ANNUAL STATEWIDE CONSOLIDATED HCBS FE/PD WAIVER REVIEW FINAL REPORT

FE/PD Waiver Review Period 2021

Home and Community Based Services (HCBS) Waivers for the Frail Elderly (FE) and People with Physical Disabilities (PD) Quality Assurance Consolidated Review to ensure the waiver continues to meet essential Federal statutory assurances and effectively meet the recipient's needs.

State of Nevada
Division of Health Care Financing and Policy
Managed Care & Quality Assurance Unit

August 2022

Review Year: FE (WY 2) & PD (WY 4)

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Background/Introduction

The renewal of a waiver is contingent on the Centers for Medicare and Medicaid Services (CMS) determining that the State has effectively assured the health, safety, and welfare of waiver recipients during the period the waiver has been in effect.

Each State is expected to have, at a minimum, systems in place to measure and improve performance in meeting the waiver assurances set forth in 42 CFR §441.301 and §441.302. The assurances address important dimensions of waiver quality, including assuring that service plans are designed to meet the needs of waiver recipients and that the State has effective systems in place to monitor recipient health, safety, and welfare.

The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in the waiver application. Through an ongoing process of discovery, remediation, and improvement, the State assures the health, safety, and welfare of the recipients by monitoring: (a) level of care determinations; (b) individuals plans and services delivery; (c) provider qualifications; (d) recipient health, safety, and welfare; (e) financial oversight and (f) administrative oversight of the waiver.

Aims & Objectives

The annual review monitoring activities provide the foundation for quality improvement by generating information regarding compliance, potential problems, and individual corrective actions. The results can be aggregated and analyzed to measure the overall system performance in meeting the waiver assurances.

Methodology

The CMS quality requirements are founded on an evidence-based approach. The CMS requests evidence from the State that it meets the assurances and applies a continuous quality improvement approach to the assurances. The Division of Health Care Financing and Policy (DHCFP) Quality Assurance (QA) staff has used a representative sample with a confidence interval equal to 95/5 for case files and Participant Experience Surveys (PES) and 95/10 for financials for this review.

The Annual Statewide Consolidated Review for the Home and Community Based Services (HCBS) Waivers for the Frail Elderly (FE) and Persons with Physical Disabilities (PD) for the State of Nevada is conducted monthly. A combined random sample of three hundred fifty (350) case files were reviewed, one hundred forty-four (144) financial reviews were completed for ninety-four (94) recipients and one hundred sixty-seven (167) recipients completed Participant Experience Surveys (PES) for the 2021 waiver year. Due to the limited population of waiver recipients in rural areas, recipients from regional offices in rural areas are reviewed bi-annually at one hundred percent (100%). The 2021 wavier review period did not include the bi-annual review of rural area, Elko.

To avoid duplication of effort, reviews conducted by the Aging and Disability Services Division (ADSD) were obtained for a portion of the case file reviews and the PES for the 2021 review period. All provider reviews were completed by ADSD.

The following areas were evaluated during this year's annual review:

Case File Review:

1. Level of Care (LOC)
2. Comprehensive Social Health Assessment (CSHA)
3. Plan of Care (POC)
4. Forms
5. Monthly Contacts and Documentation

Financial Review:

1. Eligibility
2. Prior Authorization
3. Daily Records
4. Payment

Participant Experience Surveys (PES)

1. Access to Care
2. Choice and Control
3. Respect/Dignity
4. Community Integration/Inclusion

Listed below are the specific HCBS FE and PD Waivers, the Medicaid Services Manual (MSM) Chapters and Policy & Procedure (P&P) Transmittals that were used in the implementation of this annual review:

- Home and Community Based Services Waiver for the Frail Elderly (Effective 07/01/2015, 07/01/2020, 08/15/2020, and 12/01/2020)
- Home and Community Based Services Waiver for Persons with Physical Disabilities (Effective 01/01/2018, 08/15/2020, and 12/01/2020)
- MSM Chapter 2200 Home and Community Based Waiver for the Frail Elderly (Effective 09/25/2019 and 02/01/2021)
- MSM Chapter 2300 Home and Community Based Waiver for Persons with Physical Disabilities (Effective 09/25/2019)
- MSM Chapter 3900 Home and Community Based Waiver for Assisted Living (Effective 07/13/2012 – Merged into MSM Chapter 2200 on 02/01/2021)
- P&P FE-PD-1-2016 - Interim and Finalized Service Plan Signature and Dates
- P&P FE-PD-1-2016 - Acknowledgment Form NMO-7075 (02/16)
- P&P FE-PD-3-2016 - Requirements for the Plan of Care (POC)
- P&P FE-PD-5-2016 - Designated Representative Attestation NMO-3581 (11/16)
- P&P FE-PD-2-2017 - Statement of Understanding (SOU) NMO-3580 (04/17)
- P&P FE-PD-21-001 - Direct Case Management ongoing contacts
- P&P FE-PD-21-002 - Annual Plan of Care Updates and Changes
- Appendix K: Emergency Preparedness and Response and COVID-19 Addendum (Issued 04/15/2020 and 01/19/2021)
- P&P FE-PD-1-2017 - Consumer Direct Timesheets (Obsoleted 04/21)
- P&P FE-PD-5-2017 – Suspension of Waiver Services (Obsoleted 04/21)

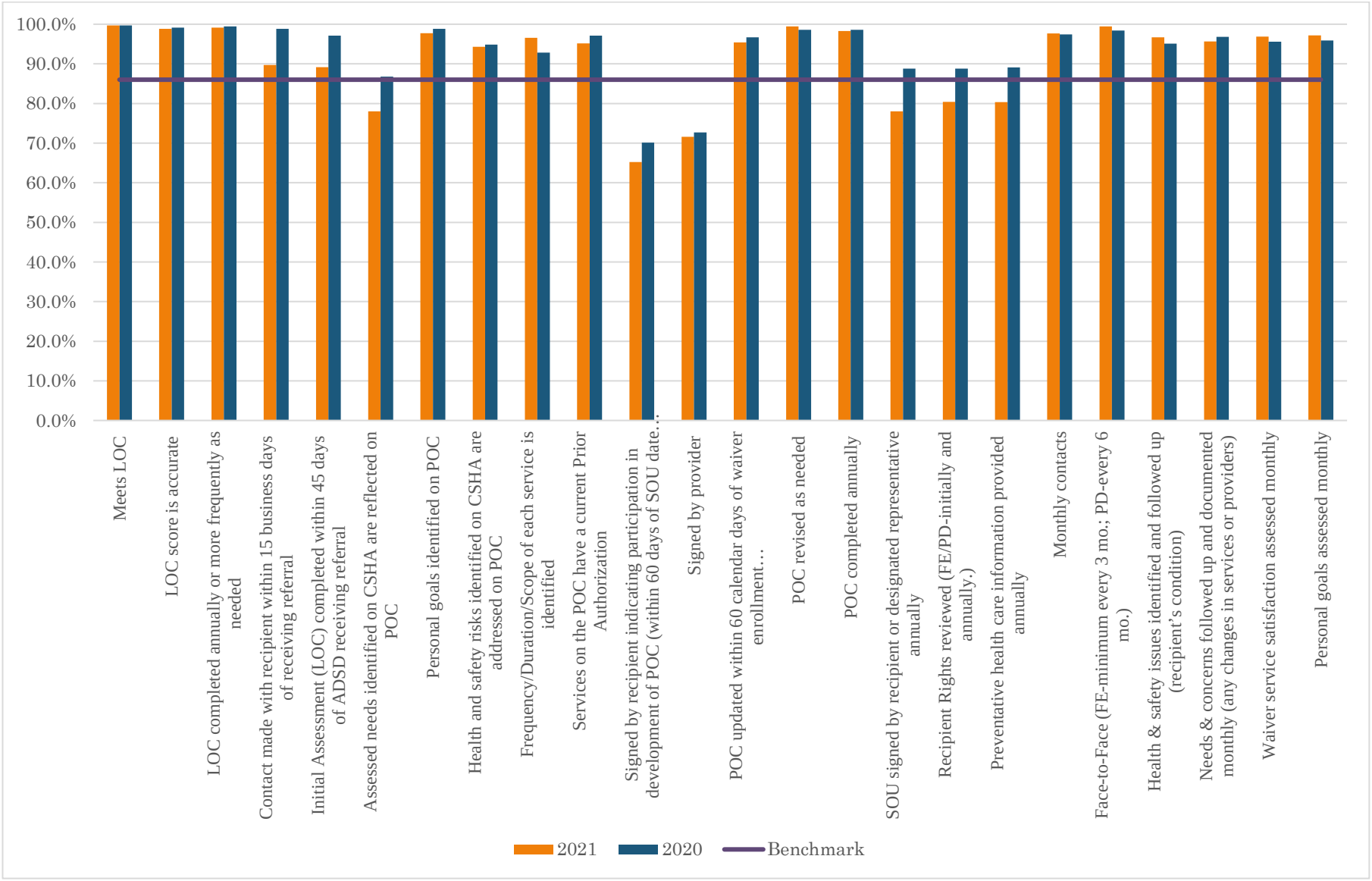
The following results identify the areas and percentages of compliance with performance measures which are required from the approved waivers and requirements outlined in the above documents.

Results

2021 Statewide Case File Results

LOC/CSHA					Plan of Care										Forms			Monthly Contacts and Documentation					
Meets LOC (at least 3 functional deficits) (New enrollees ONLY)	Meets LOC and LOC score completed accurately (Ongoing ONLY)	LOC completed annually or more frequently a needed	Contact made with recipient within 15 business days of receiving referral (New enrollees ONLY)	Initial Assessment (LOC) completed within 45 days of ADSD receiving referral (New enrollees ONLY)	Assessed needs identified on CSHA are reflected on POC	Personal goals identified on POC	Health and safety risks identified on CSHA are addressed on POC	Frequency/Duration/Scope/Amount of each service is identified	Services on the POC have a current Prior Authorization	Signed by recipient indicating participation in development of POC (within 60 days)	Signed by provider (within 60 days)	POC updated within 60 calendar days of waiver enrollment (New enrollees ONLY)	POC revised as needed (when a significant change lasting more than 30 days occurs)	POC completed annually	SOC signed by recipient or designated representative (initially and annually)	Recipient Rights reviewed (initially and annually)	Preventative health care information provided (initially and annually)	Person Centered Contact	Face-to-Face	Health & safety issues identified and followed u (recipient's condition)	Needs & concerns followed up and documented (any changes in services or providers)	Waiver service satisfaction assessed	Personal goals assessed
99.7%	98.9%	99.1%	89.7%	89.1%	78.0%	97.7%	94.3%	96.6%	95.1%	65.2%	71.6%	95.4%	99.4%	98.3%	78.0%	80.4%	80.3%	97.7%	99.5%	96.7%	95.6%	96.9%	97.2%

Case File Comparison



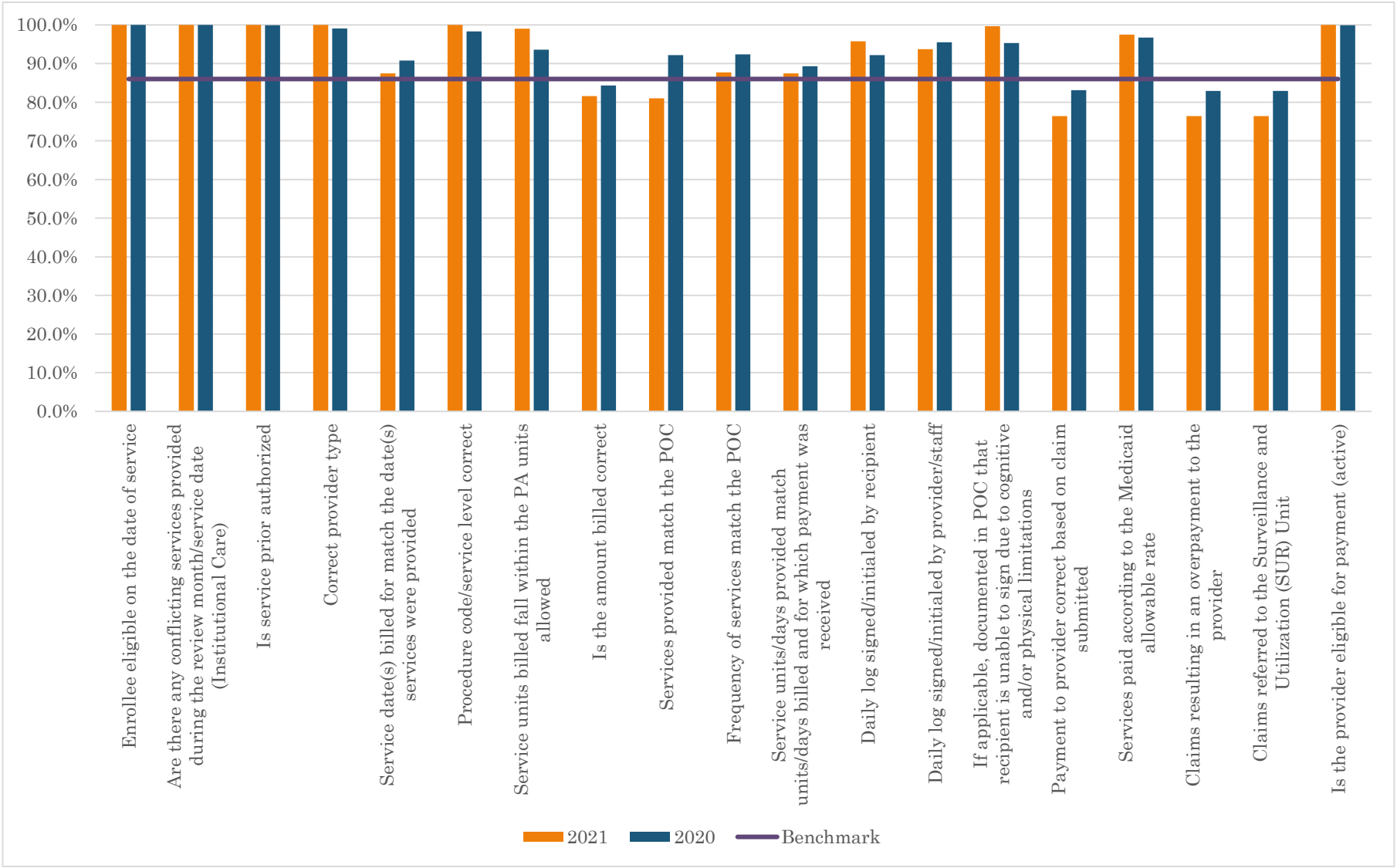
2020 vs. 2021 Case File Review Comparison

For 2021, improvement is noted for five (5) components from the previous 2020 review period. Some areas of improvement include "Frequency/duration/scope of each service is identified" at ninety-seven percent (97%), seeing an increase of four percent (4%) from the prior reporting year, as well as "POC revised as needed" at ninety-nine percent (99%), increasing one percent (1%) from the previous year. Elements within the monthly contacts continue to show upward trends from last year with health and safety issues, waiver service satisfaction assessed, and personal goals assessed all improving at least one percent (1%). Additionally, five (5) review elements all at or above ninety-eight percent (98%) remained consistent from the previous waiver year including "Meets LOC", "LOC is accurate", "LOC completed annually", "POC completed annually", and "Monthly contacts".

Note: Three (3) previously reviewed elements no longer fell within the one (1) year look back review period and therefore were removed from the comparison.

- Correct service level identified (FE)
- POC updated within 30 calendar days of waiver enrollment (FE)
- POC revised at home visit (FE)

Financial Review Comparison



2020 vs. 2021 Financial Review Comparison

For 2021, improvement is noted in six (6) components from the previous 2020 review period to the current 2021 review period. The most notable being in “Service units billed fall within the PA units allowed” at ninety-nine percent (99%), seeing an increase of five percent (5%) from the prior reporting year, as well as “Documented in POC that recipient is unable to sign” at one hundred percent (100%), and “Daily log signed/initialed by recipient” at ninety-six percent (96%), both showing a four percent (4%) increase from the previous year. Additional increases were noted in areas including “Correct provider type” by one percent (1%), “Procedure codes/service level correct” by two percent (2%), and “Services paid according to the Medicaid allowable rate” by one percent (1%). Additionally, four (4) review elements all at one hundred percent (100%) compliance remained consistent from the previous waiver year including “Enrollee eligible on the date of service”, “Any conflicting services provided during the review month”, “Is service prior authorized”, and “Is the provider eligible for payment”.

Note: The following elements reviewed are currently under compliance thresholds:

- Is the amount billed correct
- Services provided match the POC
- Payment to provider correct based on claim submitted

Findings and Recommendations

Findings identify areas of deficiency discovered through the completion of the Annual Statewide HCBS FE/PD Waiver Review. Recommendations are suggestions to help improve the effectiveness and quality of waiver operations. The following findings and recommendations are provided as guidance to develop best practices for continuing quality improvement:

Case File Review Results

ADSD Offices

The CMS requires quality improvement projects/remediation when the threshold of compliance is below eighty-six percent (86%). For the 2021 review period, six (6) elements have been identified as needing further analysis by the Quality Improvement (QI) committee.

- Assessed needs identified on CSHA are reflected on POC: 78%
- POC signed by recipient within 60 days: 65%
- POC signed by provider within 60 days: 72%
- SOC signed by recipient or designated representative: 78%
- Recipient Rights reviewed: 80%
- Preventative health care information provided: 80%

The following findings and recommendations are provided as guidance to develop best practices for continuing quality improvement:

- **Assessed needs identified on CSHA are reflected on POC**: Twenty-two percent (22%) of the files reviewed either had items identified on the CSHA that were not on the POC, or vice versa, identified on the POC that were not on the CSHA without documentation.

  Recommendation: Consistency meetings have been held with DHCFP QA, DHCFP LTSS and ADSD to review the CSHA and POC in depth and determine how case managers will notate needs and services for the recipient, as well as which sections are to be used to ensure those needs and services are addressed within the POC. Continued training of new ADSD staff members after high turnover in the last year should help to improve this area for the upcoming review year.

- **POC signed by recipient within sixty (60) days:** Thirty-five percent (35%) of the POCs reviewed were either not signed or not signed within the required timeframe by the recipient or their designated representative.

Recommendation: This review period saw a reduction in compliance for this element due to the continued COVID-19 pandemic and inability to conduct face-to-face contacts to obtain timely signatures. The restrictions have been lifting and case managers started to return to the field in June 2021. The case managers will continue to work to reduce errors within this element by creating handwritten initial and updated POCs that can be signed and dated at the face-to-face meetings. The upcoming waiver year should see an increase in compliance that was not shown in this waiver year due to the rolling year's documentation reviewed with errors during the time frame that case managers were still remote.

- **POC signed by provider within sixty (60) days:** Twenty-eight percent (28%) of the POCs reviewed were either not signed or not signed within the required timeframe by the provider or case manager.
  Recommendation: This review period saw a minimal reduction in compliance for this element due to the continued COVID-19 pandemic with providers being short staffed, shortened hours or closures impacting the ability to obtain timely signatures. With many agencies starting to return to in-person work this year, this area should also see an improvement in the upcoming year.

- **SOC signed by recipient or designated representative:** Twenty-two percent (22%) of the SOCs reviewed were either not signed or not signed annually/timely.
  Recommendation: This review period saw a reduction in compliance for this element due to the continued COVID-19 pandemic and the inability to conduct annual face-to-face reassessments and gather signatures in person. As restrictions have been lifting and case managers started to return to the field in June 2021, the upcoming waiver year should see an increase in compliance that was not shown in this waiver year due to the rolling year's documentation reviewed and errors during the time frame that case managers were still remote.

- **Recipient Rights reviewed:** Twenty percent (20%) of the Acknowledgment Forms (NMO-7075) reviewed were either not initialed/signed or not initialed/signed annually.
  Recommendation: This review period saw a reduction in compliance for this element due to the continued COVID-19 pandemic and the inability to conduct annual face-to-face reassessments and gather signatures in person. As restrictions have been lifting and case managers started to return to the field in June 2021, the upcoming waiver year should see an increase in compliance that was not shown in

this waiver year due to the rolling year's documentation reviewed and errors during the time frame that case managers were still remote.

- **Preventative health care information provided:** Twenty percent (20%) of the Acknowledgement Forms (NMO-7075) reviewed were either not initialed/signed or not initialed/signed annually.

  Recommendation: This review period saw a reduction in compliance for this element due to the continued COVID-19 pandemic and the inability to conduct annual face-to-face reassessments and gather signatures in person. As restrictions have been lifting and case managers started to return to the field in June 2021, the upcoming waiver year should see an increase in compliance that was not shown in this waiver year due to the rolling year's documentation reviewed and errors during the time frame that case managers were still remote.

Additional Recommendations

- Develop a standardized process for completing the Waiver Case File Review form for supervisor reviews:
  - This year saw an improvement with consistency in the process for supervisor reviews and notation. Supervisors have aligned their processes with utilization of percentages for recipient/provider signatures as well as annual forms. There were less instances of errors cited without appropriate commentary, as well.
- Ensure that supervisor reviews appropriately address questions specific to new enrollees. The DHCFP QA staff found that the following questions were answered as Not Applicable (N/A), when a Yes or No answer was applicable:
  - Contact made with recipient within 15 business days of receiving referral.
  - Initial Assessment (LOC) completed within 45 days of the ADSD receiving referral.
- Ensure that supervisor reviews appropriately assess required documentation including a complete look at the rolling year, which consist of all sets of documentation that effect the selected time frame.

As previously reported, in April 2021 DCHFP LTSS, DCHFP QA and ADSD worked together to review all policies, waiver, MSM, CFRs, etc., to ensure all items reviewed are in accordance with policy.

Progress will continue to be monitored by the QI Committee, with the ongoing collaboration efforts and COVID-19 restrictions continuing to lift, improvements should be seen throughout the next review period.

Financial Review Results

***The following elements showed an increase in errors from the previous review period*:**

- Service dates billed for match the dates services were provided: 3%
- Amount billed correct: 3%
- Services provided match the POC: 11%
- Frequency of services match the POC: 5%
- Service units/days provided match units/days billed: 2%
- Daily log signed by provider: 2%
- Payment to provider correct based on claim submitted: 7%

Elements with no change since last review period:

- Enrollee eligible on the date of service
- Are there any conflicting services provided
- Is service prior authorized
- Is the provider eligible for payment (active)

***The following elements showed a compliance increase from the previous review period*:**

- Correct provider type: 1%
- Procedure code/service level correct: 2%
- Service units billed fall within the PA units allowed: 5%
- Daily log signed/initialed by recipient: 4%
- If applicable, documented in POC that recipient is unable to sign: 4%
- Service paid according to the Medicaid allowable rate: 1%

Financial review results reflect compliance for the provider community. Six (6) elements of the review resulted in a one percent (1%) or more improvement when compared to the 2020 combined average results. Five (5) elements resulted in a three percent (3%) or more decrease in compliance when compared to the 2020 review period combined average results. Three (3) data elements remain below the eighty-six percent (86%) threshold, not meeting compliance. "Claims resulting in an overpayment" and "Claims referred to Surveillance and Utilization (SUR) Unit" showed a decrease in compliance of seven percent (7%) each. All elements with a decrease in compliance will be addressed in the forthcoming QI meetings to improve the overall operation of the HCBS FE/PD Waivers.

Recommendations: During COVID-19 there was a retroactive six (6)-month rate reduction on many services. As this was retroactive, many providers were errored on billing the incorrect rate but were not overpaid for services within the system. This does not appear to be an ongoing issue. Services provided matching the POC came under compliance this wavier year. Providers would benefit from making sure that their methods of tracking recipient services provided (daily/monthly logs) accurately capture all potential needs of the recipient as listed on the POC.

Comprehensive Provider Review

The Aithent Licensing System (ALiS) provider database went live in March of 2018. This centralized database for provider reviews has provided ADSD and DHCFP LTSS Waiver Unit the ability to download the entire review, capture, and store notes from the review process, and maintain all required documentation in a centralized location. ADSD follows up on any deficiencies found during the provider reviews and DHCFP LTSS reports the findings.

DHCFP Central Office- LTSS Waiver Unit

The DHCFP LTSS Waiver Unit provided a P&P, effective 07/01/2021, providing guidance to ADSD regarding the procedure for creating and updating POCs by hand with the recipient to then be finalized in the office and mailed to the recipient for both the PD and FE waiver combined reviews.

MSM Chapters 2200 and 2300 were both updated and approved to be effective 07/01/2022.

The current PD Waiver is set to expire 12/31/2022 and the renewal for that Waiver is in process. There is also an amendment in process for the FE Waiver (previously effective 07/01/2020) in order to align with the renewing PD Waiver.

The HCBS Assisted Living (AL) Waiver expired 06/30/2014 and was combined with the HCBS FE Waiver effective 07/01/2015. LTSS held a public workshop on 11/30/2020 for updates made to MSM 2200 Home and Community Based Waiver for the Frail Elderly and the obsoletion of MSM Chapter 3900 Home and Community Based Waiver for Assisted Living. The updated FE waiver has been submitted, approved, and became effective 07/01/2020.

Participant Experience Surveys (PES)

A focus of the HCBS Waiver Program(s) is to ensure the recipient is satisfied with their services and achievement of desired outcomes. Recipients were interviewed regarding their experiences and satisfaction with their waiver services and providers. The interviews were conducted by the DHCFP QA staff and the ADSD staff using the Participant Experience

Survey (PES) interview tool developed by The MEDSTAT Group, Inc. under a contract from the CMS. Indicators used for monitoring quality within the waiver program(s) are calculated using the data captured from these surveys.

A random sample of HCBS FE and PD Waiver recipients were selected to participate in the annual PES interviews for Carson City, Las Vegas, and Reno. PES interviews are conducted on a monthly (ADSD) and biannually (DHCFP QA) basis. PES interviews included within this report, cover July 2021 through June 2022. Three hundred fifty (350) recipients were selected to meet a 95/5 sample size, wherein one hundred sixty-seven (167) PES interviews were completed. DCHFP QA staff continued to complete PES remotely due to the COVID-19 pandemic precautions; the PES tool was mailed out with an accompanying cover letter. DHCFP QA staff then called the recipients to complete the interviews via telephone or inform them that the surveys could be mailed back as well. Of the ninety-four (94) surveys mailed out and followed-up with, thirty-five (35) were completed, five (5) had returned mail with no forwarding address or invalid phone numbers, seventeen (17) were deceased, one (1) moved out of state, eight (8) closed and or were hospitalized and the remaining twenty-seven (27) recipients did not participate either by choice, or DHCFP QA was unable to contact after three (3) attempted phone calls. ADSD staff completed one hundred thirty-two (132) PES interviews via telephone calls due to the COVID-19 pandemic.

As compared to the 2020 review period, ADSD changed their internal policy to align recipient selection and review completion with the methodology of DHCFP QA. Previously, ADSD completed supervisor reviews and PES on different selected recipients, this review period they completed these reviews and interviews from the same selected list of recipients for both supervisor reviews and PES.

Recipient issues determined to be critical and in need of immediate attention were promptly communicated to the appropriate ADSD office staff.

The top twelve (12) questions with the highest recipient satisfaction were:

- ✓ Staff Time
- ✓ Case Manager Helpfulness
- ✓ Overall Satisfaction with Case Manager
- ✓ Overall Satisfaction with Services
- ✓ POC Development
- ✓ Respect by Home Care Staff
- ✓ Careful Listening by Home Care Staff
- ✓ Respect by Day Program Staff
- ✓ Careful Listening by Day Program Staff
- ✓ Respect by Transportation Staff
- ✓ Careful Listening by Transportation Staff
- ✓ Community Involvement

The six (6) questions with the highest adverse responses indicating an unmet need were:

- ✓ Access to Care
- ✓ Choice in Staff
- ✓ Changing Staff
- ✓ Directing Staff
- ✓ Contact for Reporting Staffing Problems
- ✓ Equipment or Modifications

The DHCFP QA staff understands that due to the nature of the population interviewed, inconsistencies or circumstantial answers were noted in responses from the HCBS FE/PD Waiver recipients. For example, in much of the State of Nevada currently there are staffing shortages in many of the provider fields which is why Access to Care, Choice in Staff and Changing Staff were all noted as high needs this review period. Many recipients were able to identify that they had unmet needs due to lack of available staffing and often there were comments about the diligence of the case management staff in monitoring those situations. In addition to the questions that were asked, the following positive feedback was provided by recipients and/or their family members or designated representative:

- Recipients clearly expressed their satisfaction with their case manager as well as with their providers.

- Recipients indicated that they actively participated in the development of their POC, allowing them to remain safely in their home of choice.

Best Practices

Best practices are methods or techniques that represent the most efficient or prudent course of action. The following practices were observed contributing to the quality of health, safety, and welfare of waiver recipients:

- Waiver case file reviews completed by the ADSD supervisors demonstrated that positive guidance was given to the case managers. Specific examples were given indicating a job well done and encouraging staff to improve documentation and the quality of service.

- Descriptive contacts make it easy to follow the recipient's progress and demonstrates the efforts the case manager makes to respond to the recipient's needs.

- It was noted among all the ADSD offices that a supportive and agreeable relationship between the case managers, providers and recipients is being established using a person-centered approach.

- Continued training in and implementation of new Electronic Visit Verification (EVV) system to obtain recipient and provider signatures for verification of services rendered for use in financial reviews.

- Trainings with all new staff and refreshers for current staff include walkthroughs between CSHAs, POCs, and PAs to ensure accuracy in completion of required annual updates.

- Due to the onboarding of a new private case management company, ADSD has separated their operations and providers into two (2) units to eliminate any potential conflict of interest.

QI Project Performance

As part of the consolidated review process, the DHCFP QA staff and the ADSD waiver staff gather monthly for a Consolidated Waiver Quality Improvement (QI) Committee meeting. The CMS has mandated a threshold of less than eighty-six percent (86%) for any Performance Measure indicating a need for improvement. Assurances that are below eighty-six percent (86%) for the review period are assigned to a priority grid. The QI Committee members are assigned projects to analyze and identify the probable cause of deficiencies and develop plans to improve performance and track improvement.

The QI Committee is responsible for conducting the QI Projects for the Consolidated Waiver Review as issues are identified, as well as at the time of the final Consolidated Annual Waiver Review Report. The committee will conduct all QI Projects related to the waiver reviews using the following the CMS guidance:

1. Identify probable cause(s) of problem.

2. Develop intervention(s) designed to improve performance.

3. Allow enough time for intervention to have effect.

4. Measure impact (does performance increase, decrease, remain the same?).

QI Committee

The QI Committee has been monitoring issues directly relating to issues and limitations due to the COVID-19 pandemic:

Signed by recipient indicating participation in development of POC - As part of the waiver requirements, all recipients must sign their POCs within sixty (60) days of development.

Remediation Plan:

- Restrictions have started to lift towards the end of this waiver review period. ADSD will reduce errors within this element by creating handwritten initial and updated POCs that can be signed and dated at the face-to-face meetings. With the return to home visits, this area should continue to increase for the subsequent waiver year.

Signed by provider (within 60 days of SOU date, waiver effective date, or prior POC, whichever is later) - Every waiver service requires the provider signature.

Remediation Plan:

- With COVID-19 restrictions lifting, many providers are back in their offices full time as well which will hopefully begin to improve this area for the subsequent waiver year.

SOC signed by the recipient or designated representative (initially and annually) – Recipients must initial and sign the SOC form annually to indicate choice of waiver services, and choice of providers.

Remediation Plan:

- This document is typically signed at the annual reassessment completed in the recipient's home. ADSD attempted to obtain signatures other ways during the pandemic, including mailing documentation to the recipient but there were often challenges with receiving documentation back. With COVID-19 restrictions lifting and providers re-entering the field, this area should see improvement in the subsequent waiver year.

Recipient Rights reviewed (initially and annually) – Recipients are informed of their rights annually; this is noted by the recipient initials/signature on the Acknowledgement Form NMO-7075.

Remediation Plan:

- This document is typically signed at the annual reassessment completed in the recipient's home. ADSD attempted to obtain signatures other ways during the pandemic, including mailing documentation to the recipient but there were often challenges with receiving documentation back. With COVID-19 restrictions lifting and providers re-entering the field, this area should see improvement in the subsequent waiver year.

Preventative health care information provided (initially and annually) – Recipients are provided information on preventative health care annually; this is noted by the recipient initials/signature on the Acknowledgement Form NMO-7075.

Remediation Plan:

- This document is typically signed at the annual reassessment completed in the recipient's home. ADSD attempted to obtain signatures other ways during the pandemic, including mailing documentation to the recipient but there were often challenges with receiving documentation back. With COVID-19 restrictions lifting and providers re-entering the field, this area should see improvement in the subsequent waiver year.

The QI Committee conducted consistency meetings with staff from DCHFP LTSS, ADSD and DCHFP QA to continue to address an element that has remained out of compliance:

Assessed needs identified on CSHA are reflected on POC – As part of the wavier requirements, Service Plans address all participants' assessed needs, including health and safety risk factors, and personal goals, either by the provision of waiver services or through other means.

Remediation Plan:

- Due to turnover of staff within ADSD an in-depth review of the CSHA and POC was conducted during the 2020 review period. During that time, determinations were made as to how case managers will notate the needs and services on the CSHA and how those translate to the POC for the recipient to assure that all needs are being addressed. With continued new hiring of staff, in the 2021 review period, the QI Committee held additional consistency meetings to continue to monitor this review element. ADSD is continuing to educate and train their staff to improve outcomes in this area.

During the monthly QI meetings, ADSD regional offices are given their year to date (YTD) and Quarterly reports so they can track how each office is doing and make improvements throughout the review period. The following training dates were conducted by ADSD:

- Case File Review numbers, trends, and QA updates – 06/29/2022

- Reassessment (RA) Home Visit (HV) – 07/07/2021, 08/05/2021, 08/06/2021, 09/09/2021, 10/14/2021, 02/17/2022

- Comprehensive Assessment (CSHA)/Plan of Care (POC)/Prior Authorization (PA) – 07/08/2021, 07/22/2021, 08/06/2021, 08/19/2021, 09/09/2021, 10/15/2021, 02/14/2022, 02/18/2022

- Person Centered Contact Training – 07/02/2021, 07/16/2021, 08/27/2021, 10/08/2021, 02/17/2022

Requirements[1]

Case File Review Requirements				
Level of Care (LOC)/Comprehensive Social Health Assessment (CSHA)				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Meets LOC (at least three (3) functional deficits)	FE- The assessment determines if the condition requires the level of services offered in a nursing facility with at least 3 functional deficits identified in sections 1-5 of the screening tool or a more integrated service which may be community based. PD- There are 13 total functional deficits identified on the LOC Assessment Tool. An eligible recipient or pending applicant must meet at least three deficits out of the 13 possible.	FE- Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (d) PD- Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (d)	FE- Each applicant/recipient must meet and maintain a level of care for admission into a nursing facility and would require imminent placement in a nursing facility (within 30 days or less) if HCBW services or other supports were not available. Effective 02/01/2021 – FE- Each applicant/recipient must meet and maintain a Level of Care (LOC) for admission into a NF and would require imminent placement in a NF (within 30 days or less) if HCBS services or other supports were not available PD- The applicant must meet and maintain a LOC for admission into a Nursing Facility (NF) within 30 days if HCBW services or other supports were not available.	FE- MSM Chapter 2200, Section 2203.2A(5)(a)(1)(b) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.1(A)(2) PD- MSM Chapter 2300, Section 2303.2A(2)(b)
LOC score is accurate	FE/PD- Performance Measure: Number and percent of recipients whose Level of Care (LOC) eligibility was based on accurate application of policy resulting in accurate LOC determinations.	FE/PD- Appendix B: Evaluation/Revaluation of Level of Care. Quality Improvement: Level of Care, (a)(i)(c)	N/A	N/A

[1] The requirements in this grid are cited as written in the HCBS FE Waivers effective July 1, 2015 and July 1, 2020, the HCBS PD Waiver effective January 1, 2018, the MSM Chapter 100 effective May 1, 2019 and August 28, 2019, the MSM Chapter 2200 effective September 25, 2019 and February 1, 2021, the MSM Chapter 3900 effective July 13, 2012 (obsoleted), and the MSM Chapter 2300 effective September 25, 2019. Obsolete verbiage in this report will be updated upon revision of these documents.

LOC completed annually or more frequently as needed	FE/PD- Clients must be assessed at minimum annually while receiving waiver services to reaffirm eligibility, including level of care. If there is a significant change in the client's condition that would affect the level of services or program eligibility, reassessment is made at that time. Effective 07/2020 -FE - Re-evaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule: every 12 months.	FE/PD- Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (g)	FE/PD- The recipient's level of care (LOC), functional status and needs addressed by the POC must be reassessed annually or more often as needed.	FE- MSM Chapter 2200, Section 2203.1A(3)(b) Effective 02/01/2021 FE- MSM Chapter 2200, Section 2203.11A(3)(b) PD- MSM Chapter 2300, Section 2303.1A(3)(b)
Contact made with recipient within 15 business days of receiving referral (**New enrollees ONLY**)	FE/PD- When a referral is received and assigned; the Intake Specialist makes phone/verbal contact with the applicant or his or her representative within fifteen working days of receipt of the referral.	FE/PD- Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (f)	FE- ADSD will make phone/verbal contact with the applicant/representative within fifteen working days of the referral date. Effective 02/01/2021 – FE- The ADSD intake specialist will make phone/verbal contact with the applicant/ designated representative/LRI within 15 working days from the referral date.	FE- MSM Chapter 2200, Section 2203.13A(1)(b) Effective 02/01/2021 FE – MSM Chapter 2200, Section 2203.12A (1)(b)
Initial assessment (LOC) completed within 45 days of ADSD receiving referral (**New enrollees ONLY**)	FE- The face-to-face assessment to determine level of care and waiver service need must occur within 45 calendar days of the referral date to assure timely access to services. PD – Within 45 days of the referral a face-to-face visit is made to assess the LOC, complete forms and gather the medical records.	FE/PD- Appendix B: Participant Access and Eligibility, Section B-6: Evaluation/Reevaluation of Level of Care, (f)	Effective 02/01/2021 - FE- If the applicant appears to be eligible, a face-to-face visit must be scheduled and completed within 45 calendar days from the referral date to assess eligibility including the NF LOC determination.	Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.12A(1)(c)
Plan of Care (POC)				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Assessed needs identified on CSHA are reflected on POC	FE/PD- Performance Measure: Number and percent of recipients POCs that address the	FE/PD- Appendix D: Participant-Centered Planning and Service Delivery, Section	FE/PD- The POC must reflect the recipient's service needs and include both waiver and non-	FE- MSM Chapter 2200, Section 2203.1A(3)(a)

	assessed needs identified in the social health assessment.	Quality Improvement: Service Plan, (a)(i)(a)	waiver services in place at the time of POC completion, along with informal supports that are necessary to address those needs. Effective 02/01/2021 - FE- Development of the POC identifying the waiver services as well as other ongoing community support services that the recipient needs to live successfully in the community.	PD- MSM Chapter 2300, Section 2303.1A(3)(a) Effective 02/01/2021 FE - MSM Chapter 2200, Section 2203.11A(3)(b)
Personal goals identified on CSHA are addressed on POC	FE/PD- Number and percent of recipients POCs that address personal goals identified in the social health assessment. Effective 07/2020 – FE - Performance Measure: Number and percent of recipients POC's that include personalized goals	FE/PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(a)	FE/PD- Monitoring the overall provision of waiver services, in an effort to protect the safety and health of the recipient and to determine that the POC goals are being met. Effective 02/01/2021 FE - "…POC personalized goals are being met"	FE- MSM Chapter 2200, Section 2203.4A(3) PD- MSM Chapter 2300, Section 2303.3E(3) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.3A(3)
Health and safety risks identified on CSHA are addressed on POC	FE/PD- Performance Measure: Number and percent of recipients POCs that address health and safety risk factors identified in the social health assessment.	FE/PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality improvement: Service Plan, (a)(i)(a)	FE- Monitoring the overall provision and quality of care of waiver services, in order to protect the health, welfare and safety of the recipient, and to determine that the POC goals are being met. PD- A written POC is developed in conjunction with the recipient by the DHCFP District Office Case Manager for each recipient under the waiver. The POC is based on the assessment of the recipient's health and welfare needs.	FE- MSM Chapter 2200, Section 2203.4A(3) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.3A(3) PD- MSM Chapter 2300, Section 2303.14A(4)(a)(5)(a)
Frequency/Duration/Scope of each service is identified	FE/PD- Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.	FE/PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality improvement: Service Plan, (a)(i)(d)	FE- In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC. PD- N/A	FE- MSM Chapter 2200, Section 2203.3B(1)(h) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.10B(3)(a) PD- N/A

Services on the POC have a current prior authorization	FE/PD - The case manager ensures that the services on the POC are assigned the appropriate prior authorization. PD- All waiver services are prior authorized.	FE/PD - Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (b)(i) PD- Appendix I: Financial Accountability, Section I-2: Rates, Billing and Claims (1 of 3), (b)(2)	FE- Ensure completion of prior authorization form, if required, for all waiver services documented on the POC for submission into the Medicaid Management Information System (MMIS). PD- Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility: 11. Completion of prior authorization form in the Medicaid Management Information System (MMIS).	FE- MSM Chapter 2200, Section 2203.1A(10) Effective 02/01/2021 FE- MSM Chapter 2200, Section 2203.11A(10) PD- MSM Chapter 2300, Section 2303.1A(11)
Signed by recipient indicating participation in development of POC (within 60 days of SOU date/waiver date/prior POC)	PD- Performance Measure: Number and percent of recipients POCs that contain the recipient's signature indicating participation in POC development. Effective 07/2020 - FE/PD - The plan is completed no more than 60 calendar days from waiver enrollment. The finalized service plan must be signed and dated by both the recipient and provider(s).	PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b) Effective 07/2020 - FE/PD - Appendix D: Participant-Centered Planning and Service Delivery, D-1: Service Plan Development (d)(a)	FE- If services documented on a POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible. Effective 02/01/2021 - FE- All forms must be completed with initials, signatures, and dates by the recipient/designated representative/LRI. Electronic signatures are acceptable pursuant to NRS 179 "Electronic Records and Transactions" on forms that require a signature. PD- All forms must be complete with signature and dates when required.	FE- MSM Chapter 2200, Section 2203.1A(3)(c) Effective 02/01/2021 FE- MSM Chapter 2200, Section 2203.12A(5)(d) PD- MSM Chapter 2300, Section 2303.14A(4)(a)(6)
Signed by provider (within 60 days of SOU date/waiver date/prior POC)	Effective 07/2020 - FE/PD - The plan is completed no more than 60 calendar days from waiver enrollment. The finalized service plan must be signed and dated by both the recipient and provider(s).	Effective 07/2020 - FE/PD - Appendix D: Participant-Centered Planning and Service Delivery, D-1: Service Plan Development (d)(a)	N/A	N/A

POC updated with waiver enrollment (**New enrollees ONLY**)	FE- Performance Measure: Number and percent of new applicants whose POC is completed within no more than 30 calendar days of waiver enrollment. PD- Performance Measure: Number and percent of new applicants whose POC is completed within no more than 60 calendar days of waiver enrollment. Effective 07/2020 FE/PD – The POC is completed no more than 60 calendar days from wavier enrollment.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b) Effective 07/2020 FE/PD – Appendix D: Participant-Centered Planning and Service Delivery Section D-1: Service Plan Development (d)(a)	N/A	N/A
POC revised as needed (when a significant change lasting more than 30 days occurs)	FE/PD- Performance Measure: Number and percent of recipients' POCs that are updated when the recipient's needs changed. **Information above is also still present Effective 07/2020 FE – Ongoing POC's are updated and revised when there is a significant change expected to last more than 30 days that occurs outside the annual review. PD – The POC is revised annually, or when a significant change occurs that lasts greater than 30 days.	FE/PD- Appendix D: Participant Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(c) Effective 07/2020 - FE/PD – Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d)(a)	FE- The recipient's level of care, functional status and needs addressed by the POC must be reassessed annually or more often as needed. PD- The recipient's LOC, functional status and needs addressed by the POC must be reassessed annually or more often as needed.	FE- MSM Chapter 2200, Section 2203.1A(3)(b) PD- MSM Chapter 2300, Section 2303.1A(3)(b) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.11A, (3)(b)
POC completed annually	FE/PD- Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.	FE/PD- Appendix D: Participant Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(c)	N/A	N/A

Forms				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
SOU signed by recipient or authorized representative	FE- Performance Measure: Number and percent of recipients whose SOU is signed indicating choice [of] providers and choice of services. PD- Performance Measure: Number and percent of recipients whose SOU is signed indicating choice of waiver services and institutional care, choice of providers and choice of services.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(e) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(e)	FE- ADSD will forward an initial assessment (IA) packet to the DHCFP Central Office Waiver Unit, which will include: ...the Statement of Understanding/Choice (SOU) must be complete with signature and dates. Effective 02/01/2021 FE- The Statement of Understanding/Choice (SOU) must be complete with signature and dates. PD- The recipient or the recipient's authorized representative will: …complete, sign and submit all required forms.	FE- MSM Chapter 2200, Section 2203.13A(3)(a)(6)(d) Effective 02/01/2021 FE- MSM Chapter 2200, Section 2203.12A(5)(b) PD- MSM Chapter 2300, Section 2303.3C(14)
Recipient Rights reviewed (initially and annually)	FE- The client Bill of Rights is reviewed during the initial application process and as needed thereafter. Effective 07/2020 - FE- Annually-Recipient Rights form is reviewed with and provided to the participant/guardian/family during the in personal assessment and reassessment. PD- Case managers provide a copy of the HCBW Recipient Rights to all individuals at the initial home visit and annual home visit so. In addition, case managers review the Recipient Rights at the six-month home visit.	FE- Appendix G: Participant Safeguards, Appendix G-1: Response to Critical Events or Incidents c. Participant Training and Education PD- Appendix B: Evaluation/Revaluation of Level of Care, Section Quality Improvement: Level of Care, (a)(i)(c)(ii)	FE- All required forms must be complete with signature and dates where required. Effective 02/01/2021 FE- Recipients are informed of their rights to a fair hearing at the initial face-to-face visit and annually thereafter when they are given the recipients rights form PD- The recipient or the recipient's authorized representative will: ... sign all required forms.	FE- MSM Chapter 2200, Section 2203.13A(3)(a)(9) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2205 PD- MSM Chapter 2300, Section 2303.3C(14)
Preventative health care information provided annually	FE/PD- Performance Measure: d) Number and percent of recipients who receive information annually regarding preventative health care.	FE/PD- Appendix G: Participant Safeguards, Quality Improvement: Health and Welfare, (a)(i)(a)(d)	N/A	N/A

Monthly Contacts and Documentation				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Contact with each recipient completed on a monthly basis Face-to-Face (minimum annually) (Appendix K)	FE- Contacts may be by telephone, but there must be a home visit to each recipient at least every three months, or more often if the recipient has indicated a significant change in status or if there are reasons for concern about health and safety. PD- The direct service case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every six months. More contacts may be made if the recipient has indicated a significant change in his or her health care status or is concerned about his or her health and/or safety.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d)(f) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d)(f)	FE- The case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every three months…During the monthly contact, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. Effective 02/01/2021 - FE - The case manager must have ongoing contact with each waiver recipient and/or the recipient's designated representative/LRI; this may be a telephone contact. At a minimum, there must be one face-to-face visit with each recipient annually. All other ongoing contacts may be by telephone, fax, e-mail, or face-to-face. PD- The direct service case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every six months.	FE- MSM Chapter 2200, Section 2203.4A(4)(a) &(c) Effective 02/01/2021 FE- MSM Chapter 2200, Section 2203.3A(4)(a) PD- MSM Chapter 2300, Section 2303.3E(4)(a)

Health & safety issues identified and followed up (recipient's condition)	FE- Contacts may be by telephone, but there must be a home visit to each recipient at least every three months, or more often if the recipient has indicated a significant change in status or if there are reasons for concern about health and safety. PD- In addition to the [CSHA], individualized goals, risks, back-up plans, and follow-up on health and safety needs is addressed during the monthly contacts. PD – The recipient will be informed that contact must be made with the case manager if there are any instances of health, safety, or welfare concerns, or when a significant change in their health status has occurred.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d)(f) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (5 of 8), (e) PD – Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (f)	FE- During the monthly contact, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. Effective 02/01/2021 – FE – "…promoting personalized goals stated in the POC." PD- During the monthly contact, the direct service case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC.	FE- MSM Chapter 2200, Section 2203.4A(4)(c) Effective 02/01/2021 FE – MSM Chapter 220, Section 2203.3A(4)(c) PD- MSM Chapter 2300, Section 2303.3E(4)(c)
Needs & concerns followed up and documented monthly (any changes in services or providers)	FE- During the contacts, information such as: changes since last contact, medical appointments, new medications or treatments, hospitalizations, falls, waiver services meeting needs, any new or unmet needs, satisfaction with services, any equipment or supplies needed, or other information is gathered based on interview. PD- Contacts may be by telephone, but there must be a home visit to each participant at least every 6 months or more often if the participant has indicated a significant change in health care status or if there are reasons for concern about health, safety, and welfare.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section D-2: Service Plan Implementation and Monitoring (a) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d)(f)		

Waiver service satisfaction assessed monthly	FE- Monthly contacts with the recipients are required to be initiated by the case manager to discuss the authorized services and evaluate the recipient's level of satisfaction. PD- Monthly contacts with the recipients are required and initiated by the case manager to discuss the authorized services and evaluate the recipient's level of satisfaction.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan (4 of 8), (d)(f) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (4 of 8), (d) Service Plan Development Process, (f)		
Personal goals assessed monthly	PD- In addition to the [CSHA], individualized goals, risks, back-up plans, and follow-up on health and safety needs is addressed during the monthly contacts.	PD- Appendix D: Participant-Centered Planning and Service Delivery, Section D-1: Service Plan Development (5 of 8), (e)		
Financial Claim Review Requirements				
Eligibility				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Enrollee eligible on the date of service	FE/PD- The Medicaid Management Information System (MMIS) assures that all claims for payment are made when the recipient was eligible for Medicaid waiver payment on the date of service, that the service was included in the recipient's approved service plan, and that the services were provided. This is accomplished through several subsystems within MMIS.	FE/PD- Appendix I: Financial Accountability, Section I-2: Rates, Billing and Claims (3 of 3), (d)(a)	FE- The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service is included in the approved POC, and prior authorization is in place when required. Effective 02/01/2021 - FE- The DHCFP assures that claims for payment of waiver services are made only when a recipient is Medicaid eligible, when the service is included in the approved POC, and PA is in place when required. PD- The DHCFP must assure CMS all claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service(s) are identified on the approved POC, and if the service(s) has been prior authorized.	FE- MSM Chapter 2200, Section 2203.14 Effective 02/01/2021 FE – MSM Chapter 2200, Section 2203.16 PD- MSM Chapter 2300, Section 2303.15

Are there any conflicting services provided during the review month/service dates (*Institutional care*)	FE/PD- In accordance with 42 CFR 441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, an NF or ICF/IID.	FE/PD- 6. Additional Requirements, B. Inpatients.	FE- A recipient's case may be suspended, instead of closed if it is likely the recipient will be eligible again for waiver services within the next 60 days (for example, if a recipient is admitted to a hospital, nursing facility or ICF/MR). Effective 02/01/2021 - FE- A recipient's case must be suspended, instead of closed if it is likely the recipient will be eligible again for waiver services within the next 60 days. For example, if a recipient is admitted to a hospital, NF or Intermediate Care Facility for the Intellectually Disabled (ICF/IID). PD- Recipients must be suspended when they are admitted to a hospital or an NF.	FE- MSM Chapter 2200, Section 2204.1(a) PD- MSM Chapter 2300, Section 2304.1A(1)
Prior Authorization				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Is service prior authorized	FE/PD- Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization.	FE- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability (a)(i)(a) PD- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability (a)(i)	FE- All providers may only provide services that have been identified in the POC and that, if required, have a prior authorization. Effective 02/01/2021 - FE- All providers may only provide services that have been identified in the POC and that, if required, have a Prior Authorization (PA). PD- Administrative case management activities include...Completion of prior authorization form in the Medicaid Management Information System (MMIS).	FE- MSM Chapter 2200, Section 2203.3B(1)(e) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.2B(1)(g) PD- MSM Chapter 2300, Section 2303.1A(11)

Correct provider type	N/A	N/A	FE- Must obtain and maintain a HCBW for the Frail Elderly provider number (Provider Type 48 or 57 as appropriate) through the DHCFP's QIO-like vendor. Effective 02/01/2021 - FE- Must obtain and maintain a provider number (Provider Type 48, 57 or 59 as appropriate) through the DHCFP's Fiscal Agent. PD- Providers may also refer to the DHCFP's website for a complete list of codes/modifiers billable under Provider Type 58.	FE- MSM Chapter 2200, Section 2203.3B(1)(a) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.2B(1)(a) PD- MSM Chapter 2300, Section 2303.15B
Procedure code/service level correct	FE/PD- Performance Measure: Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization.	FE- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)(a) PD- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)	FE- The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service is included in the approved POC, and prior authorization is in place when required. Effective 02/01/2021 FE- The DHCFP assures that claims for payment of waiver services are made only when a recipient is Medicaid eligible, when the services is included in the approved POC, and PA is in place when required. PD- The DHCFP must assure CMS all claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service(s) are identified on the approved POC, and if the service(s) has been prior authorized.	FE- MSM Chapter 2200, Section 2203.14 Effective 02/01/2021 FE – MSM Chapter2200, Section 2203.16 PD- MSM Chapter 2300, Section 2303.15
Daily Record				
Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Services provided match the POC	FE- Number and percent of recipients services that are delivered in accordance with the approved POC. PD- The individual POC lists the services by scope, frequency, and duration. Case managers	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(d) PD- Appendix I: Financial Accountability, Section	FE- All providers may only provide services that have been identified in the POC and that, if required, have a prior authorization. PD- All Providers...May only provide services that have been identified in the recipient POC and, if	FE- MSM Chapter 2200, Section 2203.3B(1)(e) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.2B(1)(g) PD- MSM Chapter 2300, Section 2303.3B(1)(d)

	fax a copy of the appropriate POC to waiver providers and may go over the POC with waiver providers if requested. Providers are required to provide the services listed in the approved POC. The daily record verifies that services were provided in accordance with the approved POC.	I-2: Rates, Billing and Claims (3 of 3), (d)(b)	required, have prior authorization.	
Frequency of Services match the POC	FE/PD- Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.	FE- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(d) PD- Appendix D: Participant-Centered Planning and Service Delivery, Section Quality Improvement: Service Plan, (a)(i)(b)		
Daily log signed by recipient	FE- The claims are compared to the prior authorizations, POC and daily logs or timesheet signatures for accuracy. PD- Waiver claims are pulled directly from the MMIS system and compared to the appropriate POC and daily records for verification of service delivery.	FE- Appendix I: Financial Accountability, Section I-1: Financial Integrity and Accountability, (b) PD- Appendix I: Financial Accountability, Section I-2: Rates, Billing and Claims (3 of 3), (d)(c)	FE- The daily record is documentation completed by a provider, indicating the scope and frequency of services provided. The documentation will include the recipient's initials daily with a full signature of the recipient on each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the recipient file. Effective 02/01/2021 - FE- The recipient or, if applicable, the recipient's designated representative/Legally responsible Individual (LRI) will…Sign the provider's daily/weekly record(s) to verify services were provides (except for case management and PERS). If the recipient is unable to provide a signature dude to cognitive and/or physical limitations, this will be clearly documented on the SOU and/or the case narrative.	FE- MSM Chapter 2200, Section 2203.3B(1)(h) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.2C(5) PD- MSM Chapter 2300, Section 2303.3B(2)(a)(10)

			PD- Each provider agency must have a file for each recipient. In the recipient's file, the agency must maintain the daily records. Periodically, the DHCFP Central Office staff may request this documentation to compare to billings submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.	
Service units billed fall within the PA units allowed	FE/PD- Performance Measure: Number and percent of recipients claims that are coded and paid correctly in accordance with the service plan, daily record, and prior authorization.	FE/PD- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)(a) FE/PD- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)	FE- May only provide services that have been identified in the recipient POC and, if required, have prior authorization. Effective 02/01/2021 - FE- All providers may only provide services that have been identified in the POC and that, if required, have a Prior Authorization (PA) PD- All Providers...may only provide services that have been identified in the recipient POC and, if required, have prior authorization.	FE- MSM Chapter 2200, Section 2203.3B(1)(e) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.2B(1)(g) PD- MSM Chapter 2300, Section 2303.3B(1)(d)

Payment

Assurance	**Waiver Requirement**	**Waivers**	**MSM Requirement**	**MSM Chapter**
Is the provider eligible for payment (active)	N/A	N/A	FE-Must obtain and maintain a HCBW for the Frail Elderly provider number (Provider Type 48 or 57 as appropriate) through the DHCFP's QIO-like vendor. Effective 02/01/2021 - FE- All service providers: Must obtain and maintain a provider number (Provider type 48, 57, or 59 and appropriate) through the DHCFP's Fiscal Agent. PD- Must enroll and maintain an active HCBW for Persons with Physical Disabilities provider number (type 58).	FE- MSM Chapter 2200, Section 2203.3B(1)(a) Effective 02/01/2021 FE-MSM Chapter 2200, Section 2203.2B(1)(a) PD- MSM Chapter 2300, Section 2303.3B(1)(c)

Medicaid payment to the provider correct Services paid according to the Medicaid allowable rate	FE/PD- A financial review is completed during the annual waiver review. The objective of this review is to confirm the accuracy of provider payments made by examining claims paid and comparing those claims with recipient files, Plans of Care, provider qualifications, waiver requirements and DHCFP policy.	FE/PD- Appendix I: Financial Accountability, Section I-1: Financial Integrity and Accountability, (b)	FE- Providers must meet and comply with all provider requirements as specified in MSM Chapter 100. Effective 02/01/2021 - FE- In addition to this Chapter, the provider must also comply with rules and regulations for providers as set forth in the MSM Chapter 100 Medicaid Program. Failure to comply with any or all these stipulations may result in the DHCFP's decision to exercise its right to terminate the provider's contract. PD- Providers must meet and comply with all provider requirements as specified in MSM Chapter 100.	FE- MSM Chapter 2200, Section 2203.3B(1)(b) Effective 02/01/2021 FE- MSM Chapter 2200, Section 2203.2B(1)(c) PD- MSM Chapter 2300, Section 2303.3B(1)(b)
Overpayment to provider Referral to Surveillance and Utilization Review (SURS)	FE- If claims are found to be incorrect, a referral is made to DHCFP SURS unit to investigate under/over payments. PD- If claims are discovered to be incorrect, a referral is made to the Surveillance and Utilization Recovery Unit (SURS) within DHCFP. This Unit investigates overpayments and underpayments.	FE- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (a)(i)(b)(i) PD- Appendix I: Financial Accountability, Section Quality Improvement: Financial Accountability, (b)(i)		

Acronyms & Definitions

ACK	Acknowledgment Form	Used as shorthand for Acknowledgment Form NMO-7075
ADC/ADHC	Adult Day Care/ Adult Day Health Care	An organized program of services during the day in a group setting for the purpose of supporting the personal independence of older adults and promoting their social, physical, and emotional well-being.
ADL	Activities of Daily Living	Self-care activities routinely performed on a daily basis, such as bathing, dressing, grooming, toileting, transferring, mobility, continence and eating.
ADSD	Aging and Disability Services Division	A State agency in Nevada's Department of Health and Human Services (DHHS) responsible for operating the Home and Community Based Services (HCBS) Waivers for the Frail Elderly, Physically Disabled, and Individuals with Intellectual Disabilities.
ADT	ADT LLC	Waiver provider noted on specific reviews.
AHC	American Home Companion	Waiver provider noted on specific reviews.
AHHC	Advanced Home Health Care	Waiver provider noted on specific reviews.
AHHH	A Helping Hand Healthcare	Waiver provider noted on specific reviews.
AL	HCBS Waiver for Assisted Living	A 1915(c) Waiver Program that provides assisted living services to individuals who are age 65 and older who, but for the provision of such services, would require a Nursing Facility (NF) level of care (LOC). This waiver was merged with the Waiver for the Frail Elderly (FE) effective July 1, 2015. Also used to refer to the service Assisted Living.
ALiS	Aithent Licensing System	Centralized database for provider reviews.
AMAC	American Medical Alert Company	Waiver provider noted on specific reviews.
AN	Alert Nevada	Waiver provider noted on specific reviews.
APC	Augmented Personal Care	Includes assistance and supervision with activities of daily living.
APCS	Advanced Personal Care Solutions	Waiver provider noted on specific reviews.
BHPV	Beehive Homes Paradise Valley	Waiver provider noted on specific reviews.
CDSFN	Consumer Direct Services for Nevada	Waiver provider noted on specific reviews.
CFR	Code of Federal Regulations	The CFR is a codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal government. The Code is divided into 50 titles which represent broad areas subject to federal regulation.
CM	Case Management/ Case Manager	Case management is a process by which an individual's needs are identified and social and medical services to meet those needs are located, coordinated, and monitored. Case management may be targeted to certain populations in certain areas of the state under the authority of Section 1905(a)(19) of the Social Security Act.
CMS	Centers for Medicare and Medicaid Services	The Federal government entity that monitors state programs to assure minimum levels of public health service are provided, as mandated in CFR Title 42.
CP	Care Plan	Plan of Care (POC)
CPAP	Continuous Positive Airway Pressure	Medical device

CPR	Cardiopulmonary Resuscitation	Cardiopulmonary resuscitation is a lifesaving technique useful in many emergencies, including heart attack or near drowning, in which someone's breathing or heartbeat has stopped. The American Heart Association recommends that everyone, untrained bystanders, and medical personnel alike, begin CPR with chest compressions.
CSHA/SHA	Comprehensive Social Health Assessment	An assessment that addresses the recipient's activities of daily living (ADLs), which are self-care activities, such as bathing, dressing, grooming, transferring, toileting, ambulation, and eating. Instrumental activities of daily living (IADLs), which capture more complex life activities, are also assessed, including meal preparation, light housework, laundry, and essential shopping. In addition, this assessment includes information regarding the recipient's medical history and social needs. The assessment includes risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs.
DD PC	DD Personal Care	Waiver provider noted on specific reviews.
DHCFP	Division of Health Care Financing and Policy	A State agency in Nevada's Department of Health and Human Services (DHHS) that works in partnership with the Centers for Medicare & Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources.
DHHS	Department of Health and Human Services	The Department of Health and Human Services (DHHS) is an office of the Executive Branch of State Government and is led by a director appointed by the Governor. DHHS is one of the largest departments in State government comprised of five Divisions including: Aging and Disability Services, Child and Family Services, Health Care Financing and Policy (Medicaid), Public and Behavioral Health, and Welfare and Supportive Services.
DME	Durable Medical Equipment	Medically necessary durable medical equipment that a doctor prescribes for use in the home.
DR/LRI	Designated Representative/ Legally Responsible Individual	Individuals who are legally responsible to provide medical support including: spouses of recipients, legal guardians, and parents of minor recipients, including: stepparents, foster parents, and adoptive parents.
DSS	Decision Support System	Database of Medicaid recipients and providers utilized by DHCFP QA for recipient selection for the review year as well as financial claims.
EAP	Energy Assistance Program	Program that provides a supplement to assist qualifying low-income Nevadans with the cost of home energy.
ELW	Emergency Lifeline West	Waiver provider noted on specific reviews.
EVV	Electronic Visit Verification	AuthentiCare database containing information about clients, services, authorizations, providers, and workers used to verify claims created by providers and services received by recipients.
FBI	Federal Bureau of Investigation	The mission of the FBI—as a national security and intelligence organization—is to protect and defend the United States against terrorist and foreign intelligence threats, to uphold and enforce the criminal laws of the United States, and to provide leadership and criminal justice services to federal, state, municipal, and international agencies, and partners.

FE	HCBS Waiver for the Frail/Elderly	A 1915(c) Waiver Program (formerly Community Home Base Initiative Program) that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for the frail elderly who would otherwise need institutional nursing facility services.
FHH	Freedom Home Health	Waiver provider noted on specific reviews.
GH	Group Home	A group home is a residence model of medical care for those with complex health needs.
HCBS/HCBW	Home & Community Based Services/Home & Community Based Waiver	Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as the frail elderly, people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.
HCQC	Health Care Quality and Compliance	The Bureau of Health Care Quality and Compliance (HCQC) protects the safety and welfare of the public through the promotion and advocacy of quality health care through licensing, regulation enforcement, and education.
HFPC	Heartfelt Personal Care	Waiver provider noted on specific reviews.
HIPAA	Health Insurance Portability and Accountability Act	The HIPAA of 1996 is a law to improve the efficiency and effectiveness of the health care system. HIPAA included a series of “administrative simplification: procedures that establish national standards for electronic health care transactions, and requires health plans (i.e., Medicaid and Nevada Check Up) and health care providers that process claims and other transactions electronically to adopt security and privacy standards in order to protect personal health information.
HMF	Highland Manor of Fallon	Waiver provider noted on specific reviews.
HMKR	Homemaker	Waiver service that includes assistance with general household chores. It can include housekeeping, laundry, shopping for groceries and other essential items, as well as the preparation of meals.
HSD	Homestyle Direct	Waiver provider noted on specific reviews.
HUD	Department of Housing and Urban Development	The agency responsible for national policy and programs that address America's housing needs.
HV	Home Visit	Contact between case manager and recipient to assess services, goals, waiver satisfaction and any new needs.
IA	Initial Assessment	This assessment is conducted as an administrative function of the waiver program and evaluates service needs based on functional deficits, support systems, and imminent risk of institutionalization.
IADL	Instrumental Activities of Daily Living	Activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication, and money management.
ICF	Intermediate Care Facility	Intermediate Care Facilities for individuals with Intellectual disability (ICF/ID) is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence.

IID/MR	Intellectual Disabilities	A term used when there are limits to a person's ability to learn at an expected level and function in daily life.
J&S SS	J&S Senior Services	Waiver provider noted on specific reviews.
LOC	Level of Care	The specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the State Plan and home and community-based services waiver. LOCs are based on current assessments showing level of functional skills and support needs. The assessments include psychological evaluation, medical records, nursing, and social assessments completed by professionals.
LS	Lifeline Systems	Waiver provider noted on specific reviews.
LTSS	Long Term Services and Supports	A unit within the Division of Health Care Financing and Policy that provides services specifically to Medicaid eligible recipients. This includes services for a diverse group of Nevadans including the elderly and people living with disabilities and special health care needs. LTSS provides both institutional and home and community-based care.
LVH	Las Vegas Healthcare	Waiver provider noted on specific reviews.
MC	Monthly Contact	Contact between case manager and recipient to assess services, goals, waiver satisfaction and any new needs.
MD	Medical Doctor	A licensed medical practitioner.
MDO	Medical/Dental/Ocular	A grouping of insurance coverage types/services noted within the SAMS system.
MFCU	Medicaid Fraud Control Unit	Statewide program that investigates and prosecutes Medicaid providers that obtain Medicaid funds through fraudulent means.
MLADHC	More to Life Adult Day Health Center	Waiver provider noted on specific reviews.
MMIS	Medicaid Management Information System	A computer system designed to help managers plan and direct business and organizational operations.
MOW/HDM	Meals on Wheels/ Home Delivered Meals	Meals on Wheels provides a nutritious, fresh meal, delivered Monday through Friday and frozen meals for weekend and holiday closures.
MSM	Medicaid Services Manual	The policies that govern Medicaid services.
MTM/MM	Medication Therapy Management/ Medication Management	MTM is a group of services that pharmacists and others can provide to find, treat, and educate patients with chronic conditions.
N/A	Not Applicable	Not Applicable
NF	Nursing Facility	NF is a general Nursing Facility, free-standing or hospital-based, which is licensed and certified by the Division of Public and Behavioral Health, Health Care Quality and Compliance, and provides both skilled and intermediate nursing services.
NMO	Nevada Medicaid Office	The Nevada Medicaid Office is responsible for policy, planning and administration of the Nevada Medicaid program; also known as the Division of Health Care Financing and Policy.
NOD	Notice of Decision	A Notice of Decision is sent to a waiver recipient for the following reasons: denial, suspension, reduction, and termination. The Notice of Decision outlines the recipient’s right to a Fair Hearing.

P&P Transmittal	Policy & Procedure Transmittal	The Policy and Procedure Transmittals are designed to provide a consistent format for communicating policy clarification within the Division of Health Care Financing and Policy and among sister agencies.
PA	Prior Authorization	A review conducted to evaluate medical necessity, appropriateness, location of service and compliance with Medicaid's policy, prior to the delivery of service.
PCA/PCS	Personal Care Assistant/Service	Personal care assistants, also known as caregivers, home health or personal care aides, give assistance to people who are sick, injured, mentally or physically disabled, or the elderly and fragile. Hands-on assistance with activities of daily living (ADLs) (such as eating, bathing, dressing, and bladder and bowel requirements) or instrumental activities of daily living (IADLs) (such as taking medications and shopping for groceries).
PD	HCBS Waiver Serving People with Physical Disabilities	A 1915(c) Waiver Program that provides the option of home and community-based services as an alternative to institutional nursing facility care and allows for maximum independence for persons with physical disabilities who would otherwise need institutional nursing facility services.
PERS	Personal Emergency Response System	An electronic device which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a landline and programmed to signal a response center once the "help" button is activated.
PES	Participant Experience Survey	An interview tool developed by Medstat Group, Inc. under a contract from the Centers for Medicare and Medicaid Services. The surveys capture data that can be used to calculate indicators for monitoring quality within the waiver programs.
PGM	Paradiso Grace of Monaco	Waiver provider noted on specific reviews.
POA	Power of Attorney	The authority to act for another person in specified or all legal or financial matters.
POC	Plan of Care	A written document identifying the recipient's health and welfare needs, along with goals and interventions to meet the identified needs. It specifies the level of assistance, type, amount, scope, duration, and frequency for all services, as well as other ongoing community support services that may meet the assessed needs of the recipient, regardless of the funding source.
PT/OT/ST	Physical Therapy/Occupational Therapy/Speech Therapy	Physical Therapy (PT) focuses on the acquisition and/or improvement of skills related to gross motor movement, such as sitting, standing, walking, jumping, running, and lifting. Occupational Therapy (OT) focuses on the acquisition of basic, self-help skills required for daily living. Speech-Language Therapy (ST) focuses on the acquisition and use of language.
QA	Quality Assurance	A structured, internal monitoring and evaluation process designed to improve quality of care. QA involves the identification of quality-of-care criteria, which establishes the indicators for program measurements and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

QI	Quality Improvement	A critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.
QIO	Quality Improvement Organization	The QIO program focuses on three aims: better patient care, better population health, and lower health care costs through improvement.
QTC	Quarterly Telephone Contact	Contact between case manager and recipient to assess services, goals, waiver satisfaction and any new needs.
RA	Re-Assessment	Annual assessment of recipient eligibility and needs for waiver/non-waiver services.
RPC	Rainbow Personal Care	Waiver provider noted on specific reviews.
SAMS	Social Assistance Management Software	Social Assistance Management Software or SAMS® manages consumer (recipient) and service data for social assistance organizations.
SHHC	Sierra Home Health Care	Waiver provider noted on specific reviews.
SNAP	Supplemental Nutrition Assistance Program	SNAP provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move towards self-sufficiency.
SOR	Serious Occurrence Report	A report of any actual or alleged event or situation involving either the provider/employee or recipient that relates a substantial or serious harm to the safety or well-being of the provider/employee or recipient. Serious occurrences may include, but are not limited to the following: suspected physical or verbal abuse, unplanned hospitalization, neglect of the recipient, exploitation, sexual harassment or sexual abuse, injuries requiring medical intervention, an 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 Waiver Services, or loss of contact with the recipient for three consecutive scheduled days.
SOU/SOC	Statement of Understanding/Statement of Choice	A form given to all applicants describing the services offered under the waiver during the intake process and as required by each waiver. The assigned case manager informs the applicant of their choice between waiver services and placement in a long-term care facility, in addition to their choice of qualified providers.
SP	Service Plan	Plan of Care (POC)
SUR	Surveillance and Utilization Review	A statewide program that safeguards against unnecessary or inappropriate use of services by preventing excess payments in the Nevada Medicaid and Nevada Check Up programs. The SUR unit analyzes claims data to identify potential fraud, waste, overutilization, and abuse; collects provider overpayments and refers appropriate cases to the Medicaid Fraud Control Unit (MFCU) for criminal investigation and prosecution.
SW	Social Worker	Social Worker
TB	Tuberculosis	Tuberculosis is a potentially serious infectious disease that mainly affects the lungs. The bacteria that cause tuberculosis are spread from one person to another through tiny droplets released into the air via coughs and sneezes.
TBD	To Be Determined	To Be Determined

TWLV	The Wentworth of Las Vegas	Waiver provider noted on specific reviews.
VA	Visiting Angels	Waiver provider noted on specific reviews.
YTD	Year to Date	Year to Date