRC has a wide range of e-learning modules developed that cover topics from Information and Assistance to Options Counseling. These modules will be shared with MFP/FOCIS staff. Additionally, the MFP/FOCIS program will provide training on transition services, qualifications and MDS 3.0 Section Q to ADRC and Ombudsman staff to enhance understanding and use.

To continue promoting this partnership, scheduled status meetings updates will be held with the Medicaid MFP Grantee, ADRC, Ombudsman and contracted staff at least bi-monthly.

Project Management

Existing staff will be used to manage the work proposed in this submittal. Nevada Medicaid has chosen to keep the LCA's within their agency as part of the existing FOCIS program. For the purposes of the MFP-ADRC partnership, they will

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expand their current MFP roles to assist in the development of the Nevada ADRC portal, conduct training to Nevada ADRC site personnel and participate in training offered by the Nevada ADRC to increase their awareness of services and support available.

Nevada ADRC will develop and perform targeted marketing/outreach campaign to increase awareness of the MFP/FOCIS program. The program will also enhance the Nevada ADRC web portal to include transition services and Medicaid benefits, develop training materials to be made available on the e-learning module of the web portal and provide education to consumers, caregivers and service providers who are interested in transition services. Through their efforts, Nevada ADRC will expand options counseling to consumers who are not Medicaid eligible and provide referral/follow-up services as needed. Ombudsman staff will also participate in outreach and marketing in nursing facilities.

As with any collaboration, challenges are expected. Primarily, the challenge will lie in the fact that there has not been a previous collaboration between MFP and ADRC. However, the general design of this project is the basis for overcoming this challenge. There is not a duplication of efforts, rather Nevada ADRC is taking on a role that entails more enhancement to services and consumers understanding rather than direct transition services. This approach not only allows Nevada ADRC to expand its capacity to provide information and access, but also expands MFP/FOCIS access to consumers who will benefit from the direct services they can offer. This funding will provide an opportunity to increase our partnership and provide a natural path in the ADRC 5-Year Strategic Plan in collaborating with MFP and Critical Pathway Providers.

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State Department of Human Services
 MFP Rebalancing Demonstration Grant Number 1LICMS330822-01-00
 NV ADRC Supplemental Request

Attachment I
 DRAFT Budget Narrative - 2 Year

400,001

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel	-			-	
Fringe Benefits	-			-	
Travel	14,000.00			14,000.00	2 staff to National Conference per year @ \$71 x 2 per diem x 3 days=\$426; Lodging 224x2x 3 days=\$1344; Airline \$900x2=\$1800; transportation \$80 x 2= \$160 Total \$3,730 x 2 years = \$7460
	-				Staff travel statewide; 6 trips between Las Vegas/Reno, per diem \$71x6=\$426;Lodging \$99x6=\$594; Parking \$30x6=\$180; Airfare \$209x6=\$1254 Total \$2454 x 2 years=\$4,908
					Statewide Travel Mileage \$1631.84 @ .56 per mile x 2914 miles
Equipment	-			-	
Supplies	14,000.00			14,000.00	General office supplies to include copy paper, postage, printing supplies;toner; mobile air card \$43x 2=\$86 x 24 mos.= \$2,064; Laptops x 2=\$5,000
Contractual	120,000.00			120,000.00	Outreach/Training Coordinator; North & South 2 P/T People; \$30 x20 hrs x 50 wks= \$30,000 x 2 people x 2 years
	80,000.00			80,000.00	Content Development Manager-Statewide P/T; \$40 x 20hrs x 50 wks= \$40,000 x 2 years
	120,870.00			120,870.00	IT Consultant for implementation and integration; \$48.50 X 21hrs x 50 wks= \$50,925 x 2 years= \$101,850 \$19,020=3 training modules
	40,000.00			40,000.00	Rural Outreach/Training Coordinator P/T; \$20 x 20 hrs x 50 wks=\$20,000 x 2 years
Other	10,000.00			10,000.00	Printing of related outreach materials; brochures, fliers, training materials through vendor
	1,130.00			1,130.00	Operating expenses; Utilize for fiscal and oversight of project
					0
					0
Indirect Costs					0
TOTAL	400,000.00			400,000.00	

